

EXHIBIT 37

With telehealth abortion, doctors have to learn to trust and empower patients (https://www.northcountrypublicradio.org/2023/01/17/telehealth-abortion-doctors-have-to-learn-to-trust-and-empower-patients)

BY MARA GORDON (HTTPS://WWW.NPR.ORG/PEOPLE/729920606/MARA-GORDON) — JAN 17, 2023 1:22PM (NPR)



<https://media.npr.org/assets/img/2022/12/05/telehealthabortion-30266e6985b05dd957a2476bec7708540c62931b.jpg?s=1000>

Image: Jesse Zhang for NPR

Like many pandemic-era remote workers, Robin Tucker starts her work day sitting on her sofa with a laptop, wearing soft pants and a T-shirt. But the Washington, DC-area nurse practitioner and midwife doesn't have a typical work-from-home job. She provides abortions over the Internet, a service that has only become available in the United States in the last few years.

Her career, she says, has turned out to be very different from what she learned in midwifery school, where she'd spend long shifts in a high-intensity labor and delivery unit, helping patients give birth.

These days, her work involves reviewing patient information and electronically prescribing the two medications — mifepristone and misoprostol — that together can end an early pregnancy. Patients take the medicines at home.

Sometimes she works from hotels, airports, or public libraries. Once, she provided an abortion from a restaurant, where she was out to dinner with friends.

"I have found ways to just sort of work it into the rest of my life," she says. "If I've got to go meet a contractor at my house, I'll be doing an abortion phone consult while I'm driving."

Tucker is one of a growing number of health care providers who offer medication abortion services online. Some work for companies like Hey Jane (<https://www.heyjane.co/>) and Aid Access (<https://aidaccess.org/en/>); others, like Tucker, work in private practice. Demand for the service, they say, has exploded since the Supreme Court overturned *Roe v. Wade* and states started passing laws banning abortion.

The growth of online abortion care is driving a radical shift in the way doctors think about caring for their patients. At the same time, it's asking them to take on new legal risks on their patients' behalf.

A historical change

In the first half of the 20th century, hospitals and medical organizations were slow to recognize abortion as a legitimate part of medical care, says sociologist Carole Joffe (<https://bixbycenter.ucsf.edu/carole-joffe-phd>), who studies abortion. That's because it called into question the traditional hierarchy between doctor and patient, she says.

Typically, doctors were used to determining both the diagnosis and the treatment – the doctor tells the patient what he or she needs. But when a patient seeks an abortion, that power dynamic is upended: The patient tells the doctor that she wants to end the pregnancy, not the other way around. (In some cases, such as a fetal anomaly or an urgent medical risk to the pregnant person, a doctor might advise an abortion.)

Joffe says that many doctors found this power shift threatening.

She interviewed doctors about abortion in the pre-*Roe* era for her book *Doctors of Conscience* (<https://www.penguinrandomhouse.com/books/204166/doctors-of-conscience-by-carole-joffe/>). One doctor told her, "I don't want to be a rubber stamp," Joffe says, describing his concerns about allowing patients to request abortions.

Advocates worked for decades both to legalize the procedure and to make abortion an accepted part of mainstream medicine. As *Roe vs. Wade* became law in 1973, abortion providers actually fought to restrict abortion care to hospitals and clinics, Joffe says, as a way to help legitimize it.

They said: "Only we medical doctors can decide what are the conditions under which it should be allowed," Joffe says. "And if it should be allowed, only we should be able to do it."

These efforts were largely successful. Up until the COVID-19 pandemic, abortion mostly did take place according to the terms set by both lawmakers and the health care establishment.

That included medication abortion. The U.S. Food and Drug Administration required that patients get mifepristone directly from a clinician. This meant patients had to go see a doctor in person, usually at a clinic focused on abortion and other reproductive health services.

Then during the pandemic, the FDA relaxed some of its rules (<https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>) around mifepristone, so it could be prescribed through mail-order pharmacies. At the same time, many state medical boards and insurance companies also made it easier for patients to see their doctors via telehealth. (Earlier this month, the FDA relaxed the rules even further (<https://www.npr.org/2023/01/05/1147044290/abortion-pills-should-be-easier-to-get-that-doesnt-mean-that-they-will-be>), making mifepristone available at regular retail pharmacies.)

These changes allowed telehealth abortion to flourish, and with its growth comes another adjustment to the traditional doctor-patient hierarchy.

Also driving demand: in states where abortion was outlawed in 2022, some patients who might have sought an abortion in-person are turning to telehealth instead. As telehealth abortion grows, both clinicians and their patients have found new ways to communicate and build trust, without the traditional in-person visit.

There's a "historical reversal," Joffe says. "Now you have a generation of doctors ... who are saying ... 'You don't need us. Our job is basically to assure you, the patient, that it's safe for you to do by yourself.'"

A patient-centric experience

Telehealth abortion – which is available up to about 10 weeks gestational age in the U.S. – requires much less clinician involvement than the pre-pandemic experience of providing an early abortion. First, it omits most of the testing that is typically done in a clinic, including getting an ultrasound to establish how far along the pregnancy is, and blood tests.

Instead, patients complete an online symptom checklist that rules out rare conditions that could make medication abortion dangerous, like an ectopic pregnancy or a bleeding disorder. The patient reports when her last period was, which establishes the gestational age of the pregnancy.

At some telehealth abortion companies, clinicians provide live video visits, but others may never interact with the patient in real time. Many companies simply have clinicians review a patient's intake form, then submit an electronic prescription for abortion pills to a mail-order pharmacy.

Several companies also offer what's called advance provision of abortion pills, which means patients can buy mifepristone and misoprostol even if they aren't pregnant, to be used if needed at a future date.

Patients pay with a credit card, a cash transfer app like Venmo, or if they don't want their purchase to be tracked, with a prepaid gift card. The pills arrive a few days later.

"I really love how empowering that is, and less paternalistic," says Dr. Kristyn Brandi (<https://www.acog.org/about/leadership-and-governance/get-involved/darney-landy-fellows>), a New Jersey family planning specialist who is a spokesperson for the American College of Obstetricians and Gynecologists. "To be able to trust people and give them the opportunity to take the medicine into their own hands."

There's a growing body of research that shows much of the testing and counseling ([https://www.contraceptionjournal.org/article/S0010-7824\(20\)30108-6/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(20)30108-6/fulltext)) that patients might receive during an in-person visit is not necessary for an abortion. A study of medication abortions provided via telehealth during the pandemic found them to be just as safe and effective at ending an early pregnancy as in-person care.

(<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451>)

Of course, certain patients may need tests or an ultrasound, and the protocol telehealth providers follow is designed to identify them. For instance, if a patient has severe pelvic pain or if she doesn't know the date of her last period, the telehealth abortion provider will usually send the patient for an ultrasound close by, then have her upload the results to the telehealth platform.

And there are specific criteria that would prompt a doctor to send their patient for blood work, including a history of severe anemia.

If it isn't safe to proceed with the telehealth abortion, either because the pregnancy is too far along or because the patient has a medical condition that makes it dangerous, the provider will refer the patient to a hospital or clinic.

Brandi says she thinks her patients understand that providing accurate information about their health is essential for safe medical care.

"In the family planning community, we have the mantra of trust women, or trust patients," Brandi says. "The patients are the experts in their lived experience. They know when their last menstrual period is. They know how certain they are of that or not."

Still, many doctors are accustomed to a "trust, but verify" approach to practicing medicine, which means confirming their patients' stories with objective medical tests. This is common in many areas of medicine. Many U.S. doctors worry they order too many tests on their patients (<https://pubmed.ncbi.nlm.nih.gov/28877170/>), yet feel compelled to do so.

And even though the research shows that telehealth abortion is safe without most testing, long-established patterns of medical practice can be slow to change.

"Providers may be set in their ways and slow to adapt the evidence," Brandi says. "I think medicine takes a little bit of time to adapt to the data and the research."

Even before the Supreme Court overturned *Roe*, abortion was often under so much scrutiny that over-testing became the norm. State laws specific to abortion drive more unnecessary testing than other areas of medicine, says Brandi. Certain states mandate that patients undergo an ultrasound (<https://www.guttmacher.org/state-policy/explore/requirements-ultrasound>), for example, even though it isn't always essential. Other states require blood and urine tests (https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/o28/chapter29/chap29toc.html&d=)).

"The testing that may often happen in the clinic, as just routine care, may not actually be as needed for everybody," Brandi says. "I think that's been driven by unnecessary abortion restrictions."

Even though telehealth abortion mostly takes place in states that don't have those kinds of laws, abortion is so politically charged that doctors everywhere remain particularly cautious about avoiding errors, says Brandi.

Telehealth abortion is also pushing the old boundaries of medicine by providing only very minimal counseling. Most patients can make the decision to end a pregnancy without needing to talk it through with a doctor, telehealth abortion providers say.

But giving up that counseling – and the close emotional bond that can arise from meeting patients in person – can be challenging for some abortion providers.

When Dr. Jamie Phifer, the medical director of Abortion on Demand (<https://abortionondemand.org/about/>) brings new medical staff on board, they often need "retraining," she says.

"There's this societal assumption that when your patient needs an abortion, it's a sad thing," Phifer adds, "You need to be present and hold their hand through it."

She encourages her staff to focus on an efficient review of medical information, rather than intensive counseling.

"You don't need to bring a lot of your own baggage as a physician into the visit," she says. "That's radical trust, in a lot of ways."

Of course, changing the culture of medicine does come with its share of pushback.

Tucker, the DC-area nurse practitioner, says she's gotten a lot of "ignorant comments" about her work providing abortion pill prescriptions online.

"This is how people are getting their Paxlovid [for COVID-19 infection] (<https://aspr.hhs.gov/COVID-19/Therapeutics/Products/Paxlovid/Pages/default.aspx>), but they don't act like that's coming off the back of a pickup truck," she says.

Even as telehealth clinicians embrace a more hands-off approach to providing abortions, many of them have to worry about being held liable for a procedure that takes place in uncharted legal territory.

That's because telehealth abortion is legal in many U.S. states (<https://www.kff.org/womens-health-policy/issue-brief/the-intersection-of-state-and-federal-policies-on-access-to-medication-abortion-via-telehealth/>), but it is also outright banned in others. And when the clinician is sitting at home in one state, and the patient is in another, and the clinic itself is online, it isn't always clear what it means to have an abortion in a given state.

When the FDA changed its policy to allow abortion pills to be sent through the mail, "there was an enormous amount of confusion," says Harry Nelson (<https://www.nelsonhardiman.com/attorney/harry-nelson/>), a health care lawyer who advises on telehealth abortion. "It was a real moment of uncertainty."

Even now, Nelson says that many of the legal subtleties undergirding the provision of telehealth abortion haven't been tested in court, and therefore aren't yet clearly established. As a result, doctors have to go to extreme lengths to legally protect themselves.

Abortion on Demand, for example, uses software that can detect approximately where a patient is located while connecting with the service. A patient can do her intake visit with the company from a state where abortion is restricted. But she must travel to a state where telehealth abortion is allowed to pick up the pills, which the company verifies by asking patients to send in a copy of a plane ticket, or taking a photograph of a receipt from a gas station along with the patient's identification.

"We keep a very, very conservative practice in terms of who we can treat and where their location is," Phifer says. "There's a lot of legal nuance around that."

Doctors haven't generally needed to worry about legal risks when prescribing many other types of medication across state lines, says Nelson, like sending in a refill when a patient's on vacation in a different state.

But with abortion, these practices are under more scrutiny. "All of a sudden, these are really highly charged questions, very high-risk questions," he says.

Tucker, the DC-area nurse practitioner, has taken steps to insulate herself from legal risk. For example, she has administratively separated her telehealth abortion company from her main private practice, where she provides general reproductive health care.

It's "due to the legal climate and the increased risk for providers," Tucker says. "Not knowing 100% ... If our pills are getting forwarded somewhere, if somebody's picking them up in Virginia, and going to Oklahoma, and my name is on this prescription bottle."

Despite these challenges, telehealth abortion companies say demand continues to grow, as patients become more comfortable with the legitimacy of the services and share their experiences with their friends.

"The most common comment that we get is: 'I can't believe this is so easy,'" says Phifer of Abortion on Demand. "Every day we have people who just start crying on the video visit ... They're crying because they're so relieved."

Seeking care over the internet can be empowering for patients, says Nelson, the health care lawyer, letting them choose the timing and location of their care.

"You don't have to explain yourself," he adds. "You're just like, 'This is what I need.'"

Mara Gordon is a family physician in Camden, N.J., and a contributor to NPR. She's on Twitter at @MaraGordonMD (<https://twitter.com/maragordonmd?lang=en>).