The Impending Crisis of Access to Safe Abortion Care in the US

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If the recently leaked ruling from the US Supreme Court in Dobbs v. Jackson Women’s Health Organization is any indication of the future of abortion care in the US, Roe v. Wade will soon no longer be the law of the land, and access to care will be determined by state laws. It is estimated that about half of states will ban abortion, putting an essential, time-sensitive component of comprehensive health care out of reach.1

People needing abortions in states with bans will have few options: seek abortion in other states, self-manage their abortion, or carry the pregnancy to term. States where abortion remains legal and accessible will likely see an influx of patients seeking care, perhaps traveling 500 miles or more. For many, this journey will not be possible. As most people obtaining abortions in the US have incomes less than 200% of the federal poverty level,2 long-distance travel will be a major obstacle. The tremendous financial and other support provided by organizations that facilitate the timely referral of patients will be unable to meet the need.

Self-managed (or self-induced) abortion looks very different in 2022 than it did during the pre-Roe era, when people commonly inserted objects into the cervix or ingested toxic substances. The advent of medication abortion, using mifepristone and misoprostol in combination or misoprostol alone, allows people to safely and effectively end pregnancy with the same regimens used in a clinic or medical office (Table).3-7 Provided people have information about how to use these medications correctly, including how to screen for eligibility, the medical risks of self-managed abortion are likely to be minimal; however, the legal risks may be substantial. As of 2018, more than 20 people reportedly have been criminally investigated, arrested, or imprisoned in the US for allegedly self-managing their abortion or helping someone else do so.6 People have been charged with various crimes, including homicide, criminal abortion, aggravated fetal assault, procuring a miscarriage, and improper disposal of fetal remains.8 As the legal environment becomes more restrictive, the frequency of criminal charges against people suspected of self-managing their abortion is likely to increase. It is also possible that people who merely experience pregnancy loss may face criminal charges, as the clinical presentation of spontaneous miscarriage is often identical to the presentation of abortion induced with medication.9

Most people living in states that ban abortion who would have sought the procedure if it were available will likely be forced to continue their pregnancy to term. Compared with abortion, continuing a pregnancy is associated with increased morbidity and mortality.10,11 According to one estimate, a total ban on abortion would be followed by a projected 33% increase for non-Hispanic Black individuals.12 This increase in maternal mortality is likely an underestimate, as people with underlying serious health conditions will also be forced to continue the pregnancy to term, placing them at greater risk of complications and death. Beyond the medical risks, continuing an unwanted pregnancy to term is also associated with an increased risk of subsequently living in poverty, a higher likelihood of remaining in a relationship with an abusive partner, and negative associations with child development, among other outcomes.13-15

Physicians and other clinicians who care for people who can become pregnant will need to change their practice in response to this policy shift, regardless of whether they at present provide abortion care. For clinicians practicing in states with bans, it will be essential to know what organizations provide information and logistical support to people seeking care out of state (Box). Clinicians should communicate their commitment to helping patients obtain the care they need if they are ever faced with an unwanted pregnancy.

Clinicians should become informed and be prepared to respond to questions from patients regarding self-managed abortion. A harm-reduction approach has been developed in other countries with restrictive abortion legislation, such as Uruguay and Peru, and could be applied in the US.16 Using this approach, a clinician caring for a patient who is considering self-managed abortion evaluates the individual and provides information about evidence-based regimens using medications, which the patient then obtains on their own. Patients are encouraged to return for follow-up to ensure the abortion is complete and to treat any complications. Implementation of this model was associated with a reduction in abortion-related mortality in Uruguay.17 Although the risk of abortion-related mortality is likely to remain low

Table. Regimens for Medication Abortion at Less Than 12 Weeks’ Gestation Used in Clinical Settings and for Self-Managed Abortion3-7

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<td>Mifepristone, 200 mg, orally, followed 24-48 h later by misoprostol, 800 μg, administered bucally, sublingually, or vaginally</td>
<td>Regimen with buccal misoprostol approved by US Food and Drug Administration through 10 wk gestation; May repeat misoprostol, 800 μg, every 3-4 h if expulsion has not occurred; 97% effectiveness through 10 wk; 95% effectiveness at 10-12 wk</td>
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<tr>
<td>Misoprostol, 800 μg, administered bucally, sublingually, or vaginally, repeated every 3 h for 3 doses</td>
<td>May repeat misoprostol, 800 μg, every 3 h if expulsion has not occurred; 84% Effectiveness in clinical trials; effectiveness as high as 99% in observational study of self-managed abortion</td>
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in the US, reliable information about how clinicians can support people seeking ways to self-manage their care should be readily available. However, it remains to be seen whether this approach will comply with state laws that may be enacted if Roe is overturned.

Undoubtedly, clinicians practicing in emergency, urgent, or primary care settings in states with bans will see more patients with questions or concerns about self-managed abortion before and after the event. Although health care teams should be prepared to care for serious complications, such as uterine perforation, sepsis, and hemorrhage, these complications are likely to be rare. More commonly, patients may present with questions about whether the abortion is complete or whether mild symptoms, such as pain or minor bleeding, require treatment.

To avoid unnecessary medical or surgical intervention and increased risk to the patient, clinicians will need to familiarize themselves with the normal course of medication abortion. Many patients can be evaluated clinically; if they report expulsion of tissue and have minimal bleeding and pain, they may be followed expectantly and told to perform a home pregnancy test in 4 weeks, the results of which should be negative. If the patient is unsure if expulsion occurred or if there is unusual pain or bleeding, pelvic ultrasonography may be helpful. However, it is normal for patients to have a thickened endometrium on ultrasonography after a complete medication abortion, and if symptoms are minimal, no treatment is needed. Treatment or follow-up for incomplete abortion is only needed if the patient has unusual symptoms, such as heavy or prolonged bleeding, or if ultrasonography results demonstrate a retained gestational sac or other pregnancy tissue.

As the most substantial risk to patients attempting to self-manage their abortion is legal, not medical, clinicians should actively work to minimize the possibility of criminal charges against patients and not participate in any such efforts. Some patients, such as those who are Asian American, Black, Indigenous, or Latinx, are more likely to face legal issues in health care settings in general and in reproductive health settings specifically. In 2020, the American College of Obstetricians and Gynecologists issued a strong statement opposing the criminalization of patients during pregnancy and the postpartum period, including for actions during pregnancy, such as self-managed abortion. Thus, clinicians should consider the potential implications of documentation in the medical record. They should avoid asking patients questions about actions they might have taken to cause the abortion, which have the potential to be used as evidence if the patient is charged with a crime. In almost all cases, the management of pregnancy loss induced with medications is identical to the management of spontaneous miscarriage. Importantly, there is no reason to report a self-managed abortion, which would be a violation of patient privacy; at present there are no mandates for such reporting. Concern about arrest and prosecution can keep those who are experiencing pregnancy complications or loss from seeking needed medical care.

Clinicians in states where abortion will remain legal should work with advocates and policy makers to reduce barriers to safe abortion care in their state. They should advocate for proactive policies to expand care and increase funding for patients seeking care. Abortion funds and practical support organizations will need financial assistance from either state or local governments or private donations to help patients traveling from other states. Physician and clinician educators will have increased responsibilities to provide training in abortion care to clinicians in states with bans. For example, obstetrics and gynecology residents are required to obtain abortion training, and more than 2500 trainees of the approximately 6000 trainees in the US are in programs located in states that are likely to ban abortion. Obstetricians and gynecology residents, as well as residents in other specialties seeking this training, will need to travel to other states.

Across the US, clinicians will need to actively work against the chilling effect of state abortion bans. For example, clinicians in a state with supportive laws may be concerned about the potential legal risks of providing abortion-related care to a patient traveling from another state. A 2022 Connecticut law offers legal protections to cli-
nicians who provide abortion care to patients from other states. Other states should enact similar laws.

In states with abortion bans, other reproductive health services may also be affected. For example, state laws, depending on their wording, could limit care for patients with spontaneous pregnancy loss and ectopic pregnancy. Clinicians should work to minimize harmful effects, and researchers should document these negative effects, which may eventually contribute to reversing the bans.

After almost 50 years of legalized abortion in the US, most clinicians who provide reproductive health care find it difficult to fathom the far-reaching effects that state bans on the procedure will have. However, it is abundantly clear that the health and socioeconomic well-being of people with the capacity for pregnancy will be adversely affected. Clinicians will bear witness to this adversity and should be vocal advocates against state laws that interfere with medical care.

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