Complex Abortion Care: rural & remote perspectives

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RURAL HEALTH WEST O&G FORUM

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A bit about me

I wear two hats:

Rural Generalist (0.5 FTE)

-District Medical Officer in Obstetrics and Gynaecology and Emergency Medicine at Hedland Health Campus for the last 10 years

Abortion Care Specialist (0.5 FTE)

-Pregnancy Choices and Abortion Care (PCAC) at King Edward Memorial Hospital

-MSI Australia, Midland Clinic

-Nanyara Clinic

If you truly love what you do, you never work a day in your life

Each of you stand at the coal face of providing reproductive health care for the women of rural and remote WA.

This is a position of incredible honour and privilege.

Within our regions we have dedicated medical staff who are facilitating local abortion care.

However, we face **challenges** in care provision:

-The geography of our state (tyranny of distance)

-Medical and social complexity of our patients

-Assisting patients in navigating beaucratic processes (eg. PATS)

-Stigma associated with accessing abortion care

-Time sensitive nature of abortion care, especially in and beyond the second trimester

Aim of today's presentation

- Identifying and facilitating care for patients who require complex abortion care
- To increase understanding of processes for patients requesting second and third trimester abortion care so that you can counsel about what their potential journey may entail
- The referral pathways when the needs of your patient exceed the resources available within your region

What is complex abortion care?

- Surgical abortion care at > 14 weeks gestation
- Medical abortion care at >21+6 weeks
- Women with concomitant medical issues eg. BMI >40, cardiac disease, haematological disorders
- Adolescents <14 years
- Women with significant psycho-social issues, including but not limited to:
  - Significant mental health disorder/s
  - Active FDV
  - Homelessness

My remote perspective: Port Hedland

HHC is a regional referral centre, 4 x GP practices (1 local GP is prescribing EMA)

Staffing: team of DMOs / 1 FRANZCOG as second on-call 24/7 (FIFO roster)

Early Pregnancy Assessment Service (EPAS) which runs 1 day per week, staffed by DMO.

Clinic sees:

- Complications of early pregnancy (eg. PUL, miscarriage, HG)
- Complex women who requiring early (pre booking) antenatal care (eg. Type 2 DM, PTB) AND
- Women requesting abortion care

Provide EMA and STOP to 14 weeks. Our FIFO roster complicates scheduling!

3 doctors provide STOP to 14 weeks

2 doctors provide STOP to 12 weeks

2 doctors willing to consult abortion care requests & prescribe EMA but do not want to perform STOP

3 doctors are conscientious objectors

Everyone works together as a team to ensure our patient's health care needs are met

Complex Abortion Care

Surgical abortion care >14 to 19+6 weeks

Referral options: PCAC @ KEMH and MSI Midland Clinic

PCAC@KEMH: Public Hospital, free healthcare for Medicare eligible patients. Overseas visitors will have to pay. Offers STOP to 19+6. Outpatient appointment first then will be booked to a list on another day. There is no choice of procedure dates. Tuesday and Friday clinics & lists. 1 day procedure 14 to 15+6. 2 day procedures for 16+ weeks.

MSI Midland Clinic offers STOP to 19+6 weeks. Private facility, a fee is payable. Choice of date of procedure- 3 lists per week (Thursday / Friday / Saturday). Patients with PHI. Same day service 14 to 15+6 weeks. 2 day procedures for 16+ weeks. PATS is payable if the service is not offered within region of residence.

*If patient has financial distress & cannot afford to pay privately please ensure they are referred to PCAC @KEMH. Patients **may** be funded by KEMH to have their procedure at MSI Midland Clinic- if appropriate.*

Medicare ineligible patients

This is a **common** group of patients that I see across all 4 facilities.

Do they have PHI? Does it cover inpatient and outpatient care?

Often with the coverage usually more cost effective for STOP.

If no PHI at all, EMA prescribed in the GP setting is likely to be the most affordable option for rural/remote patients. Especially if the GP can do POC dating scan.

$400 for MS-2 Step on private script- shop around ($200 difference between pharmacies in Hedland)

Plus consult fees, other medications, imaging and possible pathology costs

If patient without PHI prefers STOP or is ineligible for MS-2 Step- admission to public hospital facility is very expensive.

It may be more cost effective to refer to Nanyara Clinic or MSI Midland Clinic.

Encourage them to get quotes so they can have informed financial consent

Surgical abortion care >14 weeks

Prior to referral it would be much appreciated if you could arrange:

-Urgent obstetric USS for dating + placental localisation: we want to know if the placenta is clear of the os and if an anterior placenta, is it clear of any prior CS scar?

If they were first scanned at 7 weeks and have now represented at 17 weeks, they will need to be rescanned. If they were scanned at 14 weeks and placenta was documented was fundal, they do not need to be rescanned at 19 weeks.

-FBC, Group and antibody screen

-CT/NG, Syphilis, HIV, Hep B and C screening

-CST results, if available

Medical abortion care >20 weeks

At KEMH, ALL patients >20 weeks are offered medical abortion.

Reviewed in clinic, given a time to take mifepristone followed by LBS admission 2 days later where misoprostol will be administered.

This admission can take 1 to 3 days.

They can expect labour type pains, vaginal delivery of the pregnancy, pain relief is offered

They need to be aware that signs of life are possible at 20 to 21+6 weeks gestation.

Comfort care is provided to the fetus. They can choose to see or not see the fetus at delivery.

Need to be aware of the risk of retained placenta requiring MROP in OT, consented for this as part of the medical abortion.

Tip: Abortion & Perinatal Loss Medications Guideline, WNHS Restricted Area Guideline (misoprostol dosing)

Medical abortion care at >22+0

At or above above 22+0 at time of LBS admission patients will be required to undergo a feticide procedure

The are admitted via Day Surgery Unit and then go to MFM Department for this procedure. They are given midazolam and morphine.

Once the feticide is complete, mifepristone is administered.

They return to the LBS 2 days later for misoprostol administration.

Some WACHS facilities are suitably equipped to manage medical abortion up to 21+6.

It will depend on having supportive medical and midwifery staff at your sites.

Patient 22+0 and beyond can be returned to suitable rural sites for misoprostol administration following feticide if there are supporting medical staff. If you want to offer this for your patient, communicate it at the time of referral.

Pathway for >23 weeks

Fetal anomalies- please refer to MFM @ KEMH who will manage these patients

All others please refer these patient directly to PCAC @ KEMH as a matter of urgency, ideally a phone call to the team would be appreciated to notify us of the referral.

Any information that you can provide us regarding the patient and their circumstances is helpful.

Please ensure that patients are aware that their individual circumstances will be reviewed by a MDT including midwifery, social work, psychological medicine +/- AHLO.

They will then need to have 2 doctor support for their request. This whole process can take 1 week.

PCAC prepares these patients at the initial intake phone call that most patients will not be offered abortion care at >23 weeks.

PCAC also inform them that at the conclusion of their process, if not offered an abortion care pathway, they will be referred to their local maternity team for antenatal care.

23+ week pathway

Circumstances where request for abortion is likely to be viewed favourably by PCAC Team:

Active FDV where there is a significant risk of harm to mother

Sexual assault resulting in pregnancy

Incest resulting in pregnancy (CSA)

Culturally inappropriate or forbidden pregnancy resulting in safety concerns (wrong skin relationship) or significant social impairment if the pregnancy continues

Young adolescent patients <14 years

LARC failures

Severe mental health disorder

Significant social issues- homelessness, current children in out of home care

Late diagnosis of pregnancy

Concomitant medical issues

If the patient has medical issues that make them unsuitable for local abortion care please refer them to PCAC @ KEMH

They will be seen in the outpatient clinic.

Depending on the issue may also need to see Pre-Anaesthetic Clinic or be discussed with haematology or other medical specialties for a management plan.

We have had a recent case of patient with newly diagnosed stage 3 heart failure who was 17 weeks pregnant and seeking abortion care. After being reviewed at KEMH, she was required to be transferred to FSH for her procedure to ensure her cardiac co-morbidity and possible complications could be adequately managed.

Adolescents <14 years

Abortion care should be offered locally. That way it can be offered in a time-sensitive manner without disruption from support network.

There may be individual circumstances where the care required exceeds local resources and those patients should be referred to PCAC @ KEMH

Essential to see the patient on their own and get a good history of the situation and assessment of Gillick competence.

Strongly recommend that you involve Social Work Team at your local hospital and that they review patient.

You may wish to involve the local paediatric team, especially if there are safety concerns requiring CPFS or WAPOL input.

Be aware of CSA. Report and escalate to Central Intake Team at Dept Communities as well (Social work support very helpful in these situations).

If there is sexual assault disclosed ensure escalated to WAPOL and that they are available to collect any forensic specimens. STOP only option not EMA.

Significant psycho-social issues

Ideally these patients are managed in region using the resource network that will continue to support them post abortion.

- GP
- Hospital Social Work- FDV, Homelessness, other social complexities
- Community Mental Health Team +/- Inpatient Mental Health Team
- Private psychiatrists, clinical psychologists
- Community support organisations eg. Mission Australia

May need overnight admission pre and post surgical procedure to facilitate holistic care

May require inpatient care for EMA

Case Study- EW

25 year old

G2P1

Obs Hx: 1 x Caesarean section 7 years ago

Aboriginal woman who resides in a remote indigenous community in the far north of WA

Single mother

Informs PCAC staff this is a concealed pregnancy

Dating scan just completed- 20+6 weeks gestation

Case study continued

14/1: First contact with PCAC. Agrees to involvement of the locum RAN to assist with communication and making transfer arrangements.

22/1: Phone call from RAN- EW refusing to get on the mail plane. EW's sister was supposed to be in community to care for her 7 year old. But has since left and EW no longer has safe child care. 22+0/40

23/1, 24/1, 28/1: Text messages, phone calls, voicemails. No response from patient

29/1: New RAN (who is female and a midwife) commences in the community and contacts PCAC with EW. EW advises still wants to pursue abortion care 23+0.

31/1: Attempts at Telehealth consultation by SW and Clin Psych but poor engagement limiting assessment. Discloses late diagnosis pregnancy, concealed pregnancy, worried about judgement from family/community regarding seeking abortion care. Currently men's business happening in community. EW not comfortable to leave her child in community. 23+2

Case study continued

04/2: RAN has contacted us and advised that she insisted that EW inform her mother and encourage mother to travel with her to Perth to provide care for 7 year old daughter. EW's mother lives in another remote Aboriginal community 500km away. EW has agreed,

RAN advises us that there are **significant cultural barriers** to accessing care:

Men's Business- cultural related reasons who can enter and leave the community

Risk EW may not be able to re-enter community for weeks / months therefore must have her daughter with her

EW is very concerned about being judged for accessing abortion care

This may extend to consequences if the community become aware who the PIP is

Financial barriers to care: gap in covering finances for transport and accommodation for EW's daughter. PATS advocacy commences with involvement of local PATS office with Co-Ord for Aboriginal Health Liaison services at KEMH and PCAC Team.

AHLO contact to EW to prepare for travel to Perth.

Case study continued

05/02/25- 10/02/25: AHLO, SW, local PATS liaising re: flights, accommodation at Ronald McDonald house. Confirmed EW, her mother and 7 year old child travelling to Perth

11/2/25- 24+6 First face to face consult at 24+6 with AHLO and SW

Continuing to conceal pregnancy from her mother- told her coming for gynae treatment

No longer in relationship with PIP, consensual sex, unaware of pregnancy

Pregnancy is the result of a wrong skin relationship

Reluctant to talk about cultural processes and implications of her pregnancy

Significant safety concerns, cultural protocols dictate she can’t speak about this, men’s business and would be punished. Subjected to tribal lore and punishment if the pregnancy continues

Risk to patient, her parents and her daughter if pregnancy continues

Outcome of MDT assessment

Attempting to access care for a month. Significant barriers:

Remoteness of home town

Lack of informal supports resulting in childcare issues

Stigma of accessing abortion care resulting in decision to conceal pregnancy and reason for needing to go to Perth

Financial issues- request for special support to local PATS office

Continuing pregnancy represents a safety risk as a wrong skin relationship and possible tribal lore punishments including shaming, exclusion and corporal punishment as per advice of AHLO.

11/2: Two doctor support obtained at 24+6 weeks gestation

Consented for feticide, medical abortion process, Implanon insertion

Case Study continued

Planning meeting 12/2

Attendees: CMS PCAC, Nurse Manager DSU & Theatre, CMC LBS, CMC PLS, PCAC SW

To be made anonymous for admission

Complex care plan

Confirmed admission 14/2

Cab charge vouchers so no transport issues

Contact PCAC CMS on arrival to be escorted to DSU to ensure well supported

IV meds in DSU, transfer to medical imaging then back to DSU for recovery and mifepristone administration, Cab charge home

LBS admission 16/2

Further events

14/2: Presented for feticide at 25+2, appeared hesitant in MFM dept, SW and PCAC doctor review

Initially unable to articulate her wishes, sitting for a long time then said she had changed her mind

Asked about adoption options, wants to continue with the pregnancy, wants to go back to Ronald McDonald house and talk to her mother

Phoned back at 3pm that afternoon stating she now wanted to proceed with the abortion. Plan to meet on Monday 17/2 with AHLO and SW.

17/2: EW advises her mum supportive of whatever she decides. Still wants procedure but nervous about what procedure entails as no experience with prior vaginal delivery. Whole procedure explained again in detail by AHLO- EW advises she cannot cope with this procedure and would consider the adoptions pathway.

Outcome

- Final decision that EW is to be discharged from PCAC Services
- Smart rider to return to return to local accommodation
- Local PATS office contacted to arrange transport home and local accommodation to be maintained until those transport arrangements are confirmed
- Contact with RAN to advise coming back to community
- Referral to maternity service at local birthing site 600km from community
- Referral to Adoptions Team at Dept of Communities

Some women who are offered a 23+ week abortion care pathway will choose not to walk the path, it can be a difficult journey for many reasons

Resources

Western Australian Abortion Care Clinical Guidelines- released March 2025 (open access)

RANZCOG Clinical Guideline for Abortion Care 2024 (open access)

Pregnancy Choices and Abortion Care Team (PCAC), KEMH

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