BRIEF REPORT

# Telehealth Medication Abortion in Primary Care: A Comparison to Usual in-Clinic Care

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***Introduction:*** **Providing abortion in primary care expands access and alleviates delays. The 2020 COVID-19 public health emergency (PHE) led to the expansion of telehealth, including medication abortion (MAB). This study evaluates the accessibility of novel telehealth MAB (teleMAB) initiated during the PHE, with the lifting of mifepristone restrictions, compared with traditional in-clinic MAB offered before the PHE at a Massachusetts safety-net primary care organization.**

***Methods:*** **We conducted a retrospective electronic medical record review of 267 MABs. We describe sociodemographic, care access, and complete abortion characteristics and compare differences between teleMAB and in-clinic MABs using Chi-squared test, fisher's exact test, independent *t* test, and Wilcoxon rank sum. We conducted logistic regression to examine differences in time to care (6 days or less vs 7 days or more).**

***Results:*** **184 MABs were eligible for analysis (137 in-clinic, 47 teleMAB). Patients were not significantly more likely to receive teleMAB versus in-clinic MAB based on race, ethnicity, language, or payment. Completed abortion did not significantly differ between groups ($P = .187$). Patients received care more quickly when accessing teleMAB compared with usual in-clinic MAB (median 3 days, range 0 to 20 vs median 6 days, range 0 to 32; $P < .001$). TeleMAB patients had 2.29 times the odds of having their abortion appointment within 6 days compared with in-clinic (95% CI: 1.13, 4.86).**

***Conclusion:*** **TeleMAB in primary care is as effective, timelier, and potentially more accessible than in-clinic MAB when in-person mifepristone regulations were enforced. TeleMAB is feasible and can promote patient-centered and timely access to abortion care. (J Am Board Fam Med 2024;37:295–302.)**

***Keywords:*** **Abortion-Induced, Access to Health Care, Logistic Regression, Mifepristone, Patient-Centered Care, Primary Health Care, Quantitative Research, Reproductive Health, Retrospective Studies, Telehealth, Women's Health**

## Introduction

The *Dobbs v Jackson Women's Health Organization* US Supreme Court decision (*Dobbs*) ended the federal protection to abortion, curtailing access for more than 35 million women and pregnancy-capable people who now live in 18 states that have banned or severely restricted provision.[1,2] Decades of research demonstrates that when abortion is restricted, those seeking care experience significant delays due to challenges navigating limited appointment availability and increased travel distances.[3–5] Medication abortion (MAB) in primary care has the potential to meaningfully increase access to care.[6–8] Early abortion is within the scope of primary care, and family physicians routinely provide safe and effective medication and aspiration abortion in outpatient settings.[9–13] Some patients prefer obtaining abortion care with primary care because of the trust, privacy, and continuity of care it affords and are

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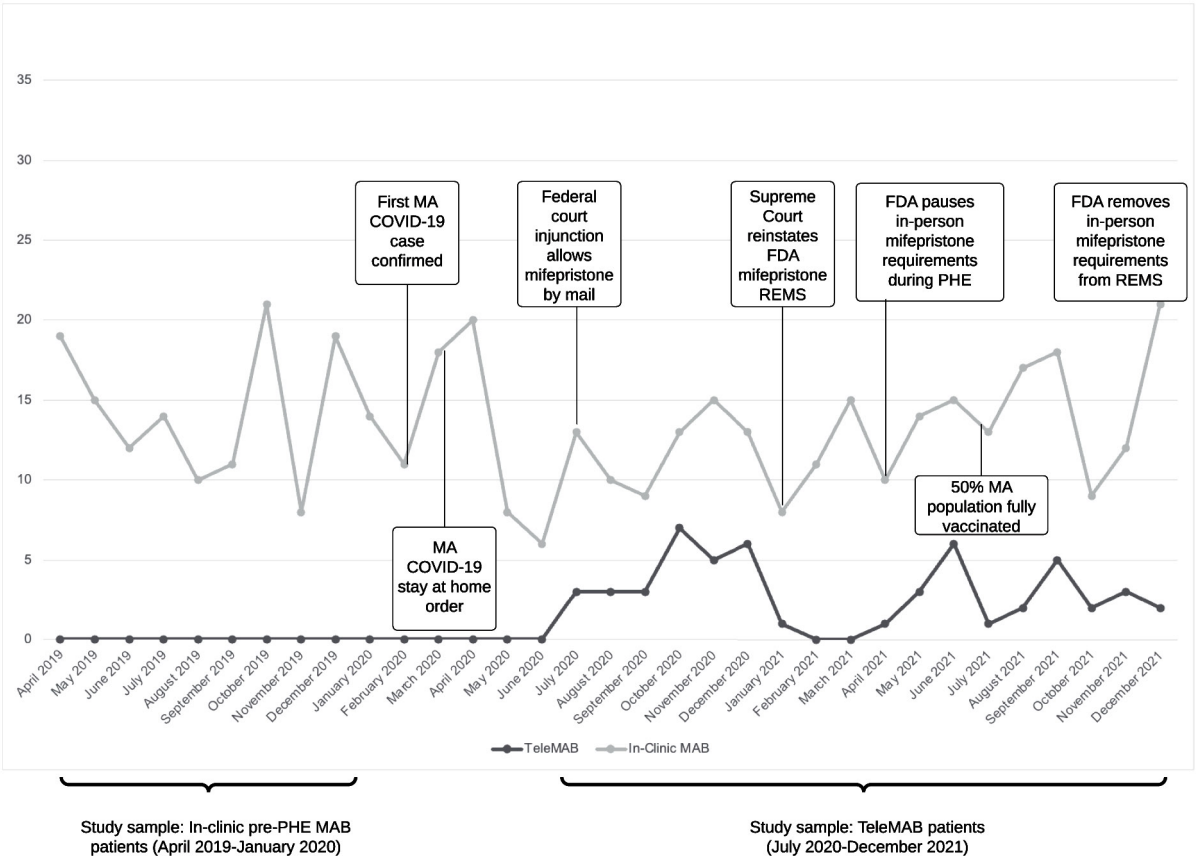
highly satisfied with this care.[14,15] Yet, as of 2018 only 3% of family physicians reported providing abortion, although before its Food and Drug Administration (FDA) approval, 45% of family physicians anticipated offering MAB in their practices.[16,17] Despite its proven safety, since its approval the FDA has restricted mifepristone, the first of a 2-drug MAB regimen, under a "Risk Evaluation and Mitigation Strategy" (REMS), requiring clinicians to physically assess patients' pregnancies and dispense the medication in-clinic, until the COVID-19 Public Health Emergency (PHE).[18]

The PHE led to sustained changes in health care delivery, expanding telehealth services, including in primary care.[19] A temporary injunction on the FDA REMS and dissemination of evidence-based protocols supporting remote clinical assessment of patients allowed for telehealth MAB (teleMAB).[18,20,21] Although some clinics successfully adapted to the changing environment, few safety-net primary care clinics transitioned from in-clinic MAB to teleMAB with medication delivery. Barriers to novel abortion provision include unsupportive leadership, community or professional stigma, and burdensome systems, federal, and state regulations, including pre-*Dobbs* restrictions on teleMAB in 19 states.[22–24]

Although teleMAB can alleviate geographic barriers to abortion, medically underserved communities are impacted by harmful economic and social policies and conditions—poor broadband infrastructure, low access to education and job opportunities, residential segregation, and more—that impede their abilities to use telehealth, resulting in further inequities.[7,25] The extent to which primary care settings can meet the needs of diverse populations by offering teleMAB compared with usual in-clinic MAB is unclear. This study evaluates the accessibility of novel primary care teleMAB, initiated during the PHE with the lifting of mifepristone FDA restrictions, compared with traditional in-clinic MAB offered before the PHE.

**Figure 1. Total medication abortions per month at Massachusetts primary care health system before and during public health emergency (April 2019–December 2021).**



## Methods

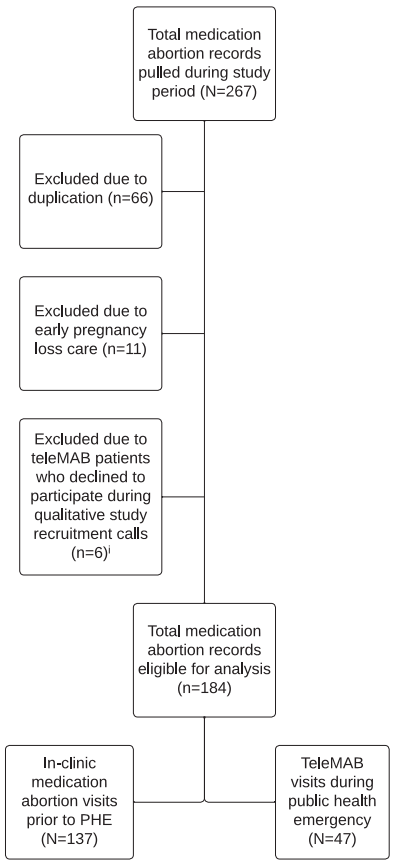
### *Study Design and Setting*

We conducted a retrospective electronic medical record (EMR) review at a large primary care safety-net health system in Massachusetts. This organization serves an economically and culturally diverse population of 120,000 patients across 15 primary care clinics. Many identify as immigrants, the majority hold public or subsidized insurance, and 42% have limited English proficiency requiring professional interpretation in more than 60 languages. The organization has routinely provided MAB since 2003, providing on average 14 MABs per month (2019) and does not publicly advertise their abortion services.

In response to the PHE and temporary lifting of FDA restrictions, the organization expanded MAB to offer synchronous telehealth consultations, remote consent signing, and medications delivered to patients via courier from July 28, 2020 to present, except from January to April 2021 when the Supreme Court reinstated FDA enforcement of the in-person requirements (Figure 1).[18] Patients up to 11 weeks' gestation could choose between in-person and teleMAB appointments, though access to in-person appointments was severely curtailed during the PHE due to temporary clinic closures, staffing changes, and backlogs of appointments leading to health care delays for an extended time. Still, in-clinic visits were required for patients with contraindications to remote care, like symptoms of potential ectopic pregnancy. The in-clinic pre-PHE sample best represents the organization's abortion-seeking patient population during the same months as examined for teleMAB to account for seasonal tendencies in abortion.[26,27] MAB protocols changed in March 2020; first requiring ultrasound and recommending lab work, then only requiring ultrasound and labs when indicated, consistent with published standards of care.[21]

We extracted EMR data for eligible patients (n = 267): in-clinic MAB (April 12, 2019-January 12, 2020) and teleMAB (July 28, 2020-December 31, 2021). Figure 2 illustrates exclusion criteria.

**Figure 2. Flow diagram of inclusion criteria into study.**




[i]Due to institutional review board requirements, eligible patients who declined to participate in an complementary qualitative study were excluded from this chart review (n= 6)

### *Data Collection*

DN, HM, and AT developed an encrypted Google Forms chart abstraction tool to systematically summarize sociodemographic, care access, and relevant medical information in a deidentified dataset. Sociodemographics included race (self-report, predetermined categories), ethnicity (self-report, open-ended), form of payment (private, public, missing), language of care, and whether a patient was an established patient at time of MAB. Race, ethnicity, payment, and language were included to explore racial, ethnic, and income-related differences in teleMAB access and serve as proxy measurements for systemic social, economic, and political barriers to accessing care.[28]

Care access measures included gestational age at time of MAB appointment and time to MAB appointment, calculated in days from when a patient first requested MAB (phone call or visit) to their MAB appointment date. We dichotomized time to MAB appointment as 6 days or less versus seven days or more based on an analysis of the 2014 Abortion Patient Survey, which found an average abortion

**Table 1. Sociodemographic and Access Characteristics of Patients Receiving Medication Abortion in a Primary Care Health System Before and During the COVID-19 Public Health Emergency**

| | In-Clinic MAB Pre-PHE (n = 137) | TeleMAB during PHE (n = 47) | P-Value |
|---|---|---|---|
| Established Patient at Time of MAB* | 124 (91.2%) | 43 (91.5%) | 1.0 |
| Race | | | 0.19 |
| Asian | 9 (6.6%) | 6 (12.8%) | |
| Black | 52 (37.9%) | 13 (27.7%) | |
| White | 22 (16.1%) | 12 (25.5%) | |
| Other | 50 (36.5%) | 15 (31.9%) | |
| Unknown/Preferred not to Share | 4 (2.9%) | 1 (2.1%) | |
| Ethnicity[±] | | | 0.46 |
| African American | 16 (11.8%) | 6 (13.9%) | |
| Hispanic | 19 (14.1%) | 6 (13.9%) | |
| Brazilian/Portuguese | 24 (17.8%) | 9 (20.9%) | |
| Haitian | 25 (18.5%) | 3 (6.9%) | |
| Other | 51 (37.8%) | 19 (44.2%) | |
| Primary Language[‡] | | | 0.18 |
| English | 110 (80.3%) | 42 (89.4%) | |
| Portuguese | 12 (8.8%) | 3 (6.4%) | |
| Other | 15 (10.9%) | 2 (4.3%) | |
| Form of Payment | | | 0.95 |
| Private Insurance | 24 (17.5%) | 14 (29.8%) | |
| Public Insurance[§] | 76 (55.5%) | 33 (70.2%) | |
| Not documented in EMR[‖] | 37 (27.0%) | 0 (0%) | |
| Gestational Age in Days at Time of MAB Appointment[¶] | 48.1 (28 to 68) | 45.3 (30 to 75) | 0.049[#] |
| 41 days and under | 32 (23.7%) | 20 (42.6%) | |
| 42 to 56 days | 79 (58.5%) | 20 (42.6%) | |
| 57 to 69 days | 24 (17.8%) | 5 (10.6%) | |
| 70 to 77 days | 0 (0%) | 2 (4.3%) | |
| Completed Abortion** | 130 (94.9%) 95% CI: 89.8%, 97.9% | 42 (89.4%) 95% CI: 76.9%, 96.5% | 0.187 |

*1 in-clinic patient missing (n = 136).
[±]Ethnicity was self-reported by patients. "Other" category includes ethnicities such as: Nepali, Moroccan, Nigerian, American, Korean, etc.
[‡]$\chi^2$ test compared English and non-English speaking. Other languages included: Spanish, Haitian Creole, Nepali, and Arabic. Patients used phone interpreters, face-to-face interpreters, or spoke English during their visits.
[§]Includes payment by public insurance, grant, or out of pocket.
[‖]37 visits' form of payment not documented in EMR due to a technology issue during specific segment of time. Assigned missing in fisher's exact test.
[¶]2 in-clinic cases missing due to pregnancy of unknown location, medication abortion complete by drop in hcg; n = 135; mean, range, and independent *t* test for statistical differences reported here.
[#]significant results at $P = .05$.
**Complete abortions without additional doses of medication; no patients lost to follow-up as in-person appointments or phone calls were required to confirm completed abortion.

appointment delay of 7.6 days.[29] Complete abortion was dichotomized to describe MAB completions per protocol 1 to 28 days after abortion.

### *Data Analysis*

We reported sociodemographic, care access, and complete abortion measures using descriptive statistics and compare differences between in-clinic and telehealth groups using $c^2$, fisher's exact test, independent *t* test, and Wilcoxon rank sum. We conducted logistic regression to examine time to care differences. We used R (4.1.1, R Core Team 2022) to conduct analyses. We set significance at $P = .05$; unknown responses were assigned missing. This study was approved by the two organizations' institutional review boards.

## Results

Of 267 medical records extracted, 184 were eligible for analysis, of which 137 (74.5%) MABs occurred in-clinic pre-PHE and 47 (25.5%) were teleMAB encounters during the PHE (Table 1). The vast majority in both groups (91%) were established patients. Patients were not significantly more likely to receive teleMAB versus in-clinic MAB based on race, ethnicity, language, or form of payment. Completed abortion did not significantly differ between teleMAB and in-clinic MABs ($P = .187$).

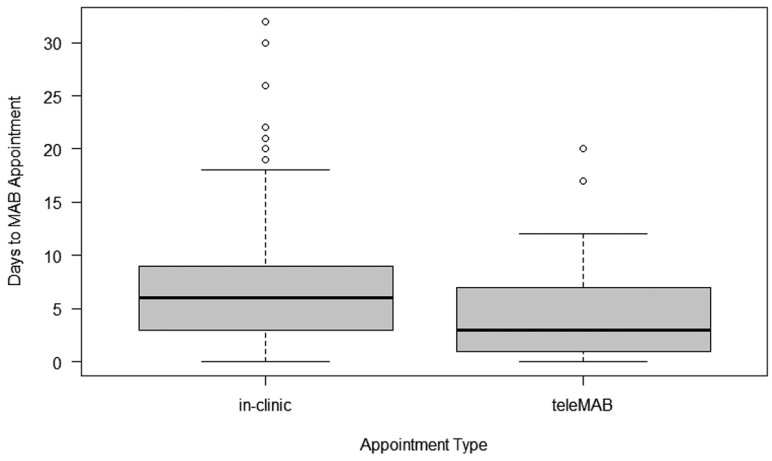
In-clinic visits had a mean gestational age at time of appointment of 48.1 days compared with 45.3 days for teleMAB ($P = .049$). Patients received care more quickly when accessing teleMAB compared with in-clinic services (median 3 days to teleMAB, range 0 to 20 days vs median 6 days to in-clinic, range 0 to 32; $P < .001$, Figure 3). TeleMAB patients had 2.29 times the odds of having their abortion appointment within 6 days compared with in-clinic (95% CI: 1.13, 4.86).

## Discussion

In a safety-net primary care system we found that teleMAB was as effective, timelier, and potentially more accessible than in-clinic care (when the FDA enforced in-person assessment and medication acquisition). This demonstrates the feasibility of primary care organizations to integrate novel abortion services to meet their patients' needs. In addition, timely clinical visits is an important indicator of quality abortion care.[30,31] Reducing delays enhances patient-centeredness, reflecting a health system's responsiveness to patients' preferences, needs, and values.[30] Increasing access in primary care is critical as *Dobbs* and other abortion restrictions have increased demand at remaining facilities, contributing to delays and prolonged care.[4,32–35]

We found no differences in sociodemographic characteristics or complete abortion between in-clinic and teleMAB patients. Although we cannot draw conclusions regarding MAB safety due to the study's small sample, our findings are within the range of other studies evaluating complete abortion after MAB in primary care.[36–38] And, although not statistically significant, we found a smaller percentage of teleMAB patients were Black, Haitian, and non-English speaking. Studies during the PHE have found racial, ethnic, and language inequities in broad telehealth utilization.[39–42] Structural barriers drive these inequities, including challenges integrating interpretation into video visits, reimbursement for audio-only visits, and systematic disinvestment in predominantly Black and/or low-income communities and consequences on access to and comfort using digital health infrastructure.[41] Like other telehealth services, teleMAB may not be as accessible due to this digital divide.[25,42] Employing strategies to increase abortion access in community-based settings where and how underserved communities obtain their usual health care is critical. Beyond telehealth, primary care organizations should prioritize access to timely in-person

**Figure 3. Days between first contact for medication abortion and appointment between in-clinic pre-PHE visits and teleMAB visits during the PHE. *Abbreviation:* PHE, public health emergency.**



appointments for patients who cannot or do not want to use telehealth. Research is needed to ensure introducing teleMAB does not exacerbate access disparities.

This study has limitations. We sought to collect comprehensive demographics but were limited by IRB requirements that restricted collecting age, parity, and other clinical data. Although time-related factors comparing in-clinic pre-PHE MAB with teleMAB during the PHE may have created systematic differences in the study's abortion-seeking population, this comparison is appropriate given the reduced in-person appointment and staff availability during the PHE, and the need to compare newly introduced teleMAB to usual in-clinic care. As the FDA permanently revised the mifepristone REMS in December 2021 by removing in-person requirements and allowing a pharmacy certification process, future research should compare access to and timeliness of primary care teleMAB to in-clinic MAB, as both are now similarly available in unrestricted states. Further study of the feasibility and effectiveness of primary care teleMAB may motivate more clinics to offer this care, thus reducing delays and improving access. And although the Supreme Court prepares to hear *Alliance for Hippocratic Medicine v FDA*, which may reverse the FDA's REMS modifications that enabled remote mifepristone dispensing, misoprostol-only teleMAB protocols will still be available.[43,44]

Novel teleMAB was comparable to in-clinic services historically provided in a primary care safety-net health care system. TeleMAB seems feasible and can promote timely access to abortion care. Primary care settings should consider implementing teleMAB provision to facilitate timely, patient-centered access to care.

*To see this article online, please go to: http://jabfm.org/content/37/2/295.full.*

## References


1. McCann A, Schoenfeld Walker A, Sasani A, Johnston T, Buchanan L, Huang J. Tracking the states where abortion is now banned. *New York Times*. Available at: https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html. Published April 14, 2023. Accessed April 16, 2023.
2. Kirstein M, Dreweke J, Jones RK, Philbin J. *100 days post-Roe: at least 66 clinics across 15 US states have stopped offering abortion care*.; 2022. Accessed November 4, 2022. Available at: https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care.
3. Grossman D, White K, Hopkins K, Potter JE. Change in distance to nearest facility and abortion in Texas, 2012 to 2014. JAMA 2017;317:437–9.
4. White K, deMartelly V, Grossman D, Turan JM. experiences accessing abortion care in Alabama among women traveling for services. Womens Health Issues 2016;26:298–304.
5. Gerdts C, Fuentes L, Grossman D, et al. Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas. Am J Public Health 2022;106:857–64.
6. Singer MR, Bartz D, Pace LE. The role of primary care clinicians in protecting access to abortion services. JAMA Intern Med 2022;182:897–8.
7. Thompson KMJ, Sturrock HJW, Foster DG, Upadhyay UD. Association of travel distance to nearest abortion facility with rates of abortion. JAMA Netw Open 2021;4:e2115530.
8. Patel P, Narayana S, Thill Z, Gold M, Paul A. Family physicians' role in simplifying medication abortion during the COVID-19 pandemic. J Am Board Fam Med 2021;34:S33–S36.
9. Beaman J, Prifti C, Schwarz EB, Sobota M. Medication to manage abortion and miscarriage. J Gen Intern Med 2020;35:2398–405.
10. Weitz TA, Taylor D, Desai S, et al. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health 2013;103:454–61.
11. Prine LW, Lesnewski R. Medication abortion and family physicians' scope of practice. J Am Board Fam Pract 2005;18:304–6.
12. Amico JR, Cheng TL, Godfrey EM. Providing abortion services in the primary care Setting. Prim Care 2018;45:599–613.
13. Committee on Reproductive Health Services: Assessing the Safety and Quality of Abortion Care in the U.S., Board on Population Health and Public Health Practice, Board on Health Care Services, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. *The safety and quality of abortion care in the United States*. National Academies Press; 2018:24950.
14. Rubin SE, Godfrey E, Gold M. Patient attitudes toward early abortion services in the family medicine clinic. J Am Board Fam Med 2008;21:162–4.
15. Wu JP, Godfrey EM, Prine L, Andersen KL, MacNaughton H, Gold M. Women's satisfaction with abortion care in academic family medicine centers. Fam Med 2015;47:98–106.
16. Patel P, Narayana S, Summit A, et al. Abortion provision among recently graduated family physicians. Fam Med 2020;52:724–9.

17. *Will 1999 be the year for Mifepristone (Ru-486)? And, an update on women's other options for very early abortion*. Kaiser Family Foundation; 1998. Available at: https://www.kff.org/womens-health-policy/will-1999-be-the-year-for-mifepristone/.
18. Questions and answers on Mifepristone for medical termination of pregnancy through ten weeks gestation. US Food and Drug Administration. Published January 4, 2023. Accessed January 28, 2023. Available at: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.
19. Cortez C, Mansour O, Qato DM, Stafford RS, Alexander GC. Changes in short-term, long-term, and preventive care delivery in US office-based and telemedicine visits during the COVID-19 pandemic. JAMA Health Forum 2021;2:e211529.
20. Godfrey EM, Fiastro AE, Jacob-Files EA, et al. Factors associated with successful implementation of telehealth abortion in 4 United States clinical practice settings. Contraception 2021;104:82–91.
21. Raymond EG, Grossman D, Mark A, et al. Commentary: no-test medication abortion: A sample protocol for increasing access during a pandemic and beyond. Contraception 2020;101:361–6.
22. Summit AK, Lague I, Dettmann M, Gold M. Barriers to and enablers of abortion provision for family physicians trained in abortion during residency. Perspect Sex Reprod Health 2020;52:151–9.
23. Razon N, Wulf S, Perez C, et al. Exploring the impact of mifepristone's risk evaluation and mitigation strategy (REMS) on the integration of medication abortion into US family medicine primary care clinics. Contraception 2022;109:19–24.
24. Anderson E, Salganicoff A, Sobel L. *State restrictions on telehealth abortion*. Kaiser Family Foundation; 2021. Available at: https://www.kff.org/womens-health-policy/slide/state-restrictions-on-telehealth-abortion/.
25. Clare CA. Telehealth and the digital divide as a social determinant of health during the COVID-19 pandemic. Netw Model Anal Health Inform Bioinform 2021;10:26.
26. Parnell AM, Rodgers JL. Seasonality of induced abortion in North Carolina. J Biosoc Sci 1998; 30:321–32.
27. Franklin TE, Theisen G, Salyer CV, Pinkston C, Gunaratnam B. The seasonality of abortion in Kentucky. Contraception 2017;95:181–5.
28. Boyd RW, Lindo EG, Weeks LD, McLemore MR. On racism: a new standard for publishing on racial health inequities. Health Aff Blog 2020. Published online July 2.
29. Jones RK, Jerman J. *Time to appointment and delays in accessing care among U.S. abortion patients*. Guttmacher Institute; 2016. Available at: https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients.
30. Agency for Healthcare Research and Quality. Six domains of health care quality. Published November 2018. Accessed June 5, 2022. Available at: https://www.ahrq.gov/talkingquality/measures/six-domains.html.
31. Dennis A, Blanchard K, Bessenaar T. Identifying indicators for quality abortion care: a systematic literature review. J Fam Plann Reprod Health Care 2017;43:7–15.
32. *#WeCount Report April to December 2022 Findings*. Society of Family Planning; 2023. Available at: https://societyfp.org/wp-content/uploads/2023/03/WeCountReport_April2023Release.pdf.
33. Maddow-Zimet I, Kost K. *Even before Roe was overturned, nearly one in 10 people obtaining an abortion traveled across state lines for care*. Guttmacher Institute Accessed November 16, 2022. Available at: https://www.guttmacher.org/article/2022/07/even-roe-was-overturned-nearly-one-10-people-obtaining-abortion-traveled-across.
34. Upadhyay UD, Desai S, Zlidar V, et al. Incidence of emergency department visits and complications after abortion. Obstet Gynecol 2015;125:175–83.
35. Lindo J, Pineda-Torres M. *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*. J Health Econ 2021. Epub 2021 Sep 16.
36. Prine L, Shannon C, Gillespie G, et al. Medical abortion: outcomes in a family medicine setting. J Am Board Fam Med 2010;23:509–13.
37. Bennett IM, Baylson M, Kalkstein K, Gillespie G, Bellamy SL, Fleischman J. Early abortion in family medicine: clinical outcomes. Ann Fam Med 2009;7:527–33.
38. Godfrey EM, Bordoloi A, Moorthie M, Pela E. Medication abortion within a student health care clinic: a review of the first 46 consecutive cases. J Am Coll Health 2012;60:178–83.
39. Redd SK, Rice WS, Aswani MS, et al. Racial/ethnic and educational inequities in restrictive abortion policy variation and adverse birth outcomes in the United States. BMC Health Serv Res 2021; 21:1139.
40. Eberly LA, Kallan MJ, Julien HM, et al. Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. JAMA Netw Open 2020;3:e2031640.
41. Payán DD, Frehn JL, Garcia L, Tierney AA, Rodriguez HP. Telemedicine implementation and use in community health centers during COVID-19: Clinic personnel and patient perspectives. SSM Qual Res Health 2022;2:100054.
42. Adepoju OE, Chae M, Ojinnaka CO, Shetty S, Angelocci T. Utilization gaps during the COVID-19 pandemic: racial and ethnic disparities in telemedicine

uptake in federally qualified health center clinics. J Gen Intern Med 2022;37:1191–7.

43. Center for Reproductive Rights. Alliance for Hippocratic medicine v. FDA. 2023. Available at: https://reproductiverights.org/case/alliance-for-hippocratic-medicine-v-fda/.

44. Johnson DM, Michels-Gualtieri M, Gomperts R, Aiken ARA. Safety and effectiveness of self-managed abortion using misoprostol alone acquired from an online telemedicine service in the United States. Perspect Sex Reprod Health 2023;55:4–11.