Medical abortion

CPD

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Background
Medical abortion (using mifepristone followed by misoprostol to end an early pregnancy) is a more accessible and less invasive option than surgical termination and can be provided in primary care settings. However, few general practitioners (GPs) currently provide this service, and there remains great inequity in access to abortion across Australia, particularly for young women and those living in rural and remote area.

Objective
The aim of this article is to help Australian GPs better understand the practical and legal considerations of providing medical abortion to patients.

Discussion
Provision of medical abortion is well within the scope of community general practice and improves the comprehensiveness of women's sexual and reproductive health services that GPs can deliver. This article will help GPs to better understand the process involved in providing medical abortion, including the practical considerations for patients; be better equipped to support patients who have decided that medical abortion is an appropriate choice for them; and make an informed decision as to whether to become a provider of medical abortion.

ONE-THIRD of Australian women experience an unintended pregnancy in their lifetimes,[1] and 30.4% of these pregnancies will end in abortion (one in five Australian women).[2] Rates of unintended pregnancy are disproportionately higher among women who are sociodemographically disadvantaged and those living in rural areas.[3] Abortion remains strongly associated with factors affecting women's control over their own reproductive health, such as partner violence, illicit drug use and either non-use of contraception or use of less effective forms of contraception such as the combined oral contraceptive pill.[4]

Access to services, particularly in rural areas, and high out-of-pocket costs remain significant hurdles for women wishing to exercise reproductive choice.[5] A recent study of women attending one large private service provider reported a median out-of-pocket expense of $560, resulting in over two-thirds of women needing financial assistance for the procedure.[6]

Historically, state-based legislative barriers and outdated cultural norms have contributed to stigma associated with provision of abortion care. This has created barriers to training and access to abortion care for both women and their doctors.

It was anticipated that the introduction of medical abortion to the Pharmaceutical Benefits Scheme (PBS) in Australia in 2012 would improve equitable access to abortion services through integration into primary care. However, as of August 2019, there were only 1345 certified GP prescribers of medical abortion in Australia out of an estimated 35,000 practising GPs (Dr P Goldstone, personal communication), and it remains unclear how many are actively providing this service.

Many women are unaware of the availability of medical abortion or the fact that it is only available in Australia up until the sixty-third day of the pregnancy (nine weeks' gestation). One study found that women travelling >4 hours to a city-based clinic, those who experienced financial difficulty, and Aboriginal and Torres Strait Islander women had a higher probability of presenting beyond the nine-week gestation limit, making them ineligible for a medical abortion.[6] In many countries around the world, medical abortion accounts for more than 95% of first trimester abortions and is routinely carried out by nurses and midwives;[7] the World Health Organization (WHO) promotes this through task sharing to increase access to services.[8] Nurse-led models of care[9] are currently being undertaken in community health settings, but consideration is required regarding how these models can be implemented in the general practice setting.

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How does medical abortion work?

Medical abortion involves the use of two agents: mifepristone, a synthetic steroid with antiprogestogen activity, and misoprostol, a prostaglandin analogue. Mifepristone competes with progesterone at a receptor level, blocking its action. This causes the pregnancy to stop progressing and the placenta and embryo to detach from the endometrium, followed by dilation and softening of the cervix. Mifepristone also increases uterine contractility and sensitisation of the myometrium to prostaglandin-induced contractions. Misoprostol is taken 24–48 hours after mifepristone. This induces contractions, cervical opening and evacuation of the uterine contents. For most women, bleeding and expulsion occurs within 3–4 hours of misoprostol administration, and vaginal bleeding declines over 10–16 days. The process of a medical abortion is therefore similar to that of miscarriage, with the woman experiencing bleeding and cramps.

How safe and effective is medical abortion?

The medications used for medical abortion are on the WHO Model List of Essential Medicines.[10] When mifepristone and misoprostol are used for medical abortion up until 63 days' gestation, the efficacy is between 95.16% and 97.7%.[11,12] Complications are rare, with the most common being a retained clot rather than ongoing pregnancy. In an Australian study of 13,078 women, 4.8% required surgical intervention, but only in 0.76% was this due to a continuing pregnancy.[12] The odds of needing aspiration for any reason are greatest at higher gestational ages. Rates of infection requiring hospitalisation and rates of transfusion are 0.01 and 0.03%, respectively.[11]

What is holding GPs back from offering medical abortion in their practice?

Integration of medical abortion into general practice may have been hampered by GP concerns about the legality of provision. Decriminalisation has now occurred in every state except South Australia, but there are state-specific considerations that GPs should familiarise themselves with. A current summary of these is provided in Figure 1.

GPs may also hold the misperception that prescribers are required to be on call 24 hours per day to manage any potential complications. However, there is no requirement for this. The management of complications arising from medical abortion is no different from the management of complications arising from spontaneous miscarriage. Women should be advised to stay close (ie within a two-hour drive) to a hospital capable

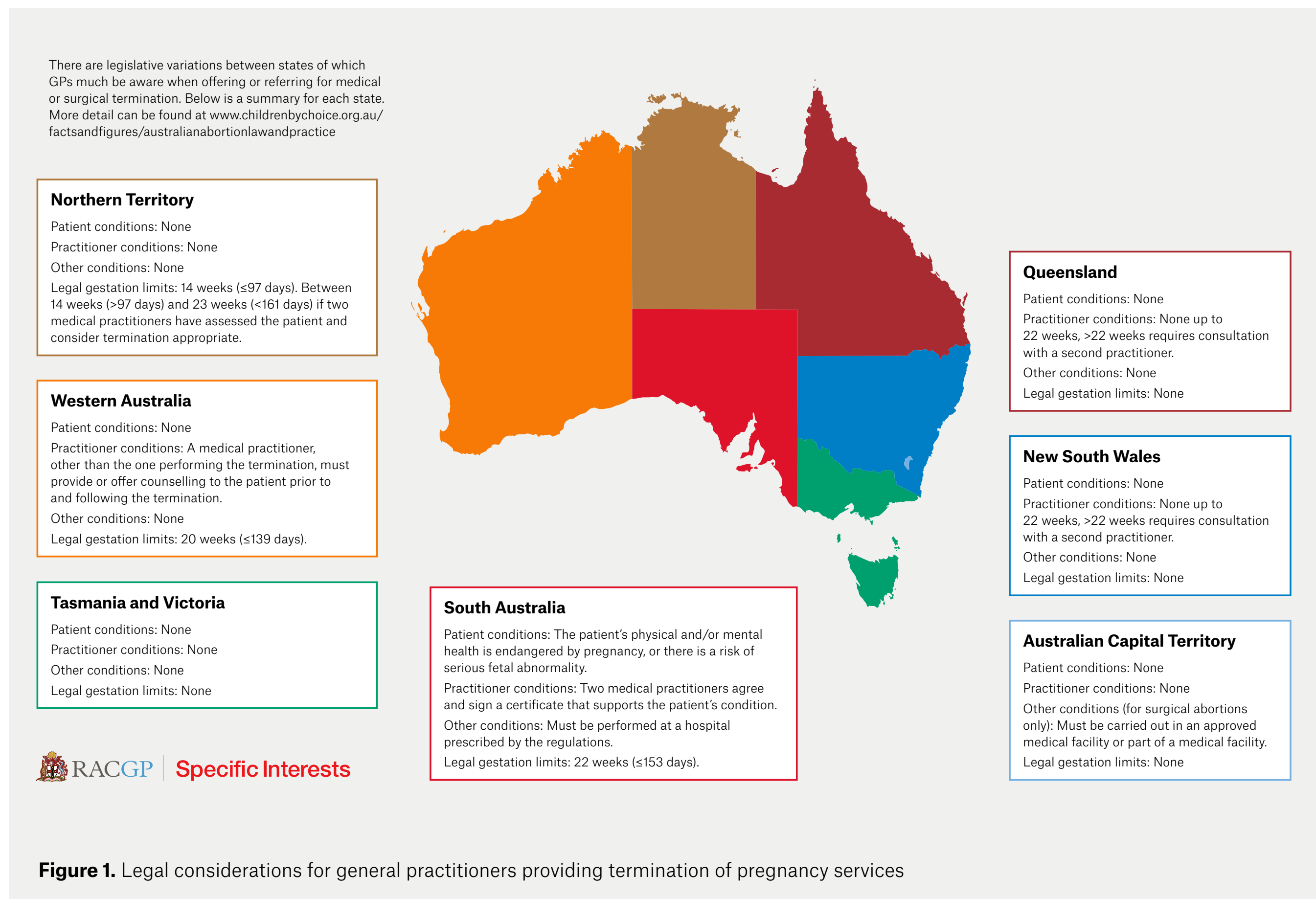

Figure 1. Legal considerations for general practitioners providing termination of pregnancy services

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of managing a miscarriage following treatment. MS Health also provides a 24-hour telephone advice line for women who are using MS-2 Step.

There are other perceived barriers: some GPs feel medical abortion is beyond their scope of practice or that they would be stigmatised. Many feel isolated and speak of the need for peer support and referral pathways to assist them.[13] Abortion service providers, other stakeholders,[14] and international commentary[15] echo these findings and acknowledge the need to develop and implement new service models; consider the role of the nurse; strengthen partnerships with other health professionals and community services; and enhance training, support and ongoing mentoring for clinicians. In Australia, excellent resources to support primary care professionals are available through local Family Planning Organisations and the Victorian Rural Clinical Network for Unintended Pregnancy and Abortion website (www.cersh.com.au/resource-hub).

Why offer medical abortion in general practice?

Women who receive medical abortion in general practice describe high levels of satisfaction, appreciate the convenience and continuity of care provided, and indicate that the connection to the clinic and to the provider creates a context of comfort and trust.[16] Provision of this service in general practice increases access, especially for the most vulnerable of patients; adds to the comprehensiveness of women's health service delivery; and decreases stigma and, potentially, cost. Patients can also access ongoing contraception, pregnancy planning and sexually transmissible infection (STI) screening through their GP. For the GP, medical abortion provision allows the GP to practice at the top of their complexity and skill mix, bring a new service to the clinic and keep more of patient care within the clinic.

What are the regulations for prescribing medical abortion in Australia?

In Australia, MS-2 Step (a composite pack containing Mifepristone Linepharma 1 × 200 mg tablet and GyMiso misoprostol 4 × 200 μg tablets) is indicated under the PBS for medical termination of an intrauterine pregnancy of up to 63 days of gestation. Women can only obtain an authority prescription for MS-2 Step from doctors who are registered prescribers. Only registered pharmacists are able to dispense MS-2 Step. Registered prescribers are currently required to re-register every three years. A private prescription can be given to patients without a Medicare card.

How do I become a provider?

Practitioners can register by completing the 2–3-hour free online training provided by Marie Stopes Australia (available at www.ms2step.com.au). This training is open to any registered medical practitioner. If a practitioner holds a Fellowship (FRANZCOG) or Advanced Diploma (DRANZCOG Advanced) of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), they are able to register as prescribers without having to undertake the training. Pharmacists must register using the same website. GPs may claim continuing professional development points for this course as self-reported learning, but it is not currently accredited as required or recommended training for Diplomates of the RANZCOG (DRANZCOG).

Are there any legal considerations?

For the purpose of medical insurance medical abortion is considered a similar procedure to the insertion of intrauterine devices and implants. GPs who provide medical abortion are considered 'non-procedural' by medical insurers but are advised to confirm this with their insurance providers.

What needs to be considered before prescribing?

Prior to prescribing MS-2 Step, GPs need to undertake several steps (Figure 2).[17] Intrauterine pregnancy and gestational age (not >63 days) need to be confirmed and an ectopic pregnancy excluded. This is best done via ultrasonography. While access to imaging in a woman's immediate community can sometimes be challenging, it is also required for the routine care of other gynaecological and obstetric issues in the community such as in the management of menstrual problems, pregnancy and miscarriage and should be relatively easy to achieve for most Australians within a two-hour drive.

Initial serum beta–human chorionic gonadotropin (beta-hCG) and blood group tests are currently recommended. Contraindications are: chronic adrenal failure; diseases requiring long-term oral steroids; hypocoagulation diseases; anticoagulation therapy; and allergy to mifepristone, misoprostol or other prostaglandin. Consideration should also be given to other conditions in which medical abortion is not recommended (eg anaemia, renal failure, hepatic impairment, malnutrition or cardiovascular disease). Australian guidelines previously recommended administering anti-D to women who are rhesus negative and having a medical abortion.[18] However, as a result of the COVID-19 pandemic, these guidelines have been revised, consistent with international recommendations,[19] to 'a clinician may appropriately decide not to administer anti-D prior to 10 weeks, for medical management of abortion, particularly when an additional visit may increase exposure of women and staff. For surgical management of abortion prior to 10 weeks, checking rhesus status, and administration of anti-D, is discretionary, based on the individual woman's risk benefit profile and her preferences' (https://ranzcog.edu.au/news/covid-19-anti-d-and-abortion).

What do women need to know about medical abortion?

Women may not know about the availability of medical abortion or the fact that it is only able to be accessed in Australia up until nine weeks' gestation, or how to find a provider. Including information on the practice website or in a newsletter regarding whether your practice provides this service and, if

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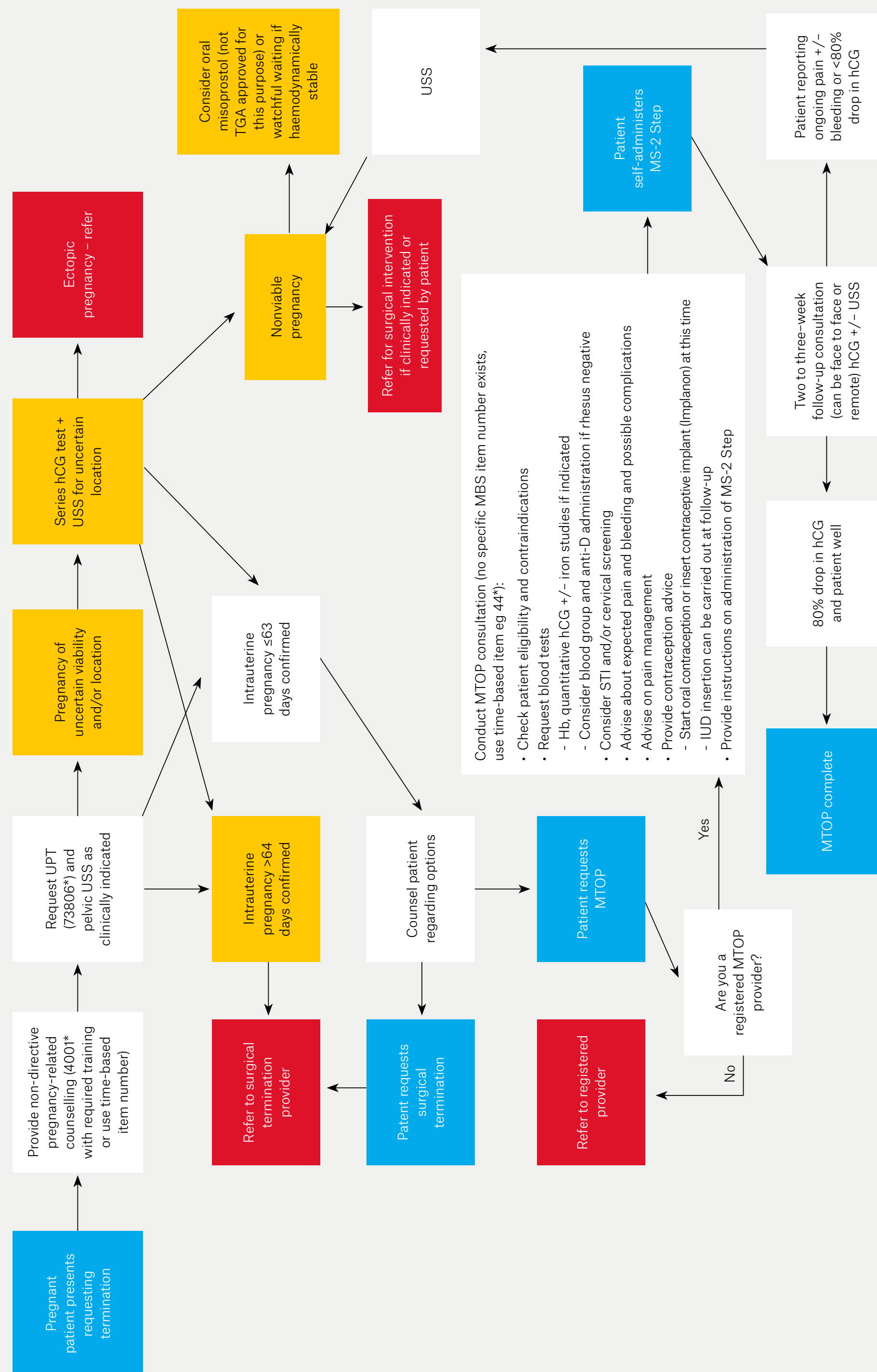

Figure 2. Overview of process for providing termination of pregnancy services in primary healthcare

Note: This chart is designed as an aid for GPs to provide termination of pregnancy services to their patients. It is not intended as a training tool or as a substitute for the simple online training for GPs to become registered prescribers of MS-2 Step provided by MSHealth.

**Medicare Benefits Schedule item number*

GP, general practitioner; Hb, haemoglobin, hCG, human chorionic gonadotropin; IUD, intrauterine device; MBS, Medicare Benefits Schedule; MTOP, medical termination of pregnancy; STI, sexually transmissible infection; TGA, Therapeutic Goods Administration; UPT, urinary pregnancy test; USS, ultrasound scan

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not, where the service can be accessed can help educate women about this option. Women should be provided with information to help them to decide whether they should have a medical or surgical abortion. The National Institute of Clinical Excellence[20] guidelines suggest that the issues in Box 1 be discussed. Women should also be advised about possible side effects of the medication and procedure and how to manage them (Table 1). Further clinical resources including patient information sheets are available at the Centre for Excellence in Rural Sexual Health website (www.cersh.com.au/resource-hub/info-for-practitioners/clinical-practice) or through the MS-2 Step website (www.ms2step.com.au).

What follow-up is required?

It is important to confirm that the pregnancy has ended. This can be with ultrasonography, a repeat serum beta-hCG at least seven days after taking mifepristone (demonstrating a decline of at least 80%) or using a low-sensitivity urine pregnancy (LSUP) test (recently approved by the Therapeutic Goods Administration [TGA]) to exclude an ongoing pregnancy.[20] Follow-up may be face to face, via telehealth or via telephone consultation.

What else do I need to think about if a woman presents for a medical abortion?

Women may require ongoing contraception and testing for STIs. For women who desire hormonal contraception (eg oral contraceptive pills, contraceptive ring, contraceptive implant or contraceptive injections), these can be started immediately after taking mifepristone. Women who rely on contraceptive injections should be aware that this may increase the risk of ongoing pregnancy, although overall the risk is low.[21] Intrauterine methods of contraception should be inserted as soon as possible after expulsion of the pregnancy. Women having a medical abortion do not routinely require antibiotic prophylaxis.[20]

How can I integrate medical abortion into my practice?

Medical abortion can be delivered either through face-to-face consultations or via telehealth.

The delivery of medical abortion through telehealth is highly acceptable to women and providers, and success rates and safety outcomes are similar to those reported in literature for in-person abortion care.[22] The recent introduction of Medicare Benefits Schedule item numbers for GP delivery of telehealth in relation to the COVID-19 pandemic should facilitate this, as the previous criteria were very restrictive regarding which patients could receive it (ie patients were previously required to: live in a Modified Monash Model [MMM] 6 or 7 location, have an existing clinical relationship with a GP telehealth provider [defined as three face-to-face consultations in the previous 12 months] and live at least 15 km by road from the GP).[23]

Medical abortion provision works well with systemisation that involves protocol-driven patient flow, use of patient information sheets and routine follow-up. As per Deb et al,[24] other facilitators to integration of medical abortion into general practice include establishing a network of supportive local health professionals such as a radiologist to facilitate ultrasonography provision, a pharmacist to dispense MS-2 Step (the website has a searchable database of registered pharmacists) and a gynaecologist or public hospital obstetrics and gynaecology department for support and advice in case of complication. Of note, any hospital that has the capacity to manage an early miscarriage can also manage any complication arising from a medical abortion. Advising the practice and patients of commencement of the service, having discussions with clinic receptionists about how to respond to phone calls from women seeking a medical abortion and becoming networked with other medical abortion service providers are also helpful steps.

How can access to medical abortion be further improved?

If we are to improve access to medical abortion and remove disparities that currently exist, then many more GPs would need to both register as providers and provide this service in their practices,

Box 1. Information to provide to women seeking abortion, adapted from the National Institute of Clinical Excellence guidelines[20]

- Reassure patients that having an abortion is **not** associated with increased risk of infertility, breast cancer or mental health issues.
- Provide information about the differences between medical and surgical abortion (including the benefits and risks; refer to Table 2), taking into account the patients' needs and preferences. Do this without being directive, so that patients can make their own choices.
- As early as possible, provide patients with detailed information to help them prepare for the abortion. Discuss what is involved and what happens afterwards, including how much pain and bleeding to expect and what follow-up is required.
- Provide information in a range of formats, such as video (www.howtouseabortionpill.org) or written information (www.betterhealth.vic.gov.au/health/HealthyLiving/abortion-procedures-medication).
- Ask patients if they want information on contraception; if so, provide information about the options available to them.
- For patients who are having a medical abortion, explain that they may see the products of pregnancy as they are passed, and that this will generally look like large blood clots.
- For patients who are having a medical abortion, explain how to be sure that the pregnancy has ended.
- Provide patients with information on signs and symptoms that may indicate they need medical help after an abortion, and whom to contact if they do.

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especially in rural areas of Australia. The Canadian experience has taught us that requirements to register and re-register only introduce more hurdles to health professionals' engaging with this form of women's health service delivery.[25] Nurses could also take on the role of providing this service through nurse-led models,[26] as occurs in Sweden and other countries around the world, if funding models supported this.

Barriers for women could also be removed. The gestational age for provision of medical abortion could be extended as per WHO recommendations, and self-assessment of the outcome of the abortion could become routine using an LSUP test. Free service provision to vulnerable groups, along with free contraception at the point of abortion, could reduce the burden of repeated unwanted pregnancy. Several of these steps require funding and policy changes from government, and others require new submissions to the TGA. Meanwhile, GPs can support their patients by becoming providers and integrating medical abortion into primary care, where it undoubtedly belongs.

Table 1. Common medical abortion side effects and recommended management

Side effect	Recommendations
Bleeding – typically starts a few hours after taking misoprostol; bleeding usually heavier than regular menses, with clots, for 2–4 hours	Patients should be advised to seek help if they soak >2 maxi pads per hour for >2 consecutive hours, or feel dizzy or lightheaded, or have a racing heartbeat.
Pain – cramping and pain is expected before and at the time of expulsion	In most cases, nonsteroidal anti-inflammatory drugs can be used to manage pain as needed. Mild opioid analgesics can be prescribed to be taken as needed. Patients should be advised to seek help if severe pain during abortion is not controlled by analgesics.
Prostaglandin effects – nausea, vomiting, flu-like symptoms, diarrhoea, dizziness, headache, chills/fever	Nausea can be treated with metoclopramide or ondansetron. Diarrhoea, fever and chills are usually self-limiting and can typically be managed with over-the-counter medications. Patients should be advised to seek help if they experience fever >38°C lasting >6 hours, especially after the day of misoprostol administration, and if they experience flu-like symptoms, weakness/faintness, nausea, vomiting and diarrhoea in the days after abortion.

Table 2. A comparison between medical and surgical abortion

Medical abortion	Surgical abortion
Avoids surgery	Surgical procedure
Can occur in the privacy of the patient's own home	Day hospital admission
Can take days to complete	Completed in 5–10 minutes followed by 30 minutes to one hour of observation time
Somewhat and variably painful	Usually less painful; anaesthesia is available
≥95% success rate within 1–3 weeks	99% success rate
Generally much heavier bleeding than a period	Light bleeding
Typically 2–3 office visits plus ultrasonography and blood tests	Typically 1–2 office visits
	Requires a support person to drive depending on anaesthesia

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