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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Physicians Manage Abortion Pain Experienced by Remote Telehealth Patients?

Eloise Smellie, MBChB and John J. Reynolds-Wright, MBChB, PhD, MFSRH

Abstract

Pain is a recognized adverse effect of medication abortion, but its management has been understudied. This commentary on a case draws on principles of nonmaleficence, beneficence, and autonomy to consider equity in remote and in-person medication abortion pain management.

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Case

JN is a 24-year-old cis woman who has been pregnant twice and given birth vaginally both times. JN lives in a rural area, 75 miles from the nearest pharmacy or clinic. JN's last menstrual period was 7 weeks ago. She had a positive home pregnancy test, and an intrauterine pregnancy was confirmed at an out-of-town urgent care clinic. She wants to terminate the pregnancy and met virtually with Dr OBGYN, who prescribed mifepristone and misoprostol. JN took mifepristone 2 days ago and misoprostol yesterday. JN is experiencing severe cramping pain, despite taking over-the-counter analgesic medication. She messages Dr OBGYN to ask for a prescription medication to help manage her pain. Dr OBGYN considers how to respond.

Commentary

Use of telemedicine for abortion has steadily increased over the last decade and was dramatically accelerated by the COVID-19 pandemic.[1] Remote consultations are safe, effective ways to provide medication abortion, which can particularly benefit patients in remote, rural locations.[2,3,4] Although telemedicine abortion safety has been questioned because physicians at a distance are generally unable to attend as quickly as those in in-person settings to bleeding, ectopic pregnancy, and other urgent complications, adverse events of medication abortion are rare.[3,5,6] In the interests of nonmaleficence, it is important for abortion providers to consider the relative personal, legal, and financial risks to patients of attending telemedicine vs in-person appointments.

Following the US Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* in 2022, abortion facilities across several states have been forced to close, resulting in dramatic increases in the distance some people must travel to their nearest service.[7] Consequently, telemedicine might become increasingly important for the delivery of medication abortion and the management of its adverse effects. However, it is important to highlight the ethical tension between acting within the medico-legal restrictions of each state and providing safe and compassionate abortion care to ensure patient access and to sustain the abortion provider workforce.

Pain is a known adverse effect of medication abortion, but effective interventions for pain management are not well defined. Only a small number of studies have investigated an optimal analgesic regimen, and these provide a low level of certainty due to small sample sizes, high risk of bias, and high levels of between-study heterogeneity.[8] The best available evidence supports the use of ibuprofen, a widely used analgesic that can safely be self-administered without the need for an in-person assessment for medication abortion-related pain relief.[8] Nevertheless, it is important to highlight that pain is a single dimension of an abortion care experience, and considerations such as privacy and disclosure, relationships, clinical or institutional settings, and interventions preferences all factor into acceptability of abortion care. Given limited available evidence of how to manage pain, we review some ethical considerations of telemedicine abortion care and strategies clinicians can draw upon to promote pain management equity for remote and in-person consultations.

Equity of Remote and In-Person Pain Management

Assessment of pain. Pain experience is subjective, and its management is guided primarily by patients' self-report about its nature and severity. Pain can be assessed remotely or in-person and clinicians might, in the best interest of the patient, require a patient to be assessed in-person. In the case, JN had an ultrasound-confirmed intrauterine pregnancy, so it is unlikely to be a pathological pregnancy, and medium-term complications of medication abortion, such as infection or retained products of conception, would typically present after a longer time frame. Dr OBGYN has grounds for confidence that the pain is isolated with no associated features (eg, hemorrhage or vasovagal symptoms).

Traveling to a clinic for an in-person assessment could exacerbate JN's pain and would make it more difficult for her to use nonpharmacological pain management techniques, such as heat or mindfulness. Therefore, remote assessment and analgesia without delay is likely in JN's best interest. If patients are required to make potentially symptom-exacerbating journeys with additional financial and time burdens, it must be recognized that discomfort and risk of travel might outweigh in-person assessment benefits.

Management of pain. Clinicians rely on evidence to act in the best interest of their patients. Because there is limited evidence on the management of pain during medication abortion, there is uncertainty as to what treatment option is the most beneficent and therefore the most ethical.[8] In the absence of specific recommendations for pain management, clinicians routinely apply the World Health Organization's analgesic pain ladder, which advises escalation to weak opioids with or without adjuvants or other nonopioid analgesics for moderate pain.[9] Although there are limitations to applying this model, it can be helpful in the absence of suitable alternatives.[9] Suitability and safety of opioid medication can be assessed equitably using a remote or in-person consultation.

When developing pain management strategies for abortion, it is important to consider how pain is managed during other types of early pregnancy care. There are physiological similarities between an (induced) medication abortion and a miscarriage (spontaneous abortion), resulting in a comparable risk profile. Patients who proceed with expectant or medication management of a first trimester miscarriage are routinely able to do so at home; with adequate counseling, pain relief, and safety advice, it is accepted that the home environment is usually an appropriate location for this care.[10] If we consider at-home pain management to be an acceptable balance of risk and benefit in miscarriage, then it would be reasonable to apply the same approach in medication abortion, and, if we don't, then we need to question whether a different approach is rooted in stigma. Recommendations for pain management during medication abortion advise that opioids only be prescribed when requested and with strict limitations on dose and quantity.[11] These recommendations differ from those for miscarriage, which advise that clinicians provide patients with prescription analgesia.[10] These subtle differences in guidance for 2 physiologically similar processes imply that it is acceptable to trial potent pain relief in miscarriage, but not necessarily in abortion.

Pain is multifactorial in origin, and many psychosocial factors, including stigma, can impact individual pain experiences. The stigma of induced abortion is well documented.[12,13,14] Providing abortion-related care at home increases privacy, which can reduce potential stigmatization by health care professionals and other patients, as well as a patient's need to explain an absence to family or community members. Remote abortion-related care could particularly benefit members of Indigenous communities, who face disproportionate discrimination and can benefit from the cultural safety of remaining within their home environment to receive health care.[15] Managing medication abortion at home is also preferable to many patients due to increased flexibility, convenience, and access to home comforts.[16,17] For some patients, creating an optimal therapeutic environment and reducing the influence of stigmatization could directly reduce their perception of pain. For other patients, these factors might not directly contribute to pain levels but could improve the overall experience of abortion and thereby counteract adverse effects of medication abortion such as pain.

Adapting Pain Management Approaches

Preparing for pain. Informed consent is integral to ethical clinical practice and requires patients to understand the benefits and risks of the proposed treatment and alternative options before proceeding with a medical intervention. Pain is an important adverse effect of medication abortion, so it is essential for clinicians to counsel patients about pain expectations to ensure that valid consent is obtained. A spectrum of pain severity is associated with medication abortion, and though some patients report low-to-moderate levels of pain, we recognize that, for some patients, the pain is severe. As abortion care providers, we have an ethical obligation to ensure that patients considering medication abortion understand the spectrum of pain experiences—including the potential for severe pain—so that they can make an informed choice and to explain alternative options, including inpatient medication abortion and surgical abortion.

Decisions about telemedicine abortion occur at the intersection of nonmaleficence and respect for autonomy. Although we have an obligation to do no harm, many interventions do cause adverse effects, and, in practice, we will often accept an adverse effect if it is outweighed by the overall benefit.[18] As the evidence overwhelmingly supports the safety of telemedicine abortion, determining the balance of burden and

benefit should lie with the patient. If the patient makes the informed decision to proceed with a telemedicine abortion, then we should respect their autonomy.

As clinicians, we act to benefit our patients, and, in this scenario, we can do so by ensuring their mental and physical preparedness for pain. Pain that is worse than expected can result in anger, fear, and overall dissatisfaction with the abortion method.[11,19,20] Although not studied, fear could be even greater for patients living in remote locations who are reliant on telemedicine for support due to the lack of proximity to emergency services. Adequate pain counseling is therefore of particular importance when delivering telemedicine abortion. For patients using telemedicine, physical preparations should be advised, such as ensuring an adequate supply of menstrual pads, pain relief, and any nonpharmacological products they wish to use. It could be recommended that they have a friend, partner, or family member nearby who can support them with pain management and arrange urgent help if required. Patients with caregiving responsibilities should be advised when possible to arrange alternative provision, which might require additional planning if they live long distances from friends or relatives. These preparations help to promote patient welfare and ensure ethical delivery of care.

Responding to pain. Even with good preparation, pain is a common reason for patients to contact health care services during and after an abortion. Importantly, given growing recognition of gender bias in pain estimation,[21] JN's experience of severe cramping pain needs to be acknowledged and appropriately acted upon. Dr OBGYN should ensure that JN, who has specifically asked for further medication to manage her pain, has utilized the maximum safe doses of over-the-counter pain relief, which has the strongest evidence base, and discuss the role of nonpharmacological techniques (eg, a heat pad, hot water bottle, and relaxation techniques) as adjuvants to pain medication. As mentioned, the evidence base for pain relief escalation is limited, but in the absence of specific recommendations, we would advise providing weak opioid medication, which was not provided at JN's initial assessment. Dr OBGYN could consider prescribing a higher dose or quantity of weak opioids than would be prescribed for patients living in urban areas, as it is likely to be more difficult for JN to travel to and from the pharmacy. For patients like JN who travel long distances to access care, it could be in their best interest to provide a small supply of opioids at the initial assessment. This decision—as well as the formulation, dose, and quantity provided—should be made using clinical judgment that takes into account the patient's distance from health care services and the potentially addictive qualities of the drug. For patients using telemedicine, close communication is important to ensure that they are supported. Dr OBGYN could offer a telephone follow-up in a few hours to review JN's pain and arrange an in-person assessment if her symptoms have not improved by this time. Depending on local service provision, this follow-up may require Dr OBGYN to work with other health care professionals or create a network of health care professionals.

Conclusion

Ethical clinical practice is rooted in evidence-based medicine. Pain management during abortion is understudied, demonstrating an ethical need for high-quality research on this topic. Based on available evidence, we believe that standards of pain management equivalent to in-person consultations can be achieved using telemedicine with additional safety considerations. It is important not to exceptionalize abortion and to aim for a standard of pain management that is in line with other areas of early pregnancy care, as structural barriers to pain management can increase stigmatization. Conversely,

mandating that medication abortion only be provided in settings with specific pain resources would limit access to care. Importantly, given the evidence supporting the safety of telemedicine abortion, we must give patients the autonomy to decide if pain—and self-management of pain—is an acceptable level of burden when balanced with the benefits of receiving treatment at home. The growth of telemedicine demonstrates how abortion services can respond to patient needs. Medication abortion pain management is a need that continues to be inadequately met for many, so, as telemedicine abortion expands, we encourage health care services to review their approach to pain management to ensure that patients utilizing telemedicine can access the pain relief that they require and are not disadvantaged in their care. We also encourage further research in this area.

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Eloise Smellie, MBChB is a specialist trainee in community sexual and reproductive health. She has experience working in the United Kingdom providing comprehensive sexual and reproductive health care, including in-person and telemedicine abortion care. She has previously delivered sexual and reproductive health education in sub-Saharan Africa.

John J. Reynolds-Wright, MBChB, PhD, MFSRH is an NHS Education for Scotland, Chief Scientist Office clinical lecturer in sexual and reproductive health. He has conducted research on the use of telemedicine for medical abortion care and on development of novel contraceptives and is currently developing a tool to consistently measure pain during medical abortion. He is also an associate editor of *BMJ Sexual and Reproductive Health*.

Editor's Note

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Conflict of Interest Disclosure

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