Telemedicine Abortions: Misfits Lowering the Standard of Care

Center Insights Blog
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Patient EducationFeatured abortionMifeprexMifepristoneplanned parenthoodtelemedicinewomens health
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Planned Parenthood (PP) of the Heartland in Iowa is on a mission to ensure ready access to abortion on demand for all women in that state. Instead of opening more clinics in remote locations, in 2008, they started giving rural women a T.V. screen and pill drawer. These "telemedicine abortions" were subsequently challenged by the state medical board in 2013 and deemed "unsafe medical practice." PP sued the Iowa Board of Medicine and appealed the rule. Finally, in June of this year, the Iowa Supreme Court voted unanimously to reject the rule, thus endorsing PP's telemedicine abortion practices. So, is induced abortion a good fit for telemedicine, or not?

Born out of necessity to bring needed services to patients in remote locations, telemedicine had its origins in the military and space program in the 1950s. According to NASA, “Telemedicine is the interactive transmission of medical images and data to provide *better health care* (emphasis added) for people in remote or medically underserved locations. Today, more than half of all U.S. hospitals use some form of telemedicine, and the Veterans Health Administration delivered more than 300,000 remote consultations in 2011. The American Telemedicine Association has developed standards for practice to promote safe and secure delivery of services. Alarmingly, some are using this technology to provide medication abortions, casting a long shadow on the original intent and purpose.

The Mifeprex® Abortion

In 2008, the Guttmacher Institute reported that medication abortion accounted for 25 percent of the 1.2 million abortions performed under nine weeks and 17 percent of all abortions that year. In 2000, the Food and Drug Administration (FDA) approved mifepristone together with misoprostol for inducing abortions in women up to 49 days from the start of their last menstrual period (LMP). In 2016, the FDA subsequently approved the use of Mifeprex up through 70 days from the start of a woman's LMP. Mifepristone is one of a growing class of anti-progesterone drugs being developed for abortion and emergency contraception.

How Does It Work?

Given to a pregnant woman, mifepristone binds to the progesterone receptors blocking progesterone’s critical role in sustaining the embryo’s attachment to the uterus and thus his/her blood supply. Mifepristone alone only completes the abortion 4 percent of the time, so the regimen includes the administration of a potent prostaglandin, misoprostol, given two days later if the abortion is not complete, to cause intense uterine contractions that result in expulsion of the embryo.

Side Effects & Risks: The Tip of the Iceberg

Since approval in 2000 through April 2011, the FDA received reports of 2,207 cases of adverse events (AERs) among approximately 1.5 million users. This may not seem significant, but according to the Government Accountability Office (which provides post-marketing oversight to the FDA to ensure drug safety), common estimates of the proportion of AERs captured by

FDA range from only 1 to 10 percent. Extrapolating, a closer estimate of the actual number would be anywhere from 22,000 to 220,000!

Of the 2,207 AERs, more than one-half of the 612 hospitalized women bled enough to need a transfusion. Gary and Harrison analyzed AERs in 2006 and found that more than one-third were due to hemorrhage, the majority required a blood transfusion and 18 percent were life-threatening. More than 5 percent of women undergoing medication abortions between eight and nine weeks from their LMP will need a D&C to stop the bleeding.

A study of more than 233,000 medication abortions reported a mortality rate of 0.4 per 100,000 (one death due to undiagnosed ectopic pregnancy) and had an overall clinically significant adverse event rate of 16 per 10,000.

Holly Patterson was only 18 years old when she died of septic shock following a mifepristone abortion. Ten of the known 14 deaths were due to overwhelming sepsis caused by toxin producing *Clostridia sordellii.* The FDA and Centers for Disease Control hypothesized mifepristone's immunosuppressive effects coupled with the "ideal bacterial culture" of the aborting uterus created a perfect storm to produce the rapid fulminating lethal shock syndrome observed. Victims do not develop fever and, once established, the infection is 100 percent fatal. Off label use (buccal or vaginal misoprostol) was associated with eight of the 10 known victims who died of sepsis.

Danco Labs and the FDA deny a causal link between the mifepristone regimen and the reported adverse events, yet it is undeniable that young healthy women became sick and some died after its use.

The psychological impact of a medication abortion is unknown. Touted as "private and safe," women who choose medication to terminate their pregnancies are effectively "giving themselves" abortions. Unlike the surgical counterpart, these women are wide awake and see everything that is passed. One woman describes it this way: "I woke up in excruciating pain; it was like cramps, but the worst feeling I had ever had...Once it was all over I wanted to die. Blood and tissue were everywhere. I looked in the toilet and all I could think is 'those are pieces of my baby.'"

A significant portion of women who choose medication to avoid the surgical abortion will get both as the failure rate rises with increasing gestational age (per the sole U.S. uncontrolled, non-blinded, non-randomized trial on which the FDA approval was based):

Up to 49 days from LMP: 8 percent of women fail to abort

50-56 days from LMP: 17 percent of women fail to abort

57-63 days from LMP: 23 percent of women fail to abort

Prompted by concerns, the FDA added mifepristone to the list of drugs requiring a Risk Evaluation Mitigation Strategy (REMS) to ensure the benefits outweigh the risks. Abortion providers routinely prescribe this drug in an off-label manner, based on reports of increased efficacy rates, taking a chance that the complications associated with alternative regimens won't manifest.

The Iowa Story

In 2008, Planned Parenthood of the Heartland, a network of 16 clinics located in Iowa, began offering telemedicine abortions in select clinics not staffed by a physician. Their objective was "to improve access to early abortion and reduce physician travel to outlying clinics."

On the first visit, the patient's medical history and ultrasound report are sent to the offsite physician. By videoconference, the doctor reviews her medical information then enters a password on the computer that unlocks a drawer in front of the patient containing the mifepristone and misoprostol tablets. Using an off-label protocol, the physician observes the patient swallow the mifepristone tablets and instructs her to take the misoprostol tablets in two days. A two-week follow-up visit is scheduled where a repeat ultrasound is performed and, if still pregnant, she is given the option of taking more pills, scheduling a surgical abortion or continuing her pregnancy, knowing that birth defects are possible.

Induced Abortion: A Basic Human Right?

The Iowa clinics' primary motivation presumed that women *need* to have ready access to abortion. Some abortion proponents assert that induced abortion is a basic reproductive right and should be easily available to every woman. Why should this procedure merit special status? Some men want vasectomies, must there be a urologist in every town? People need root canals, yet we don't hear a public outcry about insufficient numbers of endodontists. Further, the vast majority of abortions are non-emergent, elective procedures. A woman who decides to abort her pregnancy is not being compelled or required to do so, but is simply choosing that outcome for her pregnancy. It is her right under the law, but that does not translate into a basic human right.

Better for the Patient-or the Doctor?

The second rationale for the telemedicine program was to “reduce physician travel to outlying areas.” So, there was not an actual lack of providers, just a lack of willingness to drive. Instead, the woman suffering complications is forced to drive or see a stranger. What reputable physician performs a procedure on a patient but doesn’t provide emergency coverage? This used to be called patient abandonment. Former abortion clinic director Abby Johnson recalls how medication abortions were handled in her clinics: “In our Gulf Coast of Texas Planned Parenthood clinics during 2008-09, doctors routinely authorized medication abortions remotely. They would be sent the ultrasound images, the patient’s vital signs and would then text back, “Okay for abortion,” on their BlackBerrys while sitting on the beach in Cancun, Mexico.” This brings new meaning to the term, “Beach bum.”

How Safe Is It?

A 2011 prospective cohort study of the Iowa group found no significant differences between the telemedicine group and the face-to-face group in overall satisfaction or adverse event rate, but 25 percent of the telemedicine group said that they would have preferred to be in the same room with the physician.

This small study does little to inform about the true safety of telemedicine abortions in remote areas, but does expose an important point: many women want to sit eye-to-eye with their physician. Women considering abortion don’t need less professional contact, they need more. If complications arise, a virtual doctor just doesn’t cut it.

Planned Parenthood calls the Mifeprex abortion “safe and effective” and likens it to a “natural miscarriage.” There is nothing natural, safe or effective about a medication that ends a life, carries the risk of massive hemorrhage and life-threatening infection and has a significant failure rate. While reported risks of severe complications are low, discovering the actual frequency of adverse events is limited.

Telemedicine creates access to services where there are none. Medication abortion prescribers are required to ensure that the patients have ready access to surgical intervention, if needed. If these services are in place, then telemedicine isn’t needed; if there isn’t a qualified professional available, then the procedure should be automatically disqualified from a telemedicine application. This is the medical equivalent of forcing a square peg in a round hole: abortion and telemedicine are misfits.

To pair them lowers the standard of care for women. This is just plain bad medicine.

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