A Streamlined Model for Medication Abortion Access

— Screening patients for abortion pills using history alone is highly effective and low risk

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The recently leaked Supreme Court draft decision on abortion recently revealed that our nation is on the edge of a major shift in the abortion care landscape. As the federal right to abortion may soon be overruled, patients in many states will be forced to travel hundreds of miles to get care, endure higher costs, and miss time from work, school, and/or family. Clinics and providers in states where abortion remains legal will be hard pressed to manage the influx of patients. Many are asking what can be done to make abortion care easier and more convenient, particularly in states where abortion is restricted. One answer is to make abortion pills more accessible.

Our new study in *JAMA Internal Medicine* shows that prescribing the pills doesn't require expensive equipment or even a pelvic exam. We found that among the nearly 4,000 medication abortions provided by 14 clinics nationwide without pelvic exams or ultrasounds, the vast majority were completed without additional medical intervention (95%) or adverse events (99.5%). Given these findings, people can feasibly receive abortion care from the same person who sees them for colds and coughs. This is the model at the family health center where one of us (Marji Gold, MD) works as a family medicine physician.

We found that people can safely and effectively obtain an abortion up to 11 weeks of pregnancy, simply by confirming a few details about their pregnancy. This streamlined process would allow a broader range of clinicians, including primary care physicians and nurse practitioners (in states where it is permitted), to offer abortion pills -- and it would allow people to access abortion care just like they get any other basic healthcare.

This process may seem unorthodox to clinicians who use ultrasounds as a matter of course for abortion provision, and to patients who expect one. However, using an ultrasound is a relatively new practice, popularized in the 1990s when the technology became more readily available. As a primary care provider who is not an ob/gyn, I (Gold) have been providing abortions safely without ultrasounds for decades. My patients are relieved to learn they

can go to their regular primary care provider for this kind of care. More family medicine physicians should feel empowered by our new data to follow this example and offer more people this convenience.

Our study also builds on other evidence that patients can be trusted to know their own bodies. Indeed, previous studies show that people seeking early abortion can accurately estimate how far along their pregnancy is using the date of their last menstrual period. Adding other screening questions -- such as whether individuals believe they are more than 11 weeks pregnant, more than 2 months pregnant, or have missed more than two periods -- can help clinicians accurately determine if a patient is eligible for medication abortion. The American College of Obstetricians and Gynecologists, Planned Parenthood, and the National Abortion Federation have already updated their guidelines to reflect that a clinical consultation without ultrasounds or a pelvic exam is sufficient for medication abortion.

Shifting to this new process could expand and expedite access to abortion -- a necessity at a time when many states are shrinking the window for care or doing away with it altogether. It also gives providers in abortion-friendly states the opportunity to expand abortion care. The FDA's recent ruling that mifepristone -- one of the drugs used in medication abortion -- can now be dispensed by pharmacies and mail will further expand access.

Our findings also open the door for more abortion via telehealth. A patient can call a virtual clinic, answer a few questions, and get the medication mailed to them without going to a clinic. In addition to offering greater convenience and privacy, this new process is aligned

with trauma-informed care. Ultrasounds, especially transvaginal ones, and pelvic exams are invasive and may be triggering for some patients. Avoiding them could, by extension, avoid unnecessary distress.

However, this new process is not a panacea. Nearly a dozen states have non-evidence-based laws in place mandating providers perform ultrasounds on abortion patients. Other state laws require patients be given the option to view an ultrasound image; force patients to receive counseling in person before their appointment; or ban abortion via telehealth outright. FDA guidelines require licensed clinicians to have additional certification by the distributor to write a prescription for mifepristone, which creates yet another potential and arbitrary hurdle. In addition, logistical, financial, and legal challenges can still stand between a patient and their necessary care. This is especially true for people of color, those living on low-incomes, and those living in rural areas, who are all more likely to live in states with restrictive policies.

All of these hurdles will only become much worse with the impending fall of Roe, especially in states that ban abortion, both procedural and medication abortion. However, this model of care might still help residents in these states to some degree -- rather than trying to get an appointment with overburdened providers in states where abortion remains legal, people could travel across their border to a state that offers telehealth, and have the abortion medications mailed to the nearest post-office after the telehealth consultation. This option may help relieve the surges we expect to see in protected access states.

Ultimately, this model could help expand access to abortion, lower costs, and shorten time to treatment. It can also empower a broader range of clinicians to provide abortion care at a time when the options are shrinking for so many. For patients and providers, that's a win-win.

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