Podcast Transcript

# Women's Reproductive Health Issues in the Face of Changing Legislation

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At Colibri Healthcare, we developed this educational content with a genuine approach to bringing attention to mental health-related topics from a healthcare professional's perspective. This podcast contains content that may be unsettling for some listeners. The episodes may discuss abortion, the unborn, miscarriage, and other sensitive topics. We do our best to discuss sensitive topics such as these with discretion and sincerity. Because of the sensitive topic being discussed, we recommend this podcast for adults only.

Content warnings: Mentions of abortion, termination of pregnancy, sterilization, death, ectopic pregnancy, miscarriage

## Guest

Erica Springer, MSN, CRNP, WHNP-BC

- Active clinical nurse practitioner
  - Nearly 2 decades of experience in women's healthcare
  - Over a decade as a practicing nurse practitioner for an OB/GYN practice
  - Board Certified Women's Health Care Nurse Practitioner
- Educator and professor
  - Assistant clinical professor for women's health and gender related nurse practitioner courses
  - Co-presenter for Women's Health Nurse Practitioner Certification Exam Review & Advanced Practice Update (Fitzgerald Education Health Associates)
  - 2021 Drexel University College of Nursing and Health Professions Teaching Excellence Award Nominee

## Host

Leana McGuire, BS, RN

- Leana McGuire has extensive experience with leadership development and executive coaching and a background in content development, visual performance, speaking, and podcast hosting.

## Content Reviewer

Maria Morales, MSN, RN, CLNC

- Maria Morales is a nurse planner for Colibri Group and a certified legal nurse consultant. She is a quality-focused, results-driven nursing education professional. As a continuing education leader with nurse executive experience in developing interprofessional educational programs, she supports healthcare workers with educational activities to help increase communication within the healthcare team.

## Peer Reviewer

Shawn Pompa, MSN, APRN, CNM

- Shawn Pompa is a Certified Nurse Midwife with 9 years of experience providing care to women from adolescence through menopause. She has worked in various settings throughout her career, but has focused on providing women's reproductive health, pregnancy, and childbirth services to women near the Texas-Mexico border for the last decade.

## Transcript

# Episode 1 – Understanding Changing Legislation

SOUNDBITE OF MUSIC

LEANA MCGUIRE, HOST: Welcome to this multi-episode series about women's reproductive health issues in the face of changing legislation, and thank you for taking time to join us. I'm Leana McGuire, your host for this Elite Learning podcast by Colibri Healthcare. The July 2022 Supreme Court of the United States' decision regarding Roe versus Wade has spurred much discussion about how healthcare and women's health issues are and may be impacted.

We wanted to have a nonpartisan, nonpolitical discussion of matters related to women's health and reproductive healthcare to help bring clarity to the current conversation. Through these podcast episodes, we will discuss some concepts to consider related to the recent Supreme Court of the United States', also known as SCOTUS, decision, some clarifying information about reproductive health in the United States, and some women's healthcare topics that are at risk for misinformation today.

We have an expert in women's health joining us for this conversation. Erica Springer is a board-certified women's health nurse practitioner. Welcome, Erica! Erica Springer, MSN, CRNP, WHNP-BC, lot of initials, nicely done!, wears many hats! She is an assistant clinical professor and director of women's health and gender related issues for a nurse practitioner program at Drexel University.

She's also clinically active as a practicing nurse practitioner for an OB/GYN practice in Pennsylvania. In addition, she co-presents a Women's Health Nurse Practitioner Certification Exam Review & Advanced Practice Update for Fitzgerald Health Education Associates. We are glad to have you with us today. Erica, is there anything you'd like to add to your introduction?

ERICA SPRINGER, GUEST: Thanks, Leana! While my passion and clinical expertise is women's health, my nursing career actually started as a critical care nurse at a level one shock trauma unit. Through this really early experience of my nursing career, I learned the art of difficult conversations. I was raised also by, as the second

child of, teen parents who are still happily married. Perhaps most impressive is that they never once had a political conversation in my presence. Perhaps that's the key to their happy marriage! So my undergraduate studies took place at a small Catholic college, so ... diverse background. And currently I'm pursuing a doctorate in nursing practice. My teaching, my full-time job, focuses primarily on clinical components of the Women's Health and Gender Related Nurse Practitioner program, as well as health assessment and pharmacology. ... so pretty broad. My academic interests include experiential learning, simulation. I love to create interdisciplinary experiences, and we've even collaborated the nurse practitioner students with some of our law students at the university.

MCGUIRE: Wow. You certainly have the women's health background, the related academic and clinical experiences, to help explain more about this topic to us today and spread awareness about these matters. And I'd like to hear more about you personally and the many aspects that have helped to shape you personally and professionally. That's really interesting. Let's jump into the discussion at hand.

Changes to laws in healthcare policies create a need to understand how to navigate the new and different healthcare environment based on the influence and effects of those laws and policies. But sometimes misinterpretation, the surprise of the announcement of new legislation-related matters, and rumors begin to circulate, yielding possible misinformation.

Why don't we begin by discussing Roe versus Wade, what the SCOTUS decision from July 2022 was, and what it all means for us now. But first, some background info. What was the Roe versus Wade decision from approximately 50 years ago in the 1970s?

SPRINGER: So back in 1970, the state of Texas had a law that abortion was illegal unless it was to save a pregnant person's life. Henry Wade was a district attorney in Dallas County, Texas, at that time. Norma McCorvey, known as Jane Roe, the Roe in Roe versus Wade, was a young woman who lived in Texas at the time. Her biography includes quite the traumatic childhood and adolescence with abuse, substance use, and an array of religious affiliations throughout her life. Her first pregnancy occurred at the age of 18 with her first two offspring being placed with adopted families, and it was actually her third pregnancy, which really brought about this as she sought an abortion. She was unable to access a clinic, because it had been an illegal clinic and had been shut down for the authorities. And so, she didn't have access to that choice.

So, Texas lawmakers were looking for women to use as part of their fight to legalize abortion, and so they connected with Jane Roe, and so the argument was that bans on abortion were unconstitutional as it infringed on the personal privacy as protected by various amendments ... the first, fourth, fifth, ninth, and the fourteenth. So, this went all the way to the U.S. Supreme Court and was decided in 1973, long after McCorvey's third child had been born and adopted. For the past nearly 50 years, this benchmark case kept states from legislating against abortion prior to viability, which we'll talk about, or the ability of a fetus to live outside the womb. So, this viability line really determined balance between a person carrying a pregnancy and the state's protection of the fetus. Roe versus Wade served as a precedent for SCOTUS cases regarding marriage equality, same sex intimacy, and contraception access as well. So, it goes far beyond just abortion.

MCGUIRE: Sure. Okay. That was really informative to learn more about the background of that case. And now in 2022, what was the SCOTUS decision related to Roe versus Wade? The actual case that SCOTUS had to discuss was the Dobbs versus Jackson Women's Health Organization. Is that right?

SPRINGER: So the case of Dobbs versus Jackson Women's Health Organization followed a 2018 state law in Mississippi that banned most abortions after the 15th week of pregnancy based on a last menstrual period. Mississippi already had a law in place since 2014, and that law prohibited pregnancy termination beyond 20 weeks, not viability. So interestingly enough, even though 20 weeks is prior to that typically accepted viability of 24 weeks, nobody had contested it, and neither had any of the similar laws in other states despite Roe versus Wade protecting through viability. So, there was already discrepancy. It just hadn't been contested until this Dobbs versus Jackson case.

So, who's involved? Thomas E. Dobbs was the state health officer with the Mississippi State Department of Health. Jackson Women's Health Organization was the only abortion provider in the entire state of Mississippi. Mississippi State Department of Health claimed that abortion is not constitutionally protected and that the viability standard doesn't allow for states to protect maternal and fetal health. They also claim that Roe versus Wade was outdated because of availability of protected measures for parents in the workplace. Things like

leave time, pregnancy discrimination protections, childcare assistance. They claim that because of availability of contraception, abortion is unnecessary for equality in economic life. This case was appealed all the way through the Mississippi Court system and was presented for SCOTUS and upheld on June 24th, 2022. It shifted abortion regulation back to elected officials at the state level.

MCGUIRE: When it comes to matters of law, I've heard that the law is not an issue of what is best or worst, convenient or inconvenient, or even right or wrong, but rather if a certain matter is a matter of legislation. For example, if the Constitution or state law is determined not to address an issue, then the said issue is not a legal issue for courts to decide. It's outside of the court's control. Do you think that analogy applies here in any regard? Like the Supreme Court has said, the issue of elective abortion is essentially no longer a federal one, and that states will decide their regulations regarding abortion.

SPRINGER: This is obviously complex particularly with regards to pregnancy termination, right?

MCGUIRE: Right, right.

SPRINGER: Some would say that a fetus is a life, regardless of gestation, and killing a life is absolutely a legal issue and should fall under legislation. Simple. It gets really complex when we look at it from different cultural perspectives as to whether a grouping of human cells with electrical activity is a living being with the same rights as the host parent who's carrying the pregnancy. And, we see this really broad continuum of description for a previable pregnancy from a group of cells, a living embryo or fetus, a potential life, or an unborn human being. When we look at it from various religious and cultural perspectives, abortion becomes much more of a moral question than a legal one. And then we have to ask, is this to be legislated at all?

Thus, when we look at Roe versus Wade, it was approached as a liberty of privacy. It kind of makes sense when you look at it that way and why it was approached that way. Federal legal protection of privacy between a patient and their medical provider allowed for practitioners to practice under the Hippocratic Oath. They applied ethical principles and take care of patients individually.

In an earlier SCOTUS case, Casey versus Planned Parenthood of Southeastern Pennsylvania, Roe was upheld, because they based it on the 14th amendment, privacy as a liberty set by the court's precedents. Basically, in the Dobbs case, the court's ruling was under the premise that abortion is not specifically protected in the Constitution, nor is it protected “deeply rooted in the Nation's history and tradition” or necessary for our “ordered liberty” (Dobbs). Therefore, the Dobbs decision shifted abortion regulation back to the state level, back to the people.

Something to consider: We all elected all current state legislature when abortion had some national protection under Roe v. Wade. So, some states including ... are including questions regarding abortion on recent and upcoming ballots in an effort to hear the people's voices, while other states have legislation awaiting changes in leadership, and some even had some trigger laws that were set up to go into effect as soon as Roe v. Wade was overturned.

MCGUIRE: Got it. What are some of the ramifications of the 2022 SCOTUS decision? It didn't remove abortion from the country as some misinformation may state, but an abortion will be harder to obtain if one lives in a state that has limited its use. Is that accurate?

SPRINGER: Medical and procedural abortion is very much available in the United States as a whole. Access to care is and will continue to be significantly impacted by abortion restrictions, both in affected states and those states where abortion is legal. It won't only affect people of reproductive age or those seeking abortion. People with money, transportation, resources will be able to travel to states to access abortion and the care that they need. Those who have limited resources and support will continue to face the greatest challenges, further increases in health disparity.

For example, many abortion clinics often provide women's health services such as contraception and screenings for breast and gynecologic cancers. If these clinics close, because they're no longer allowed to offer abortion services, patients lose an access point to wellness and preventative services as well. We're already seeing a shifting in resources. We have increased number of patients in states allowed to provide abortion services, and it's putting a strain on those providers and staff. Patients at, that are local to the clinic who may also obtain contraception and screenings at that source, they may have delayed access too, because they're overflooded. Providers may choose to practice in states where they have a lower risk for litigation. For example,

I practice in a state where abortion is currently legal. If a patient comes to me with a desired pregnancy, and I identify there's no fetal cardiac activity, there's no heartbeat, there's these guidelines that I follow to get a diagnosis of a missed abortion or a non-viable pregnancy. Simple. I can give the patient options. We can talk about expectant management. We can talk about medication to promote passing of the tissue. We can talk about a dilation and evacuation procedure or a D&E. This conversation between me and my patient, and together we decide what's best treatment for them, for the very sad loss of their very desired pregnancy.

If I step back and look at this same situation in a different lens, in a state where abortion's illegal, I not only need to be aware of what the best medical care is for my patient, the best emotional support for them and their family, but now I need to think about, "What are the restrictions in place for providing diagnosis of this non-viable pregnancy?" Is my still picture of an ultrasound going to be enough to prove absence of cardiac activity? It's not gonna capture lack of movement.

Since D&E procedures for missed abortions or nonviable pregnancy are the same exact procedure as an elective termination, will there be regulation around the procedure itself regardless of the underlying purpose? Every major medical organization supports abortion as an evidence-based comprehensive healthcare practice, but in the landscape of quickly changing state regulations, those in healthcare system will need to be very diligent.

MCGUIRE: What are some of the possible ramifications of the issue of the legality of abortion moving from a federal to a state matter? What does it mean for now?

SPRINGER: In addition to changes in access to both abortion services, possible shifts in women's health services, the greatest ramification is inconsistency between states. Providing the same medical care or procedure to a patient in one state could bring criminal charges against a provider for doing the exact same procedure for the exact same reason in another state. You can kind of equate this to things like legalized recreational marijuana or concealed carry laws that vary from state to state. What is perfectly legal in one place could land you in jail in another state next door.

So, these variances of state regulations from state to state are not new. Variances in state abortion regulations from state to state are not new. States have imposed gestational age limits on abortion, the types of providers who can offer medical and procedural abortions, types and timelines of counseling prior to procedure, and even limitations as to the types of facilities that can allow procedural abortions to be performed.

Even before this SCOTUS decision, these patient safety regulations, as they called them, varied amongst states ... with some claiming they were not necessary for patient safety but actually created this limitation to abortion access already. Essentially the same awareness, prevention, education, and access we have balanced in family planning for many years will still apply.

Awareness: Patients and providers need to be aware of the regulations, where they practice and any potential barriers that are created.

Prevention: We need to be really sure that we're at the top of our game with prevention of undesired fertility, both for patients and providers. This includes not only access to contraception and emergency contraception but also access to wellness services. This is a time to fine tune our systems for access to contraception. Sexual health amongst all genders can be addressed outside of traditional women's health arenas.

Our primary care providers: It needs to be on everybody's radar in healthcare.

Education: Providers in patient education is essential. I've known really highly educated people who think that if they have an unintended pregnancy, they just call their OB/GYN, and they can just get a prescription for a medication abortion. It's not that easy.

Access: We have to continue working to identify and eliminate barriers to care.

Small things: So, avoiding placing unnecessary barriers for effective contraception and promote use of highly efficacious contraception.

Things like annual exams for contraception prescriptions. We can divorce those two things. We can prescribe contraception without having a patient have to present to the office for an annual exam. It's evidence-based practice.

Waiting for insertion of long-acting contraceptives like IUS's or contraceptive rods. Waiting for their period: Those are no longer evidence-based, but it's still happening more than it needs to, and it increases the risk for unintended pregnancy when we have these unnecessary delays.

A couple of resources that I find really important for providers to stay up to date with what their current legislation is in their area: Guttmacher.org and KFF.org are really doing a great job at updating current state regulations on abortion.

MCGUIRE: Okay. And how do abortion laws work at the state level?

SPRINGER: In general, most states have some type of legislation that it either supports access to abortion or it limits by gestational age, fetal cardiac activity. It may allow for abortion as the result of rape or incest if the proper reports have been filed. In addition to the federal protections, which we'll discuss later, some states have exceptions written into their law for medical emergencies where pregnancy would put the mother at risk of harm or death. Enforcement, it varies. For example, in Texas, a citizen can actually file charges against an abortion provider. While in most states, where abortion is illegal, providers or abortion seekers could be prosecuted, just only by law enforcement.

MCGUIRE: Okay, and can you speak about insurance? I'm really curious about this. How might insurance be affected by changing laws regarding abortion or birth control?

SPRINGER: There's always been a misconception with this. In general, elective termination of pregnancies have never been well covered by many insurance plans. Though the exact same procedures used and are likely covered for medically required cases for health and safety of the carrying parent. The Hyde Amendment, which is a federal restriction, it was enacted by congress, and it's assured that federal funds cannot be used for abortion services with exceptions of rape, incest, and severe maternal risk. So, states can choose to use their own funds to support abortion services within their Medicaid programs, which provide health benefits to those of low income and special needs. This does extend to other federally backed insurers as well, and oftentimes commercial payers. Our commercial insurance companies use those similar federal Medicare and Medicaid guidelines when they decide their own coverage restrictions. So, overall, it's never been well covered anyway, so the change there isn't gonna be as significant as what one might think.

Something else to consider. Our reimbursement system for medical services in the United States has changed a lot over the last 50 years since Roe versus Wade was put into place. Providers were previously paid for the services they provided. Now there's this complex balance between providers and medical systems and insurance companies or payers, and that's how reimbursement's determined for care and services provided. I really don't foresee these changing laws making coverage better for most states, and in some ways may offer further support for insurance plans to avoid covering abortion services.

We have seen, interestingly enough, some employers, who publicly are offering with regard to abortion access, reimbursement for abortion-related expenses like travel for their employees. Something to think about with technology: Remote employment has become an option, so an employee may live in one state, but their health plan may be administered in a different state. We may see some things there with the differences in requirements by state and what health insurance has to cover ... and employment regulation there.

MCGUIRE: Okay. And how might the SCOTUS decision impact the issue between the FDA stance on medically induced abortion via pill form and elective abortion?

SPRINGER: Many of the same states who put abortion bans in effect after the Dobbs case was decided, have also made efforts to block medication abortion. The two medications used in the FDA protocol for medication abortion are mifepristone and misoprostol. Mifepristone is a progesterone antagonist, and it works by blocking progesterone receptors. Progesterone's necessary for a developing pregnancy. ... the drug blocking this necessary hormone that halts the pregnancy development and leads to a separation of that pregnancy from inside the uterus. Many of these same states have bans on abortion, already had significant regulations on this medication. Things like counseling that was necessary, performance of an ultrasound that the patient sees, waiting periods. Regulations as to who can dispense the medication. For example, in Pennsylvania, I, as a nurse practitioner, cannot dispense this medication.

Misoprostol is a prostaglandin. It causes the cervix to soften. It dilates and causes the uterus to contract. While it's used in combination with mifepristone for medication abortion, originally the FDA approved it as a stomach

medication, believe it or not, and as pre-medication for some gynecologic procedures. We use it before we put in IUDs sometimes, and there's, it's also part of some of the protocols used for medication abortion alone without mifepristone.

States typically regulate the practice of medicine; however, the FDA regulates medication safety and efficacy in the United States. Medication abortion lies in the realm of both. So typically, in the U.S. because of supremacy law, federal regulation supersedes state legislation. So, in this case, the federal support of mifepristone and misoprostol would prevail. Now, while the supremacy clause was intended to extend a prescription, drug regulation remains to be determined through current litigation. So, there are ongoing cases with this and yet to be determined a bit. Some also argue that the dormant clause supporting interstate commerce prevents an individual state from banning a safe and effective drug.

However, significant regulation around its use is quite possible and in many ways has long been in effect. Yet another argument is that the abortion ban that essentially bans the drug, the drug itself is not being banned by the state. Therefore, the FDA regulations are not being violated at all. It gets really confusing.

MCGUIRE: Right.

SPRINGER: Finally, some say that since the state bans are not related to the safety, they don't conflict with the FDA regulations whatsoever, and it's fine. So, I really see there being some “to be determined” with this one.

MCGUIRE: Yeah, I, yeah, I see that. What do you foresee as an impact on a legal abortion or self-managed abortion as a result of changing legislation?

SPRINGER: When humans are desperate or determined, they will go to great lengths to do what they think they need to do. And, the overall concern that I hear is that we'll see an increase in illegal or unsafe abortions in areas where abortion is illegal or difficult to access.

We definitely saw those prior to Roe v. Wade, a decrease in abortion complications after that decision was made in 1973. So, patients will seek self-managed medication abortions, either from sources not regulated by the FDA or with little to no medical oversight. They might ingest large amounts of harmful substances. Those who are uninformed regarding medication abortion are likely to tempt physical means of ending pregnancy, such as insertion of physical objects. And, we see this in studies. We may see an increase in unsafe abortions occurring in states where abortion is illegal, some even using devices ordered off the internet. Because illegal and self-managed abortions are not reported, we're really only gonna have a sense of the complications of those who actually seek care, and will they seek care?

MCGUIRE: What are you seeing in your clinical practice since the SCOTUS decision?

SPRINGER: The majority of patients in our private practice are really highly educated and consistently have their basic needs met. We're having lots of discussions about the best, most effective contraceptive method for them, and I've definitely seen an increased number of referrals for sterilization procedures. This is in the state of Pennsylvania, where abortion laws have not changed and were significantly regulated prior to the SCOTUS decision. However, November election outcomes could really potentially change this here, and I'm seeing my patients really take action about it. One of the most impressive cases that I had recently was a patient in her late twenties.

She had never been sexually active. She had always shared with me she never wanted to rear children. She didn't wanna birth children, she didn't wanna parent children. She actually requested a pre-op consult for permanent sterilization, because she just wants to make sure that her reproductive choices, that she remains childless, and it can't ever be impacted.

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MCGUIRE: Wow. Well, thank you for explaining some of this background information about the legal cases and the possible impacts on people and practice experiences. That's all the time we have for episode one. Thank you for joining us. We will continue the conversation in episode two, covering helpful terminology, statistics, and clarifying information with regard to abortion and healthcare. A very sincere thank you to Erica Springer. This is Leana McGuire for Elite Learning by Colibri Healthcare.

SOUNDBITE OF MUSIC

## Episode 2 – Terminology, Statistics, and Clarifying Information

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MCGUIRE: Hello and welcome back for episode two of our podcast, Women's Reproductive Health Issues in the Face of Changing Legislation. I'm Leana McGuire, your host for this learning experience with Elite Learning by Colibri Healthcare. And back with me is Erica Springer. Thank you for taking the time to continue this discussion, Erica.

A quick recap of what we have discussed so far. In episode one, we focused on talking about the July 2022 SCOTUS decision regarding abortion and possible impacts on people and practice experiences. For the second episode, we'll examine and review some helpful terminology and statistics. We will also address some clarifying information around reproductive health.

Okay, let's define abortion as there are different terms depending on what's being discussed. And, the different terms have different meanings and influences on care decisions. Unfortunately, when the term is not defined, conversations with misinformation can happen, right?

Sometimes the lay public can misunderstand what is being discussed, especially when terms aren't defined. Can you please review with us some of the important terms like spontaneous abortion, miscarriage, missed abortion, induced abortion, elective abortion. Those are some, just to name a few.

SPRINGER: Leana, this is so important. The word abortion is medical terminology, and it differs from how it's described in legislature. It's not surprising that people often use the terms miscarriage or spontaneous loss instead of abortion, to avoid that association with elective termination of pregnancy.

In the medical community, abortion is a pregnancy that ends prior to viability. That's it. This can happen naturally or it can be induced through medication or a procedure. The difference in definition is not new.

Let's look at the Texas Abortion Facility Reporting and Licensing Act from 1989. So, this has been around for a while. In the legislature, they describe abortion as, it "means the act of using or prescribing an instrument, a drug, a medicine, or any substance, device, or means with the intent to cause the death of an unborn child of a woman known to be pregnant. The term does not include birth control devices or oral contraceptives. An act is not an abortion if the act is done with the intent to:

(A) save the life or preserve the health of an unborn child;

(B) remove a dead, unborn child whose death was caused by spontaneous abortion; or

(C) remove an ectopic pregnancy."

Spontaneous abortion is the unprompted passage of a pregnancy. So, the patient usually presents with bleeding. They have cramping and passing of tissue. About 80% of these occur before 12 weeks gestation, so early in that first trimester, but the majority really being caused by chromosomal abnormalities. This is a common occurrence.

So missed abortion is an intrauterine pregnancy that will not result in a live birth. The embryo or a fetus stops growing. It does not have cardiac activity at a size or gestation where it should be developmentally. Early embryonic development's really predictable. It's very consistent in relation to gestational age. So easy to identify when that happens. Miscarriage tends to be used more as a lay term. And, it usually describes a spontaneous abortion or a missed abortion.

Therapeutic abortion is when a pregnancy is terminated because of a medical indication, so something either with the fetus or the carrier. Some expand this to include terminations of pregnancies that are the result of rape or incest.

Induced abortion: In Williams Obstetrics, they describe it as the "surgical or medical termination of a live fetus that has not reached viability" 2018 (25$^{th}$ ed.).

Elective abortion, sometimes also referred to as voluntary abortion, is a termination of a pregnancy prior to viability at the request of the patient but not because of a medical complication.

When we talk about illegal abortion, an illegal abortion would be a medical or procedural intervention, so medical or surgical abortion, that ends a pregnancy with a potential for live birth. So, a living fetus or embryo where the person performing the procedure, the place, or the timing of the intervention doesn't meet the law or regulations for that place.

An unsafe abortion, well most abortions medical or surgical, are considered quite safe. All medical procedures come with an accompanying risk, and nearly all sources report medical and procedural abortions to have less risk than childbirth. So, an unsafe abortion occurs when the provider is either not qualified to provide abortion services, or the actual procedure, the instruments, the medications, the environment, something that's happening there is increasing the patient's risk of harm and makes the procedure or intervention unsafe.

MCGUIRE: Gotcha. Thank you for delineating all of that. Do you think there are any additional terms that would be helpful to discuss at this point in the podcast?

SPRINGER: I think we should talk about legal induced abortion and early medication abortions.

MCGUIRE: Okay. I actually have this information from the CDC, saying "a legal induced abortion is defined as an intervention performed by a licensed clinician …." For example, " … a physician, nurse-midwife, nurse practitioner, physician assistant) within the limits of state regulations, that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth" (CDC, 2021).

And the other term was early medical abortion. Okay. The CDC says early medical abortion "is defined as the administration of medications(s) [*sic*] to induce an abortion at ≤9 completed weeks' gestation, consistent with the current Food and Drug Administration labeling for mifepristone (implemented in 2016)" (CDC, 2021).

SPRINGER: Those definitions are going to be very important when we talk about some statistics here shortly. It's also important to note that in October of 2020, ACOG expanded the use of medication abortion with mifepristone to 70 days past the last menstrual period. Some studies are even supporting evidence used up to 77 days past the last menses.

MCGUIRE: Okay, now that we've defined or reviewed some terms, let's talk about some statistics, as you mentioned. What are some of the stats related to elective or induced abortions?

SPRINGER: There are world level statistics, and there are statistics that are related to the United States.

MCGUIRE: Okay. Let's start with global.

SPRINGER: From information published in November of 2021, the World Health Organization provides some data, (WHO, right?), the World Health Organization. About 60% of unintended pregnancies, and about 30% of all pregnancies worldwide are terminated via abortion. Approximately 45% of those abortions are considered to be unsafe. About 97 out of a hundred occur in developing countries. So, unsafe abortions are a significant source of maternal morbidity and mortality globally. Approximately 73 million abortions are induced annually across the globe.

MCGUIRE: Okay. Well, that gives us some kind of perspective on the global scale. Now what about stats based in the United States?

SPRINGER: Well, some background information here can be helpful. So, the CDC began collecting information about legally induced abortions in 1969 (so, pre-Roe v. Wade). The following information regards this kind of data. Remember, it's harder to track illegal and unreported abortions, and consider that states do not have to report data to the CDC. They report based on their own choice. So, numbers could be a little higher than what's discussed here.

The Guttmacher Institute also performs extensive reproductive research and may, may actually offer additional sources of family planning-related data and abortion statistics. So, here are some of the statistics from the CDC. So, in 2019 there were 629, 898 reported legal induced abortions in the United States. There were at least 195 abortions for every 1000 live births.

MCGUIRE: What are some of the descriptors pertaining to women obtaining legally induced abortions?

SPRINGER: Over 55% of legal induced abortions were for women from ages 20-29, and the breakdown of the timing for gestational age is as follows:

Nearly 92% are equal to or less than 13 weeks, so in the first trimester, early in pregnancy

Nearly 6% between 14 and 20 weeks

Less than 1% at 21 weeks or more

Approximately 42% of abortions are classified as early medical abortions.

From 2018-2019, there was a 10% increase in early medical abortions.

From 2010-2019, there was a 123% increase in early medical abortions.

MCGUIRE: Whoa, 123% increase over a decade seems like a really significant number. I mean, if there'd been a 10% increase each year, that seems 123% is still a growing increased percentage. Do you have any idea or explanation as to why there was a notable increase for the past decade for early medical abortion?

SPRINGER: I do. So, we did see a significant increase in medication abortions in the U.S. from 2010 to 2019. We'll talk about that. We'll talk about why that probably is. Despite an increased number of medication abortions and abortions less than nine weeks' gestation increasing, the total number of abortions in United States from 2010 to 2019 actually decreased. So overall, the numbers went down.

Technology's one factor. We have better accuracy and availability of over-the-counter pregnancy tests, so it's improved and led to early detection of unintended pregnancies. Ultrasound technologies also improved and that helps us to better confirm pregnancies at an earlier gestational age. The greatest factor is likely that medication abortion has become more accessible in the U.S. One of the most effective medications used for medication abortions, mifepristone, was FDA approved in the year 2000. In 2013 and 14, clinical practice guidelines were published, and it expanded the use of this medication, mifepristone and misoprostol, for pregnancy abortion up to 70 days of pregnancy. And then in 2016, this drug label was expanded to match.

MCGUIRE: How does US legislation surrounding abortion compare to other countries?

SPRINGER: This is a great question. We can learn a lot from global data and perspectives, especially with a complex topic such as abortion. I can give some examples of statistics on that. Since 2000, 38 countries have changed their abortion laws, with all but one trending toward liberation.

In 2018, Ireland previously having some of the strictest abortion laws increased abortion access to allow termination up to 12 weeks, or where maternal health is at risk. Since 2020 alone, abortion has been decriminalized in Mexico and South Korea. And New Zealand lessened abortion restriction. And Argentina and Thailand legalized abortions with gestational limits. The US joined Honduras in increasing abortion restriction. When we look at Honduras, where abortion had been banned since 1985, and an abortion ban was added to their constitution in 2021, the effect we see there per the UN is a significant number of unsafe abortions. Now, Poland, though some of the strictest abortion regulations in Europe, allowing only for medical reasons, with providers facing up to three years in prison for performing illegal abortions. Can't imagine! The Council for Foreign Relations indicates an overall decrease in abortions in nations where abortion is legal and an increase in abortions, especially unsafe abortions, where tight restrictions exist.

MCGUIRE: In addition to global perspectives, I'd imagine history plays an important role as well. What can you share with us regarding early history of abortion in the United States?

SPRINGER: In early America, the legal system used British common law to determine legality of abortion. This was long before pregnancy tests, an ultrasound that we talked about with technology. So, they really relied on the perception of fetal movement or quickening to identify the cause of what was often referred to as obstructed menses.

Prior to quickening, it was considered a potential life and any remedies used to cure their obstructed menses was legal. Post quickening abortions were a misdemeanor, required a woman to admit she had felt movement, and most likely were protective. As you can imagine, the high rate of complications of women terminating pregnancy between/after four to six months in early America. It couldn't have been very safe. So medical care at this time was not only provided by physicians, but a variety of healers. It may have actually been physicians either believing their medical care was superior to the healers or to corner the market that supported lawmakers to create anti-abortion laws. When you combine this with an increase of knowledge of embryonic development, by 1900, every state in the US had a law prohibiting abortion with some offering exceptions when

provided by physicians for medical reasons. In the 1960s, we saw this increase in major birth defects from thalidomide, a widely used sleeping pill, as well as German measles.

This combined with women correlating reproductive choices with citizenship was used as a platform to support abortion. At that same time, primary religious-based groups advocated for the unborn. Though not all states were on board, we saw states like Colorado, California, and New York pass legislation in support of abortion access. Then in 1973, Roe v. Wade created some consistency across the entire country (which we talked about in the previous episode). However, by 1976, the topic of abortion started to become politicized as an anti-abortion stance was starting to align with Republican platform. It's so interesting to explore the history and see the similarities and differences between now and earlier times in the U.S. Similarities between states, political parties, religious affiliations, yet some of the biggest proponents of reproductive freedoms come from major medical associations, the organization of which may have started the whole movement.

MCGUIRE: Wow. Interesting information for sure. Now let's transition to talking about some more clarifying information to address emergency care, which we'll discuss more in episode three. Can you clarify how emergency care is still offered to pregnant women? The United States Department of Health and Human Services on July 11th of 2022 issued guidance that women who are pregnant and those experiencing loss of pregnancy have access to emergency care, and providers are protected under EMTALA for administering legal lifesaving care.

SPRINGER: Yes, well, EMTALA is the Emergency Medical Treatment and Active Labor Act.

MCGUIRE: Gotcha. Okay. Can you please tell us more about that?

SPRINGER: Sure, it’s really important to understand this so we understand the protections of providers. And so EMTALA was created in response to an executive order by the president to help assure pregnant patients facing severe complications do not have necessary healthcare measures, including abortion, withheld because of state laws. A letter from the Department of Health and Human Services to providers very clearly states that the federal EMTALA statute supersedes any state or any of their local restrictions.

They cite examples of emergency that include, but they're not limited to, things like “ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features” ... and that treatments may include surgical removal of one or both tubes, administering methotrexate (a medication that causes harm to the pregnancy), antihypertensive therapy, and/or abortion. Enforcement of EMTALA is only by complaint in the United States (U.S. Department of Health & Human Services, 2022).

MCGUIRE: Okay, interesting. I've heard some discussion from nurses who are concerned that some women may travel out of state to try and obtain abortion measures from states where it's offered. Their concerns include women hemorrhaging or having other serious effects while traveling after some kind of intervention instead of staying under medical supervision. Have you heard any discussions like this?

SPRINGER: Yes, so patients will travel to great distances for medical or procedural abortion services to a place where it's legal and accessible. While the risk of complications after abortion are very low, they do happen. So in an effort to save money or minimize the impact of their lives, they may turn around and head back, right back, to their homes right after a procedure after taking a medication. They could be traveling through a state that doesn't permit abortions, and these patients might hesitate to seek care for their complications. Kind of similar to patients who might hesitate to seek care if they've utilized a self-managed abortion.

MCGUIRE: It seems more discussions about birth control and pregnancy prevention efficacy may occur in light of changing legislation. As a women's health nurse practitioner, can you educate our podcast audience and give them information that they can share on general pregnancy prevention?

SPRINGER: Of course, so contraception has long been our primary prevention to unintended pregnancy. With so many methods available today, there's really no shortage of options when it comes to contraception. My goal when I counsel my patients on contraception is to come to an agreement with my patient on the most effective method that they're most likely to use consistently and as directed. I confirm that this method aligns with their short- and long-term goals for family planning and make sure they don't have any medical contraindications for the method, and I usually use the U.S. Medical Eligibility criteria for Contraceptive Use to determine that. I offer the patient a visual chart with all the methods. We talk about the most effective to the

least effective, and then we rule out methods until we use shared decision-making, and we choose the best method for them at this time in their lives. It's really important that we listen to our patients.

We can counsel them on why we think a method might be best, but ultimately, unless medically contraindicated, the patients are gonna be best motivated to be consistent with the method they choose. So, we really need to honor that. In addition to efficacy, we talk about risks and side effects of a method. I often include a “next best methods” in the event that they decide the first choice doesn't work out.

This helps prevent that “I didn't like birth control pills, so I stopped it on my own and oops, now I'm pregnant!” I also recommend barrier methods such as condoms in addition to any other method. No method is perfect, and so by adding two, it not only helps to reduce transmission of sexually transmitted infections, it offers an additional layer of prevention against pregnancy. The only, because the only truly 100% effective method against unintended pregnancy is abstinence. So, if a patient chooses to use natural family planning or a barrier method that requires a, has a larger margin for human error, we discuss where and how to obtain emergency contraception and even consider giving a prescription as sometimes it can be less expensive with a prescription for patients who have a prescription plan. Even though emergency contraception is available in most places over the counter, though, there may be some regulations on age and access. Patients do not need a pap smear or even a gynecologic exam for most birth control methods. So, there is no reason for us to withhold birth control.

We need to look at our healthcare systems for evaluation for insertion of long-acting reversible contraceptives, like intrauterine systems or contraceptive rods. If a provider can be reasonably sure the patient’s not pregnant, the device can be inserted outside of the menstrual period, including insertion of same day IUDs, also known as IUSs or intrauterine systems.

MCGUIRE: Okay. And at the heart of this topic, which interventions or birth control options fail the most and which have the highest effectiveness?

SPRINGER: So when we compare efficacy of contraceptive methods, we typically look at the number of pregnancies that occur during the first 12 months of use. So obviously, sterilization procedures and Long-Acting Reversible Contraception, or LARCs, as we call them, have been shown to be the most effective at preventing pregnancy. There's no risk for human error.

So many assume the sterilization procedure is the most effective when actually the contraceptive rod has been shown to be the more effective method followed by vasectomy, then IUDs containing progesterone, followed by tubal ligation or female sterilization, then the copper IUD. Actual use and perfect use are pretty similar with these methods, because they're either surgical or the provider's inserting them.

Next here would be hormonal methods. The injection, because of its three-month dosing by a provider, has a higher actual use efficacy than some of the other hormonal methods such as pills, patches, and rings, because these methods require the user to participate in the administration on a regular basis. So, the efficacy with perfect use of a birth control pill is usually about 0.3 in a hundred pregnancies per year.

Then we have male condoms. So, we usually have about two in a hundred pregnancies in 12 months of perfect use. But actual use, we have about 13 out of a hundred pregnancies with actual use. So much more accurate information there. However, when, like I said, when we combine a condom with another method, math tells us the risk for pregnancy becomes very, very low, so definitely the way to go.

Other methods such as spermicides, we can use them alone or in combination with a diaphragm, contraceptive sponge, internal or female condom.

Fertility awareness ranges from about two to 34% of actual use, depending on which method’s being employed. So, withdrawal or coitus interruptus, it's about 4% with perfect use, about 20% with actual use. Usually, those patients, I put on prenatal vitamins!

Compare this with no method. So, if we had no contraceptive method at all, about 85 in a hundred women would get pregnant the first year of having unprotected sex.

MCGUIRE: Thanks for that summary. Some good info there. I like the way you mentioned perfect use versus actual use. What's that old saying? A chain is only as strong as its weakest link. Something like that.

We know that the U.S. maternal mortality rate isn't good, and there are racial disparities where non-Hispanic black women have a statistically significant higher mortality rate. In your expert opinion, do you think changing legislation will have an impact on the maternal mortality rate?

SPRINGER: Yeah, so as a developed nation, our increasing morbidity and mortality in the United States, especially in patients of color, is unacceptable. This during a time where maternal morbidity and mortality in other developed nations has declined significantly. So, the Black Mamas Matter Alliance toolkit identifies several barriers that are necessary to maternal care.

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They are availability with regards to facilities, providers, and supplies.

Accessibility, both physical and economic accessibility, as well as information accessibility and non-discrimination.

Acceptability (with respect to the individuals' communities which they serve from respecting cultural and gender requirements), as well as quality of facilities, goods, and services. We discussed earlier how physical and economic availability of family planning services have really shown to be, place barriers to the care and potential generational poverty too.

MCGUIRE: Yeah, these are really serious issues. Anything else you'd like to add as far as clarifying information about women's reproductive health?

SPRINGER: The only way we can really improve maternal child health in the U.S. is to work together from primary care to emergency medicine, regardless of gender or your personal beliefs and views on abortion. I really encourage you to look at the big picture and find one way which you can make a difference in these maternal child health outcomes. We really all have to work as a healthcare team.

MCGUIRE: Well said. What a great way to leave us on that note and wrap up episode two. It's truly important to begin efforts or continue efforts by finding one way, then another, then another, that we can make a positive difference in maternal child outcomes. Please continue with us for episode three, the final episode, where we will discuss misinformation around abortion and women's reproductive health. This is Leana McGuire for Elite Learning by Colibri Healthcare.

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## Episode 3 – Women's Health and Misinformation

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MCGUIRE: Hello and welcome back for episode three of our podcast, Women's Reproductive Health Issues in the Face of Changing Legislation. I'm Leana McGuire, your host for this Elite Learning podcast by Colibri Healthcare, and we are happy to have Erica Springer with us for this concluding episode. I'm looking forward to learning more. Let's talk about some information that's been at risk for misinformation lately. What is a topic that you've heard that has been blown out of proportion or highly misunderstood regarding abortion or women's reproductive health?

SPRINGER: As you can tell from our previous discussions, the ripple effect from this legislative change is huge. Everyone's evaluating what these changes mean for their roles in reproductive health, whether they're a consumer, a family member, or their provider. So even in the months after that Dobbs decision, there are a lot of unknowns and continued changes from state to state. When we have unknowns, we often have fear, so it's not surprising that we're getting some reactionary concerns.

MCGUIRE: Hmm Hmm.

One concern is that care for pregnant people with pregnancy-related medical emergencies will be impeded because of fear of prosecution in states where abortion laws are the strictest.

I would say the other biggest concern I hear is continued availability of emergency contraception and contraception in general. One of the things we have now that we didn't have pre-Roe versus Wade is the internet. Information travels very quickly regardless of its validity or its safety.

MCGUIRE: Isn't that the truth?

SPRINGER: Right?

MCGUIRE: Let's address some more of that, of the feedback that's been heard or that's going around the internet. There is some dangerous information out there about reversing an abortion with a progesterone type medication. Can you speak to this?

SPRINGER: Yeah, so as we discussed in our previous episode, the mechanism of mifepristone is, uh one of the medications that are indicated in a medical abortion, is a progesterone antagonist. It fills progesterone receptors so that the progesterone naturally occurring in pregnancy is unable to do its job in maintaining the pregnancy.

Some states have implemented regulations that require literature and counseling to accompany any abortion. And in some states, a provider is legally required to share information claiming that giving progesterone can reverse the pharmacologic mechanism of mifepristone and reverse a medication abortion. There may be some evidence that this is possible. One study that administered large doses, very high doses of intramuscular progesterone by injection, to six women who had taken mifepristone, four of the six successfully carried the pregnancies to term. However, according to ACOG, they state that this isn't enough scientific evidence to support this practice because of the small sample size and being only one key study. The challenge is, the best method for providing valid evidence in medical practice are double blind placebo studies. We can all agree that using pregnant women as test subjects when experimenting with things such as abortion medication is unethical.

MCGUIRE: Right. Wow. I didn't know some providers are required to discuss certain things. That's a complicated situation. There's also information out there about vitamins, herbs, or alcohol intoxication causing a self-induced abortion. Some of this is not only a myth but also extremely dangerous misinformation. Can you talk about this as well?

SPRINGER: First, people have been using home remedies in hopes of ending an unintended pregnancy long before Roe versus Wade was overturned.

MCGUIRE: Good point.

SPRINGER: Yeah, when we look at early history, this is likely how early healers supported abortion in the 1800s before the medical movement. The challenge is we don't have any large reliable studies or significant data to demonstrate effectiveness or safety. So in general, we know that these methods are overwhelmingly ineffective, and some are downright harmful.

MCGUIRE: Right. So, let's emphasize that. You said overwhelming, overwhelmingly ineffective and some harmful. That's an important point.

SPRINGER: Yeah, a quick search of the internet and social media reveals an extensive list of suggestions for self-managed abortion with home remedies. One general theme seems to be using substances or medications that are contraindicated in pregnancy, encouraging people to take a lot of it to end the pregnancy. The problem is, even if something is teratogenic or can cause a birth defect to a fetus, it doesn't necessarily mean that it's effective in ending a pregnancy.

MCGUIRE: Wow. That's also a very significant concept to understand. Birth defects can occur without causing an end to a pregnancy.

SPRINGER: Patients hoping to end pregnancy have tried vitamin C, parsley, dong quai, rose hips, ginger root, chamomile, black cohosh, pineapple, lots of pineapple, pain medications like analgesics, illicit drugs, antibiotics, birth control pills, and caffeine pills, just to name a few.

MCGUIRE: I've never heard the pineapple one.

SPRINGER: The list goes on. Things like vitamin C and excessive pineapple consumption are not known to be harmful. They're just not effective.

MCGUIRE: Right.

SPRINGER: So, there are other remedies like pennyroyal that have significant side effects. ... things like seizure, fainting, cardiopulmonary collapse, kidney and liver damage, even death. Even at small doses, it can be very dangerous.

Even in restricted areas, the safest place to seek advice for an unintended pregnancy is a professional healthcare provider. They can review options with you and also support access to care if they themselves are unable to because of local legislation or regulation. It's especially important if you are someone you know, encounters complication from a pregnancy or an abortion method.

MCGUIRE: As some people may choose to search for possible options on the black market if they think they can't obtain something legally, some might consider buying illegal pills or other medications. Some might also read about purchasing medication from other countries. What are some of the reasons that this is dangerous and should not be considered?

SPRINGER: In many states, FDA approved mifepristone and misoprostol can be purchased through telehealth and/or appropriate regulated websites. There are international companies who will sell and ship these medications to the United States regardless of where someone lives. These medications coming from other countries are not evaluated by the FDA, which means the contents of the medications are not regulated according to U.S. standards. The FDA actually has specific warnings regarding obtaining mifepristone from other countries on their website and has a resource, BeSafeRX, to help guide consumers on identifying safe online pharmacies in the U.S. ...not just for abortion medications, but all pharmaceuticals.

MCGUIRE: Many in healthcare may already understand the concept of U.S. standards for production of medications and FDA approval, but it's such a serious issue which can have significant consequences. Let's emphasize that again. Every medication is not the same. There can be dangers for buying medications which are not regulated or held to certain standards for their manufacturing. One more question about self-managed abortion. Can you weigh in on the healthcare dangers of trying to take matters into one's own hands and self-manage an abortion in general? Even if one has heard a story about someone who did this and survived, besides immediate dangers that you have already talked about, what are some of the long-term risks?

SPRINGER: Keep in mind that self-managed abortion does not necessarily mean illegal or unsafe. So, with the availability of abortion medications through telehealth and legitimate online pharmacies, in some states medication abortion can be self-managed if the patient desires.

Self-managed as when someone tries to use home remedies ... some may attempt multiple methods, or they might combine methods. What this does is it may delay access to methods known to be effective like a medication abortion. The other concern with these methods is if someone attempts a self-managed abortion and has a complication such as hemorrhage, excessive bleeding, infection, it may delay seeking care (and in areas where prosecution's a concern). Historical data suggests that those with the fewest resources are most likely to attempt some type of physical means of ending pregnancy, such as inserting an object into the vagina or the uterus.

As far as long-term complications, physical attempts at self-attempting to end a pregnancy carry the greatest long-term risk. Basically, the uterus or the womb is sterile. The vagina is not. Inserting things that pass through the non-sterile vagina into the uterus can cause an infection that could lead to sepsis, scarring of the uterus, future fertility issues, even death. This is especially true if the person who has attempted a self-induced abortion undergoes complications, and they're afraid to seek care.

MCGUIRE: Right. Those are good points. From another perspective, some reactionary information out in the world may concern the topic of how women who have a serious or life-threatening situation during pregnancy will not be able to get care if they're in a state which has made elective abortion illegal. Some have tried to say pregnant women or mothers will be placed at risk. Can you address this?

SPRINGER: Yes, this is definitely something we heard talked about a lot when the overturn first occurred. The concern regarding ectopic pregnancy or bleeding and infection in early pregnancy in which the fetus may still have cardiac activity .... It's been made very clear through an executive order and the Department of Health and Human Services that providers are protected in providing emergency care to patients with dangerous medical conditions related to pregnancy. I will admit that as a provider, it does add an extra level of decision-making in

determining that threshold of emergency or life-threatening, if practicing in a highly regulated state. Some states, including Texas and Oklahoma, the states have actually even added further description to their recently passed law to specify that the word abortion does not describe a procedure to remove a pregnancy that is spontaneously incapable of continuing to term where a physician believes the mother's life to be in jeopardy.

MCGUIRE: Okay, good clarifying information. Another source of misinformation is that there are no dangers or risks at all from elective abortion. While many may have had abortions managed by medical providers and healed, there are many women who report infertility issues or uterine scarring, particularly after surgical abortion. As part of informed consent, what are some of the possible complications that women should better understand who aren't aware of any possible risks?

SPRINGER: There are risks and dangers to every medical intervention as well as risk to not undergoing some medical interventions.

MCGUIRE: Hmm.

SPRINGER: The risks of a procedure for elective abortion are the same as risks for a procedure for a patient who had a missed abortion. It's extremely important that patients are fully informed prior to consenting to any procedure. The overall safety of medication and procedural abortion is very, very high, and we know the greater the gestational age, the greater the associated risk of termination procedures. So, let's talk about the risk.

MCGUIRE: Okay. Yes, please educate us about that.

SPRINGER: So, with medication abortion, there are common side effects like gastrointestinal upset, nausea, cramping, bleeding. Even with the lack of instrumentation into the uterus, infections can still occur. There's also a chance that it doesn't work, and the patient remains pregnant.

MCGUIRE: That's true. There's not a 100% guarantee.

SPRINGER: When we talk about procedural abortion, the risk during the actual procedure includes perforation of the uterus and laceration or physical damage to the cervix, the opening of the uterus. Each of these occur in less than 1% of procedures. It's low. This is in addition to the risk of infection and bleeding.

Longer term risk after the uterus is instrumented with any type of curetting procedure include forming of synechiae, little scar tissues. This may or may not affect future fertility. Another potential condition which correlates to uterine procedures like D&E is called Asherman's. It's a rare condition where the buildup of adhesions in the uterus, and it can cause pain, changes in menstrual patterns, and fertility issues down the road.

If someone has a failed medical abortion and then they undergo a procedural abortion, their risk of complication increases. There's also discussion of risk associated with retained fetal bone fragments after procedural abortions. So overall abortions are safe, but not without any risk at all. There's evidence that risk increases when performed by unqualified persons in areas with poor access to legal abortion. Data from older sources may support evidence of decreased fertility or even infertility related to prior abortions. Oftentimes, abortion safety balances this data with the risk of complications and even death from childbirth.

I want to mention mental health as a potential outcome in patients undergoing abortion as well and acknowledge the controversy surrounding this correlation. So even if we had excellent research infer cause and effect of abortion on mental health, we really need to acknowledge patient's individual reproductive choices and offer respect, support, and individualized care surrounding their emotional health.

MCGUIRE: And, I'm so glad you brought up mental health and emotional health. Deciding about reproduction and pregnancy are definitely serious decisions. Whatever a person decides about reproduction in pregnancy, even including matters such as adoption after birth, these can be emotional and life-affecting decisions. Just because a decision is made, it doesn't mean the matter is over or not to be discussed again. People still need love, support, counseling, help, etc., right?

SPRINGER: Absolutely ... and ongoing throughout their entire health lifespan.

MCGUIRE: Right, exactly. I've heard commentary about how changing legislation on abortion may change the practice of nursing. However, most states don't allow advanced practice nurses to independently provide

abortions, and registered nurses care for persons based on the need of medical and nursing care, not based on whether they agree with political, religious, ethical, financial, or other personal decisions. Do you think nursing practice will radically change based on legislative changes regarding abortion?

SPRINGER: Let's start with registered nurses. So according to the ANA, nursing must provide comprehensive and unbiased education as to all options with regard to sexual and reproductive health. However, “Nurses have the right to refuse to participate in SRH care based on ethical grounds, as long as patient safety is assured, and alternative sources of care have been arranged” (ANA, 2022) (SRH= sexual reproductive healthcare). This has been the case and aligns with what I've seen in practice too. If a nurse is morally or ethically opposed to elective termination of pregnancy, I have seen them switch assignments with another nurse to avoid interruption in the care of all the patients.

I don't see any radical change here with actual abortion. Nurses also play a huge role in education and advocacy for patients. As the details of these legislative changes get ironed out, prevention of unintended pregnancy becomes an absolute priority. We need nursing support in this area for sure.

MCGUIRE: Right, very good and practical clarification of information. Thank you for that.

SPRINGER: So as for advanced practice nurses or APNs who carry a broader scope, as you said, they're already quite restricted in many states from performing and participating in abortion services. In states taking a significant stance on protecting reproductive services, we may see an increase or broadening of the scope to support demand as patients cross state lines for services. In restrictive states, the role of prevention for all healthcare providers will be really imperative. Nurse practitioners, certified nurse midwives, physician assistants, along with our physician colleagues all have a role to play in the prevention of unintended pregnancy. We may see shifts in where providers choose to practice also, as a result of legislation. Advanced practitioners will play a role in continuing to offer primary care resources as well.

MCGUIRE: Yeah, that's a good point. As far as misinformation, it might be beneficial to note that incorrect information can be spread with and without bad intentions. Some misinformation may come from persons who don't intend to cause harm at all. However, misinformation, intended or otherwise, can sometimes cause terrible consequences. It's important to check resources and not blindly accept information for information’s sake. I think you would agree, right?

SPRINGER: Absolutely. Please remember that despite changes in legislation, medical providers’ beliefs and values have not changed. We continue striving to take excellent care of our patients despite this ever-changing landscape in healthcare. When seeking information, always consider the source, and try to look at the whole picture behind the data.

MCGUIRE: Okay. And can you give us a couple of examples of good sources?

SPRINGER: Absolutely. So, we talked a little earlier about Guttmacher and KFF. They both are excellent resources for providers. ACOG, the American College of Obstetricians and Gynecologists, have both a provider facing side and a patient facing side.

The CDC websites and their contraceptive information is very, very important for us. There's another website called Plan C, which is an online resource for medication abortion, and they are very up to date as to which states they can provide telehealth and ship to, and really structuring that whole primary, secondary, tertiary prevention of contraception, emergency contraception, and abortion, medication abortion access in a safe way.

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MCGUIRE: Fantastic. Thank you for sharing that. And thank you so much for addressing some of this serious information and misinformation that we've talked about during this episode. If we don't talk about these topics and help to educate patients and clients regarding facts, sadly, many people can be influenced negatively by the latter, right?

SPRINGER: Absolutely. The conversations are important, especially in topics that can be emotionally charged or political. Sometimes they get avoided, and I'm really thankful to have this opportunity to talk about it in a really objective, factual way.

MCGUIRE: Yes, it's great. And this has been an interesting conversation for sure. We've navigated some controversial and emotionally charged topics without becoming partisan or biased. And we just wanted to have a chance to discuss issues at the forefront of healthcare today based on facts and objectivity, which you've certainly brought to the table. I can see where more awareness and conversations are needed to help combat misinformation or a lack of awareness in our rapidly changing world, for sure. Another sincere thank you to you, Erica Springer, for sharing your knowledge with us today. We very much appreciate it.

SPRINGER: Thank you for having me.

MCGUIRE: Absolutely! This is Leana McGuire for Elite Learning by Colibri Healthcare.

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