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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

Lawrence Leeman[a,b,*], Eve Espey[b]

[a]Family and Community Medicine, University of New Mexico School of Medicine, Albuquerque, NM 87101, USA
[b]Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, NM 87101, USA

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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.
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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

* Corresponding author. Tel.: +1 505 272 9304, +1 505 342 2605; fax: +1 505 272 8045.
E-mail address: lleeman@salud.unm.edu (L. Leeman).

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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

abortion. Educational grants are available for resident abortion training in FM through the Center for Reproductive Health Education in Family Medicine (212-366-9320) and for Ob/Gyn programs through the Kenneth J. Ryan Residency Training Program (www.reprohealth.ucsf.edu).

5. Provision of surgical backup and consultation for medical abortion

Providing medical abortion requires ready access to surgical evacuation of the uterus. Uterine aspiration may be required due to excess or prolonged bleeding or failure of the regimen to terminate the pregnancy; however, at UNM, all D&C procedures were done in the operating room. A D&C in the operating room is expensive and usually requires patients with complete abortion to wait several hours in the emergency room. The nursing policies prevented physicians from offering D&C procedures in the Emergency Department (ED) or outpatient clinics.

We proposed the use of manual vacuum aspiration (MVA) for hemorrhage or unsuccessful medical abortion. Manual vacuum aspiration, an alternative to traditional D&C with electrical suction [5,6], offers several advantages; it uses inexpensive equipment that fits on one small portable tray, allowing the procedure to be done in virtually any clinical setting. We hoped that the introduction of MVA would circumvent the prohibition on D&Cs in the outpatient clinics and ED.

However, in order to use MVA for the rare complications of medical abortion, we felt it was important that the procedure be approved for use in the far more common setting of incomplete and missed abortion. Both faculty and residents would then become adept in its use. We approached the Department of Emergency Medicine first, as the majority of incomplete abortions present to the ED, and we were aware of a faculty member who was supportive of introducing MVA.

This supportive faculty member helped us arrange an educational session on MVA in the ED for management of incomplete abortion due to early pregnancy loss or medical abortion. The ED faculty approved the decision to initiate MVA in the ED for these clinical situations. A key factor in their approval was evidence that its use would decrease patient waiting time and expense [7]. The ED also agreed that medical abortion patients with complications presenting to the ED could be seen directly by the FM and/or the Ob/Gyn residents rather than undergoing initial evaluation by ED physicians. We were encouraged that three medical school departments had sanctioned the introduction of medical abortion at UNM. However, we still lacked access to mifepristone.

6. Mifepristone on the University Hospital formulary

We felt that mifepristone would be most easily available if it were on the University Hospital (UH) formulary; however, the FDA requires that mifepristone be distributed to patients directly from physicians' offices. Physicians who desire to offer medical abortion enter into an agreement with Danco Laboratories, the sole distributor of mifepristone. The physicians then pay for and receive the medication in their offices. Patients are given the mifepristone in the office and the physician directly observes the patient swallowing the pill.

The use of mifepristone in a hospital setting requires a different approach from the standard office distribution. Hospital physicians do not store medications and are not accustomed to dispensing them. By adding mifepristone to the UH formulary, we could allow use by any physician in any UNM-affiliated primary care clinic who entered into the agreement with Danco. We contacted Danco Laboratories to discuss our desired approach to obtaining the medication. Although Danco was unaware of any precedent for distribution through a central University pharmacy, the company was willing to provide the medication to UH physicians through purchase by our pharmacy if the medications were dispensed directly by physicians in the office. This arrangement allowed us to avoid the cumbersome paperwork and effort for each physician and clinic to contract separately with the pharmaceutical distributor.

Representatives from FM and Ob/Gyn petitioned the Pharmacy and Therapeutics Committee for the addition of mifepristone to the hospital formulary. These representatives were members of the abortion policy committee and were advocates strongly committed to approval of the product (the authors). We prepared for the meeting by discussing the issue beforehand with a clinical pharmacist, as well as with the representatives from the two departments. Several at the meeting, therefore, spoke in favor of approval, which was secured with minimal opposition.

7. Negotiated introduction of medical abortion services into University clinics

Prior to developing the abortion philosophy statement and prior to enlisting support from FM, Ob/Gyn and EM, we had informally discussed the introduction of medical abortion with the nurse managers of the primary clinical training sites for the FM and Ob/Gyn departments. Their opinion was that abortion services could not be offered through UH clinics.

We decided to defer an appeal of this opinion until we had secured support through the medical school, which is under separate administration from UH. After obtaining the support of the Chairs and faculty of FM, Ob/Gyn and Emergency Medicine, and after receiving approval to add mifepristone to the UH formulary, we approached the nurse managers of the UH again.

Upper level administrators of UH explained that we could not offer abortion services at UNM clinics because of a policy that prohibited abortion care in UH clinics. We asked to see the policy. A lengthy standoff occurred. The

administrators continued in their assertion that we could not offer medical abortion without their approval. They were unable, however, to produce the written policy prohibiting abortion care services. Numerous other reasons were cited to discourage us from pursuing the introduction of medical abortion. These reasons included the concern that no nurses would wish to be involved in any part of the procedure and that the hospital would not subsidize abortion.

After 6 months of delays, we announced that we would begin offering medical abortion in 1 month unless we received a written prohibition. We assured the hospital administration that only willing nurses would participate in the care of patients seeking medical abortion and that the hospital would not be asked to subsidize abortion. We soon received a terse response that the UH would allow us to offer medical abortion. The response reiterated the requirement that the hospital would not subsidize the service.

8. Equipment issues: ultrasound

Introduction of obstetrical ultrasound into outpatient clinic sites facilitated access to medical abortion through the FM and Ob/Gyn residency clinics. Physicians must be able to date a pregnancy to offer medical abortion care as the upper gestational age limit is 63 days by the evidence-based protocol. Unfortunately, the usual wait for an ultrasound at the University Hospital Women's Ultrasound Center was about 2 weeks. Having onsite ultrasound in the clinics would facilitate obtaining the initial dating ultrasound and follow-up ultrasounds to assure a completed medical abortion. The expense of high-resolution obstetrical ultrasound machines has fallen rapidly over the last decade. We were able to obtain portable ultrasound machines for each clinic through the residency-training grant. Billings for ultrasounds done for medical abortion and other indications will rapidly recover this expense in most clinical settings. The procurement of a portable ultrasound machine for each clinic was helpful in promoting a favorable attitude from our department Chairs and residency directors.

9. Staff issues: values clarification and conflict resolution with clinic staff

A major hurdle we faced in introducing medical abortion was the strongly negative attitudes of some receptionists and nursing staff in our clinics. A recent study shows that Ob/Gyn nurses' willingness to participate in the delivery of abortion services has decreased to 39% over the last decade [8]. When the concept of providing medical abortion services was first introduced, our receptionists and staff voiced strenuous opposition. Although we provided reassurance to the staff that no nursing personnel with moral objections would be required to participate directly in medical abortion, some nurses claimed they did not want to work in a clinic where abortion was provided. Some receptionists stated they did not want to talk to patients who were pursuing abortion. Our nurse managers supported us at this point. As the delivery of medical abortion had been "approved," the nurse managers required that all staff be cordial to all patients and be willing to schedule appointments for medical abortion.

Because of the opposition, we arranged a values-clarification workshop for the staff and resident physicians of both the FM and Ob/Gyn departments. The purpose of the values-clarification workshop was to allow participants to voice their emotions and beliefs about the provision of abortion care. This workshop was facilitated by an experienced presenter from The Access Project.

When we began offering medical abortion in the clinics, our impression was that a significant minority of staff remained hostile and angry. Over time, we believe that staff has become accepting of the provision of these services.

10. Money issues: funding medical abortion

New Mexico Medicaid has paid for medically necessary surgical abortions since 1995. In 2003, this coverage was extended to medical abortion. Medicaid is the most common form of insurance for women seeking reproductive services in New Mexico. Medicaid coverage of medical abortion has reduced the financial barrier to abortion access for many of our patients. Most other insurance carriers cover mifepristone as well. The largest uninsured group in Albuquerque consists of the recent immigrants from Mexico who are ineligible for Medicaid until they have lived in the state for 5 years. Women whose insurance does not cover medical abortion may receive partial coverage for the prenatal visit, labs and ultrasound. These women are required to pay for the mifepristone at the time of service in accordance with our agreement with administration.

11. Faculty and resident training for medical abortion care

Medical abortion was introduced with a Grand Rounds presentation in the Departments of FM, Ob/Gyn and Pediatrics. The Grand Rounds was an excellent forum for presenting our new medical abortion guidelines. The lead faculty members for medical abortion from FM and Ob/Gyn (the authors) spent 2 weeks at several "train the trainer" sites for medical abortion, MVA and first-trimester ultrasound. Three additional FM faculty members completed a 2-week mini-fellowship in abortion care through the University of Rochester Reproductive Health program. The three FM faculty were credentialed by the UH in MVA and first-trimester dating ultrasound after the mini-fellowships. Interested Ob/Gyn faculty participated in an MVA workshop and received individualized training at UNM in the use of MVA.

All UNM FM and Ob/Gyn residents currently receive training in medical abortion. The FM residents spend 2 days per week in abortion care during a 4-week required third-year

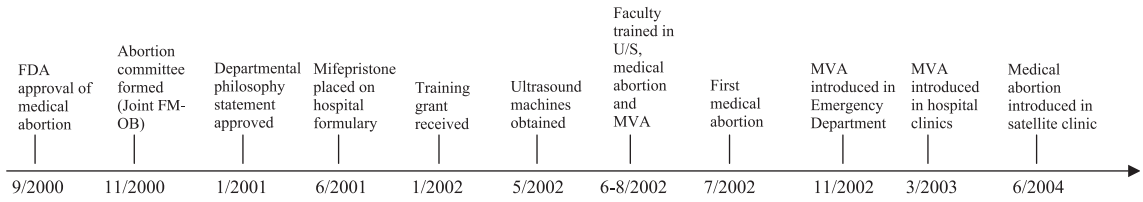

Fig. 1. Timetable for introduction of medical abortion at the UNM primary care clinics.

rotation. Residents spend a full day at Planned Parenthood and half days at the Family Practice Reproductive Clinic as well as at a private family physician's office. The Ob/Gyn interns spend one-half day per week at the Ob/Gyn Family Planning Clinic and are scheduled for 8–10 abortion training sessions at Planned Parenthood during their second year.

12. Introducing MVA in the clinic: a first step

Introducing medical abortion in the clinics took about a year and a half (Fig. 1). The next step is to introduce surgical abortion, an even greater challenge. We felt that the introduction of MVA in the outpatient clinics for missed and incomplete abortion would be a first step in the process of introducing surgical abortion. We also desired to extend the outpatient MVA service to women with nonurgent bleeding (i.e., those who presented to the clinic, not to the ED). Although the ED had accepted the introduction of MVA with minimal opposition, the personnel in the clinics were more wary. They were concerned that the introduction of MVA for abnormal pregnancies could be the first step towards the introduction of surgical abortion.

We were again told that we could not offer D&Cs in the clinic due to the complicated and high-risk nature of the procedure. We pointed out that both FM and Ob/Gyn clinics offered procedures such as loop excision of the cervix and cervical dilation for endometrial biopsy. As the dilation for an endometrial biopsy was only a few millimeters less than that for MVA, we asked for the precise guidelines under which MVA would be prohibited. At the next clinic meeting, one of the authors brought all the needed MVA supplies in his coat pocket. The administrative nurses realized that prohibition due to procedure complexity would not be a defensible position. They subsequently approved use of MVA for miscarriage and failed medical abortion. We agreed that we would not offer MVA for elective surgical termination at this time.

13. Future directions for abortion care

We have now offered over 100 medical abortions through the residency clinics of FM and Ob/Gyn. A third University FM clinic has recently initiated medical abortion services. Two other UNM FM clinics are considering the introduction of medical abortion services, but internal politics at each clinic may delay plans to initiate services.

The next step in our plan to integrate abortion care into resident training and clinical practice at the UNM is the introduction of surgical abortion services at one or more sites. Objections by clinic staff may be intense, particularly due to the more extensive patient interaction required for surgical procedures and the increased complexity of the procedure. We anticipate hiring dedicated nurses and support staff. We do believe, however, that since we are currently offering medical abortion and MVA for early pregnancy loss, abortion opponents have limited rationale to prevent MVA for pregnancy termination.

14. Conclusions

Multiple challenges face those who aim to introduce abortion services in a University medical center. A stepwise approach involving physicians united across departments allowed us to integrate medical abortion care into our departmental clinics. The training of FM and Ob/Gyn residents in this setting has many advantages including promoting the future integration of medical abortion into primary care and expanding access to reproductive health services.

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