Personal reflections of providing abortion care in a rural setting ASRH Conference – Adelaide 2025

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Disclosure of Interests

- Nil

My Journey

- Medical School 1980's –The Royal & Ancient Hospital of St Bartholomew (Barts) "You can always tell a Bart's man but you can't tell him much"
- Very traditional teaching - long white coats/ collar and tie/ Consultants in 3 piece suits
- BUT Gynae lists clearly stated Surgical Termination of Pregnancy

- Mid 90’s – Australia
- Fertility Control Clinic/ Women’s Clinic on Richmond Hill
- Protesters outside & death of a security guard
- Few options for women in Rural Australia
- Monash Medical Centre – ring between 2-4pm on a Thursday for an appointment!

- Myself – GP Obstetrician for 28years in the Latrobe Valley 2hours East of Melbourne
- A semi-rural town of 25,000
- I felt there was a gap in care & decided there was a need to provide abortion services after MS 2step was introduced so started in 2019

Barriers (perceived)

- Myself – I would see women after hours & they could use the rear(after hours) entrance for access
- Made the service “private” on 1800 MYOPTIONS
- My Work Colleagues
- The Public

The Reality

- Nothing untoward happened – no protesters at the Rear Entrance
- Colleagues referred to me (Notably 1 conscientious objector)
- Reception staff incredibly supportive & became adept at putting women through to the Nursing staff to facilitate appointments in a timely fashion
- Nursing staff very supportive - initial “triage” to clarify dates & ensure appointment
- Women very grateful to be seen in a timely fashion without any judgement (but still needed U/s & Beta HCG)

6 Months later

- Went public on 1800MYOPTIONS
- No “backlash” from colleagues or community
- Purchased Philips “Lumify” U/s after 1 day refresher U/s course primarily to speed up the dating process there was uncertainty rather than refer to Ultrasound providers

2023

- Moved to LCHS after 28 years in private practice
- Sexual Health Hub at LCHS had started a few months earlier
- We discovered a brand new ultrasound machine still in its protective plastic packaging in a cupboard!
- Began to do our own U/s to confirm dates etc.

Guidelines

- eTG:
- Very early medical abortion (VEMA) refers to medical abortion when an ultrasound has not shown definite evidence of an intrauterine pregnancy (no evidence of a yolk sac or fetal pole in an intrauterine sac) – requires an U/s though
- Advantages of very early medical abortion include avoiding delay and reducing the risk of retained products of conception. It may also cause less pain and bleeding than later medical abortion, although evidence is currently lacking.
- Alternatively, medical abortion can be deferred until ultrasound confirms that the pregnancy is intrauterine.
- Very early medical abortion of PUL(implies U/s has been done) should only be offered by experienced practitioners who have clear follow-up protocols in place**. Follow-up is critical to limit the risk of undetected ectopic pregnancy**.

- Very early medical abortion should not be undertaken if:
- there are risk factors for ectopic pregnancy (eg previous ectopic pregnancy, intrauterine contraceptive device in place, a history of pelvic inflammatory disease or tubal surgery)
- there are signs or symptoms of ectopic pregnancy
- the gestation estimated by dates is incompatible with the quantitative serum human chorionic gonadotrophin (hCG) measurement and the first ultrasound (requires investigations though)
- the individual is unable to provide informed consent or **comply with early follow-up**

RANZCOG

- The gestational age of the pregnancy should be determined prior to an abortion; this could be **by clinical means** (history including LMP, with or without clinical examination) **OR by ultrasound scan**
- Where gestational age has been established by clinical means, the decision about ultrasound prior to abortion should be made according to patient preferences and access to services

- A large retrospective cohort study comparing two months before and after service changes due to COVID-19, used a flowchart, based on risk factors for ectopic pregnancy, and found that no-test (no-ultrasound) abortion was deemed appropriate for 61% of women having EMA.
- Compared to the group that had in-clinic assessment and ultrasound, the no-test group had a statistically significantly higher rate of successful abortions with no differences in serious adverse events.
- Indirect non randomised studies reported little or no difference in ectopic pregnancy, complete abortion without repeat surgical intervention, or ongoing pregnancy

RCOG (UK)

- Use of **routine** pre-abortion ultrasound scanning is unnecessary
- There is **no direct evidence that routine ultrasound improves either the safety or efficacy of abortion procedures** and no RCT’s have been undertaken comparing the outcome of abortions with and without routine pre-procedure ultrasound

Investigations (eTG)

- A baseline quantitative serum hCG measurement is recommended before medical abortion.
- This should be repeated 7 days after the mifepristone is taken; a drop to below 20% of baseline confirms there is no continuing viable pregnancy.
- Measure the baseline quantitative serum hCG on the day (or as soon as possible before) the mifepristone is taken. The serum hCG concentration increases rapidly while the pregnancy is viable; the earlier the gestation, the faster the hCG will rise between baseline measurement and the mifepristone being taken.
- The fall in serum hCG concentration after medical abortion may require careful interpretation (particularly in early gestations) if the baseline was measured early.

“Normal” abortion care

- Patient does home urine pregnancy test - +ve
- Potentially several visits to a GP:
- to get blood test form to confirm pregnancy (despite women often having done 3-4 urine tests prior to GP visit)
- return for results
- get sent for U/s (Rural area so not necessarily same day service)
- return for results
- arrange referral
- All of the above can take 3+weeks so potentially getting close to the 9week mark for MTOP (especially if GP’s are not regular providers of Women’s health care)

“Ask not what you can do for your Nurses but what can your Nurses do for you”

- Behind every good Doctor is an even better Nurse
- Fortunate to work with Cath Bateman who is a passionate advocate for Women’s Health & abortion access
- Ensured our booking appointments on Hot Doc states Medical Abortion
- We were able to start another service in Warragul 30minutes closer to Melbourne with the recruitment of another like minded Doctor
- BUT - we were still seeing more women who were presenting late having had numerous investigations & returning for the results with their GP before finally being referred to us at 8+weeks

LCHS

- The “fuck it” moment!
- We were fed up with patients presenting late because of experiences based on the previous slide
- Word of mouth/ Cath’s advocacy/ advertising stating abortion services/ 1800MYOPTIONS referrals meant we were getting busier
- Cath kept saying the guidelines don’t require us to do an Ultrasound
- A patient presented at just over 5weeks by her (certain) dates with no risk factors – so we (I) breathed deeply, said the magic words and went ahead with a medical abortion

- Since then
- 150 out of approx. 450 abortions have been “no touch” – ie. No U/s or Beta HCG performed (mostly women presenting to us early after ringing 1800MYOPTIONS or word of mouth or “advertising”
- 1 ectopic (0.67%) & 2 failed (but were given repeat MS 2 Step successfully)

- Ectopic risk = 1-2% of all pregnancies
- Maternal Mortality from ectopic = 0.1 – 0.3%

The ectopic

- I provide remote support for an area of Victoria lacking abortion services but has an experienced Sexual Health Nurse
- Patient was from overseas – no Medicare
- Did not follow up with Nurse as planned – x3 attempts to contact her without success
- Presented in A&E because of bleeding & pain – diagnosed ectopic (O&G Reg apparently very angry with the Nurse but didn't ring me as the provider)
- Has made us somewhat cautious about providing VEMA to those whose primary language is not English (Ref. eTG guidelines - the individual is unable to comply with early follow-up)
- We stress the importance of follow up more clearly in those situations

- We have performed approx. 450 Medical abortions & referred approx. 70 for STOP – local services are difficult to obtain but are slowly improving (over 12+6 weeks referred to Royal Womens Hospital in Melbourne)
- The higher rate of complications (mostly bleeding) is in the cohort presenting later for MTOP
- Our experience mimics what the literature reports

- We select patients who are suitable:
- reliable dates & good history
- No risk factors
- Have support
- 20minutes with the Nurse – includes discussion about coercion/understanding/ options (medical or surgical)/ STI screen or CST/ follow up/ future contraception
- If we have concerns we will investigate as needed (I have no wish to improve my relationship with the Coroner!) & advise the patient why

Telehealth

- We do provide telehealth abortions (lots in the literature about the UK experience of providing telehealth abortions during COVID)
- The service is similar
- The Nurse does the workup/ discusses the patient with me/ I ring back later & provide the script by phone (only problem is if patient is from overseas & Visa does not allow access to Medicare so unable to supply escript)
- We are “seeing” some patients from well outside our area (referred by 1800MYOPTIONS or word of mouth)

Follow up

- Usually by the Nurse by phone at 3 & 7 days
- Relying on the clinical history to guide us – if not typical further follow up warranted
- If patients have had a serum Beta HCG from elsewhere we can repeat it but I find the history is usually sufficient
- We can do low sensitivity Urine Beta HCG if needed
- We can do follow up scans if needed but we do not do vaginal scans

Conclusions

- There shouldn’t be any barriers to providing abortion care in a rural (or any) setting
- VEMA is safe if you are sensible in who you select (the majority)
- We are not doing anything outside what Guidelines advise (but I acknowledge Gynae Consultants may disagree as they have to deal with the ectopics)
- It should be a collaborative effort – Nursing & administrative staff - from my work with the Australian Collaboratives it was very clear that you must get things right at the start ie. reception
- Ultrasound and bloods are not necessary (but helpful in those uncertain cases)

Finally

- It’s good to have friends!
- If I am told “No”, I hear “yes” but it will be difficult
- *Dr Nisha Khot – President Elect of RANZCOG*

- Thankyou
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