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Patient experience with early pregnancy loss in the primary care setting: a qualitative study

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Research

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Abstract

Aim: This qualitative study describes patient perspectives on early pregnancy loss (EPL), the medical term for miscarriage, care in one federally qualified health centre (FQHC) that initiated provision of a mifepristone plus misoprostol regimen. *Background:* EPL is a common pregnancy complication that can generally be treated by primary care providers (PCPs), yet many PCPs report barriers to providing the most effective medication regimen: mifepristone plus misoprostol. Limited data exist on patient experiences with EPL in the primary care setting. *Methods:* Researchers conducted semi-structured interviews with a sample of patients who received EPL care from one Illinois FQHC between 2021 and 2022. Interview transcripts were coded and analysed to identify themes regarding how primary care can address patients' needs when experiencing pregnancy loss. *Results:* Participants ($n = 16$) expressed satisfaction with EPL management at the FQHC, specifically that the option of medication management eased concerns about potential complications and provided clear expectations of the passage of the pregnancy. Medication management became a more accessible option for patients after the clinic began stocking mifepristone. Participant suggestions to improve EPL management in primary care included stronger and/or more timely analgesia, increased education, and mental health support. Participants identified barriers to EPL care including difficulty scheduling visits and perceived lack of urgency when triaged by clinic staff. *Conclusion:* Patients report comfort with and interest in the option of medication management for EPL in the community-based primary care setting. Barriers in primary care clinic infrastructure and logistics must be considered and optimized to provide timely and safe EPL care.

Introduction

Early pregnancy loss (EPL), failure of an intrauterine pregnancy prior to 13 weeks gestation, is one of the most common complications of pregnancy (ACOG, 2018). Treatment options for EPL, the medical term for miscarriage, include expectant management, medication, or procedural management (uterine evacuation). Mifepristone plus misoprostol is the most effective medication regimen for the treatment of EPL (Schreiber *et al.*, 2018), with less need for unplanned uterine aspiration than with misoprostol alone. The American College of Obstetricians and Gynecologists' (ACOG) 2018 guidelines state that adding mifepristone 24 hours before misoprostol may improve treatment efficacy and should be considered when available (ACOG, 2018; Schreiber *et al.*, 2018). Despite extensive safety data, use of mifepristone is limited by the Food and Drug Administration's Risk Evaluation and Mitigation Strategy (REMS) restriction (Raymond *et al.*, 2017). Consequently, mifepristone is primarily offered by providers that see a high volume of pregnant patients, traditionally staffed by obstetrician gynecologists (OBGYNs), despite data showing that it can be safely utilized by primary care providers (PCPs) and advanced practice clinicians (Prine *et al.*, 2010; Porsch *et al.*, 2020). Despite proven benefit, only a small percentage of patients in a commercial insurance database containing de-identified patient-level healthcare claims received mifepristone plus misoprostol for EPL medication management (Boos *et al.*, 2023).

PCPs nationwide have reported that the lack of mifepristone in the primary care setting has adversely affected patient care including unnecessary appointments, less continuity of care, and more procedural management (Srinivasulu *et al.*, 2020). Prior research has demonstrated that, when provided with appropriate infrastructure, it is feasible for community-based primary care clinics to overcome the barriers to mifepristone provision (Wu *et al.*, 2023).

Prior studies have investigated patient satisfaction with EPL management in clinical settings including emergency departments (ED) and OBGYN ambulatory clinics (Dalton *et al.*, 2006; Miller *et al.*, 2019; Benson *et al.*, 2023). Though there is data demonstrating patient interest in and preference for induced abortion services with PCPs, there is limited research on patient

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experiences with EPL management in the primary care setting, specifically, community health centres serving uninsured and underinsured patients (Rubin *et al.*, 2008; Godfrey *et al.*, 2010; Wu *et al.*, 2015). Community health centres, also known as federally qualified health centres (FQHCs) deliver accessible comprehensive and continuous primary care to patients and families aligned with the medical home model (Rosenthal, 2008; Shi *et al.*, 2017). A medical home is a patient-centred primary care model in which an ongoing –physician-patient relationship coordinates comprehensive, continuous, and accessible health care across referrals and services to improve overall health outcomes (Rosenthal, 2008). This study aims to understand patient experiences with their PCPs and their medical home for EPL management and how primary care clinics can better address their needs.

Methods

This qualitative study was approved by the University of Chicago Institutional Review Board (*IRB21-1802).* We used the Standards for Reporting Qualitative Research (SRQR) guidelines to structure the reported findings (O'Brien *et al.*, 2014). This study was part of the Excellence in Providing Access to New Directions in Mifepristone Use (ExPAND) learning collaborative, which supports clinics in overcoming barriers to provision of mifepristone for EPL and/or induced abortion (Calloway *et al.*, 2021). ExPAND worked with this study's Chicago-area, multisite FQHC. Before ExPAND, this FQHC used primarily expectant management (i.e., 'watchful waiting'), misoprostol only medication management, or referred patients to OBGYN for misoprostol only medication and procedural management of EPL. After ExPAND, both mifepristone and misoprostol were available to PCPs for the most effective medication management of EPL.

The FQHC assisted in recruitment by displaying study flyers and sending portal messages to patients with reproductive capabilities, directing patients to complete a Research Electronic Data Capture (REDCap) secure web-based survey to screen for eligibility (Paul *et al.*, 2009). Inclusion criteria included age ≥18 years, diagnosis or treatment of miscarriage on or after January 2020, and ability to consent in English or Spanish. Study personnel obtained participant verbal consent and then conducted semi-structured one-on-one interviews via phone; all participants chose to have their interview conducted in English. Demographics were collected after completion of the interview; demographics and reason for non-participants is not available. Verbal consent allows researchers to de-identify data since the only record linking the subject and the research would be the consent document. This qualitative research study presents minimal risk to study participants and verbal consent protects against potential harm from breach of confidentiality. The IRB approved the use of verbal/oral consent and waived the requirement for signed consent. Interview questions focused on participants' experiences with miscarriage, abortion, and their perspectives on EPL management at their primary care clinic. Themes related to induced abortion were analysed and published separately (Hennessey *et al.*, 2026). Interviews lasted 14–31 minutes, followed by a brief survey assessing demographic background and obstetric history. Participants were compensated $50. Recognizing the risk of discomfort regarding personal experience with, and views on, EPL and abortion, the institutional ethics review board reviewed a plan for participants to discontinue the study at any time. Additionally, the standard protocol if a crisis arises during a study is to identify our institution's crisis mental health team and provide immediate mental health resources and services.

Table 1. Patient characteristics

	n (%)
Total enrollment	16
Age	
18–34	11 (69)
≥35	5 (31)
Race	
Black/African American	7 (44)
White	4 (25)
Hispanic/Latinx	4 (25)
Unknown	1 (6)
Initial EPL management (*n* = 17)	
Expectant	9 (52)
Medication	6 (35)
Procedural	2 (13)

Interviews were conducted by a medical student and a Complex Family Planning fellow, audio recorded and transcribed verbatim. All transcriptions were de-identified prior to analysis. Qualitative analysis software (ATLAS.ti), was used to code and organize data. Codes were analysed using principles of modified grounded theory (Corbin and Strauss, 2014; Glaser and Strauss, 2017), applying an initial codebook that was subsequently modified in the process of data review. Two study team members, a medical student and a Complex Family Planning fellow, individually read and coded interview transcripts using a pre-determined coding framework. New themes/sub-themes were identified through discussion and coding discrepancies were resolved using consensus coding. Before the collection of data, the research team had anticipated an *a priori* sample number of 20 patients, recognizing that the final sample size would be determined based on thematic saturation. Interviews were coded and analysed in batches through iterative group discussions, and thematic saturation was achieved when no new themes or codes were identified during data analysis.

Results

A total of 124 individuals were screened; 28 were eligible; 12 declined or were lost to follow-up; and 16 individuals completed interviews until thematic saturation was achieved. The remaining 96 patients were ineligible based on inclusion criteria, most commonly due to miscarriage outside of the study period. This group represented 17 episodes of EPL between 2021 and 2022: 52% of patients initially received expectant management, 35% medication management, and 13% procedural management (Table 1). Most participants, 81%, had received healthcare at the FQHC for at least three years, and four had been lifelong patients there. Over half of participants had family members who were also patients at the clinic, highlighting the patient-and family-centred medical home model that supports coordinated, relationship-based care for the whole family and community. Major themes and subthemes are described below, with illustrative quotes further expanded in Table 2. Four major themes from the interviews included: factors

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Table 2. Additional illustrative quotes highlighting major themes and subthemes

Subtheme	Quotes
I. Patients desire EPL management from PCP	
i. Trusted relationships and continuity at medical home	"*Yeah. I would recommend [FQHC]. I had two good best doctors ever. The first time I went, they introduced themselves. They told me how this is going to go. They told me what to expect. They were very clear crystal from the beginning. And once they told me I had a miscarriage, they stayed in the room with me. I didn't know I would feel like I would cry at some point, but I did. And I didn't—I was just—hormonal thing—whatever. And I just cried. And they stayed with me because I was by myself. And then they said, "whatever you need—" they got me to choose. They was very helpful—very nice—two doctors. (P7)*" "*I really like the way it gets taken care of. The doctors are great. Even the nurses, all the staff in general. I appreciated my nurse a lot. She did so much for me. Being in a setting like that, you could be a little embarrassed. And with their help, you kind of just push that away and they make you feel comfortable. So 100% (P2).*" "*I think it would be way easier. I run into this problem constantly where I'm being referred out to a specialist that can't prescribe things that say my primary care should be after getting the diagnosis like X, Y, Z. And then the primary care says, "I'm sorry, I can't do that." It's like, "well, then send me back to the specialist." And the specialist is like, "but your primary should be doing this for you. (P16)*"
ii. Financial necessity	"*I really don't know because one clinic might work for somebody else and the other one might not. I want to say they can—I don't really know, honestly. I probably tell them go there. The only reason why I'm still going is because I've been there all my life and all my stuff is connected with the hospital. Everything is in the system. My insurance card you have to have. Your insurance connected with that clinic. And it's just different stuff involved with it. But I feel like it just depends on what kind of care you would be looking for. (P1)*"
iii. The option of medication management addresses the concern/ misconceptions of developing complications from expectant management or undergoing surgical management.	"*Yeah. It is needed. And it would be great if somebody, maybe, like myself—if I was never sick, and I found out that my baby no longer had a heartbeat, I would much rather be able to take medication to go through the miscarriage and pass the pregnancy rather than going into an operating room and having this removed from me, which is a very risky procedure, rather than I could just take a medication and just let it pass through my body on its own.(P6)*" "*Okay. So one of them was just like, "Wait and see if it passes on its own." And the other one was medication management, which I knew right away I wanted to do because I was immediately worried about complications or an infection of some kind. I don't think there was a third option. I think those were the two. It was wait and watch and see if it passes on its own or medication. And I definitely would have—if they had given me the option for taking medication that first day that I talked to them—if they had offered it to me in the Emergency Room, I would have taken it because I kind of wanted it over with and I knew that there are risks associated if everything doesn't pass.(P5)*"
iv. Medication management allows faster passage of the pregnancy and provides clearer expectations of the miscarriage process, and less life burden	"*Well, I didn't want to get the vacuum thing because of my knowledge that's kind of something sort of like an abortion. And I didn't want it to just go naturally because I didn't know how long it was going to take. I knew it was just going to constantly remind me that I'm losing my baby. So I just wanted to go and just kind of just get it done quickly, which I thought the pills would do, which it did, but I didn't anticipate the pain.(P11)*"
II. Recommendations for EPL management in the primary care setting	
i. Address grief & monitor for ongoing psychological morbidities	"*I was very depressed. Cause my husband never had kids. I was very depressed. That time with that miscarriage I was really depressed. Because he didn't have any kids, I had kids, but I wanted a kid by him. And when that happened to me, I was messed up after a while for that. I think like a good six weeks you know. It took me to get back to myself. (P15)*"
ii. Increased education on expectations regarding pain, bleeding, passage of POC, causes of EPL	"*She wanted me just to come back and to discuss how the medication did. And basically, I guess she wanted to make sure that the process actually worked because I really wasn't told what to expect after I took the medication. They didn't really tell me to expect pain, to expect when I go to the bathroom, that's where everything was just going to come out at. So I wasn't really prepared for that. So when I get to the visit, I kind of talk to her about that if I would've known I was going to be in so much pain, I probably would've went a different route. (P1)*"

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Table 2. (*Continued*)

Subtheme	Quotes
iii. Treat pain more effectively and sooner	*"And I also wish that I had been given pain medication sooner because I really could have used it that first night. So those are my complaints. (P5)"* *"We're aware of how painful this is going to be. Not just an emotional thing for you but it's going to be a physically painful process. And we only have so many rights within our spectrum of doctor-nurse X, Y, Z of what we can do to help you," versus say you have a kidney infection. You end up in the emergency room. You know what I mean? The pain management and the allowance that those doctors are allowed to give to a patient where you're allowed to say, "I'm in pain," and you have the right as a person to have pain management when it comes to reproductive rights or anything to do with women's downstairs make up for that matter, it's just considered a deal with it or suffer the consequences kind of. (P16)"*
III. Logistical and Structural Barriers to Ideal EPL management at community based primary care	
i. Difficulty scheduling an initial or follow up visit.	*"Well, I love their midwives. I really do, and that's why I'm still there. And they provide the good patient care. I mean, it's just the other staff that dropped the ball, and it's just getting to the midwives that's a problem. But I think that, overall, they're very good providers. And again, when I got the news, it was at the walk-in one, which there was no midwife there. It was just a different provider on site. So I believe they're good providers. It's just making sure you're communicating right also to get to them, to get that patient care, because otherwise, they won't care, and they'll drop the ball. (P8)"* *"I went to the emergency room because it was on a Sunday. [FQHC Clinic] was closed, but it is the hospital that they're associated with. And they just did an ultrasound. They said, "oh, you're good. We can hear the baby's heartbeat. The baby's heartbeat is fine." Just an ultrasound—nothing else, and I went home . . . When I went to go see a different provider, because [FQHC Clinic] had no available appointments that day, and I needed to be seen urgently, because, again, I had just been in the emergency the night before—they told me I was perfectly fine. (P6)"*
ii. Lack of appropriate urgency when triaging patients requiring EPL care	*"Everybody was very nice. All the doctors that I saw were very compassionate. I would say my only complaint is that things weren't—it wasn't treated with a little more urgency. I understand there was a scheduling issue too, and they got me in as fast as they could, but I feel like over 48 hours from diagnosis to actually being seen and then having to go back again the next day before I can get the medication, I wish that things had been expedited a little more. . . . . But overall, I'm very happy with the attention and compassion I was treated with. But logistically, I think if things could have happened a little—if we could have been in front of the problems a little more.(P5)"*

influencing participants' decisions to seek care from their primary care clinic, appreciation for having the option of medication management, logistical barriers to accessing care, and recommendations for improving EPL management.

Theme 1. Factors influencing seeking EPL care from medical home

Trusted relationships and continuity at medical home

Participants commented on trusted relationships and continuity of care at their clinic contributing to their satisfaction. Specifically, they valued providers and staff for their compassion, lack of personal or moral judgement, and bedside manner. Participants reported feeling more comfortable seeking future EPL care at their medical home instead of a new clinical setting.

> *'I have always stuck with [FQHC], even if I moved . . . For the fact that no matter what provider I am seeing-the OBGYN, the behavioural health, or if I'm going to the regular doctor, or even the people in the front, like the nurses-everyone at the [FQHC] that I have interacted with have always been extremely caring and compassionate and nonjudgmental and have always done their best to be good providers. I have told them things that you might feel scared or embarrassed to tell a doctor. (P13)'*

Financial necessity

Some participants stated they receive care at this FQHC due to financial necessity or limited insurance coverage or being uninsured.

> *'. . . it's close to home and, basically, they have an affordable payment plan or affordable fees for when I didn't have insurance. And then, now, after my pregnancy, since I'm no longer pregnant, I will be losing my Medicaid insurance. So anywhere else I go it's $200 just to be seen, and they only charged me $30. So that's basically the only reason I stayed there. (P6)'*

Theme 2. Option of medical management

Faster passage, clearer expectations for return to lives, families, duties

Compared to expectant management and the wait time of being referred to an OBGYN for procedural management, participants commented on the additional option of medication management for faster pregnancy resolution, clearer expectations of the process, and the ability to pass the pregnancy at home with less disruption to their lives. One patient who received expectant management reflected on the benefits if she had received medication:

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'I think that would have been really helpful if it had just been like, 'okay. We can take care of this now.' Because I'm waiting and wondering like, 'when am I going to bleed again? When is this going to happen?' So it would have been helpful to just get things moving. (P5)'

A patient who received mifepristone and misoprostol described some of her reasons for choosing medication management:

'. . . I don't want my kids to stay with my mom for two days, and then they will miss school or whatever. I was thinking of a lot of things other than myself, too, but it [medication management] was the best course. Drop them off at school, stay home for two days, and then I can still take care of them, because it wasn't that crazy. And then I have my parents around just in case . . . But being in a hospital would make me not feel as good. (P7)'

Reduced time spent grieving & enduring trauma of pregnancy loss

Participants noted that faster passage of the pregnancy with medication compared to expectant management could help reduce the amount of time spent experiencing the trauma and grief of pregnancy loss. Responding to what she would advise a friend going through a similar situation, one patient explained:

'If they were having a miscarriage? I would probably tell them to see if they can get a medical and induce the miscarriage because it is very painful and especially if you don't have a support system then you can fall easily into possible depression or something like that. So I would probably see if they can try to get it out as fast as they can. (P14)'

Concern of complications

Multiple participants expressed concern of an increased risk of infection or incomplete passage of pregnancy with the option of a 'watch and wait' approach. Some feared procedural management as they perceived it as 'really dangerous', citing concerns about possible infertility, injury, or death. In some cases, this fear appeared related to misconceptions about procedural abortion management, particularly beliefs that abortion could cause infertility, bodily harm, or other long-term consequences. While abortion, like any medical procedure, carries potential risks, participants reported fear around these risks that were sometimes exaggerated or inaccurate, contributing to fear and uncertainty about abortion:

'They were telling me how after you have an abortion, sometimes you can have fertility issues. So I was very scared about doing the procedure, thinking that maybe in the future I wouldn't have kids again or um that it can affect my body or I could even die with the procedure so it was a pretty scary topic. (P14)'

Theme 3. Logistical barriers to EPL management in community-based primary care

Difficulty scheduling an initial visit or follow-up

Some participants were unsatisfied with their EPL care due to difficulty scheduling initial or follow-up visits. Scheduling barriers included: clinic closure on weekends, lack of available timely appointments, last-minute clinic cancellations, and lack of availability of specific providers such as midwives.

'It's like they're always kind of backed up. Yeah. Even when I went to the emergency room and I had to make that follow-up appointment - I just thought about it - the emergency room, I think, made it for me. Had I tried to call and make that appointment, it probably wouldn't work. (P11)'

Lack of urgency when triaging patients' EPL care

A common theme related to scheduling was a perceived lack of urgency in the FQHC's triage process. Some participants were frustrated that they were not able to be seen sooner despite the urgency of their symptoms and felt they were not followed up with them in an appropriate timeframe.

'. . . I felt like every time I called them and told them, 'I'm pregnant, I'm cramping, I'm bleeding,' they were like, 'Well, if you feel like it's serious, go to the hospital,' or, "we can't give you an appointment. (P8)'

Theme 4. Recommendations for EPL management in primary care

Treat pain more effectively and sooner

Some participants described their experiences with expectant or medication management as very painful and desired more effective and timely analgesia. Specifically, one patient following up from the Emergency Room experienced passage of the pregnancy prior to her scheduled visit at the primary care clinic before analgesics were able to be prescribed.

'So [the Emergency Room] kind of ran through what my options were and made an appointment for me to follow up at [FQHC], I think, the next day. So it was a Monday when I finally talked to them, and my appointment, I believe, was for Tuesday. And it was [Monday] night that I passed the majority of the products. . . . , but it was very painful that night. So I kind of, in retrospect—well, even at the time, I really wished that they had given me something for the pain right away so that I would have had it handy. Because I took like five Motrin just to try and take the edge off, and it didn't even really. So anyway, that I felt like could have been improved. So then when I went in on Tuesday, they did give me something for nausea and for pain and then again talked about my options. (P5)'

Increased education

Participants cited a need for increased education about what to expect regarding pain levels, and passage of the pregnancy. Others expressed gaps in their knowledge such as being surprised by what products of conception looked like and causes of EPL.

'. . . I think their patient education should have been a little bit better for people to know what to expect. I'm happy that it happened in the middle of the night where my husband was home. If he wasn't home, I could have passed out. I could have possibly died there. And I think that it's better for patient communication, that way we're prepared for things like this. (P8)'

Address the grief and monitor for ongoing psychological morbidities and social needs

The physical and emotional toll of pregnancy loss contributed to periods of grief of varying severity. Some participants reported experiencing more severe depression requiring intervention from their PCP. They discussed how the pregnancy loss impacted their whole support system and exacerbated other traumatic experiences such as substance use disorder recovery or housing displacement.

'. . . During that time, I just kind of wanted to be alone. But my support system really didn't want me to go into a depression, which is kind of where I was heading because . . . we were displaced. And we're still displaced. So having the miscarriage on top of being displaced, I had a lot of stress on me . . . (P11)'

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Discussion

Participants expressed appreciation for having the option of medication management for EPL available in their primary care medical home. Some patients choosing medication management for EPL appeared partially influenced by misconceptions about procedural management and abortion stigma. Staff knowledge and training, clinic infrastructure and logistics related to scheduling remain barriers to receiving timely and optimized EPL care.

Our study expands upon work exploring patient experiences with EPL management in the primary care setting by adding the perspective of patients attending an FQHC. A 2019 study comparing patient experiences with EPL management in the ED versus an unspecified outpatient setting found that patients were dissatisfied with their care in the ED and had more streamlined experiences with diagnosis and treatment in the primary care setting (Miller *et al.*, 2019). Our findings highlight the importance of long-standing relationships between PCPs, clinic staff, and patients that cultivate trust and compassion required for quality EPL care. More specifically, nurses who are trained in and knowledgeable about EPL protocols are integral to efficient clinic workflows including medication storage, tracking and logging, patient-centred triage of telephone calls and electronic medical record messages, and maintaining consistent, collaborative communication with their physician partners to ensure coordinated, high-quality care. At times, EPL care at the FQHC was influenced by financial need, demonstrating the importance of expanding and improving EPL management in under-resourced settings serving vulnerable patient populations who may lack access to specialized care.

Our results are concordant with prior research demonstrating wide-ranging considerations impacting patient preference for management of EPL including pain, duration, and time spent in the hospital (Petrou and McIntosh, 2009; Schreiber *et al.*, 2016). Prior studies also found avoidance of procedural management due to an association with induced abortion (Wong *et al.*, 2003). Our results indicate that patients may benefit from further non-biased counseling on all treatment options to address misconceptions about procedural treatment related to abortion stigma.

Primary care is well poised to do this given continuity of care, trusted relationships, number of clinics, and financial accessibility, but there remains room for improvement. Similarly, patients may benefit from further counseling for pain management and the EPL process Wong *et al.*, 2003; Wallace *et al.*, (2010). Dissatisfaction among some patients due to scheduling issues is consistent with prior research indicating interruptions to streamline care decrease patient satisfaction (Dalton *et al.*, 2006).

Additionally, the study period (2021–2022) was during the COVID-19 pandemic, a time of extreme strain on FQHC infrastructures, so patients' logistical barriers – such as scheduling difficulties and lack of triage urgency – may be symptoms of pandemic-era staffing shortages rather than specific failures in EPL clinical protocols. A prior study on staff perceptions of the ExPAND Learning Collaborative found that the pandemic's staff shortage 'led to a limited number of same-day appointments . . . which poses a problem for time-sensitive miscarriage and abortion care' (Sakthivel *et al.*, 2024). Data were collected during the COVID-19 pandemic when healthcare delivery, community resources, and patient experiences differed substantially from usual practice. Although this may limit the generalizability of some findings, these participant perspectives remain relevant and highly the importance of patient access to a range of treatment options that align with their preferences and needs. During and after the pandemic, primary care clinics must continuously consider how to optimize their infrastructure for the timely nature of EPL management.

This study clinic's ability to provide medication management of EPL was facilitated by its participation in the ExPAND learning collaborative. Patient satisfaction with EPL management at their FQHC and desire for medication management aligns with ExPAND's goal of supportive holistic, patient-centred pregnancy care (Calloway *et al.*, 2021). ExPAND's goal of breaking down abortion stigma may be further supported if clinics offer mifepristone for medication abortion, which would also be supported by many FQHC patients (Hennessey *et al.*, 2026).

Strengths of this study include the qualitative approach which allowed our team to explore participants' experiences with EPL and receiving care at their medical home. Our team members are medical and public health professionals, with no patient representatives participating on the team. This could lead to bias in data analysis and interpretation; however, we used iterative methods for coding which incorporate input from multiple coders, allowing perspectives and experience of different team members to inform analysis. A limitation is that participant perspectives represent a single FQHC in a large urban area and patients attending FQHCs in different locations with distinct resources may have varied experiences. While we cannot infer generalizability, findings are likely applicable across varied primary care settings. Furthermore, the sample size of 16 was small and financial necessity of the participants may have influenced their reported satisfaction with the medical home, potentially masking dissatisfaction with clinical outcomes. Despite this small sample size, however, we did reach thematic saturation. While only 35% of participants received medication management for EPL, this may reflect patient preferences for treatment type, limited access to medication, or other unmeasured barriers to care which limits our ability to distinguish between patient choice and other access-related factors. Finally, self-selection bias is an important consideration, as EPL can be a challenging experience to process, so participating patients may have shared characteristics that make them more willing to discuss their experience.

Conclusion

This qualitative study asked participants about their experiences and perspectives on EPL management at their primary care clinic. While participants valued having medication management for EPL available within their primary care medical home, gaps in staff knowledge and training as well as clinic-level scheduling and infrastructure can limit timely and optimized access and quality of care. These findings demonstrate patients' interest in having the option of EPL medication management from their PCPs at their medical home, call for future patient-centred studies about access and clinic workflow improvements, and highlights the patient-centred benefit of a learning collaborative model that helps clinics provide access to mifepristone into the primary care setting.

Data availability statement. The interview data gathered and analysed during this study are not publicly available due to the sensitive nature of the interview data and to protect participant confidentiality.

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Ethical standards. University of Chicago Institutional Review Board (IRB21-1802).

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