# The Growing Importance of Self-Managed and Telemedicine Abortion in the United States: Medically Safe, but Legal Risk Remains

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Excessive regulation under state law has made it increasingly difficult for Americans to get a legal abortion. State lawmakers passed more than 100 restrictions on abortion in 2021, more than any previous year.[1] Meanwhile, the Supreme Court shifted rightward with the appointment of three justices during the Trump administration, threatening constitutional protection for abortion and setting a course for state-level abortion bans.

In light of these developments and new research, we revisit the groundbreaking research article "Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States"[2] and comment on its significance and implications since publication. This study by Aiken et al. examined the demand for remote medication abortion (a regimen consisting of mifepristone and misoprostol pills) among US residents in 2017 through 2018 and assessed variation in barriers to clinical abortion care by state policy context (hostile vs supportive). Metrics collected by *AJPH* demonstrated that this study garnered much attention from *AJPH* readers and the media (https://bit.ly/3kKAG0I). The article presented a model of abortion care that sidestepped long-standing barriers to clinical abortion care and presented evidence of a strong interest in and need for this model among US residents.

The salience of the study has grown as the proportion of Americans who use medications to end their pregnancies has increased and as state-level legal barriers to abortion access have proliferated, with outright bans expected within months.[3] The ongoing COVID-19 pandemic has also increased demand for at-home medication abortion because of concerns about the risk of contracting COVID-19 in a clinic or in transit; this has added to long-standing barriers to access for clinic-based abortion care, including long distances to the nearest clinic, arranging care for dependents, and more.[4] Aiken et al. note the effect of abortion restrictions on increasing demand for at-home medication abortion and offer a preview into the future of abortion seeking for the growing number of Americans who will be legally unable to obtain abortion in a clinical setting.

## ABORTION AND THE LAW

In their study, Aiken et al. examined US residents' requests to the online telemedicine abortion service Women on Web, for which consultation included a medical doctor's review of a client intake form. The Women on Web model of online telemedicine, quite uniquely, combines elements of two models of abortion care: (1) telemedicine—"the delivery of healthcare services . . . by a healthcare practitioner to a patient in a different physical location . . . through telecommunications technology,"[5] and (2) self-managed abortion—the use of medication to end a pregnancy on one's own, without clinical supervision.[6] To fully understand the implications of the article by Aiken et al., we distinguish between "self-managed" abortion and "telemedicine" abortion because of differing treatments of these two models in research and law, with the acknowledgment that the Women on Web model uniquely combines both approaches.

Although the medications (misoprostol alone or in combination with mifepristone) taken through both telemedicine abortion care and self-managed abortion are the same and the process is largely similar, laws apply to self-managed abortion differently than to telemedicine. The difference is largely because telemedicine abortion involves a licensed clinician, whereas self-managed abortion does not.

After the article by Aiken et al. was published, telemedicine became legal

in some states, when, in December 2021, the Food and Drug Administration (FDA) removed an in-person dispensing requirement for mifepristone, permitting patients to access medication abortion by mail. The FDA's move codified a previous decision not to enforce the in-person dispensing requirement during the pandemic.[7] In other states, however, laws require in-person visits or have explicit bans on telemedicine for abortion or mailing abortion pills—laws that may apply regardless of the FDA decision. Questions remain about the challenging legal issues that will arise with actions that cross borders of states with differing laws.[3]

Self-managed abortion may place the person having the abortion or people who help them at risk for criminal and civil penalties[8]; indeed, people who self-managed their abortion and individuals who helped them have been arrested and prosecuted in the United States.[9] The laws of some states specifically criminalize self-managed abortion, whereas laws unrelated to abortion (e.g., fetal harm laws, homicide laws) may also be used to prosecute people who self-manage.[9]

The distinction between self-managed abortion and telemedicine is also pertinent to the study of the safety and effectiveness of telemedicine abortion, which is well-established as on par with clinic-based medication abortion.[4,10] Research on self-managed medication abortion has similarly found levels of effectiveness and safety comparable to clinical care.[6,11] Because of the ambiguous legality and decentralized nature of self-managed abortion, however, research on this experience faces unique challenges, such as difficulty identifying a representative sample of people who self-manage and difficulty gaining their trust in the face of privacy and legal concerns—challenges that are less likely when researching telemedicine abortion.[12]

The model that Aiken et al. studied is somewhat of a hybrid, with the record-keeping end more closely mirroring telemedicine models and the experience of the person seeking abortion more closely mirroring that of self-managed models. There are lessons for researchers in both spaces, including the value of using existing systematic records collected by community-based organizations that provide access to or support of at-home medication abortion, as well as the central importance of close partnership with these trusted groups.

## RESEARCH SIGNIFICANCE AND IMPLICATIONS

Aiken et al. compared data on requests for abortion between states, based on whether the policy context in each state was classified as hostile to or supportive of abortion access. The researchers found that demand for mailed medication abortion was higher in states with hostile policies than in those with supportive policies, with barriers related to legislative restrictions more pronounced in hostile states.

The hostility to abortion in policy will become more severe in the coming months.[3] In December 2021, the Supreme Court heard arguments in *Dobbs v Jackson Women's Health Organization*, a case in which the court is predicted to overturn or significantly undermine *Roe v Wade* by June 2022. If, as anticipated, federal constitutional protections for abortion are abandoned, more than half of US states are positioned to ban abortion outright. Twelve states have laws that were created to ban abortion automatically if *Roe* is overturned, and nine states have pre-*Roe* bans (a law enacted before 1973 that was never removed from the legal code), which will also go into effect if *Roe* is overturned. Ten states have six-week bans, and two have enacted total abortion bans.[13] Viewing the study results of Aiken et al. through the lens of the future abortion landscape in the United States would predict an increase in demand for out-of-clinic abortion, as state law becomes more restrictive with the weakening of federal constitutional protections.

The study positions future researchers well for investigating the effect of specific state-level abortion policies, which are likely to have differential effects on different groups of people. For instance, the authors cite the Hyde Amendment as a policy that reduces clinic access for Medicaid users. Other such policies include burdensome requirements for minors and unfounded requirements for ambulatory surgical centers.[14] The field of legal epidemiology offers tools for research on the relationship between restrictive abortion laws and health outcomes. For example, policy surveillance methods can account for the compounding effect of specific policies. And the development of causal models for the operation of laws can set the stage for accurately measuring the relationship between policy and demand for and incidence of self-managed abortion among specific populations.[15]

## NEW RESEARCH

The study authors appropriately noted the growing evidence of the safety and efficacy of self-managed medication abortion through online telemedicine and highlighted that the primary risk associated with self-managed abortion

may be legal risk. Since the study was published, new research has further established the high levels of safety and effectiveness of self-managed medication abortion across a range of out-of-clinic models—ranging from 94% to 100% abortion completion without surgical intervention.[11,16]

One recent study in particular—the SAFE (Studying Accompaniment model Feasibility and Effectiveness) study—evaluated the safety and effectiveness of self-managed medication abortion with support from accompaniment groups, whereby non–clinically trained counselors provide information and support over the telephone as needed to people self-managing their abortions.[11] The SAFE study further established the effectiveness and safety of self-managed medication abortion and, importantly, concluded that effectiveness in the self-managed setting is not inferior to the clinical setting. Indeed, findings from the SAFE study also indicate that self-use of misoprostol alone is similarly effective to self-use of misoprostol in combination with mifepristone—a particularly important finding given that misoprostol is much less heavily regulated and more easily accessible in the United States than mifepristone.

## CONCLUSIONS

In short, the findings of Aiken et al. establish that there is a demand for telemedicine and self-use of medication abortion in the United States and that this demand increases in hostile policy climates. Given the anticipated major shift toward even more hostile policy climates in the United States in the coming months,[3] we can extrapolate from the article of Aiken et al. that demand for at-home medication abortion will increase. Considered in light of recent research such as the SAFE study, we can set aside public health and clinical safety concerns following an increase in self-managed medication abortion. However, legal risk remains, and people who self-manage and those who support them are especially at risk for criminalization. Further research collaboration between legal and public health experts using legal epidemiology approaches will produce a fuller picture of the effect of post-*Dobbs* state abortion restrictions.

The evidence base continues to overwhelmingly lead to the conclusion that telemedicine abortion and self-managed abortion, with misoprostol alone or in combination with mifepristone, are safe and effective modes of abortion care. As legislatures hostile to abortion rights move to ban abortion altogether, state lawmakers who support evidence-based policy must take steps to remove legal risk for everyone involved in self-management of abortion. It is a public health imperative. AJPH


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