Making Medication Abortion a Part of Internal Medicine

Xanthia A. Tucker, MD

University of Michigan, Internal Medicine-Pediatrics Residency Program, Ann Arbor, MI, USA.

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I recently saw a patient with an unintended pregnancy. She was seventeen, in her senior year of high school, and she occasionally forgot to take her daily oral contraceptive. Like many pregnant women, she had already taken a test at home but wanted to confirm the result. Her last menstrual period put her at nine weeks gestation.

> "How are you feeling about all this?" I asked.
> "I don't know yet. It's a lot to process. What are my options?"

I validated her feelings of uncertainty and explained the variety of decisions she could make, from continuing her pregnancy and becoming a parent, to giving birth and placing her baby for adoption, to having an abortion by medication or procedure. I referred her to an intake appointment with an obstetrician and showed her the adoption resources available through the Michigan Department of Health & Human Services. On the back of her visit paperwork, I wrote down the phone number and website of a nearby Planned Parenthood.

Despite my efforts to be comprehensive, my care that day felt inadequate. I had referred my patient out to several services that I am not trained to provide. But one of those options should not have needed a referral: medication abortion.

Medication abortion is the term for non-surgical abortion using two medications, mifepristone and misoprostol. Mifepristone blocks the pro-gestational action of progesterone on a developing pregnancy, and misoprostol is a prostaglandin receptor agonist that stimulates the uterus to pass a pregnancy.

Although mifepristone was initially approved by the FDA (Food and Drug Administration) in 2000,[1] its use has evolved significantly over the last two decades. The initial regimen for medication abortion covered gestations up to 49 days and consisted of 600 mg oral mifepristone, given in clinic, followed two days later by 400 mcg oral misoprostol, also in clinic. Doctors were required to conduct another visit seven to fourteen days later for a follow-up assessment. Providers optimized the regimen as they gained experience, decreasing the dose of mifepristone to 200 mg and increasing misoprostol to 800 mcg, delivered buccally.

Medication abortion has proven both effective and safe.[2] In a systematic review of 33,846 medication abortions, Chen and Creinin found an overall effectiveness rate of 96.7% for gestations up to 63 days and 93.1% up to 70 days.[2] Rates of infection and need for blood transfusion were less than 1%; subsequent hospitalizations or emergency department visits were inconsistently reported but ranged from 0.04 to 1.3% and 2.9 to 3.7%, respectively.[2] The FDA accordingly revised its approval of medication abortion in 2016,[1] extending its use up to 70 days and reducing three visits to just one by allowing patients to take misoprostol at home and follow up over the phone or another virtual platform. Medication abortion has been increasingly utilized since these patient-centered modifications; in 2017, medication abortion accounted for 39% of all US abortions, up 25% from 2014.[3]

I plan to offer mifepristone and misoprostol when I finish residency. As a future internist who will take care of women of all ages, family planning falls within my scope of practice. Half my patients will have the ability to become pregnant, and a quarter of these will have an abortion by age forty-five.[4] That means that roughly one-eighth of all my patients will have an abortion during their lifetime—a prevalence that rivals that of diabetes.[5] But while I will graduate from residency knowing how to manage insulin by default, I will need to intentionally seek training to provide mifepristone and misoprostol. And yet abortion ought not to be a subspecialty issue; in fact, recognizing the inadequate supply of abortion providers, the American College of Obstetrics and Gynecology and the World Health Organization have called for the expansion of the pool of non-subspecialty abortion providers since 2014 and 2016.

Furthermore, many patients want their primary care doctors to offer medication abortion.[6] We can provide continuity of care for our patients' reproductive needs, which can mean the difference between receiving counseling, education, treatment, and follow-up testing from a familiar doctor versus going to a separate, possibly distant clinic. Even with mandatory waiting periods, we can reduce delays in care that limit our patients' options. We have the chance to limit school or work absences and the need for childcare coverage or transportation in moments when our patients may already feel vulnerable and overwhelmed. There will always be skills and levels of risk that exceed our scope of practice, but medication abortion need not be one of them.

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So why aren't more general practitioners providing medication abortion? Interested internists face several barriers: lack of knowledge, limitations by employers, stigma, and logistical hurdles. Unlike many family medicine and obstetrics and gynecology programs, most internal medicine residencies do not offer "opt-out" family planning training. Many hospital systems restrict their employees' ability to counsel their patients on abortion and even some kinds of contraception. Abortion providers also face judgment and even threats of violence from some of their colleagues and patients.

And finally, doctors who want to offer medication abortion must cut through an impressive amount of red tape. The FDA's 2016 revision notably upheld mifepristone's Risk Evaluation and Mitigation Strategy (REMS),[1] which requires that prescribing clinicians register in a database and store and dispense mifepristone at their office rather than a pharmacy. During the Covid-19 pandemic, however, the FDA has intermittently suspended this in-person requirement, thereby allowing doctors to conduct virtual counseling visits and deliver mifepristone or prescribe it through mail-order pharmacies. If permanently approved, medication abortion through telemedicine could increase access for patients living in states with provider shortages and restrictive laws.

So where do internists who want to provide medication abortion go from here? How can we add mifepristone and misoprostol to our toolkits?

1. Learn more. Read the excellent review by Beaman et al.[7] and explore the abundance of online evidence-based resources, a sampling of which is listed here:

Resource	Description	URL
CORE (Curricula Organizer for Reproductive Health Education)	Open access tool to build educational presentations on reproductive health topics	https://core.arhp.org/
Innovating Education in Reproductive Health	Educational videos and cases, including a spotlight on telemedicine for medication abortion	https://www.innovating-education.org/
INROADS (International Network for the Reduction of Abortion Discrimination and Stigma)	Network of abortion advocates, scholars, providers, and donors addressing abortion stigma	https://endabortionstigma.org/
Reproductive Health Access Project	Non-profit offering abortion, contraception, and miscarriage resources for primary care providers	https://www.reproductiveaccess.org/
TEACH (Training in Early Abortion for Comprehensive Healthcare)	Interactive online workbook for training in early abortion	https://www.teachtraining.org/

2. Take individual and collective action. For example, negotiate your contract to include the ability to provide medication abortion; form interest groups and collaborate with colleagues in obstetrics and gynecology and family medicine; ask your professional organization to petition the FDA to allow for no-touch medication abortion and remove mifepristone's REMS stipulations.
3. Train the next generation. Offer family planning electives and medication abortion workshops for residents and medical students. Consider "opt-out" programming such as lectures during routine conferences to reach a broader audience of trainees.

Please join me in adding medication abortion to your practice. Our patients are waiting.

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Corresponding Author: *Xanthia A. Tucker, MD; University of Michigan, Internal Medicine-Pediatrics Residency Program, Ann Arbor, MI, USA (e-mail: xanthiat@med.umich.edu).*

Declarations:

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