

Abortion as Essential Health Care and the Critical Role Your Practice Can Play in Protecting Abortion Access

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Few obstetrician–gynecologists (ob-gyns) provide abortion care, resulting in abortion being separated from other reproductive health care. This segregation of services disrupts the ob-gyn patient–clinician relationship, generates needless costs, delays access to abortion care, and contrib-

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utes to stigma. General ob-gyns have both the skills and the knowledge to incorporate abortion into their clinical practices. In this way, they can actively contribute to the protection of abortion access now with the loss of federal protection for abortion under *Roe v Wade*. For those who live where abortion remains legal, now is the time to start providing abortions and enhancing your abortion-referral process. For all, regardless of state legislation, ob-gyns must be leaders in advocacy by facilitating abortion care—across state lines, using telehealth, or with self-managed abortion—and avoiding any contribution to the criminalization of those who seek or obtain essential abortion care. Our patients deserve a specialty-wide concerted effort to deliver comprehensive reproductive health care to the fullest extent.

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On June 24, 2022, the Supreme Court overturned nearly 50 years of federal precedent protecting abortion access in its *Dobbs v Jackson Women's Health* opinion.¹ The American College of Obstetricians and Gynecologists (ACOG) has replied by messaging that, “Abortion is essential health care.”² A commanding 95% of obstetrician–gynecologists (ob-gyns) agree with ACOG and support provision of abortion care, reporting that they would provide or facilitate provision of care, even for indications that conflict with their own personal values.^{3,4} However, abortion provision is not a routine part of most general ob-gyn practices; currently, only 14–24% of ob-gyns perform abortions.^{5,6} Because few care for many, and are asked to do so primarily in independent clinics, abortion has long been legislatively vulnerable, practically speaking, through TRAP (Targeted Restrictions on Abortion Providers) laws and through more subtle harms created by distancing trainees and attendings from the lived realities of providing stigmatized care.

Now, ob-gyns must recognize this vulnerability and consider how their practices could be used to strengthen the U.S. abortion-provision network.

In a field that values longitudinal relationships, it is problematic that our patients have to seek care in abortion-specific settings, unaffiliated with their usual ob-gyn practices.⁷ The journey to find abortion care is complex and riddled with deliberate disinformation, discriminatory barriers, labyrinthine legislative hurdles, and the burdensome costs of out-of-pocket care, lodging, lost wages, travel, and childcare.⁸ Even when ob-gyns are eager to guide their patients through this circuitous referral path, 53% of these well-intentioned physicians are unable to make effective referrals due to their own lack of knowledge regarding the abortion-referral process.⁹ Resulting delays in accessing abortion appointments lead to greater patient cost, more complex logistics such as a multiday abortion procedures and fewer clinician options, and elevated risk of complications at advanced gestational ages.^{10–12} Ultimately, delays may result in total denial of abortion care, which is associated with medical-, economic-, and safety-related harms.^{13,14} These harms already accumulate disproportionately among racial and ethnic minority groups, particularly Black people who can become pregnant, a disparity that will be profoundly exacerbated now that *Roe* has been overturned.¹⁵

Abortion is an essential part of health care, but our collective action as a specialty has not historically lived up to this principle. Now is the time for ob-gyns to actively participate in abortion care and to critically

consider the needs of our patients, our personal conscience to act, and the responsibility to wield our professional skills. If we truly believe that abortion is standard health care, we should consider how we can directly contribute to equitable abortion care. We propose that all ob-gyns consider the most that they can do within the confines of their own practice environment from the following recommendations.

FOR THOSE WHO PRACTICE IN STATES WHERE ABORTION REMAINS LEGAL

Provide Abortion Care

General ob-gyns have the required skillset both to perform procedural abortion with first-trimester uterine aspiration and the counseling required to guide patients through medication abortion. Consider how you may expand the use of those skills. For either procedural or medication abortion (detailed below), experts have developed clinical resources to refresh your patient-counseling points (Table 1),^{16,17} and patients can seek counseling and supportive care independently through organizations such as Reprocare,¹⁸ All-Options,¹⁹ and Exhale.²⁰

Provide Medication Abortion

Medication abortion may offer the logistically easiest route toward integrating abortion care into clinical practice.²¹ Early pregnancy loss and medication abortion require the same medications and office resources; counseling, evaluation, medications, potential complications,

Table 1. Options Counseling Considerations

Assess Patient Decision*	Describe Options
<p>Review sentiment</p> <p>Make no assumption of patient preferences when pregnancy is diagnosed. Do not contribute to stigma or use influence from personal values when sharing accurate information related to abortion, adoption, and prenatal resources.</p> <p>Evaluate decision confidence</p> <p>Ask about patient's experience of making the decision to appreciate emotions, ease of conclusion, clarity of decision, and other important factors for the individual.</p> <p>Discuss safety and support</p> <p>Evaluate for decision pressure and presence of intimate partner violence or reproductive coercion. Identify supportive people and coping strategies.</p>	<p>Medication abortion</p> <p>Avoids instrumentation; takes place in a comfortable setting; may feel more natural or independent; heavier bleeding; symptomatic for several hours; recommended follow-up.</p> <p>1st-trimester procedural abortion</p> <p>Brief intervention with knowledge of immediate completion; requires instrumentation; takes place in a clinical setting; may have greater anesthesia options; lighter bleeding; typically no follow-up.</p> <p>2nd-trimester abortion</p> <p>Variable practices, typically misoprostol cervical preparation in the hours before suction curettage for 13–15 wk of gestation and 2-day procedure after 16 wk, with placement of osmotic dilators in the 24 h before dilation and evacuation; some institutions are using expedited pathways and alternative measures, eg, with a Foley balloon.</p>

* *Decision Assessment and Counseling in Abortion Care: Philosophy and Practice*, by Alissa C. Perrucci¹⁶ includes an excellent approach and significantly more detail.

and follow-up are remarkably similar. Important differences that require investment before expansion of care include the development of appropriate consent forms as well as protocols for incorporating unique state mandates for abortion care (eg, counseling scripts, required information modules). Numerous resources, including ACOG and UpToDate, provide guidance on the provision of this care, summarized in Box 1.^{22,23} The coronavirus disease 2019 (COVID-19) pandemic prompted the growth of extraclinical pathways for medication abortion, including telehealth, postal mail distribution of mifepristone, and history-based care.^{24,25} These practices are effective and safe and decrease barriers to care.^{26,27} Many, but not a majority of, ob-gyns have established mifepristone as part of their practice for medication management of missed abortion given its superior efficacy to the regimen of misoprostol alone (Neill S, Goldberg A, Janiak E. Medication management of early pregnancy loss: the impact of the U.S. Food and Drug Administration risk evaluation and mitigation strategy [A289] [abstract]. *Obstet Gynecol* 2022;139:83S. doi:10.1097/01.AOG.0000825716.77939.40).²⁸ With the fall of *Roe*, the need to provide medication abortion services now should compel remaining ob-gyns to incorporate mifepristone into standard practice. This may involve education of other stakeholders, such as managers and administrators. A primary barrier to clinical use of mifepristone has been limited knowledge of mifepristone indications, safety, and provision logistics, primarily stemming from the Risk Evaluation and Mitigation Strategy (REMS) program (Neill et al. *Obstet Gynecol* 2022;139:83S; and Kaiser J, Kurtz T, Glasser A, Brintz B, Turok D, Sanders J. Current knowledge and use of mifepristone for miscarriage in Utah and the impact of an educational video on future use [A292] [abstract]. *Obstet Gynecol* 2022;139:84S. doi:10.1097/01.AOG.0000825728.94972.6d).²⁹ The American College of Obstetricians and Gynecologists' position statement on improving access to mifepristone, which includes citations of important additional literature, offers an authoritative source to educate concerned staff.³⁰ Until the REMS program is dissolved, a change supported by robust safety data, a one-time prescriber agreement form must be filled out, often by just one person on behalf of the entire clinic.^{31,32} The U.S. Food and Drug Administration has yet to release its certification process for pharmacy dispensation of mifepristone; once details are available, ob-gyns should encourage pharmacist colleagues to satisfy requirements.

Provide Procedural Abortion

Because the procedural steps are the same for suction aspiration or dilation and curettage no matter the

indication, ob-gyns already have the professional skills and expertise to provide procedural abortion in their medical practices. Seek to bolster your training as needed if you do not feel proficient at first-trimester surgical procedures or if you would like to start providing dilation and evacuation at later gestations. Although more than 90% of abortions are performed in the first trimester, induced abortion by suction aspiration through 15 weeks of gestation can be readily integrated into standard ob-gyn care as a single-day procedure with a curette size of 14–16 mm.^{34,35} Individuals experiencing pregnancy loss or induced abortion benefit from an office or outpatient capacity to deliver manual vacuum aspiration and suction dilation and curettage under local or moderate sedation.^{36–38} In-clinic procedures may be the most affordable option in these circumstances, and ob-gyns do many other in-clinic procedures that confer the same degree of risk as first-trimester uterine aspiration. The option for a procedure in a main operating room should be made available for individuals who need or desire procedural care under greater anesthesia support. Relationships with labor and delivery unit staff are central to existing care delivery under (at least) exigent circumstances, such as previsible or perivable rupture of membranes, advanced cervical dilation, abruption or hemorrhage, and fetal anomalies. In practice settings that create significant barriers to procedural abortion care for most individuals, inroads may begin with institutional policies around the populations for whom there may be exceptions, such as the care of sexual assault survivors, incest survivors, minors, and pregnant people with life-threatening conditions. It is important to generate mutually agreed on, ideally expansively defined, diagnoses that jeopardize maternal health to avoid any delay confirming that care is in line with state and institutional policies at the time of patient presentation. Such conversations may require input from colleagues in subspecialties, namely complex family planning, maternal–fetal medicine, and pediatrics, as well as legal and ethics representatives. Identification of community allies may strengthen referrals and support outside of the institution (eg, child services, intimate partner or sexual violence support advocates) as well. Additionally, financial teams should generate a self-pay package to meet the needs of individuals who travel from states with restrictions on private and public insurance.

Improve Referral Pathways for Patients Who Need Abortion Care Beyond Your Expertise

Conscientious refusal to participate in any aspect of standard reproductive medicine is narrowly defined

Box 1. Guide to Facilitating Medication Abortion

History: LMP, options counseling, rule out the following contraindications below:

- Pregnancy longer than 77 d
- Suspected ectopic pregnancy (pain, bleeding)
- Anemia (typically hemoglobin less than 9.0)
- Anticoagulated, bleeding disorder
- Long-term oral steroid use
- Adrenal insufficiency, porphyria
- IUD in place
- Allergic to mifepristone

Examination: usually not indicated unless workup for pain, bleeding, or vaginal discharge

Laboratory results

- hCG (if needed for follow-up purposes or PUL workup)
- CBC (if a history of anemia or heavy bleeding)
- Type and screen (more than 56 d of gestation*; may be extended to 12 weeks)

Ultrasonographic indications

- Unclear LMP (can be an informal ultrasonogram in the clinic for gestational dating)
- Concern for ectopic pregnancy

Counsel and prescribe medications

- Sign state[†] and institutional consents
- Sign mifepristone patient agreement[‡]
- Provide mifepristone medication guide[§]
- Provide mifepristone
 - 200 mg orally × 1
 - Patient may swallow pill in clinic or bring the pill home to take when it is convenient
 - No side effects typically
- Provide misoprostol pills or prescription
 - Dose 24–48 h after mifepristone
 - 200 micrograms × 4 tablets buccally or vaginally; repeat 4 h later buccally if more than 63 d of gestation
 - Swallow pill remnants after 30 min in buccal mucosa
 - May premedicate for pain (ibuprofen 600 mg) or nausea before misoprostol
- After-care instructions
 - Expected effects within 2–6 h of misoprostol
 - Cramping, bleeding, passing clots normal
 - Flu-like symptoms normal
- Provide desired contraception as indicated
- Red flag symptoms to call 24-h number:
 - Bleeding more than 2 pads/h for 2 h
 - Severe abdominal pain for longer than 24 h
 - Fever 100.4° F for longer than 4 h
 - Feeling sick more than 24 h after misoprostol

Follow-up to confirm complete abortion

- Phone call for symptom check at 1 wk and negative home UPT at 4 wk, or
- hCG level at 5–14 d with greater than 80% decline, or
- Ultrasonogram at more than 48 h from misoprostol with no gestational sac

LMP, last menstrual period; IUD, intrauterine device; hCG, human chorionic gonadotropin; PUL, pregnancy of unknown location; CBC, complete blood count; UPT, urine pregnancy test.

* May be extended to 12 weeks.

[†] State counseling and waiting period laws: <https://www.gutmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>.

[‡] U.S. Food and Drug Administration–mandated Patient Agreement Form—select and sign correct manufacturers' version: <https://genbiopro.com/wp-content/uploads/2019/05/GenBioPro-Patient-Agreement.pdf>; <http://www.earlyoptionpill.com/wp-content/uploads/2016/02/Patient-Agreement-Form-March2016-1.pdf>.
[§] Patient Medication Guide—available in Spanish, Arabic, French, Chinese, Hindi, Vietnamese: <https://genbiopro.com/wp-content/uploads/2019/05/GenBioPro-Medication-Guide.pdf>; http://www.earlyoptionpill.com/wp-content/uploads/2016/01/DAN_MedGuideEng_FINAL.pdf.

and always requires timely, nonjudgmental, accurate referral to care.³⁹ If you will not provide abortion care directly, learn the best way to facilitate care with a colleague who provides the care your patient needs (eg, what anticipatory workup, such as ultrasounds, can your practice provide while the patient is waiting for an appointment?) Now is the time to solidify your relationships with and support for colleagues who provide complex abortions. Many current family planning clinicians, particularly in places such as Colorado, New Mexico, Illinois, and California that neighbor abortion-hostile states, are experiencing enormous increases in demand for care. Support of these colleagues, if not by providing first-trimester care yourself then by developing a streamlined referral process, will be essential in facilitating necessary patient care.

Become a Spokesperson Committed to Dismantling Abortion Stigma

Talk to your patients, your colleagues inside and outside of obstetrics and gynecology, and your community about accessible abortion care as a requirement for safe, autonomous reproductive health. Become a thoughtful and effective messenger by educating yourself on abortion speaking points supplied through reputable organizations such as ACOG,⁴⁰ Physicians for Reproductive Health,⁴¹ and the American Civil Liberties Union.⁴² Your complex family planning colleagues may not be available to contribute to this education while they provide direct clinical abortion care.

FOR THOSE WHO PRACTICE IN STATES WHERE ABORTION IS ILLEGAL OR SEVERELY RESTRICTED

Do Not Contribute to Patient Criminalization

Since 2000, at least 21 people have been criminalized for abortions, many of whom were reported by health care professionals.⁴³ The World Health Organization, the American Medical Association, and ACOG denounce criminalization of abortion.^{44–46} As of July 2022, no state mandates clinicians to report those who they suspect have undertaken self-managed abortion.⁴⁷ In fact, reporting counters current federal and state legal protections of health information. The Department of Health and Human Services affirmed this by releasing guidance on the Privacy Rule as it pertains to reproductive health, clearly stating that intention to seek a legal abortion is not a, “serious and imminent threat to the health or safety of a person or the public,” regardless of local state abortion pol-

icy.⁴⁸ There is a disgraceful and discriminatory history of collusion between medical professionals and the carceral system in regulating marginalized members of society (eg, biased prenatal substance use testing and reporting, court-ordered and physician-placed contraceptive implants among racial and ethnic minority groups, and forced sterilizations).⁴⁹ It is a moral and professional imperative to avoid participation in such discriminatory practices. This includes assuring patients of their right to privacy and limiting history-taking to what is clinically indicated as reports of physician interrogations arise.⁵⁰ Despite (poorly substantiated) concerns regarding the health risks of self-managed abortion, the greater risks facing some pregnant people with the fall of *Roe* are legal persecution and the carceral system; ob-gyns must not contribute to this risk.

Educate Those Inside or Outside of Your Professional Workplace Who May Encounter Patients Who Want or Need an Abortion

For colleagues in health care, such as emergency department clinicians, emphasize the clinician’s role in avoiding any contribution to criminalization as above. Confirm that there is no way and no need to determine a difference between induced abortion and miscarriage. Educate your medical colleagues to perform pregnancy-options counseling and timely abortion referrals when they cannot offer abortion services themselves.

For our medical and nonmedical acquaintances and communities, normalize abortion talk and speak up to correct misinformation and abortion myths. Share the reality that abortion, including self-managed abortion with misoprostol, is safe, especially when framed in direct contrast to the inevitable, dangerous effects of abortion restriction and forced continuation of pregnancy.⁵¹ Review intentional vocabulary in speaking in a medically accurate, nonstigmatizing, and inclusive way about abortion.⁴⁰

Identify the Lowest Health-Risk and Legal-Risk Path for Patient Care

The lowest health-risk and legal-risk path for patient care may include self-managed abortion, as outlined by the World Health Organization and the Society of Family Planning.^{46,52} Familiarize yourself with extraclinical resources and support, such as:

- Women Help Women, SASS – Self-Managed Abortion; Safe & Supported: comprehensive resource for medication abortions, available at <https://abortionpillinfo.org/>

- AidAccess: online consultation with physicians and mail service for medication abortion, available at <https://aidaccess.org/>
- Repro Legal Helpline: legal hotline to support those pursuing self-managed abortion, available at <https://www.reprolegalhelpline.org/>
- Miscarriage + Abortion Hotline: support hotline for any questions related to self-managed abortion or miscarriage, staffed by clinicians, available at <https://www.mahotline.org/>
- National Network of Abortion Funds: centralized source to support funding an abortion, including identification of local abortion funds, available at <https://abortionfunds.org/>

Assist Patients With Safely Accessing Periabortion and Postabortion Care if Needed

Consider providing supportive services, such as ultrasound reports or images, laboratory test results, and anticipatory guidance, for patients who can use that information for abortion by telehealth or by mail.⁵³ For the many patients who have not already independently connected with care and support, become a knowledgeable clinician who can facilitate warm referrals to online or out-of-state abortion care as well as to abortion funds. Empower your patients with the knowledge that clinicians cannot distinguish between miscarriage and induced abortion. Because the clinical presentation and any necessary clinical care is the same, patients can be reassured that they will receive appropriate treatment if they choose not to share with a health care team information regarding self-managed or induced abortion services they may have received.

Refresh Your Management of Complications of Abortion⁵⁴

Medication abortions (self-managed or clinically overseen) are expected to increase in volume, so the absolute number of rare complications, such as infection or clinically relevant bleeding, may as well. Importantly, those who take mifepristone and misoprostol or misoprostol alone to manage first-trimester pregnancy terminations will have extremely low rates of complications, with or without clinician involvement.⁵⁵ It remains to be seen how readily these medications will be obtained by pregnant people. If self-administration of the U.S. Food and Drug Administration–approved regimen for medication abortion is not an option in one state, some may be able to seek care in other states. For the majority of individuals seeking abortion with existing financial, logistic, and societal barriers to care, access will likely become (or already had become) impossible. There-

fore, alternative measures may be sought, some familiar to those who practiced in the era before *Roe*. Concerns related to ingestion of substances unfamiliar to clinicians can be reviewed for free and confidentially 24-hours a day through the national toxicology hotline (800-222-1222); callers will be routed to toxicology-trained pharmacists or physicians.

Intensify Abortion Training for Clinical Staff

Regardless of state legislation, all those involved in patient care should continue to receive education in referral and options-counseling training,^{56,57} use of hospital simulation spaces,⁵⁸ and recruitment (and payment) of family planning clinicians for grand rounds, resident training sessions, clinical shadowing, and apprenticeships. These learning opportunities also establish institutional norms around abortion care and allow for those who desire more involvement in abortion care to have their interests recognized.

FOR THOSE WHO PRACTICE ANYWHERE IN THE UNITED STATES

The task of professional and practice transformation may seem great, but it is long overdue. As you personally, and as a practice, work to improve abortion provision, complementary exercises in advocacy include the following.

Know Your State Laws

The Guttmacher Institute provides an excellent overview of state laws, updated monthly.⁵⁹ However, legal counsel may provide more nuance and address specific questions (eg, initiating mailing of mifepristone, caring for people from out of state), particularly in what is anticipated to be a rapidly changing landscape.

Leverage Your Professional Position

Physicians and other clinicians have both medical expertise and public trust.⁶⁰ By developing relationships around your work and personal communities (eg, with the department chair, hospital committees, state and district professional societies, and community organizations), efforts in destigmatization, buy-in from stakeholders, and pathways for policy change may be easier.

Identify Your Geographically or Professionally Close Complex Family Planning Specialists

Depending on state politics, these individuals may be eager to share with you means of complementing their work, relief of what will be a potentially enormous care burden, and pathways for local advocacy. In other settings, these individuals may have the capacity

to support professional development by refreshing your counseling and procedural training or to facilitate practice changes by sharing protocols or relevant troubleshooting efforts.

Support Each Other in a Rapidly Changing Legal Landscape That Puts Good Medical Practice and Legal Practice at Odds

The language of anti-abortion state laws is intentionally threatening and, if upheld, holds new legal precedence within and across state lines. Thus, clinicians and our patients have legitimate concerns regarding the risk of criminalization. The relationship between clinicians in states where abortion is illegal and those in states where it is legal may become one of critical support, trust, and empathy as cross-state transfers potentially increase to care for those with *gray-area diagnoses* (a term we are using here for individuals who have detectable fetal cardiac activity in the setting of a pregnancy complication that is life-threatening but may not yet be imminently life-threatening). Clinicians will be expected to accept, deny, or transfer care based on what is legally less risky instead of what is best clinical care for the patient, an impossible task for our colleagues in restrictive states that warrants special compassion. For those residing in states with and without legal abortion, ACOG has a toolkit to guide institutional discussions regarding transfer policy, capacity building, and expected legal support for clinicians in an era in which legislation will do irreparable harm to the medical community and those we serve.⁶¹

Center Equity in Abortion Advocacy

In the wake of a number of professional organizations and educational bodies publicly committing to anti-racism and the dismantling of white supremacy over the past 2 years, we must realize that abortion protection is a key part of that work.⁶² More than half of abortion need is among people who identify as Black or Latina, a disparity generated by racism, similar to many other aspects of medical care.⁶³ Further, other intersecting sources of oppression, such as classism, ableism, and the rural-urban divide, have and will continue to generate inequities in reproductive care. Abortion access is a critical tenet in Reproductive Justice, alongside other essential rights of bodily autonomy and having and parenting children in safe and sustainable communities.⁶⁴ Uplift the voices and organizations that operate from a Reproductive Justice framework, such as SisterSong, the National Latina Institute for Reproductive Justice, and the Black Women's Health Imperative.⁶⁴⁻⁶⁶ For our White colleagues and masculine-identifying colleagues, commitment to equity may take the form of self-education, community organizing, and advocacy that demands your

efforts while creating and preserving space for marginalized members of the abortion advocacy movement to be the vocal, public-facing authorities that this moment demands.

The time for a minority of ob-gyns to provide the nation's abortion care is over. In an era of breathtaking restrictions to access, this division of clinician labor simply cannot be sustained. Our patients deserve continuity of timely, compassionate care from their clinicians. Moreover, most of us are already skilled to perform most abortions. By continuing the status quo within the ob-gyn community—as protections for this clinical care crumble around us—supportive but abstaining ob-gyns contribute to stratified reproduction.

This is a fight for the autonomy, the dignity, the equity, and the lives of our patients and our own loved ones. In our personal lives or through our professional duties, we are all abortion beneficiaries. Obstetrician-gynecologists are qualified to provide this care already; more ob-gyns providing this care not only supports a human right, but also elevates patient experience, trainee education, and parallel services such as pregnancy-loss management. We have contributed to the vulnerability of abortion care, but it is within our power to correct our wrong. Now is the time to act on our principles: abortion is essential health care.

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