Health

# ER Doctors Need to Be More Knowledgeable About Self-Managed Abortions

We're probably already seeing patients who ordered pills online – we just don't know it.

By **Dara Kass, MD**

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Last week, there was an unexpected cancelation at the largest national conference of emergency medicine doctors in the U.S. Without skipping a beat, I volunteered to fill in and give a lecture about caring for patients who come to the ER after taking medication to induce their own abortion. It's something I've been thinking about doing for a couple of years.

In my practice, I care for newly pregnant patients every single shift. Some come because they're scared about spotting in the days after a very wanted positive pregnancy test. Others come to the ER with severe cramping and bleeding, knowing in their hearts that this pregnancy is unlikely to last. And there are patients who want to double check a home pregnancy test before they consider whether or not they want a child, or whether they want more children. As a physician and mother, the complete care of patients like these is near and dear to my heart. As an educator, I have been lecturing for years on compassionate care of pregnant patients with vaginal bleeding.


Recently I decided to talk to my colleagues about a new category of pregnant patient. I was born in a post-*Roe v. Wade* era, training and living in New York City where hostilities toward reproductive health felt real but far away. Growing up, I thought that "protecting *Roe*" was enough, especially since that's how the assault on reproductive rights was framed. But with the exponential rise of laws that target abortion providers with unnecessary regulations, the appointment of anti-choice Supreme Court justices, and this administration barring family planning clinics that get federal funds from telling their patients where they can get an abortion, it's clear that "protecting *Roe*" is not enough.

For me, that means knowing more about self-managed abortion using pills and encouraging my fellow emergency medicine doctors to do the same.

Medication abortions are rather simple. A patient takes two kinds of pills in the first 10 weeks of pregnancy. The first, mifepristone (RU-486) blocks progesterone, which prevents the pregnancy from continuing, and then a second medication, misoprostol, causes uterine contractions and bleeding,

**The FDA Is Restricting Access to the Easiest, Safest Form of Abortion**

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ending the pregnancy. It's medically indistinguishable from a miscarriage.

Medication abortions are also very common. A recent study from the Guttmacher Institute showed that about 40 percent of people who terminated their pregnancy choose medication abortion. It's effective 95 percent of the time, with a near-zero rate of serious complications.



Although the Food and Drug Administration has confirmed that mifepristone is extraordinarily safe, the drug is tightly regulated by the FDA, and only available from specialty providers and clinics (it's not available in pharmacies). In addition, despite the simplicity and safety of taking a pill at home early in pregnancy, patients can be subject to the same mandatory waiting periods in their state as an abortion procedure and telemedicine visits are also effectively banned in 18 states.

These barriers exist in the age of Google, so some people seek out the drugs online in what's known as a self-managed abortion (SMA). Patients may choose a self-managed abortion because clinic care is inaccessible or expensive, or because going to a clinic poses concerns for their own safety—like facing protesters or immigration officers. Some choose a self-managed medication abortion simply because they want to end their pregnancy in the privacy of their own home.

A study was published last week in the *American Journal of Public Health* reviewing increased traffic from the U.S. to Women on Web, a website that prescribes and sells abortion pills abroad. Although a visit to the site is purely informational for U.S. residents (the site can't distribute medication here) the site had visits from over 6,000 women in the U.S., 70 percent of whom live in states hostile to abortion. A companion site that does operate in the U.S., Aid Access, received requests from 21,000 women in its first year, starting April 2018. The FDA is trying to shut it down.



These barriers to care are a focus of innovation, especially when it comes to telemedicine—that is, a doctor's visit typically via a video chat. Gynuity Health Projects is sponsoring TelAbortion.org to provide medication abortions to patients in eight pilot states after a telemedicine visit.

Although I haven't referred patients to Gynuity's program before, if I lived in a more remote area of New York (one of the pilot states) I would encourage my patients with limited access to family planning services to see if this program could provide them the care they otherwise would not be able to find.

So why might I capitalize on every opportunity to teach my peers about self-managed abortion with medication? Because, as a doctor who vowed to care with compassion for patients who are bleeding with highly desired pregnancies, I also vow to care with compassion for patients who are bleeding after terminating their pregnancies.

Generally, at-home medication abortions are very safe, but when patients are scared, or have pain or bleeding, they come to me. Recently published results of the Gynuity pilot project showed that 8 percent of their patients who received abortion medication sought follow-up care at a local urgent care clinic or emergency department. It is not my job to question someone about whether they took medication to induce their abortion or whether it happened naturally. Given the ambiguity of most state laws in the prosecution of self-managed abortion and the variety of possible reasons a pregnant patient may miscarry, it's not surprising that the American College of Obstetricians and Gynecologists formally opposes any policy that requires providers who suspect a patient may have induced their own abortion to report them to law enforcement.

I envision a near future where medication abortions are available without barriers—patients who don't want to be pregnant could leave an ER visit with medication in their hands. As someone who uses telemedicine in my practice, I see a way to provide care to patients regardless of their ZIP code or socioeconomic status that keeps them safe at home, away from the risk of retribution, deportation, or public shame.

We know that medication abortions are safe, effective, and can be performed at home. It's time for emergency medicine doctors to get up to speed, since we're probably seeing patients in our practice who ordered pills online—we just don't know it.

When I started my talk at the conference, I'm not sure if people knew what to expect. Although I was speaking to a like-minded group, would they push back or think I was promoting a political agenda? It didn't take long to find out, as soon after I finished, a male colleague of mine tweeted back at the conference, suggesting that I give this talk again next year, but this time from the main stage. I'm looking forward to that invitation.



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