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Medication Abortion Restrictions Hurt My Patients

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Colleen McNicholas

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This blog post was published in conjunction with Repro Health Watch, an exciting new edition of the Women's Health Policy Report, which compiles and distributes media coverage of proposed and enacted state laws, ballot initiatives and litigation affecting women's access to comprehensive reproductive health care.

As a practicing physician in St. Louis, Missouri, I provide comprehensive reproductive care to my patients. This encompasses prenatal and obstetric care, family planning, gynecologic, and abortion services including medication abortion using mifepristone, which is also known as Mifeprex, RU-486, or the abortion pill.

Approximately 90 percent of abortions in this country occur early in pregnancy.[i] In MO, there are two methods of abortion available to women in the first 63 days of pregnancy–a surgical procedure, or one using medications alone. Both medication and surgical abortion are very safe and effective.[ii]

And yet despite the wealth of evidence in support of the safety and effectiveness of medication abortion as currently practiced, Missouri State Senate Bill 175 (SB 175) would require an additional visit for the administration of misoprostol (the second medication in the protocol) at the clinic or physician's office. This would pose an incredible hardship for women who live far from the clinic, which is not unusual in MO where there are few abortion providers and women travel hundreds of miles to get needed medical care.

In MO, women seeking abortion are already faced with the burden of multiple visits with the required 24-hour consent waiting period. Currently, it is not until their second visit to the clinic that their abortion care is initiated. Women choosing medication abortion then make a third visit to confirm successful completion of the abortion. This bill adds yet another visit to this process, meaning that a Missouri woman using medication to end her pregnancy would need to make **four trips to the clinic or doctor's office**.[iii]This is outrageous and not in any

way medically necessary. I can think of no other procedure or service that I provide in which the state dictates the number of visits a patient must make or how I prescribe a medication.

There are reasons women choose medication abortion over surgical abortion. I will never forget my patient Julie[iv].When she came to my clinic she was a scared 19-year-old who found herself pregnant after surviving a sexual assault. Prior to her rape, Julie had been a virgin, and had never had a gynecologic exam. She wanted nothing more than to have this ordeal end. For her, medication abortion was the best option. As is standard in my practice, I described both options for pregnancy termination with Julie. In our discussion of the surgical option, she stopped me and said, "Do you have to put that inside me? I don't think I can stand to have anything else inside me." She decided to use medication to end the pregnancy resulting from her rape. Julie lived about 60 miles from the clinic. I fear that had she been required to return for an additional visit, she would have felt pressured to choose the more invasive surgical procedure, which would clearly have been traumatic for her.

In addition to creating significant barriers for women, SB 175—and bills just like it appearing in legislatures across the country—are medically unjustified and unnecessary. They are an inappropriate intrusion into the doctor-patient relationship and completely disregard patient autonomy, a cornerstone of medical ethics. There is no legitimate medical reason for these restrictions, leading me to conclude that the real purpose behind bills like SB 175 is to discourage women from using a safe, effective, and legal method of early abortion. Restrictions on medication abortion may discourage women from using medications to end a pregnancy, but it will not prevent them from having abortions. I assure you, women do not arrive at the decision to have an abortion lightly and the patients I see are very sure of their decisions. This type of legislation is designed to burden women and interfere with medical care. If lawmakers truly cared about women and reducing the need for abortion, they would work more to prevent unintended pregnancy through access to family planning and comprehensive sex education, and less on restricting access to safe medical procedures.

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[i]Meckstroth K, Paul M. First trimester aspiration abortion. In: Paul M, Lichtenberg S, Borgatta L, Grimes DA, Stubblefield PG, Creinin MD, eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Sussex, UK: Wiley Blackwell; 2009: 135.

[ii]Meckstroth K, Paul M. First trimester aspiration abortion. In: Paul M, Lichtenberg S, Borgatta L, Grimes DA, Stubblefield PG, Creinin MD, eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Sussex, UK: Wiley Blackwell; 2009: 136. See also Grimes DA. Risks of mifepristone abortion in context. *Contraception.* 2005; 71(3):161 and Bartz D, Goldberg A. Medication abortion. *Clin Obstet Gynecol* . 2009*;* 52(2)140-150.

[iii]Please note that other clinicians may use different protocols for the third visit. For example, a woman may visit a practitioner closer to her home for a high sensitivity pregnancy test to confirm that she is no longer pregnant. Or a woman may take a home pregnancy test and then have a telephone consultation. There is ample medical evidence to support these approaches as safe and effective. See, e.g.Harper C, Ellertson C, Winikoff B. Could American women use mifepristone–misoprostol pills safely with less medical supervision?. *Contraception*. 2002;65:133–142; Fiala C, Safar P, Bygdeman M, Gemzell-Danielsson K. Verifying the effectiveness of medical abortion; ultrasound versus hCG testing. *Eur J ObstetGynecolReprod Biol*. 2003;109:190–195.

[iv] Please note that the patient's name has been changed to protect confidentiality.

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