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Concept and design: Kolkailah, Uzendu, Girotra.

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Editor's Note

Automated External Defibrillators Are Only Effective If Put to Use

In their cohort study in this issue of *JAMA Internal Medicine*, Kolkailah et al¹ found that rates of bystander automated external defibrillator (AED) use were similarly low in both states that mandate and those that do not mandate such devices in recreational facilities: 19% vs 18%. The fact that cardiac arrests with ventricular tachycardia or ventricular fibrillation rhythms have significantly better odds of survival when early cardiopulmonary resuscitation is performed has likely motivated policies to expand AED availability.² How-

ever, availability alone does not guarantee appropriate use by bystanders.

To effectively increase bystander AED use, AED availability needs to be coupled with educational programs designed to reach broad community stakeholder audiences. A simple educational campaign might emphasize 4 key messages: (1) AED use saves lives, (2) anyone can use AEDs safely, (3) AEDs can and should be used before arrival of emergency medical services, and (4) the device itself provides step-by-step instructions to the bystander.

Policy interventions, such as the mandate for seatbelts or AED availability, can be potent tools to improve population health, particularly for high-risk health conditions and/or in places where a high-risk health condition is likely to occur. However, policies can only be effective when they are implemented with community stakeholder collaboration and training. While most US states have legislative mandates for layperson AED use training, only a handful of states require demonstration and monitoring for appropriate AED use, review of AED use data, and quality improvement planning. This study¹ demonstrates continued need for public access to AED education, training, and quality improvement initiatives and related implementation research, as called for by the Institute of Medicine.³

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Disclaimer: Dr Wang reported this Editor's Note was written in a personal capacity and does not necessarily reflect the views of the Patient-Centered Outcomes Research Institute.

1. Kolkailah AA, Chan PS, Li Q, Uzendu A, Khan MS, Girotra S. Automated external defibrillator use after out-of-hospital cardiac arrest at recreational facilities. *JAMA Intern Med*. Published online January 2, 2024. doi:10.1001/jamainternmed.2023.7248

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Advance Provision of Mifepristone and Misoprostol via Online Telemedicine in the US

Advance provision of abortion medications is the prescription of mifepristone and misoprostol before pregnancy occurs.¹ Physicians in the US do not routinely engage in advance provision, yet there is considerable interest among US populations.²⁻⁴ Following recent abortion bans, advance provision could allow people to have abortion medications immediately available if needed.

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Supplemental content

Table. Demographic Characteristics of People Requesting Advance Provision of Medication Abortion Pills Compared With Those Requesting Medication Abortion Pills for a Current Self-Managed Abortion Between September 1, 2021, and April 30, 2023

Characteristic	No. (%)		P value
	Advance provision (n = 48 404) ^a	Self-managed abortion (n = 147 112) ^b	
Age, y			
<20	5075 (12.3)	20 895 (18.2)	<.001
20-29	22 078 (53.6)	62 714 (54.7)	
30-39	10 916 (26.5)	27 388 (23.9)	
≥40	3085 (7.5)	3564 (3.1)	
Mean (SD)	27.5 (7.6)	25.8 (6.5)	<.001
Racial and ethnic identity			
Asian	2044 (4.8)	4103 (3.3)	<.001
Black or African American	3073 (7.1)	33 553 (27.3)	
Hispanic/Latina/Latinx	5550 (12.9)	25 584 (20.8)	
Native American	497 (1.2)	1466 (1.2)	
Pacific Islander	168 (0.4)	529 (0.4)	
White	28 723 (66.8)	48 457 (39.5)	
Another race or ethnicity	231 (0.5)	780 (0.6)	
Prefer not to say	2697 (6.3)	8252 (6.7)	
No. of children			
0	36 125 (74.6)	70 458 (47.9)	<.001
≥1	12 279 (25.4)	76 652 (52.1)	
Census region classification			
Urban	39 651 (81.9)	112 740 (76.6)	<.001
Rural	8753 (18.1)	34 372 (23.4)	
Census region poverty rate			
Less than half the national average	803 (2.1)	1437 (1.4)	<.001
Below the national average	13 466 (36.0)	30 935 (29.4)	
At or above the national average	22 143 (59.2)	68 178 (64.7)	
More than twice the national average	964 (2.6)	4797 (4.6)	

^a Missing data: age, n = 7250 (15%); racial and ethnic identity, n = 5421 (11%); census region poverty rate, n = 11 028 (23%).

^b Missing data: age, n = 32 551 (22%); racial and ethnic identity, n = 24 388 (17%); number of children, n = 2 (0.001%); census region poverty rate, n = 41 765 (28%).

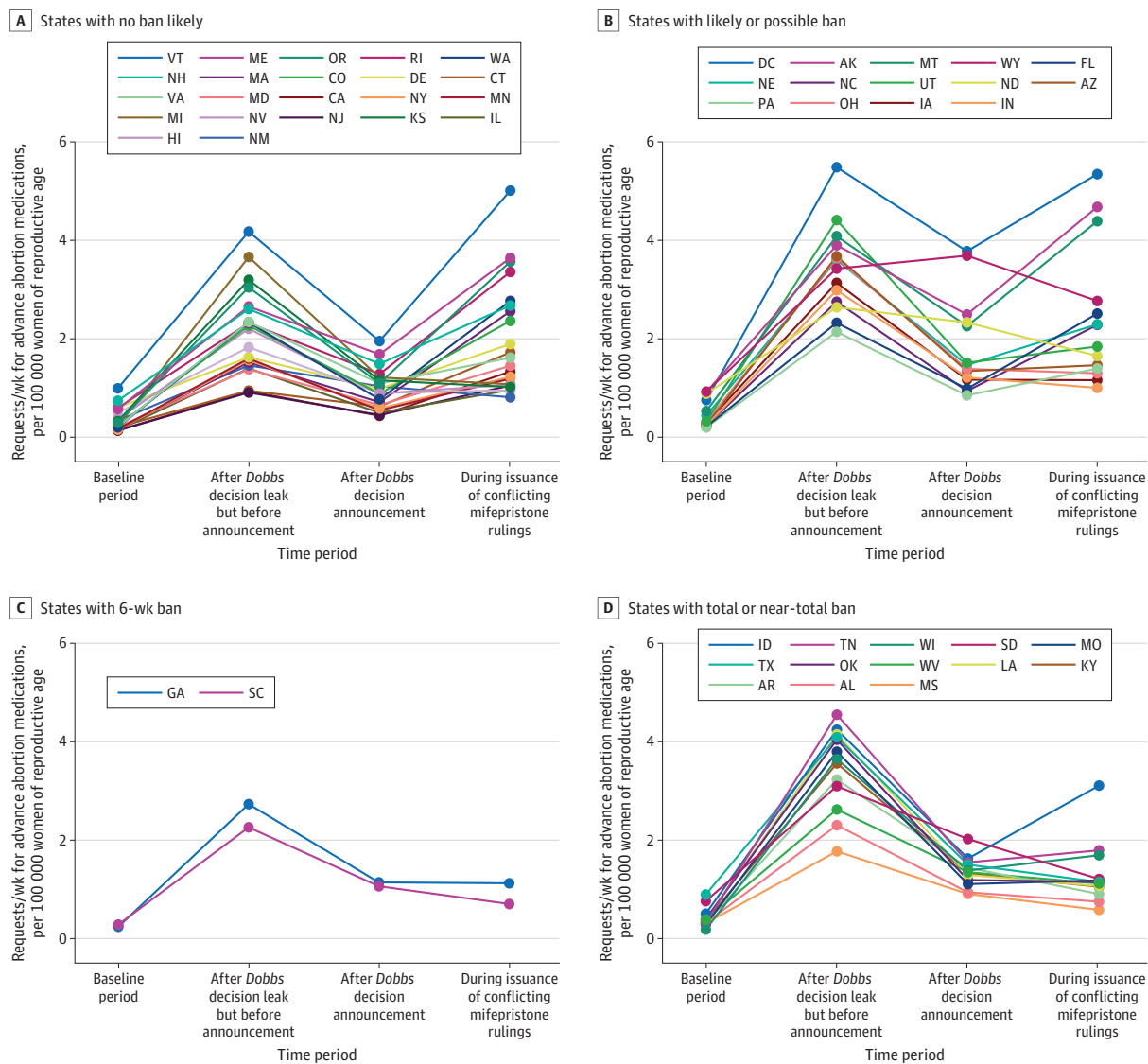
Using data from Aid Access, an online telemedicine service that has offered advance provision since September 2021, we examined trends in the demand and characteristics and motivations of requestors.

Methods | This cross-sectional study included residents of all 50 states and Washington, DC, who requested advance provision between September 1, 2021, and April 30, 2023. We compared the mean daily request rate across 4 periods: baseline (September 1, 2021, to May 1, 2022); after the *Dobbs v Jackson Women's Health Organization* (*Dobbs*) decision was publicly leaked but before the decision was formally announced (May 2 to June 23, 2022); after the *Dobbs* decision was formally announced (June 24, 2022, to April 6, 2023); and during conflicting judicial rulings on FDA approval for mifepristone (April 7 to April 30, 2023). Across all periods, we compared mean weekly request rates per 100 000 female residents aged 15 to 44 years for each state.⁵ We categorized states as follows: 13 states that banned abortion following *Dobbs*; 2 states that implemented 6-week bans; 13 states plus Washington, DC, that indicated that bans or restrictions were likely; and 22 states with no current or planned legal changes.⁶

We examined requestor demographic characteristics, including age, self-reported racial and ethnic identity (Aid Access collects these data to assess inequities in service delivery), number of children, US Census-level rural vs urban residence, and US Census-level regional poverty level (at or above vs below the national average),⁵ and compared them with those requesting medications for a current self-managed abortion. We used difference in proportions tests, χ^2 tests, and *t* tests to examine differences, with statistical significance set at $P < .05$. All requestors shared information about their motivations from a list of responses or using open-ended text. We used R, version 4.3.1, for data analysis. The University of Texas, Austin institutional review board approved the study. Requestors checked a box to indicate consent for the anonymous use of their data at the time of making the request. All data provided by Aid Access were fully deidentified. We followed the (STROBE) reporting guidelines.

Results | During the study period, Aid Access received 48 404 advance provision requests. Compared with those requesting self-managed abortion, a higher proportion of those requesting advance provision were 30 years or older (34% vs 27%;

Figure. Requests for Advance Provision of Abortion Medications Before and After *Dobbs v Jackson Women's Health Organization (Dobbs)*



Weekly requests by state for advance provision of abortion medications during 4 periods (baseline: September 1, 2021, to May 1, 2022; after the *Dobbs* decision leak: May 2, 2022, to June 23, 2022; after the *Dobbs* decision announcement:

June 24, 2022, to April 6, 2023; and after conflicting mifepristone rulings: April 7, 2023, to April 30, 2023) as stratified by state-level abortion policy after *Dobbs*.

$P < .001$), self-identified as White (67% vs 39%; $P < .001$), had no children (75% vs 48%; $P < .001$), lived in an urban region (82% vs 77%; $P < .001$), and lived in a region with a poverty rate less than the national average (38% vs 31%; $P < .001$) (Table). The most common reasons for requesting advance provision were to ensure personal health and choice (35 855 [74%]) and to prepare for possible abortion restrictions (35 405 [73%]).

The mean number of daily requests was 24.8 (95% CI, 21.0-28.6) during baseline, 247.3 (95% CI, 117.0-377.5) after the *Dobbs* leak, 89.1 (95% CI, 35.3-143.0) after the *Dobbs* decision, and 172.1 (95% CI, 118.0-226.3) after opposing rulings regarding mifepristone approval. After the *Dobbs* leak, the mean weekly rate increased from 0.4 to 3.5 per 100 000 reproductive-age women in states where an abortion ban was inevitable.

After the decision, requests were highest in states with a likely future ban (Figure).

Discussion | In this cross-sectional study, we observed substantial demand for advance provision of abortion medications. Requests peaked following the *Dobbs* leak and after conflicting legal rulings regarding FDA mifepristone approval created confusion and uncertainty. States considering future abortion bans had the highest rates of requests, and requestors were motivated by a desire to preserve reproductive autonomy. While the study sample did not include all advance provision requests, it represents a large proportion since very few organizations offered advance provision during the study period. The demographic differences in requestors of advance provision vs self-

management likely reflect structural barriers. A key focus for services will be ensuring affordability, visibility, and access for racial and ethnic minority groups and marginalized groups.

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Data Sharing Statement: See the [Supplement](#).

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COMMENT & RESPONSE

Preventing the Continuing Tragedy of Silicosis

To the Editor The case reports of silicosis associated with occupational exposure to dust from engineered stone occurring primarily among young Latino immigrant men¹ are tragic and shocking. Unfortunately, that these cases occurred was also

predictable.² While fabrication of engineered stone kitchen and bathroom countertops is a relatively new industry, the risks associated with exposure to airborne silica particles have been known for centuries, and reports of lung transplants among engineered stone workers were reported in the scientific literature in 2012.³ Disease prevention begins with anticipating that disease may occur, recognizing the conditions that permit occurrence, and responding by mitigating or eliminating the offending exposures. In this instance, as is too often the case, disease recognition was delayed, and preventive interventions are late and limited.

In 2016, the Occupational Safety and Health Administration (OSHA) issued an updated silica standard,⁴ one that if followed could have prevented many of these cases. This report demonstrates that, even with an enforceable standard, many workers, particularly immigrant workers and others employed by small employers, are at elevated risk for serious illness. Although the OSHA law requires employers to provide workplaces free of recognized hazards, OSHA is severely underresourced and cannot conduct sufficient inspections to identify employers who are not complying with regulations. As a result, even though the agency has prioritized inspecting establishments where workers are exposed to silica, most shops doing this extremely hazardous work will never see an OSHA inspector. Enabling OSHA to hire many more inspectors, increasing the size of its monetary penalties, and enacting criminal penalties for situations in which workers are sickened or killed would help prevent future silicosis cases in this workforce.

The identification of 52 cases in California¹ alone suggests there are hundreds of these cases across the country, yet few cases have been reported elsewhere. Physicians asking patients about current and past workplace exposures and informing a national occupational disease surveillance program could help address this problem. Clinicians reporting lung disease cases that may have been associated with or exacerbated by workplace exposures could alert public health authorities to the existence of establishments where other workers are being sickened, helping to prevent future cases.

In 1992, Donald Millar, MD, MPH, then Director of the National Institute for Occupational Safety and Health (US Centers for Disease Control and Prevention), called silicosis an “occupational obscenity.”⁵ It remains even more so today.

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