Pregnancy Options Counseling

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Presentation adapted from Innovating Education in Reproductive Health

Agenda

Powerpoint based lecture

- Overview (5-10 min)
- Counseling (25 min)
  - Details about pregnancy options
- Reproductive justice (5 min)

Questions

Objectives

After this talk, you will be able to:

- Reflect on personal biases that may impact responses to patients
- Be able to employ non-directive counseling for patients with + pregnancy tests
- Be able to compare medication and surgical abortion
- Be able to guide and support patients through a patient-centered decision-making process
- Use patient-centered language in options counseling and abortion settings

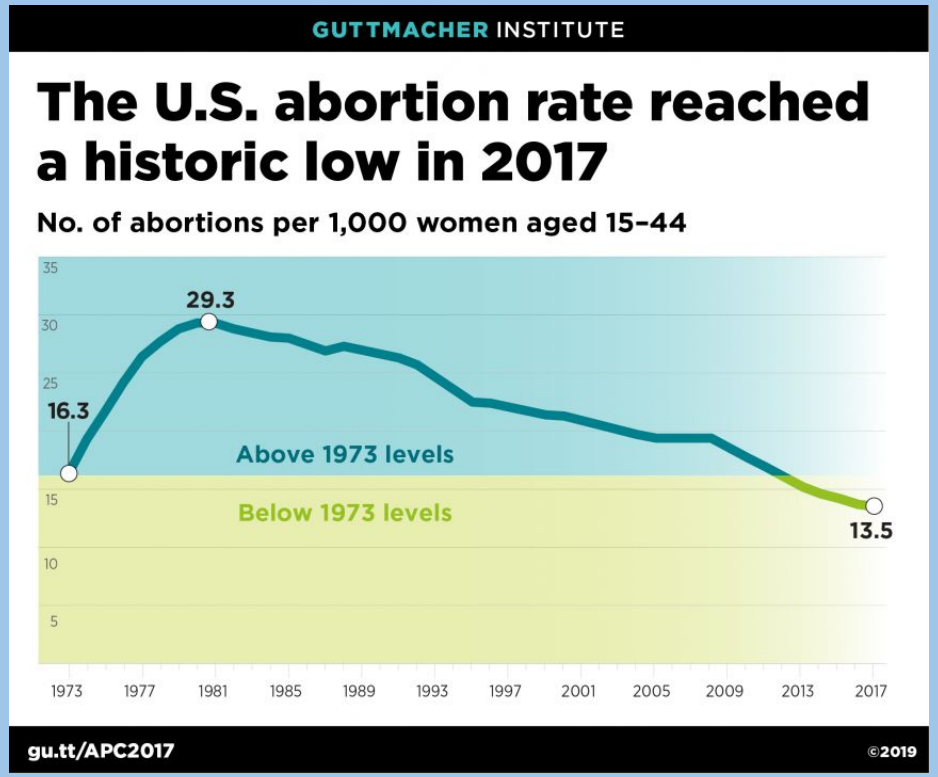
Reflection prompts

- What scenarios are hard for me?
- What particular decisions do I want patients to make?
- What decisions do I think are foolish?

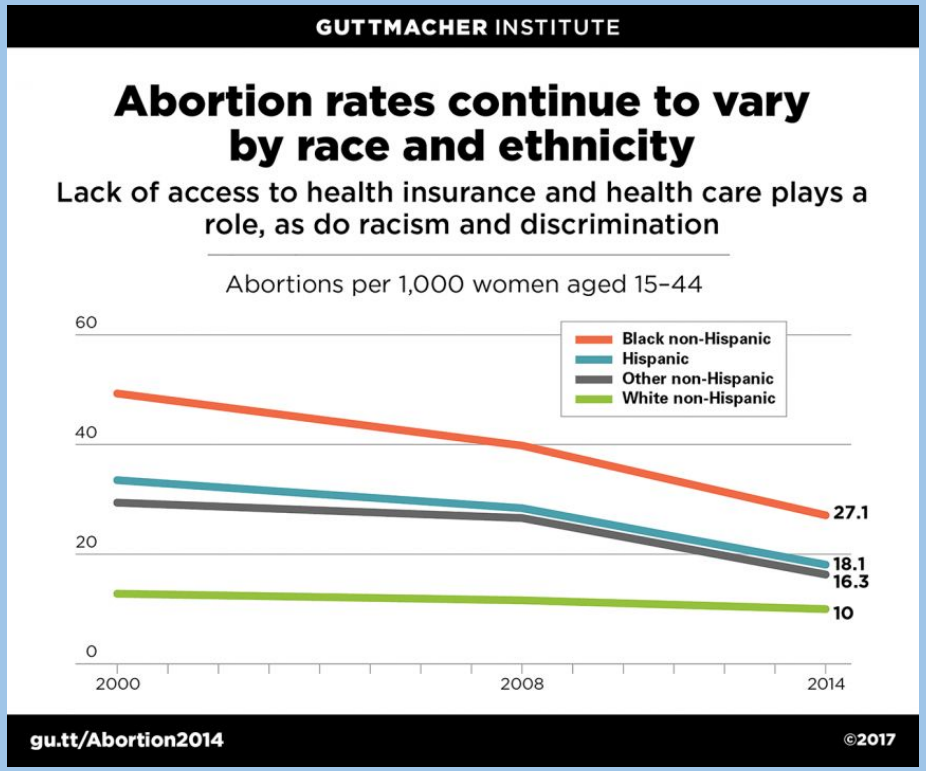
Overview

Abortion in numbers

Abortion in numbers



Abortion in numbers



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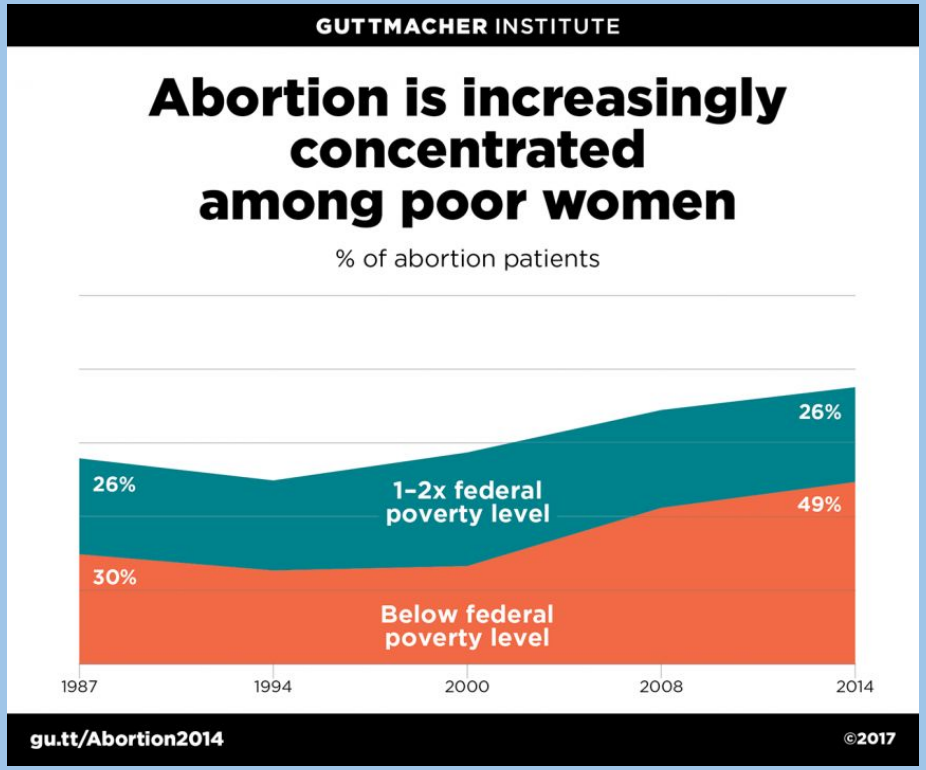

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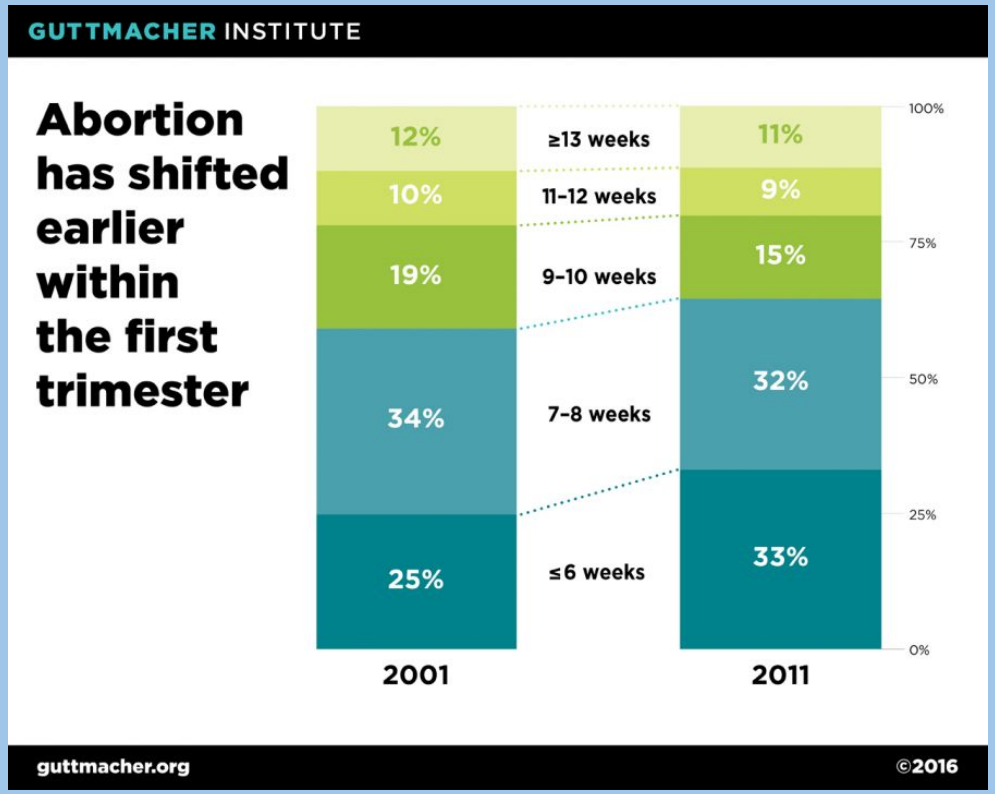

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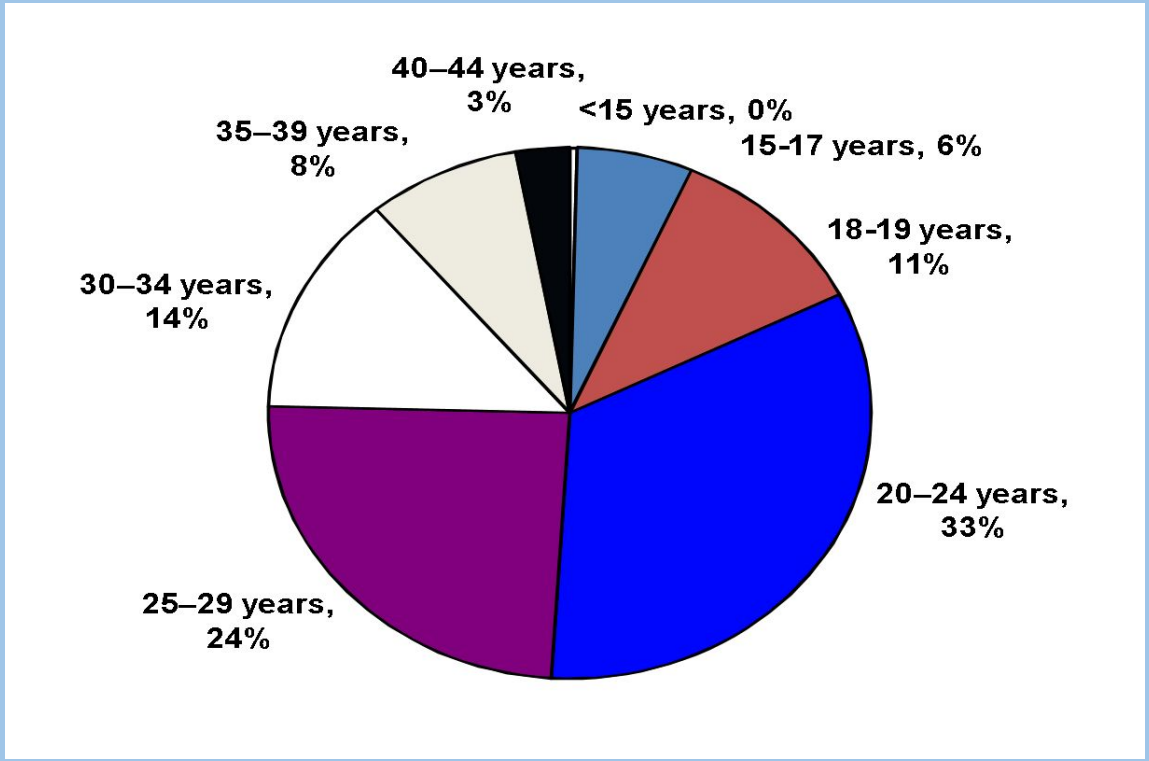
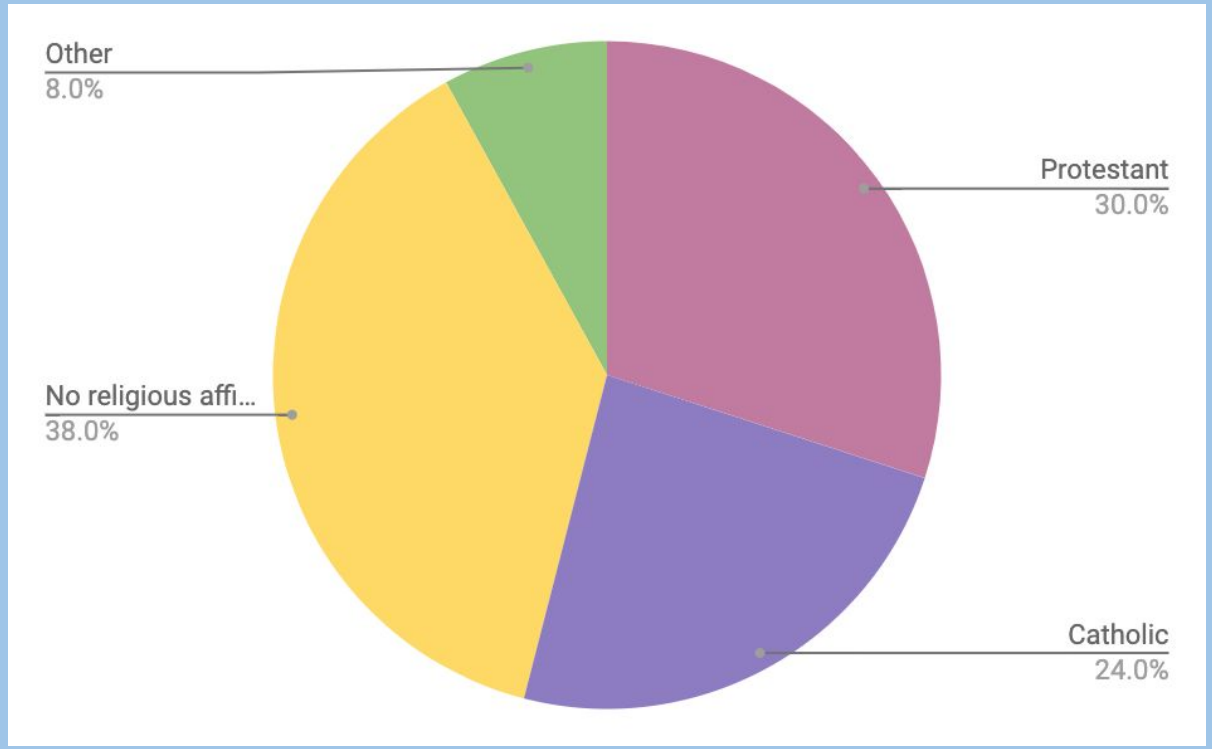


Adapted from Guttmacher, Physicians for Reproductive Health

Abortion in numbers



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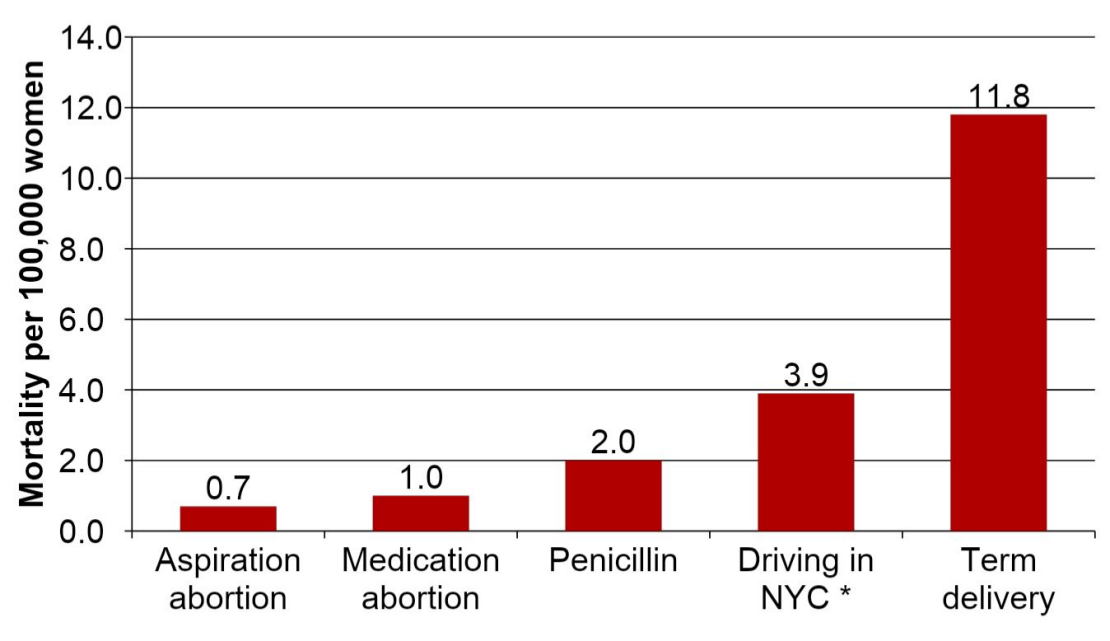


Physicians for Reproductive Health

Abortion in numbers

- 59% of people who had abortions in 2014 had at least one previous birth
- 51% of people obtaining an abortion reported contraceptive use the month they became pregnant (2008)
- 3 in 10 women will obtain an abortion by the age of 45 (2008)

Guttmacher

Counseling

Provider responsibilities

- Listen without an agenda
- Provide accurate information
- Create an environment free of stigma, esp through language

Ultimately, understand that the patient has the answer

Non-directive counseling

- The patient has the answer
- One decision is not more moral than another
- Being aware of our own biases and keeping them in check

Listen

- Silence
- Ask open-ended questions
- Be curious about a patient's process without having an agenda

Validate

- It’s okay to not know the answer
- I imagine that must have been very difficult
- I can help you with that
- I see your point; that makes sense
- I can see why it might have been hard for you to come here
- It’s okay to cry here
- You’re doing a good job

Normalize

- You know, lots of people have asked me that question
- That’s not a strange question at all; I’m glad you’ve asked
- This is a clinic where it’s okay to talk about that
- Other people have expressed those same feelings

Scenario: patient in shock

- How would you respond?

Scenario: patient in shock

- Silence
- Validate
  - “It’s okay to not know which way to go”
- Ask a closed-ended question
  - “Are you feeling [overwhelmed] by the news of being pregnant?”
- Change the subject
  - “Who came with you today? How far did you travel?”
- Break state
  - “I’m going to get us each a glass of water.”

Scenario: a patient who is unsure of a decision

- How would you respond?

Scenario: a patient who is unsure of a decision

“What do you think I should do?”

- How would you respond?

Scenario: a patient who is unsure of a decision

“What do you think I should do?”

“I actually don’t know what I would do if I were you—if I were making a pregnancy decision I’d have to look at my own life and my own situation to see what was the best way to go for me.”

Myth vs. Reality

ACOG, ACS, JAMA Psychiatry, Guttmacher, The Green Journal

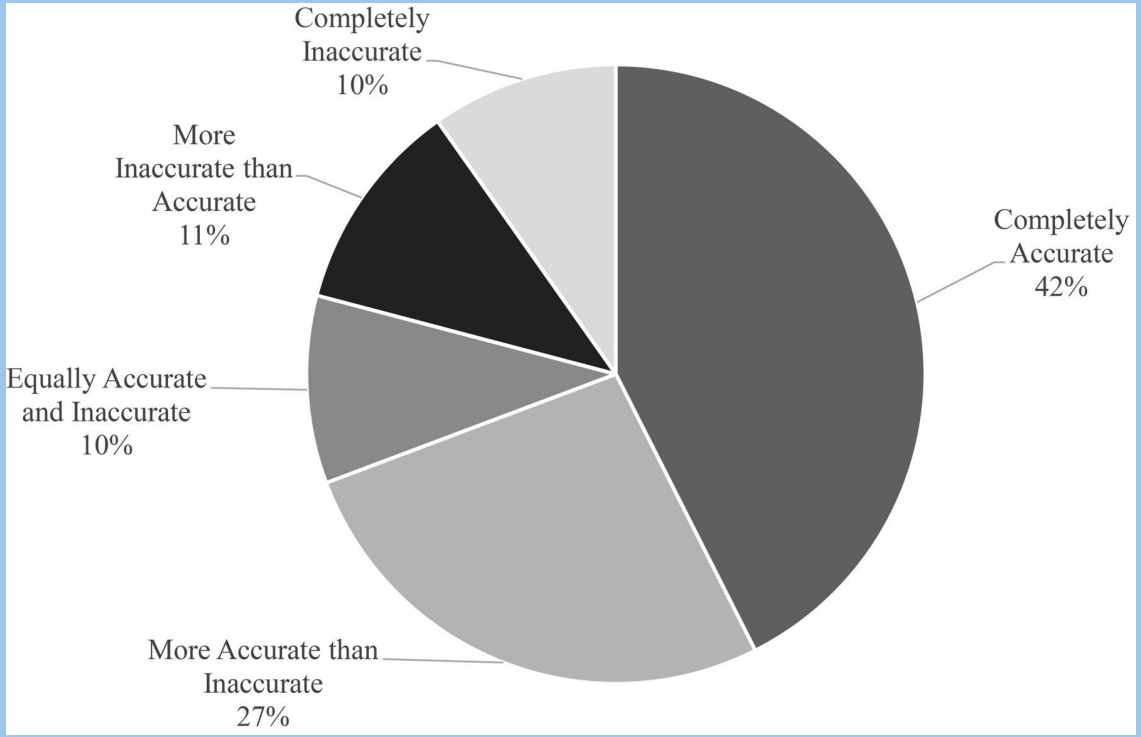
Myth	Reality
People who have an abortion have a higher risk of developing breast cancer	ACOG 2019: “recent rigorous studies demonstrate no causal relationship between induced abortion and subsequent increase in breast cancer risk.”
People who have abortions have mental health issues afterwards	Very difficult to study, but mental health issues post-abortion are most likely related to pre-existing mental health and similar to carrying to term (e.g. postpartum depression); being denied an abortion has a greater impact initially.
Abortion is much more dangerous than childbirth	Abortion is at least 10 times safer than full term pregnancy (0.6 deaths per 100,00 abortions vs 8.8 deaths per 100,000 live births by one 2014 study).
After an abortion you are much less likely to support a future pregnancy	A safe abortion does not impact ability to have a healthy, full-term pregnancy.
Most people feel regret after their abortion	Most people feel relief after ending an unwanted pregnancy.

New Mexico laws

- No term limits
- No waiting periods (vs. 26 states that have them)
- Discuss all options including adoption, parenting and abortion
- No required counseling statements or imaging description
- No parental consent for minors
- Medicaid coverage for pregnancy termination

- 1969 NM state law designating provision of abortion a felony except in cases of rape, incest or to save a woman's life
- This was rendered unenforceable after *Roe v. Wade* in 1973

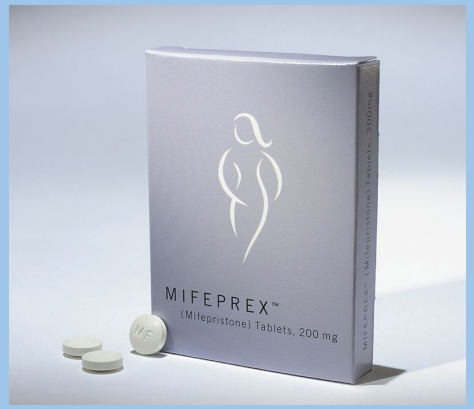
When gov't scripts counseling, >30% is medically inaccurate



Daniels, 2016

Abortion: medication abortion

- Available option up to 11 weeks, 0 days
- Two sets of pills. The first one, mifepristone is taken in clinic and stops the growth of the pregnancy. The second set, misoprostol, is taken 24-48 hours later to induce cramping and emptying of the uterus.
- Likely no symptoms after mifepristone. Usually cramping and bleeding within 1-4 hours of misoprostol
- 98% effective <8 weeks gestation, 87% between 10-11 weeks



Abortion: surgical abortion

- Available in first and second trimester

- Provider empties the uterus using gentle suction. The cervix is dilated to a size dictated by gestational age. A thin plastic straw called a cannula is inserted into the uterus and gentle suction is used to empty the uterus.

- 99% effective, tissue is examined in-clinic to ensure completion

Comparing the two

	Medication	Surgical
Pros	• Highly effective (~95%) • Avoids invasive procedure • Able to complete at home, surrounded by people of your choice • Feels more natural?	• Highly effective, 99% • Complete in a few minutes • Can be done later in a pregnancy than a medication abortion • Does not require a follow up appt
Cons	• Gestational limit (10-11 weeks) • Requires follow up appt to ensure completion • Often perceived as heavy bleeding • Cramping and bleeding may last longer than a surgical abortion	• Invasive procedure with varying pain management options available • Not able to have support people during procedure • Suction noises can be uncomfortable • Can be more expensive than medication if >12 weeks

Adoption

- Closed adoption
  - No exchange of information
- Open adoption
  - Birth parents choose adoptive parents and maintain contact through letters, visits, etc.
  - An openness agreement/plan outlines details
- Semi-open adoption
  - Identifying information is limited, though letters, pictures, etc., may be exchanged
  - Interaction through a third party
- New Mexico: All Faiths Adoption Services

Other language tips

Try to use	Try to avoid
• Terms the patient uses; e.g. “pregnancy” • “Decision” • “Continuing the pregnancy” • “Make an adoption plan,” “Place the child for adoption” • Validate • Facts without numbers • Be aware of your own biases, fall back on seeking curiosity	• Referring to pregnancy as “baby” • “Choice” • “Keep the baby” • “Put the baby up for adoption” • Don’t fix • False reassurances, eg “You won’t feel pain” • Making assumptions

Reproductive Justice

- Unbiased counseling
- Hyde Amendment

Summary/Main Points

- Abortion is a very common, exceedingly safe medical procedure
- As providers, we should understand that patients have the answer; it is not the provider's job to find it for them
- It is our responsibility to be trustworthy and provide accurate medical info

Resources

- Reproductive health education: RHEDI.org
- Repro health data: Guttmacher
- Abortion resources: National Abortion Federation, Reproductive Health Access Project
- Adoption: All Faiths Adoption Services

For patients:

- Religious/spiritual orgs: Religious Coalition for Reproductive Choice, Catholics for Choice
- Patient support: Exhale Pro-Voice

Questions?

References

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