A Patient-Centered Approach to Abortion

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I have no disclosures to report

Your role in abortion?

- Have a working knowledge of the safety of abortion
- Recognize the social context of abortion
  - Be familiar with misinformation so you can dispel myths
  - Help patients avoid stigmatizing experiences
- Be able to explain what she can expect
  - The internet is a scary place
- Be an advocate, provide resources
- Act in a timely fashion

Incidence of abortion

- 1.21 million abortions per year in US
- By age 45, ~1/3 of all US women will have had an abortion
- Abortion is one of the most common surgical procedures in the US
Pregnancies in the US: ~6.4 million/year

Outcomes of unintended pregnancies: ~3.1 million/year

Abortions by gestational age

Henshaw adjustments to Strauss et al., 2007 (2004 data)
How safe is abortion? Is it more or less safe than

- Colonoscopy: 1/3,333 – 1/33,333
- Penicillin: 1/50,000
- Pregnancy: 1/8,474
- Being a pedestrian: 1/47,273
- As a motorcycle rider: 1/89,562
- As an occupant of a pickup truck or van: 1/67,182
- Surgical abortion: 1/142,857

And so...

Well, weighing risks... it’s personal
Deaths from abortions after legalization

Number of abortion-related deaths

Deaths per 100,000 abortions

Causes of abortion-related deaths

% of abortion deaths (on average, 8 per year)

Long-term safety of abortion

Abortion does not cause
- Infertility
- Ectopic pregnancy
- Miscarriage
- Breast cancer
- Negative mental health outcomes
Who has abortions: economic status

- 22% ≥300% of poverty
- 18% 200–299% of poverty
- 31% 100–199% of poverty
- 27% ≤100% of poverty

Who has abortions: race/ethnicity

- 41% White
- 32% Black
- 32% Hispanic
- 6% Asian/PI
- 1% Native American

Who has abortions: religious identification

- 43% Protestant
- 27% Catholic
- 25% Other
- 8% None

Who has abortions: prior pregnancies

- 25% Previous birth
- 12% Previous abortion
- 36% Previous abortion and previous birth
- 27% None

Methods of induced abortion

<table>
<thead>
<tr>
<th></th>
<th>1st trimester (5-14 weeks)</th>
<th>2nd trimester (14-24 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>Dilation &amp; curettage (D&amp;C)</td>
<td>Dilation and evacuation (D&amp;E)</td>
</tr>
<tr>
<td></td>
<td>Manual suction</td>
<td>-Standard D&amp;E</td>
</tr>
<tr>
<td></td>
<td>Electric suction</td>
<td>-Intact D&amp;E</td>
</tr>
<tr>
<td>Medical</td>
<td>Medication</td>
<td>Labor induction</td>
</tr>
<tr>
<td></td>
<td>Misoprostol + Mifepristone</td>
<td>Misoprostol +/- Mifepristone</td>
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</table>

Abortion: evidence-based practices

- Antibiotic prophylaxis
  - High risk women: RR 0.50, NNT 10
  - Low risk women: RR 0.64, NNT 35
- Pain control
- Vasopressin in paracervical block to reduce bleeding
- Immediate contraception
- Cervical preparation

1st trimester surgical abortion: uterine aspiration

- Pelvic exam, GC/CT culture, betadine prep
- Anesthesia
  - IV or PO or SL and/or paracervical block
- Cervical dilation if needed
- Aspiration of uterine contents
  - manual or electric
- Visual examination of products of conception
- Observation, antibiotics, Rhogam prn
- Home with contraception

Manual and electric aspirators

Manual uterine aspirator

Electric vacuum
Manual uterine aspiration (MUA): key points

- Safety and efficacy same as electric
- Quiet
- Low-tech/ low-resource
  - Simple
  - Portable
  - Low-cost
  - Small

Medical abortion agents

- Mifepristone
  (RU-486, Mifeprex)
  - Anti-progesterone
  - Necrotizes decidua, softens cervix, increases sensitivity to prostaglandins

- Misoprostol
  (Cytotec)
  - Prostaglandin E1 analog
  - Uterine contractions

1st trimester medication abortion regimen

<table>
<thead>
<tr>
<th>Evidence-based &amp; FDA regimen</th>
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<tbody>
<tr>
<td><strong>Mife dose</strong></td>
</tr>
<tr>
<td><strong>Miso dose/ route</strong></td>
</tr>
<tr>
<td><strong>Miso timing</strong></td>
</tr>
<tr>
<td><strong>GA</strong></td>
</tr>
<tr>
<td><strong>Efficacy</strong></td>
</tr>
<tr>
<td>93% complete in 4 hrs</td>
</tr>
</tbody>
</table>

Medication abortion

- High efficacy (92 – 99.5%)
- Extremely safe
  - Infection risk 13/100,000
  - Risk of death 1/100,000
- Counseling is critical
  - Bleeding
  - Pain
  - Passage of POCs
- Follow up 1-2 weeks
  - Description of cramping/ bleeding
  - Ultrasound to confirm no sac
Cervical preparation for 2nd trimester surgical abortion

- Misoprostol
- Manual dilators (Pratt)
  - at time of procedure
- Osmotic Dilators
  - Laminaria or Dilapan
  - 1-15 dilators placed
  - Expand and create radial pressure
  - Left in cervix for 6 – 48hrs

2nd trimester surgical abortion: D&E

- History, exam, STI screening
- Cervical dilation (1.5 or 2 cm) with osmotic dilators
- IV sedation
- Evacuation of fluid with suction
- Evacuation of fetus with forceps
- Ultrasound guidance
- Inspection of POCs
- Recovery, antibiotics, Rhogam
- Contraception

Dilation & extraction (D&X, or intact D&E)

- “Partial-Birth Abortion” coined by anti-abortion groups through focus groups
- Led to Federal Abortion Ban in 2008
- Risk mgmt, feticidal injections, cessation of services
- Goal to minimize uterine instrumentation and deliver an intact fetus
- Cervical dilation usually requires 2 days
- No evidence of increased risk

Standard D&E Induction

<table>
<thead>
<tr>
<th>Anesthesia</th>
<th>Local + IV sedation</th>
<th>IV narcotics, regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>1-3 days</td>
<td>6-11 hours (mife + miso)</td>
</tr>
<tr>
<td>Location</td>
<td>Outpatient</td>
<td>Inpatient (L&amp;D, wards)</td>
</tr>
<tr>
<td>Cost</td>
<td>$3530 ($1K - $5K)</td>
<td>$5029 ($3K - $9K)</td>
</tr>
<tr>
<td>Contact with fetus</td>
<td>Usually none</td>
<td>Patient’s decision</td>
</tr>
<tr>
<td>Providers</td>
<td>Specialized training</td>
<td>No extra training</td>
</tr>
<tr>
<td>Fetal autopsy</td>
<td>Less accurate?</td>
<td>More accurate</td>
</tr>
<tr>
<td>Involvement</td>
<td>patient &lt; provider</td>
<td>patient &gt; provider</td>
</tr>
</tbody>
</table>
Case 1: Josie Rosie

- 32yo para 1 comes into your office complaining of lower abdominal pain. She has her 5yo son with her.
- You order a UPT (because you always order a UPT).
- It’s positive!

Options counseling for Josie Rosie

- How to start the conversation:
  - “We are happy to take care of you no matter what you decide.”
  - Normalize unintended pregnancy. Because it’s normal.
  - Options... abortion, continuation, adoption
  - “Would you like to hear about these options now?”
- Follow up with the patient if she needs time to think
- You talk to her a week later and she tells you she’s decided on abortion because her 5yo son has autism and she wants to be able to care for him.

Reasons given for abortion

Concern for/ responsibility to other individuals.........................74%
Cannot afford a baby now..........................................................73%
Would interfere w/school, job, ability to care for others........69%
Would be a single parent/ having relationship problems........48%
Has completed childbearing.....................................................38%

Josie Rosie’s 1st trimester abortion

- Know your local abortion providers
- Help connect her – don’t make her do the research

http://prochoice.org/think-youre-pregnant/find-a-provider/
Abortion training ObGyn residency programs

Josie Rosie’s 1st trimester abortion

Know your local abortion providers
Give anticipatory guidance about the procedure (aspiration vs medical)
Know the local restrictions
Tell her about what she can expect (24 hr waiting period? Parental consent? Mandatory ultrasound?)
Guttmacher Institute website for all state-level restrictions
Follow up with the patient to ensure she made an appt
Assist with any barriers in getting an appt

What happens if Josie can’t get the abortion she wants

Women denied an abortion are:
- More likely to be in poverty
- More likely to stay tethered to abusive partners
- More likely to experience anxiety afterwards

Disproportionate effects of restrictions
Structural barriers to abortion access

- Mandatory waiting period (24-hr, 48-hr)
- Parental consent or notification
- Mandatory ultrasound
- Mandatory counseling
- Gestational age restrictions
- Medicaid funding
- Restricting insurance coverage
- Abortion reporting requirements
- Refusal to provide contraceptive services
- Crisis pregnancy centers

35% of US women have no abortion provider in their county

Half of all ob-gyn residencies routinely offer abortion training
- Most graduated ob/gyns don't offer abortions

60% of D&E patients couldn't obtain an early abortion

Reasons for abortions after 16 weeks

- Woman did not realize she was pregnant: 71%
- Difficulty making arrangements for abortion: 48%
- Afraid to tell parents or partner: 33%
- Needed time to make decision: 24%
- Hoped relationship would change: 8%
- Pressure not to have abortion: 8%
- Something changed during pregnancy: 6%
- Didn’t know timing was important: 6%
- Didn’t know she could get an abortion: 5%
- Fetal abnormality diagnosed late: 2%
- Other: 11%

Josie Rosie’s follow-up

- Medically, there is usually no need for a f/u appt
- But... some patients may want to be seen
  - Reassurance
  - Normalization
  - Contraception
  - Support

backline: https://www.yourbackline.org/
**Pro-choice is just patient-centered care**

- Practice this in all aspects of care around abortion
- Contraceptive counseling
- Abortion method (surgical vs medical in 1st or 2nd trimester)
- Presentation of risks
  - Encourage and invite patients to determine their own threshold for risk tolerance
  - We provide the information... they decide!

**Last thoughts**

- Be an advocate and be vocal – we can help prevent unintended pregnancies with contraception, but we can also help decrease abortion stigma
- Abortion is safe and common and is experienced by women of all walks of life. Be prepared to talk about it with your patients!
- Trust women – practice patient-centered care with abortion

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**Innovating Education in Reproductive Health (IERH)**

- Video courses

**Finding an Abortion Provider**