

Family Physicians' Role in Simplifying Medication Abortion During the COVID-19 Pandemic and Beyond

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Conflicting/Competing Interests: The authors have declared that no competing interests exist.

Funding Statement: The authors received no specific funding for this work.

Acknowledgements: We would like to thank Lars Peterson, MD, PhD and Zachary Morgan, MS from the American Board of Family Medicine in Lexington, KY for their assistance with data analysis and review of the manuscript.

Word Count: 1166

Abstract

Introduction: Despite first trimester abortion being common and safe, there are numerous restrictions that lead to barriers to seeking abortion care. The COVID-19 pandemic has only exacerbated these barriers, as many state legislators push to limit abortion access even further. During this pandemic, family physicians across the country have incorporated telemedicine into their practices to continue to meet patient needs. Medication abortion can be offered to patients by telemedicine in most states, and multiple studies have shown that labs, imaging, and physical exam are not medically necessary for the majority of cases. Furthermore, several studies have highlighted that medication abortion is safe and effective when offered in the family medicine setting.

Methods: Data from the 2018-2019 Family Medicine National Graduate Survey were analyzed to determine the proportion of respondents who indicated they were trained to provide pregnancy termination and were providing pregnancy termination upon graduation.

Results: Of the family medicine graduates three years out of residency, 3.7% of respondents reported providing pregnancy termination. However, 13.3% of respondents reported feeling prepared to provide pregnancy termination based on training during residency.

Conclusion: Family physicians are well-poised to incorporate medication abortion into their practices using approaches that limit the spread of the coronavirus, ultimately increasing access to abortion in these unprecedented times.

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Pandemic and Beyond**

1 First trimester abortion is one of the most common outpatient medical procedures in the United
2 States (US). It is extremely safe and represents over 90% of all abortions that occur in the US.^{1,2}
3 Medication abortion (MAB), which involves taking the pills mifepristone and misoprostol to end
4 a pregnancy, can entail minimal interaction between patients and clinicians. It is approved by the
5 Food and Drug Administration (FDA) for use up to 10 weeks gestation. Since mifepristone's
6 introduction to the US market in 2000, MAB has become increasingly common and represents
7 39% of all abortions that occur in the US annually.³ Complications are rare, and completion rates
8 are between 97-98%.⁴

9
10 Even prior to the COVID-19 pandemic, patients seeking abortion care have faced decades of
11 onerous legal barriers, institutional restrictions, and an inadequate distribution of abortion
12 providers throughout the US. The most recent data on regional distribution of abortion facilities
13 was published by The Guttmacher Institute and shows that 89% of US counties did not have a
14 clinical facility that provides abortion in 2017. Furthermore, 38% of reproductive-aged women
15 between the ages of 15 and 44 lived in counties without any abortion-providing facility in 2017.¹
16 Many states' governors have used their executive powers to limit or block abortion by deeming it
17 non-essential, possibly employing this rhetoric to make these abortion restrictions last beyond
18 the pandemic. With these limitations in abortion care and with workforce demands shifting
19 outpatient clinicians into the hospital, the COVID-19 pandemic has exacerbated many of the
20 oppressive barriers to abortion access that have existed for decades.

21
22 The consequences of the inability to access abortion have been well-demonstrated. Pregnant
23 people who are unable to obtain a wanted abortion are four times more likely than people who

24 are able to obtain their abortion to live below the federal poverty level, are three times more
25 likely to be unemployed, and are more likely to stay in contact with violent partners. They also
26 experience more serious health problems.^{5,6}

27

28 Practice models are evolving rapidly to accommodate essential and time-sensitive healthcare
29 services in light of the COVID-19 pandemic. First trimester abortion services are no exception.
30 Abortion services have fundamentally changed in many clinical contexts in an effort to
31 accommodate patients coping with quarantines, mandatory stay-at-home orders, limited
32 transportation options, and changing work and family obligations. The goal of these changes is to
33 safely limit the contact between patients and staff and ultimately limit the spread of the novel
34 coronavirus. “No test” protocols provide recommendations for patient eligibility,⁷ evaluation of
35 gestational age without clinical contact (e.g. omitting sonogram and pelvic exam),⁸⁻¹⁰ limited Rh
36 testing,¹¹⁻¹³ and modified follow-up via “videoconference, telephone, patient portal, email, text or
37 other telemedicine modalities.”^{7,14-19} With screening and counseling done ahead of time, the “no
38 test” protocol eliminates the majority of contact between patients and staff. However, unlike
39 other telemedicine care, in which the physician can send a prescription to the pharmacy, the FDA
40 still requires clinicians to dispense mifepristone directly to patients in person.

41

42 Increasingly, telemedicine is being employed to maintain and to improve critical access to
43 essential services. As more primary care is being provided through telemedicine, family
44 physicians are well-poised to fill gaps in abortion access via this delivery model. Moreover,
45 according to a 2018 National Academies of Sciences, Engineering, and Medicine report about

46 abortion care in the US, family physicians can provide abortions safely and effectively in the
47 outpatient primary care setting.² MAB specifically draws upon existing clinical skills of family
48 physicians including pregnancy diagnosis and obstetrics, patient-centered counseling, medication
49 management, clinical follow-up, and more.²⁰ It requires neither procedural training nor
50 specialized equipment and aligns well with the types of care many family physicians are already
51 providing, such as miscarriage management. In light of the COVID-19 pandemic, clinical sites
52 across the country, ranging from large abortion clinics to community-based practices, are
53 employing the “no test” protocol described above, making MAB counseling and follow-up ideal
54 telemedicine visits.

55
56 A widespread adoption of MAB provision by family physicians using these simplified protocols
57 could have a profound effect on access to abortion in the US. Historically, family physicians
58 practice in underserved areas of the country and provide care that is difficult to access. There are
59 roughly 200,000 practicing primary care physicians in the US,²⁰ and workforce data show that
60 family physicians are the most common specialty practicing in medically underserved areas of
61 the US. These areas also happen to be regions with the largest barriers to abortion care.²¹⁻²³
62 Providing MAB is well-aligned with the central tenets of family medicine, including the
63 commitment to help reduce health care disparities. In addition, several studies have
64 demonstrated the safety of MAB provision in the family medicine outpatient setting, showing
65 MAB success rates of 96.5% and 99.2%.^{24,25} Continuing pregnancy and missed ectopic
66 pregnancy, two outcomes deemed unsuccessful, were rare. Bennett et al found a continuing
67 pregnancy rate of 1.5% and a missed ectopic pregnancy rate of 0.08%, and Prine et al showed a
68 continuing pregnancy rate of 0.4%.^{24,25} Therefore, family physicians have the ability to provide

69 MAB safely, increasing access to abortion care, especially in parts of the US with numerous
70 barriers to receiving this care.

71
72 Although family physicians are well poised to provide abortions, few do. Data from the 2018 and
73 2019 family medicine national graduate surveys of graduates three years out of residency
74 showed that only 3.7% (172/4644) provided pregnancy terminations. Interestingly, of those who
75 reported providing abortion care, almost half (40.7%) indicated that they did not provide uterine
76 aspiration/D&C, likely signifying that they are only performing MAB (Table 1).

77
78 While only 3.7% of recently graduated family physicians provide abortions, 13.3% report feeling
79 prepared to provide abortion care based on training obtained in residency (Table 1). This
80 discrepancy suggests the barriers are not limited to lack of education or training. Indeed,
81 administrative and systems-level barriers in integrating abortion care were most frequently
82 mentioned as reasons why respondents who intended to provide abortion are not currently doing
83 so.²⁶ Other barriers to MAB provision include stringent FDA regulations that require providers to
84 register with a central database in order to dispense mifepristone to patients, strict medication
85 dispensing regulations that require a clinician to dispense the pills directly to the patient,
86 concerns for safety of clinic staff and patients, personal beliefs, lack of insurance reimbursement,
87 and lack of colleague support.^{20,27,28}

88
89 [Insert Table 1]

90

91 These barriers, like other elements of care provision, are evolving in light of the current COVID-
92 19 pandemic and may not be present to the same extent in the future with new healthcare
93 delivery methods. This time of transition marks an auspicious time to increase MAB delivery
94 within family medicine. One in four women will have an abortion in their lifetime, and nearly
95 every family physician will care for patients who can become pregnant. Now more than ever,
96 MAB services and education should be championed within family medicine. This expansion of
97 care is especially pertinent now, in a time of markedly decreased access to care, but changes
98 adopted should continue into the future to improve patient-centered outcomes in reproductive
99 health and abortion care.

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Table 1: Graduate Survey Data from Family Medicine Graduates 2018-2019, American Board of Family Medicine.

	Provides Pregnancy Termination			P value
Prepared for Pregnancy Termination Upon Graduation from Residency	Yes N=(172)	No N=(4,472)	Total N=4,644	
Yes	130 (75.6%)	489 (10.9%)	619 (13.3%)	<.001
No	42 (24.4%)	3,983 (89.1%)	4,025 (86.7%)	
Provides Uterine Aspiration/D&C	Yes (N=173)	No (N=4,472)	Total (n=4,645)	
Yes	102 (59.0%)	121 (2.7%)	223 (4.8%)	< .001
No	71 (41.0%)	4,351 (97.3%)	4,422 (95.2%)	