EDITORIAL AND COMMENT

Medication for Abortion and Miscarriage in Primary Care: Important and Possible for General Internists

Rachel S. Casas, MD, MEd and Cynthia H. Chuang, MD, MSc

Department of Medicine, Division of General Internal Medicine, Penn State College of Medicine, Penn State Milton S. Hershey Medical Center, Hershey, PA, USA.

J Gen Intern Med 35(8):2256–7
DOI: 10.1007/s11606-020-05919-7

States enacted 58 new restrictions to abortion care and signed into law 25 new abortion bans in 2019 alone, which serve to further restrict abortion access in many parts of the USA.[1] Unfortunately, these restrictions disproportionally affect vulnerable women, who are less likely to access timely reproductive health care due to deficits in facilities and providers offering these services. The ease by which new restrictions to reproductive care have been rapidly implemented during the COVID-19 pandemic has made expanding and reinforcing abortion and miscarriage care more important than ever.[2] The timely article "Medication to Manage Abortion and Miscarriage" by Beaman et al. reviews current evidence-based clinical protocols for general internists to safely and effectively incorporate abortion and miscarriage management into their primary care practices.[3]

We fully agree that general internists are well positioned to fill this gap in abortion and miscarriage care. We are the first point of contact for our patients to health care, and often their only easily accessible option in rural and low-resource areas. Beaman et al. cite that there are nearly 100,000 general internists currently practicing in the USA; if only 0.5% were to offer abortion care, this would increase the number of abortion providers by one-third (from 1500 to 2000).[3, 4] As outlined in the article, many women would prefer to have reproductive health care from their primary care provider due to their established relationship and closer proximity. Offering these services through primary care is patient-centered and may reduce the stigma that some women experience when going to family planning clinics.

While training for abortion and miscarriage management has not traditionally been incorporated into internal medicine residency curricula, well-established, national programs exist for family medicine residents. These programs include the Training in Early Abortion for Comprehensive Healthcare (TEACH Program) and the Center for Reproductive Health Education in Family Medicine (RHEDI).[5, 6] Prior studies, however, show that inclusion of abortion training in family medicine programs increases self-reported competency and intention to provide abortion care but not the likelihood to provide this care after training.[7–10] Cited barriers by residents are at individual (i.e., perceived lack of authority to implement services) and system levels (i.e., lack of institutional support).[8, 10] Even with training, a low percentage of family medicine graduates (19%) report feeling prepared to provide abortions, although this is double the percentage of graduates without training (10%).[10] Continued support following graduation, including additional training and networking, is likely required for both family medicine and general internal medicine physicians to successfully integrate abortion management into their own practice.[1, 11]

Other barriers to medication abortion and miscarriage care by general internists could be overcome by changing policy and protocols to be better aligned with current evidence. Beaman et al. describe that mifepristone is regulated under the FDA with a Risk Evaluation and Mitigation Strategy (REMS) requirement, despite its excellent safety profile and new evidence for the safe and effective use of this medication for miscarriage.[3, 12, 13] Under REMS, clinicians must register in the drug manufacturer's database and dispense mifepristone through their clinic rather than a pharmacy. Many primary care providers are unfamiliar with REMS, which may create the misperception amongst providers and staff that mifepristone is less safe than other medications typically prescribed in primary care. Additionally, the REMS requirements add administrative and operational burdens to implementation in a primary care practice. We advocate for the removal of REMS for mifepristone to reduce these barriers. Discussion of medical management of abortion and miscarriage together may also facilitate bringing both of these treatment options into the realm of primary care. While each carries its own ethical and medical considerations, the medication protocols for abortion and miscarriage care with mifepristone and misoprostol are nearly the same and can allow for patients to receive both therapies in the same place. Inclusion of the protocols and medications for women to have miscarriage managed in

This editorial is highlighting the article cited in reference #3 (https://doi.org/10.1007/s11606-020-05836-9).

Published online May 29, 2020

primary care may lay the groundwork for later provision of abortion care.

Clinical guidelines support performing medication abortion care without an ultrasound unless gestational age is uncertain or there is concern for an ectopic pregnancy.[13, 14] In spite of these guidelines, ultrasound is required by many state laws prior to medication abortion. Even in states without the ultrasound requirement, this conflict between evidence and policy may leave general internists uncomfortable with adopting medication abortion care without ultrasound, especially since assessing early pregnancy is not a frequent part of our training or practice. As an additional consideration, the COVID-19 pandemic has led abortion providers to remove ultrasound from their protocols in order to institute "touch-less" provision of medication abortion through telehealth. Clinical protocols should acknowledge that general internists may opt to routinely obtain ultrasounds prior to providing medication for abortion, although this can reduce access during the COVID-19 pandemic, complicate protocols, increase health care costs, and require additional training (if local ultrasound services are not easily accessible). While adverse events of both medication abortion and early miscarriage are rare, clinical protocols also have to prepare general internists for complications such as excessive bleeding and incomplete abortion and provide opportunities for ongoing clinical support.

General internists who incorporate medication abortion and miscarriage care into their practices will benefit from ongoing peer support from family planning colleagues in obstetrics-gynecology, family medicine, and general internal medicine. For successful implementation of this care, new providers must navigate state-based restrictions (e.g., mandatory waiting periods, mandatory counseling that includes inaccurate information), cultural and institutional barriers (e.g., reticence from staff and colleagues, after-hours coverage, legal considerations, restrictions for allowable indications), and logistical issues (e.g., medication stocking, billing/reimbursement, advertising). Peer support allows for sharing of learned experiences and best practices to help overcome encountered obstacles. Review of cases for enhanced learning and comfort will also help new providers deliver the most up to date and patient-centered abortion and miscarriage care.

We welcome this call to action to expand reproductive care services for our patients by incorporating protocols for mifepristone and misoprostol into primary care. While providing medication for abortion and early miscarriage is important and possible for general internists, few internists have successfully adopted this care into their practice. It is time to form a community to address implementation barriers. We also recognize that most general internists will not be comfortable with providing this care in their practices. However, we call on all of our colleagues to join us by increasing our comfort with pregnancy options counseling and respectfully facilitating referral of patients for family planning, which will hopefully be increasingly within our general internal medicine community.

Corresponding Author: *Cynthia H. Chuang, MD, MSc; Department of Medicine, Division of General Internal Medicine, Penn State College of Medicine, Penn State Milton S. Hershey Medical Center, Hershey, PA, USA (e-mail: cchuang@pennstatehealth.psu.edu).*

Compliance with Ethical Standards:

Conflict of Interest: *The authors have no conflict of interests to disclose.*

REFERENCES

1. **Nash E**, **Mohammed L**, **Cappello O**, **Naide S**. State Policy Trends 2019: A Wave of Abortion Bans, but Some States are Fighting Back. Guttmacher Institute; 2019. https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back.
2. **Bearak JM**, **Jones RK**, **Nash E**, **Donovan MK**. COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care. Guttmacher Institute; 2020. https://www.guttmacher.org/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care.
3. **Beaman J**, **Prifti C**, **Schwartz BS**, **Sobota M**. Medication to Manage Abortion and Miscarriage. J Gen Intern Med. 2020 https://doi.org/10.1007/s11606-020-05836-9.
4. *The Number of Practicing Primary Care Physicians in the United States: Primary Care Workforce Facts and Stats No. 1.* Agency for Healthcare Research and Quality (AHRQ), Rockville, MD, Content last reviewed July 2018. https://www.ahrq.gov/research/findings/factsheets/primary/pcwork1/index.html.
5. RHEDI: The Center For Reproductive Health Education In Family Medicine. [cited 2020 May 4]; Available from: https://rhedi.org/
6. TEACH: Training in Early Abortion for Comprehensive Healthcare. [cited 2020 May 4]; Available from: https://www.teachtraining.org/.
7. **Romero D**, **Maldonado L**, **Fuentes L**, **Prine L**. Association of reproductive health training on intention to provide services after residency: the family physician resident survey. Fam Med. 2015;47(1):22-30.
8. **Goodman S**, **Shih G**, **Hawkins M**, **Feierabend S**, **Lossy P**, **Waxman NJ**, **Gold M**, **Dehlendorf C**. A long-term evaluation of a required reproductive health training rotation with opt-out provisions for family medicine residents. Fam Med. 2013;45(3):180-6.
9. **Summit AK**, **Gold M**. The Effects of Abortion Training on Family Medicine Residents' Clinical Experience. Fam Med. 2017;49(1):22-27.
10. **Weidner A**, **Stevens N**, **Shih G**. Associations Between Program-Level Abortion Training and Graduate Preparation for and Provision of Reproductive Care. Fam Med. 2019;51(9):750-755.
11. **Block A**, **Dehlendorf C**, **Biggs MA**, **McNeil S**, **Goodman S**. Postgraduate Experiences With an Advanced Reproductive Health and Abortion Training and Leadership Program. Fam Med. 2017;49(9):706-713.
12. **Schreiber CA**, **Creinin MD**, **Atrio J**, **Sonalkar S**, **Ratcliffe SJ**, **Barnhart KT**. Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss. N Engl J Med. 2018;378(23):2161-2170.
13. National Academies of Sciences Engineering and Medicine (U.S.). Committee on Reproductive Health Services., National Academies of Sciences Engineering and Medicine (U.S.). Board on Population Health and Public Health Practice., National Academies of Sciences Engineering and Medicine (U.S.). Board on Health Care Services., and National Academies of Sciences Engineering and Medicine (U.S.). Health and Medicine Division. The safety and quality of abortion care in the United States. Consensus study report. Washington, DC: The National Academies Press: 2018:208. xiv.
14. **Bracken H**, **Clark W**, **Lichtenberg ES**, **Schweikert SM**, **Tanenhaus J**, **Barajas A**, **Alpert L**, **Winikoff B**. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. BJOG. 2011;118(1):17-23.