

## 2023 Council Resolution 44: Clinical Policy – Emergency Physicians’ Role in the Medication & Procedural Management of Early Pregnancy Loss

**Council Action:** AMENDED AND REFERRED TO THE BOARD OF DIRECTORS

**Board Action:** NOT APPLICABLE

**Status:** Completed

**SUBMITTED BY:** Rachel Solnick, MD  
American Association of Women Emergency Physicians Section  
Kelly E Quinley, MD  
Emily Erickson Ager, MD  
Kimberly Ann Chernoby, MD  
Katherine Wegman, MD

### **Purpose:**

Develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

### **Fiscal Impact:**

Budgeted committee and staff resources for the development of each new single-question clinical policy. The development of each new single-question clinical policy takes approximately one year and requires staff (0.8 FTE) and volunteer time, as well as the use of outside methodologists. Each new clinical policy would need to be added to the currently budgeted and prioritized list of new and existing policies.

WHEREAS, Approximately 900,000 emergency department visits per year in the U.S. are related to vaginal bleeding and miscarriage in the first trimester<sup>1</sup>, and as such, constitute a significant portion of emergency medicine time and resources; and

WHEREAS, Up to 20% of pregnancies end in early pregnancy loss (miscarriage in the first trimester), and compared with other ED patients, these patients are more likely to be younger, be Black or Hispanic, or be publicly insured<sup>1</sup>; and

WHEREAS, Pregnancy complications are the fifth most common reason women between ages 15-64 visit Emergency Departments in the U.S.<sup>2</sup>; and

WHEREAS, As many as 84% of pregnant people visit an Emergency Department during pregnancy<sup>3</sup>; and

WHEREAS, Legal changes in the US resulting in reduced access to family planning and abortion services will likely lead to increasing numbers of patients experiencing early pregnancy loss to seek care in an Emergency Department<sup>4</sup>; and

WHEREAS, A February 2023 report found that 217 labor and delivery units have closed across the US since 2015<sup>5</sup>, meaning that more Emergency Physicians will provide care for patients experiencing early pregnancy loss without the benefit of in-house Obstetricians and Gynecologists, and/or with the nearest obstetrical specialist located outside of their facility and farther away; and

WHEREAS, Research shows patients experiencing early pregnancy loss who are given options for medical management or procedural management versus expectant management alone are more satisfied than those not given the option<sup>6</sup>; and

WHEREAS, Research shows that medication management of early pregnancy loss using mifepristone and misoprostol compared to expectant management leads to higher rates of completed miscarriage and lower rates of complications such as hemorrhage requiring blood transfusion<sup>7</sup>; and

WHEREAS, Research indicates that adopting procedural management with uterine aspiration in the Emergency Department in lieu of admission and operating room-based uterine aspiration can reduce patient wait times and hospital costs in an era when our healthcare system is financially strained<sup>8</sup>; and

WHEREAS, Research shows that procedural management of early pregnancy loss reduces the risk of bleeding, re-admission, and need for subsequent procedure for failed therapy<sup>9</sup>; and

WHEREAS, The American College of Obstetricians & Gynecologists' (ACOG) Practice Bulletin on Early Pregnancy Loss states mifepristone and misoprostol should be used to medically manage miscarriage where available<sup>10</sup>; and

WHEREAS, A recent change in FDA policy means that mifepristone can now be dispensed from retail pharmacies like other medications prescribed from the Emergency Department<sup>11</sup>; and

WHEREAS, Mifepristone and misoprostol are routinely prescribed in outpatient settings and via telemedicine making them safe for prescription from the Emergency Department<sup>12, 13</sup>; and

WHEREAS, Offering medication management to patients with first-trimester miscarriage can reduce emergency bounceback visits for patients when compared to discharging patients with no treatments (expectant management)<sup>14</sup>; and

WHEREAS, Pregnant people who present with hemorrhage or hemodynamic instability from early pregnancy loss should be treated urgently, often with procedural uterine evacuation<sup>10</sup>; and

WHEREAS, As a primary approach, procedural uterine evacuation results in faster and more predictable complete evacuation. The success of procedural uterine evacuation of early pregnancy loss approaches 99%<sup>16</sup>, meaning these patients do not need more medications or another procedure; and are less likely to require unscheduled medical care; and

WHEREAS, Procedural management (also known as uterine aspiration or suction curettage) is most commonly performed in an office setting with a manual vacuum aspirator, under local anesthesia without the addition of sedation<sup>17, 18</sup>; and

WHEREAS, Training programs exist that teach miscarriage management to emergency physicians including medication and procedural management, such as the Training, Education and Advocacy in Miscarriage Management (TEAMM) project, a University of Washington-affiliated program that has assisted over 100 clinical and academic sites, including emergency medicine clinicians, develop tailored interventions to integrate early pregnancy loss management into their services<sup>19</sup>; and

WHEREAS, ACOG also hosts a training program where OBGYN specialists travel to Emergency Departments and hospitals to help clinicians train in uterine aspiration and medical management of early pregnancy loss<sup>20</sup>; and

WHEREAS, Research shows that emergency medicine clinicians can incorporate manual uterine aspiration for the management of early pregnancy loss into their clinical practice<sup>21</sup>; and

WHEREAS, In 2022, the ACEP Council adopted a resolution to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on early pregnancy loss care<sup>22</sup>; however, what educational expectations this entails in terms of medical versus procedural management as of yet is unclear; and

WHEREAS, In 2022, the ACEP Council adopted a resolution that ACEP supports an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care<sup>23</sup>; and

WHEREAS, ACEP clinical policies provide guidance on the clinical management of emergency department patients and are not intended to represent a legal standard of care nor the only diagnostic and management options that the emergency physician should consider and ACEP recognizes the importance of the individual physician's judgment and patient preferences; and

WHEREAS, Past ACEP clinical policies regarding early pregnancy have incorporated data from studies conducted in care settings outside the emergency department<sup>24</sup>; therefore be it

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management safe, effective, and patient-centered compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management safe, effective, and patient-centered compared to expectant management.

### **Background:**

This resolution calls for ACEP to develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

An estimated quarter of all women will experience the early loss of a pregnancy (EPL) in their lifetime (Ghosh 2021). Twenty percent of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Methods for managing a miscarriage include expectant management, medication management, and procedural management. Over 70% of obstetricians provide either procedural or medication interventions for miscarriage management (KFF, 2023). However, an [August 2023 report from the March of Dimes](#) demonstrates that almost one in ten counties in the United States do not have an obstetrics unit in their hospitals, leaving 5.6 million women in counties with limited maternity care, including EPL management. Each year, over 900,000 patients present to the emergency department with early pregnancy loss (EPL) (Benson, 2021), accounting for 2.7% of all ED visits for women ages 15-44 years.

ACEP's Emergency Medicine Reproductive Health & Patient Safety Task Force developed the policy statement "[Access to Reproductive Health Care in the Emergency Department](#)." This policy states, in part, "ACEP encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications including miscarriage, post-abortion care, and self-managed abortions."

The Clinical Policies Committee (CPC) defines a clinical policy as an evidence-based recommendation informed by a systematic review of critically appraised literature developed in accordance with accepted guideline development standards. The CPC can include studies that have not been conducted in the emergency department. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO (Problem/Population, Intervention, Comparison, Outcome) questions. A review of the clinical policy development process was initiated in 2019. During the review, workgroups of the CPC assessed the development, methodology, and value of the policies to stakeholders. One of the obstacles identified to the timely updating of clinical policies was the multiple question format. A multi-question clinical policy takes, on average, 18-24 months from initiation to completion. Each clinical policy is currently updated, on average, every 8.6 years. In April 2021, the CPC proposed trialing single-question clinical policies with the goal of reducing the time from initiation to completion to approximately 12 months. When fully implemented, the single-question format will enable the CPC to revise up to 10 clinical policies per year in addition to assigned policy statements and will allow the CPC to consider issues that are of the greatest importance to members while allowing faster turnaround time for clinical policy updates.

ACEP's current "[Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy](#)" is based on two critical questions:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a  $\beta$ -hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of  $\beta$ -hCG for predicting possible ectopic pregnancy?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has

decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging modalities in suspected pulmonary embolism. In accordance with CPC procedures, the critical questions called for in this resolution would require development of two new single-question clinical policies.

### **Strategic Plan Reference:**

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

### **Prior Council Action:**

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. Directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and advocate for universal access to emergency contraception in the emergency department.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care-

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

### **Prior Board Action:**

June 2023, approved the policy statement "[Access to Reproductive Health Care in the Emergency Department.](#)"

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

October 2016, approved the revised "[Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy](#)" and rescinded the 2012 clinical policy.

### **Council Action:**

Reference Committee C recommended that Amended Resolution 44(23) be adopted.

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management initiated in the emergency department by an emergency physician safe, and effective, ~~and patient-centered~~ compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management in the emergency department by an emergency physician safe, and effective, ~~and patient-centered~~ compared to expectant management?

The Council referred Amended Resolution 44(23) to the Board of Directors on October 8, 2023.

### **Testimony:**

Asynchronous testimony was almost exclusively in support of the resolution. Testimony in support highlighted the need for better information on the proactive management of early pregnancy loss. Members of the Clinical Policies Committee supported the intent of the resolution but pointed out that the critical questions as written would not produce clear recommendations because of the lack of comparative literature on the listed outcomes. Further testimony recommended that the resolution be withdrawn and combined with resolution #45 since both resolutions seek to achieve the same goals. In addition, amendments were requested to make the resolveds specific to emergency medicine. Finally, the aspect of a treatment being "patient centered" was eliminated as this is subjective and not something that the Clinical Policies Committee would comment upon. During live testimony, the authors of the resolution were in support of the amended language. The amendments also received support from the American Association of Women Emergency Physicians, the Emergency Medicine Residents' Association, and New York chapter. There was testimony from numerous speakers stating that emergency medicine is continually evolving, and the management of early pregnancy loss is becoming a routine part of some members' daily practice. The College should provide evidence-based resources for members who need guidance on the management of early pregnancy loss. Those opposed to the resolution raised concerns that fulfilling the requests of the resolution would inadvertently create an implied mandate that emergency physicians must provide this service. Concern was also raised that, while sometimes management of early pregnancy loss is emergent, many times this type of care is not something that needs to be provided in the emergency department. There was also a concern about the commitment of scarce College resources and the Clinical Policies Committee for something with limited scope. There was also a discussion about the difference between medication and procedural management.

### **Board Action:**

### **References:**

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### **Implementation Action:**

Assigned to the Clinical Policies Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. ACEP's current ["Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy"](#) is based on two critical questions:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a  $\beta$ -hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of  $\beta$ -hCG for predicting possible ectopic pregnancy?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging modalities in suspected pulmonary embolism. In accordance with the Clinical Policies Committee procedures, the critical questions called for in this resolution would require development of two new single-question clinical policies.

The Clinical Policies Committee and the Writing Committee on Early Pregnancy reviewed the resolution, conducted a review of the current literature on the topic in emergency medicine, and discussed the possibility of creating a robust clinical policy regarding the management of early pregnancy loss in the emergency department. In the literature review process, we identified the most current reaffirmed policy statement on early pregnancy loss management from the American College of Obstetricians and Gynecologists (ACOG) from 2018. ACOG does not have guidelines or policies regarding this topic. A Cochrane review on the topic was identified, but the included studies were not specific to emergency medicine and were critically appraised (graded) as low quality by their reviewers, and was last updated in 2012. It was also noted there is little literature (and no quality literature) on early pregnancy loss management in the emergency department. The remaining literature is written from the perspective of obstetrics and, even then, is poor quality. Based on the lack of sufficient quality literature to inform a clinical policy recommendation, the Clinical Policies Committee recommended that development of a clinical policy not be pursued and that a policy statement be developed regarding the role of emergency physicians in treating and evaluating patients presenting with early pregnancy loss as directed in Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss. The Board of Directors affirmed the findings of the Clinical Policies Committee in April 2024.

**Background Information Prepared by:** Travis Schulz

Kaeli Vandertulip

**Reviewed by:** Kelly Gray-Eurom, MD, MMM, FACEP

Melissa Wysong Costello, MD, FACEP

Susan E Sedory, MA, CAE