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Commentary article

"You can't do that 'round here": a case study of the introduction of medical abortion care at a University Medical Center

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Abstract

Mifepristone medical abortion was introduced in 2002 into the University of New Mexico Medical Center clinic system through a joint effort of the departments of Family Medicine and Obstetrics and Gynecology. A stepwise approach to the integration of medical abortion, manual vacuum uterine aspiration, and first trimester obstetric ultrasound was successful in overcoming a series of educational, political, economic and logistical challenges. The integration of medial abortion care into resident training in FM and Ob/Gyn may expand access to reproductive services in primary care settings.

Keywords: Medical abortion; Mifepristone; Resident training; Manual vacuum aspiration

1. Introduction

The FDA approved mifepristone in 2000 in a regimen combined with misoprostol for termination of early pregnancy. Although gradually being introduced into the offices of physicians, mifepristone medical abortion continues to be provided primarily through free-standing abortion clinics [1]. Few hospitals, including those where residents are trained, offer medical abortion [2]. Residents, therefore, rarely see the provision of abortion integrated into clinical practice and are less likely to offer this service in their own offices when their training is completed. Offering medical abortion through primary care residency training clinics could facilitate access to medical abortion for patients and training in medical abortion for residents and students.

The departments of Family Medicine (FM) and Obstetrics and Gynecology (Ob/Gyn) decided to introduce mifepristone medical abortion through our clinics in order to provide this service to our patients and training to our residents. Through the efforts of the two departments, mifepristone medical abortion has been on the hospital formulary and available through the outpatient FM and Ob/Gyn clinics since July 2002. Offering medical abortion in a University Medical Center presents a set of challenges that are not encountered when medical abortion occurs in the typical setting of a free-standing abortion clinic. This paper describes the steps we took and the obstacles we encountered on the path to providing medical abortion in our clinics.

2. Preexisting abortion access at the University of New Mexico

First-trimester elective pregnancy termination had been unavailable at the University of New Mexico (UNM) for 10 years prior to the approval of mifepristone. An unwritten nursing policy stipulated that all dilation and curettage (D&C) procedures must occur in the operating room for reasons of safety. This policy effectively eliminated elective first-trimester abortions, as operating room charges result in costs that are 500% greater than those associated with a procedure in the outpatient setting. Although the nurse managers of the UNM clinics were united in describing the existence of this policy, they were never able to find an actual written document.

Medical and surgical pregnancy terminations were available in labor and delivery or the operating room (dilation and evacuation) for fetal anomalies or when needed to protect the health of a pregnant woman (e.g., breast

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cancer, systemic lupus erythematosus or severe congenital heart disease). On the rare occasion when a surgical termination was scheduled in the operating room (i.e., for a fetus with anomalies), nursing and anesthesia personnel were often unwilling to assist. After 2000, mifepristone medical abortion was only available in Albuquerque through the offices of Planned Parenthood and two physicians whose practice was primarily abortion care.

3. Multidisciplinary collaboration

The collaboration between the departments of FM and Ob/Gyn was crucial to our success in introducing medical abortion. We were fortunate to have an effective liaison (LL) between the departments. He completed an Obstetrics fellowship, has a dual appointment in FM and Ob/Gyn and spends considerable time on labor and delivery with patients, residents (FM and Ob/Gyn) and medical students. He has become well known and accepted by Ob/Gyn residents and faculty. The Ob/Gyn faculty member (EE) directing abortion training and services has an extensive history of working with FM faculty and teaching FM residents. The Chairs of Ob/Gyn and FM have strongly supported the collaborative relationship between the departments. We realize that this relationship is not replicated in all institutions, but we strongly encourage the establishment of such collaboration as part of the groundwork to facilitate the delivery of women's health services in general and specifically, the introduction of medical abortion.

4. Departmental philosophy statements of abortion care and training

The FDA approval of mifepristone for medical abortion presented UNM faculty FM and Ob/Gyn physicians with an opportunity to reevaluate the provision of abortion services in the UNM system. Several faculty members in both departments felt strongly that optimal training in abortion care for residents includes provision of medical abortion in the residency training clinics. We also desired to offer this service to our own patients instead of referring them out of our system. We hoped that integrating medical abortion into our practice and providing training would increase the likelihood that FM and Ob/Gyn residents would provide this service to their own patients after completing their training. Increased access to abortion in New Mexico, beyond the urban areas of Albuquerque and Santa Fe, requires that abortion care be introduced into primary care settings.

The interested faculty members approached the Chairs of their respective departments who agreed that the issue of abortion care should be discussed at the faculty level. The Chairs appointed an abortion policy committee with members from both departments. We used a multidisciplinary approach from the initial stages of implementation of medical abortion. The committee was to recommend policies for first-trimester surgical and medical abortion and second-trimester terminations. The committee first developed an abortion philosophy statement:

> The provision of abortion services is an important aspect of women's health care. Those residents in Ob/Gyn and FM graduating from UNM who wish to provide these services to their patients must receive the training necessary to provide competent and safe medical and surgical abortions. . . . Abortion services are an important aspect of the scope of care provided by the Ob/Gyn and FM departments. We provide these services not only as a component of comprehensive women's health care but in accordance with our mandate to provide comprehensive, high quality training to our resident staff.

The philosophy statement was presented at the faculty meetings of both departments. The statement was discussed, modifications were made and both departments approved the statement. The development of this statement proved critical in the process ahead: we referred to this statement many times as we sought approval to implement medical abortion. This statement, a consensus of the faculty of two departments, repeatedly proved helpful in overcoming the roadblocks we were to encounter.

A subcommittee of faculty members from FM and Ob/Gyn (the authors) then met to design a guideline for mifepristone use. Rather than use the protocol initially recommended by the FDA, the subcommittee chose an evidence-based protocol that had been developed based on studies published since FDA approval [3,4]. The evidence-based protocol differed from the FDA protocol in using vaginal rather than oral misoprostol, 200 mg of mifepristone instead of 600 mg, home administration of the vaginal misoprostol 24–72 h after mifepristone and extension of eligibility to 63 days estimated gestational age. These modifications increase the efficacy of medical abortion, require fewer visits and cost less for mifepristone than the FDA protocol. Although the FDA protocol does not mandate the use of ultrasound for pregnancy dating and to rule out ectopic pregnancy, this requirement was added to our protocol to ensure accuracy of dating and to facilitate training of residents in first-trimester ultrasound.

The medical abortion guideline was submitted for approval to the full FM and Ob/Gyn faculty. Several members expressed concern that all faculty members would be expected to provide medical abortion services. The guideline specifically states that medical abortion will be provided only by those physicians (both faculty and residents) willing to offer the service and who submit a prescriber's agreement to the manufacturer. With this reassurance, the guideline was approved unanimously.

Once the support of the two medical school departments was obtained, we applied for an educational training grant to fund the initial faculty and resident training in abortion care and to acquire ultrasound equipment for each clinic. The Access Project, an organization dedicated to the integration of early abortion into primary medical care, provided invaluable consultation service regarding the introduction of medical