

OPINION POLITICS

The government's abortion pill policy puts mothers' lives at risk

As an OB-GYN, I know that allowing women to access abortion drugs through telemedicine is the wrong move

By Christina Francis, Contributor | May 18, 2021, 9:16am MDT



The FDA announced in April that women seeking abortion pills would no longer need to go to an in-person doctor visit. | Czarek Sokolowski, Associated Press

Getting an ultrasound for the first time is a powerful moment. As an OB-GYN, I'm there when parents see their child's silhouette and tiny hands. The humanity of the

preborn child is palpable.

So too are the varied emotions of the expectant parent — the elation from the woman who has strived so long to have a child or relief from those who might have previously suffered a pregnancy loss. But I also witness the trepidation from mothers who are unsure how they might care for their child.

Providing crucial information to a woman considering abortion, ultrasounds are sometimes the difference between life and death for a preborn child. Ultrasounds are the best way to determine the gestational age of the preborn child and can only be carried out in-person — not through telemedicine visits free of in-person consultation.

Knowing this, in April the Food and Drug Administration (FDA) lifted a requirement for women to have in-person visits with their doctors before receiving medication abortions. This may seem like an innocuous policy tweak that adds needed efficiency to women's health services. However, by removing this requirement, a woman considering abortion is now even less likely to see her baby's image before making a decision that has enormous consequences for both her and her child.

But the concerns don't stop there.

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Under this irresponsible decision by the FDA, a woman can now receive a medication abortion regimen through the mail, after — at most — a video visit with a health care professional who doesn't even need to be in the same state.

As a leader in the largest group of pro-life obstetricians and gynecologists in the United States, I appreciate the ramifications of the FDA's decisions for millions of women. The medication regime for these abortions has real risks. When Mifepristone, the first-stage medication in a chemical abortion, was first approved in 2000, it was only approved with safety regulations in place (later known as REMS) that would minimize the significant risk of hemorrhage, retained fetal tissue and infection.

These REMS were then relaxed in 2016 by the FDA absent any further safety testing and despite mounting evidence of significant adverse events and maternal deaths. And you can certainly imagine the harm they inflict on unborn life.

For unknown reasons, however, the FDA also made the decision in 2016 to stop collecting data on nonfatal adverse events related to Mifepristone, instead only collecting data on maternal fatalities related to the drug. This change ignores the women who may show up to their local emergency rooms with severe complications potentially caused by the drug — women whose lives are typically saved not by their abortionist, but by an on-call physician at the hospital.

One of the most significant reasons why an in-person visit has been required is for proper medical oversight as well as a physical exam and ultrasound. These visits are meant to accurately assess the gestational age of a woman's pregnancy, as well as rule out ectopic pregnancy, which is life threatening. The difference in size of an 8-week-old and 12-week-old preborn child is significant. And these images of the developing fetus often provide profound clarity for women contemplating decisions about their pregnancies as they see the clear humanity of their child. Women deserve to have all the relevant information at their disposal to make a fully informed decision regarding their health and pregnancy.

Mifepristone abortions are only approved for use up to 10 weeks gestation because the complication rates increase significantly beyond this stage. If the drug is used in the second trimester, the risk of a woman needing emergent surgery due to hemorrhage or incomplete abortion is up to 40%. Given the dangers of the drug, a black box warning was assigned, "If mifepristone/misoprostol results in incomplete abortion, surgical intervention may be necessary. Prescribers should determine in advance and give clear instructions on whom to call and what to do in case of emergency. Medical abortion is contraindicated if there is no access to medical facilities for emergency services."

One of the largest studies to date, which analyzed high-quality registry data obtained from nearly 50,000 women in Finland, found that the overall incidence of immediate adverse events is four-fold higher for medical abortions than for surgical abortions. The same study showed that nearly 7% of women will need surgical intervention — a

significant number when you consider there are nearly 900,000 abortions per year in the U.S., 40% of which are medication abortions.

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Requiring that a woman be seen in person in order to undergo medication abortion ensures that she is able to give her fully informed consent — a basic tenet of medical ethics.

Sadly, too many women are pressured into abortions by their partner, a family member or even an abuser or trafficker. The woman's visit with a physician in these cases is sometimes the only chance they get to report what's happening. As compassionate physicians, we should do everything we can to ensure that a woman is not being abused or pressured into an abortion not of their choosing. Screening for trafficking — or abuse — is nearly impossible during a tele-med visit because the physician does not see the full environment of the woman to know whether someone is hovering behind the computer screen.

In addition to risks posed to women from things like coerced abortions, there is the real and present danger to women who have an Rh-negative blood type. Women who have an Rh-negative blood type require an in-person visit to receive a medication called Rhogam to prevent complications in future pregnancies. Even the American College of Obstetrics and Gynecology (ACOG), who claims to be the standard-setting organization for women's health care, admits that it is normal medical care for women to receive Rhogam after a miscarriage or an abortion. Claims that this step can be skipped will undoubtedly lead to the loss of future desired pregnancies.

These are not hypothetical scenarios. And our patients are more than mere statistics. It's bad enough that preborn patients are chemically starved to death from these medications, but they also pose potential harms to our maternal patients. Abandoning patients to the closest emergency room, which may be several towns away, is not good medicine.

I implore the Food and Drug Administration to focus on health care that favors women and children instead of abandoning basic medical standards in the name of “reproductive choice”.

And I ask the FDA and the ACOG, which requested the lifting of these commonsense safety regulations, to explain why women seeking abortions deserve substandard medical care.

Taking care of my patients, both born and preborn, is one of the most profound gifts and responsibilities I have been given, so to see them being lied to and harmed by the abortion industry is heartbreaking to me.

One patient that will forever be with me is a woman who told me the second she left the abortion clinic she knew that she had made the wrong choice. A big part of this realization was seeing her child moving around on the ultrasound screen. Thankfully, her child did not succumb to the deadly effects of abortion medication because she had immediate access to me, as her physician, shortly after she left the clinic. Thanks to a life-saving intervention, she now has a beautiful son. Without in-person visits and an ultrasound, how many women will not have the chance to see the humanity of their child before they proceed with an abortion? Our women and children deserve better.

Dr. Christina Francis is a board-certified OB/GYN and chair of the board of the American Association of Pro-life Obstetricians and Gynecologists (AAPLOG).