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PRACTICE BULLETIN

EVIDENCE DIRECTING PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS
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Counseling the Abortion-Vulnerable Patient

Many physicians will encounter patients considering pregnancy termination for various reasons. This presents an opportunity not only to create a lasting bond with a patient, but also to open doors to the patient and explore possibilities she may not have considered, and thereby enable her to choose life. Given the importance of offering accurate information about abortion and continuation of pregnancy, this bulletin lists resources for the pro-life physician faced with an abortion-vulnerable patient.

Background

Epidemiology

About 45% of pregnancies in the United States are unintended (1,2). Stulber et al reported in 2011 that 97% of practicing obstetrician-gynecologists in the United States encounter patients seeking abortion (3). According to the Guttamacher Institute (4):

> The reasons patients gave for having an abortion underscored their understanding of the responsibilities of parenthood and family life. The three most common reasons—each cited by three-fourths of patients—were concern for or responsibility to other individuals; the inability to afford raising a child; and the belief that having a baby would interfere with work, school or the ability to care for dependents. Half said they did not want to be a single parent or were having problems with their husband or partner.

Definitions

The following definitions were modified from *Excellence of Care: Standards of Care for Providing Sonograms and Other Medical Services in a Pregnancy Medical Clinic (5).*

The *abortion-vulnerable* patient is one who by continuing her pregnancy faces challenges and problems that she may feel unprepared or unable to manage. She may tell her physician that she is considering abortion, may feel that abortion is her only or best option, or simply may not have ruled out abortion. She may have a medical condition affecting her decision-making.

An *abortion-minded* patient is one who is planning to obtain an abortion or who has already initiated the process by making an appointment with an abortion clinic or having had laminaria placed or having taken misoprostol.

Although this Practice Bulletin uses primarily the term “abortion-vulnerable” for the sake of clarity, the same counseling concepts and techniques may

be applied as needed for an abortion-minded patient who is open to having a conversation.

Challenges

The practicing ObGyn faces several challenges in counseling abortion-vulnerable patients: Clinic time may be limited and patients may require more counseling time than is scheduled (6-9). Some physicians may feel discomfort, or perhaps an inner conflict stemming from a desire not to condemn or alienate the patient while at the same time feeling an obligation to protect the life of the unborn. Patients themselves may feel uncomfortable discussing their circumstances because of coercion from partner or family, worries about school or finances.

Ethical Responsibilities

In counseling the abortion-vulnerable patient, fundamental values to consider are respect for the dignity of human life and the duty to alleviate suffering and distress by working with community resources to help meet needs, to make carrying the pregnancy as easy as possible for the patient. Previously established ethical systems can be applied to counseling the abortion-vulnerable patient (10-12):

Fidelity to the patient involves protection of confidentiality, a duty to provide accurate information, and a commitment to remain available to help and support the patient as she works through her decisions.

Autonomy means that the patient ultimately decides the intended outcome of her pregnancy. The physician counseling her aims to improve her ability to make a well-informed decision.

Beneficence moves the physician to act for the benefit of both patients, the woman and her unborn child.

Non-maleficence is the responsibility to mitigate, while still respecting autonomy, any harm to the patient and her unborn child. This includes patient safety.

Justice means that with utmost respect for the dignity of *all* human life, we should do our best to ensure that all patients have accurate information concerning their health and that of their unborn baby and are offered support and counseling regarding viable options that enable her to continue her pregnancy, regardless of socioeconomic status, sexual orientation, or ethnic background.

Box 1. Counseling Topics for the Abortion-Vulnerable
The woman's own feelings about parenting, adoption, and abortion
Perceived barriers to continuation of pregnancy
Your role in emotional support, encouragement, and obstetrical care if she continues the pregnancy
Your identity as a pro-life physician (i.e. she can trust you to provide care for her *and* her baby)
Open adoption (including anecdotes if possible)
Pressure and coercion, even from people with whom the patient has a positive relationship (7)
Fetal development
Fetal pain (20,21)
Abortion procedures, including medical abortion
Risks of abortion • Claims that abortion is safer than childbirth highly questionable (27-34) • Preterm birth (35-62) • Effects on mental health (63-82) • Hemorrhage • Uterine perforation (surgical abortion only) • Injury to surrounding organs (surgical abortion only) • Infection
Abortion pill rescue (104)

General Counseling Technique and Content

Preparation is very important to good counseling of abortion-vulnerable patients. A physician can improve his or her counseling by considering counseling technique, community resources (including in-office literature and relationships with local pregnancy care centers), and evidence

before being faced with an abortion-vulnerable patient (6,7).

While counseling content may vary from one patient to the next depending on individual patient needs, this Practice Bulletin aims to provide the physician with a number of topics which can be considered for discussion. In general, it is wise to start by asking questions, express empathy, and learn about the patient's situation.

If the patient has brought up the subject of abortion, it may only be necessary to ask, "How do you feel about abortion?" Some patients will express a belief that abortion is objectionable. If that is the case, the physician may need only to encourage fidelity to her deeply held beliefs, then go on to discuss how to overcome hurdles and challenges that make continuing the pregnancy seem difficult. Other counseling topics, including perceived barriers to pregnancy continuation and coercion, are listed in Box 1.

Part of comprehensive counseling is to encourage the patient to gather as much information as possible and to take time to understand and consider it carefully (6,7, 13, 14). Assure her that she does have options and use language of empowerment to specifically advise her to resist coercion, to focus on making a decision that she will be comfortable with for her entire life, and to make yourself available in the decision-making process and for support during her pregnancy. As you listen to and counsel the patient, be aware of signs of human trafficking, listed in Box 2.

Box 2. Red Flags for Human Trafficking

Working and Living Conditions:

- Is not free to leave or come and go as he/she wishes
- Is in the commercial sex industry and has a pimp / manager
- Is unpaid, paid very little, or paid only through tips
- Works excessively long and/or unusual hours
- Is not allowed breaks or suffers under unusual restrictions at work
- Owes a large debt and is unable to pay it off
- Was recruited through false promises concerning the nature and conditions of his/her work
- High security measures exist in the work and/or living locations (e.g. opaque windows, boarded-up windows, bars on windows, barbed wire, security cameras, etc.)

Mental Health and Behavioral Conditions:

- Is fearful, anxious, depressed, submissive, tense, or nervous/paranoid
- Exhibits unusually fearful or anxious behavior after bringing up law enforcement
- Avoids eye contact

Physical Conditions:

- Lacks medical care and/or is denied medical services by employer
- Appears malnourished or shows signs of repeated exposure to harmful chemicals
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture

Lack of Control:

- Has few or no personal possessions
- Is not in control of his/her own money, no financial records, or bank account
- Is not in control of his/her own identification documents (ID or passport)
- Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)

Other:

- Claims of just visiting and inability to clarify where he/she is staying/address
- Lack of sense of time, or knowledge of whereabouts and/or of what city he/she is in

• Has numerous inconsistencies in his/her story
Modified from the National Human Trafficking Resource Center.

There are a few things to avoid in counseling the abortion-vulnerable patient. Avoid negativity, don't marginalize her emotions, and don't try to tell her what to do (5).

If possible, offer to perform (or order) an ultrasound. Dating the pregnancy will be necessary regardless of her decision. Ultrasound affords the opportunity for your patient to actually see the life she is carrying. While it is unclear exactly how many women choose life because of ultrasound (15,16), experience has shown that many women choose to continue their pregnancies when allowed to see an ultrasound. (17,18)

Finally, it is generally useful to offer a follow up appointment to continue your discussions, answer questions that have come up, or repeat the ultrasound examination. You may offer to see the patient and/or her family more frequently so that she can benefit from your understanding and willingness to listen. You will make any referrals needed for her to receive the best care.

Clinical Considerations and Recommendations

Q *I am faced with an abortion-vulnerable patient in my office now and I don't have time to sift through literature or form relationships with the local pregnancy care center. Who can help me right now?*

AAPLOG.org hosts multiple documents such as this, that condense useful information. It also provides a list of pro-life physicians, who may have additional local resources or may form a referral base.

Optionline.org is associated with the hotline at 1-800-712-HELP (4357). (Patients can also text "HELPLINE"to 313131.) This site provides comprehensive option counseling. Similarly, pregnancydecisionline.org provides links to local pregnancy care centers and provides a hotline (855-910-9123).

Lifetimeadoption.org is devoted to helping women understand and consider adoption.

Care-net.org is a website devoted to pregnancy care centers, with a Christian emphasis.

Abortionpillrescue.com provides a telephone hotline and online chat for women who have initiated a medical abortion and are reconsidering their decision. The website also provides information about medical abortion and the rescue process.

Abortionprocedures.com describes various abortion methods.

When there is a concern about human trafficking, the National Human Trafficking Resource Center (1-888-373-7888, or text "BEFREE" TO 233733) is invaluable.

Q *How can a busy OB/GYN begin to establish rapport with an abortion-vulnerable patient?*

Try to create a suitable environment and a relationship with the patient that makes her feel comfortable and safe to express herself. It is helpful to show empathy, to make an effort to understand her situation from her perspective.

The patient must have a sense that the physician counselor is sincere. She must know that she can count on you and your staff to follow through with the support and help you offer.

Q *Are special laws in effect for minors participating in sex work?*

Yes. According to federal law, any minor under the age of 18 engaging in commercial sex is a victim of sex trafficking, regardless of the presence of force, fraud, or coercion.

Q *How should sex trafficking be reported? What referrals should sex trafficking victims be given?*

Report sex trafficking online at traffickingresourcecenter.org. Referrals and resources are also available there, or by calling 1-888-373-7888 (twenty-four/seven hotline) or emailing nhtrc@polarisproject.org.

Q *What about the case of the patient whose fetus has anomalies?*

Women whose unborn child is diagnosed with a serious or lethal fetal anomaly should be aware of the availability of perinatal hospice. Research regarding grief and posttraumatic stress symptoms after termination of pregnancy for fetal anomalies indicate that "women simply do not 'get over it.'" As an alternative honoring the dignity of human life, AAPLOG offers Practice Bulletin Number 1, February 2015, Perinatal Hospice: Care with Compassion for Families with an Adverse Prenatal Diagnosis. Perinatal hospice focuses on the family rather than the diagnosis. The family is placed in the center of the care and there is a continuum of support from the diagnosis, through death, and grief. Experience has shown that many men and women strongly desire to live out their calling as a loving parent, no matter how short their child's lifespan, and despite serious anomalies (19). Please refer to our Perinatal Hospice Practice Bulletin (20) for more detailed information.

Q *What language can be used to describe fetal development in a short time?*

The following is an excerpt from the AAPLOG Patient Guide pamphlet: "Your unborn child is a person. At about 22 days after fertilization your child's heart begins to circulate his or her own blood, unique from your own, and has a heartbeat that can be detected on ultrasound. At just six weeks after fertilization, your child's eyes and eye lids, nose, mouth, and tongue can be seen. Then just ten weeks after fertilization your child can make bodily movements. Around week 19-21 your child can hear. During this time you should begin to feel movement. From fertilization on, your child is a human being and a human person, uniquely distinct from you. Your child is alive, and every life is a precious and valuable gift."

Q *When can fetuses feel pain?*

It is clear that fetuses are capable of pain by 22 weeks gestational age at the latest; possibly earlier, as fetuses do respond to touch as early as 7.5 to 8 weeks (20,21). For more information, refer to AAPLOG's Practice Bulletin No. 2, November 2017, Fetal Pain.

Q *How much does abortion increase a patient's risk of subsequent preterm birth?*

Since abortion was legalized, many studies have demonstrated an increased risk of preterm birth (PTB)(36-63), notably two recent reviews. In one meta-analysis which considered over 900,000 women with prior surgical abortion, surgical abortion was found to have an odds ratio (the occurrence of preterm birth when surgical abortion has happened, compared to the occurrence of PTB when surgical abortion has not happened, which

would be 1.0) of 1.52, which was statistically significant. On the other hand, women who underwent D&C for management of spontaneous abortion also inherited a higher risk of PTB, but this was lower than surgical abortion (odds ratio of 1.19). For women undergoing surgical abortion, the odds ratio of low birth weight (LBW) was also significantly elevated at 1.41, and the odds ratio of small for gestational age neonate (SGA) was significantly elevated at 1.19 (62).

This review also examined women who had received medical abortion, and these women did not have a significantly increased risk of PTB, LBW, or SGA (62). However, if a medical abortion fails and requires surgical completion, the risk of preterm birth following surgical completion will be at least as high as a primary surgical abortion. It is important for a pro-life OB/GYN to represent this data honestly.

There is a suggestion that surgical abortion may increase the risk of very preterm birth (birth prior to 32 completed weeks) more than all preterm births taken together (less than 37 completed weeks): the odds ratio of very preterm birth was found to be 1.68 in one study, compared to 1.29 for all preterm births, suggesting that very preterm births may make up more of the preterm births that women with a prior surgical abortion suffer (63).

The risk of PTB increases with multiple surgical abortions: women with a history of multiple surgical abortions have a 1.79 odds ratio of PTB compared to women with one surgical abortion (63).

Helping patients understand why PTB is to be avoided can be helpful in some situations. Preterm birth can have both short-term and long-term health risks for the neonate. Short-term risks include the hurdles in respiratory and digestive function that neonatal intensive care patients deal with on a daily basis.

In addition, preterm birth leads to an increased risk for some long-term complications, such as cerebral palsy, impaired vision and hearing, behavioral and psychosocial difficulties, and impaired cognitive development. (The last two paragraphs of this reply were modified from the AAPLOG pamphlet on Abortion and Preterm Birth.)

Q *How much does abortion increase a patient's risk of mental health problems?*

It is important for the abortion-vulnerable patient to understand that although many abortions are purportedly done to prevent or reduce mental health risks, the medical literature offers no evidence that abortion reduces mental health risk (64,65). In fact, while some claim no abortion-related mental health risk, there are actually hundreds of studies (66-104), including a carefully designed meta-analyses in 2011 (67), revealing abortion as a significant risk factor for mental health problems. Summarizing the medical literature, Dr. Patricia Coleman has stated, "For a significant number of women, abortion initiates a life trajectory characterized by feelings of grief, loss, alienation from others, and mental health challenges" (105).

Q *Does abortion increase a patient's risk of breast cancer?*

The Howe study, a large pair-matched case-control study nested in a prospective database raised concern in 1989 when it pointed to a risk ratio of 1.9 (106). After a meta-analysis in 1996 revealed induced abortion as an independent risk factor for breast cancer (107), several subsequent large meta-

analyses which included multiparous as well as nulliparous women did not confirm an increased risk (108, 109). However, there exists evidence that abortion of a first pregnancy, especially for teens and women over the age of 30, increases breast cancer risk. Innes and Byers have demonstrated that pregnancies which end prior to 32 weeks result in an increased risk (110).

For women carrying a BRCA mutation (111), incomplete pregnancies increased the risk of subsequent breast cancer. The mechanism is stimulation of stem cell breast tissue (Type 1 and 2) in early pregnancy but lack of terminal differentiation which occurs after elaboration of human placental lactogen (HPL) by the placenta after 20 weeks gestation. HPL is required for terminal differentiation of breast tissue to lactational tissue, which is cancer resistant. Studies which look at the subset of women who abort prior to carrying a child to term show the strongest association. Studies which look at women who abort after previous term pregnancies do not show as strong an association. There is biologic plausibility as well as epidemiologic evidence (112-130) for an abortion-breast cancer link.

Q *What options are available for a patient who has taken mifepristone but then changes her mind?*

For patients who have already taken mifepristone, there is as high as 68% chance of saving the pregnancy by following an abortion pill rescue protocol (131). For patients who choose this treatment, she should know that having taken the mifepristone, her fetus is not at increased risk for birth defects. For more information, contact the Abortion Pill Rescue Network: abortionpillrescue.com.

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. Physicians should encourage the patient to gather as much information as possible, take time to make a decision, and to provide significant support (14).

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

1. Patients may be counseled that abortion causes increased risk for preterm birth, mental health problems, and possibly breast cancer (28-130).
2. For patients who have taken mifepristone, there is as high as 68% chance of saving the pregnancy by following an abortion pill reversal protocol (131).

The following recommendations are based primarily on consensus and expert opinion (Level C):

1. Physicians should prepare ahead of time to counsel abortion-vulnerable patients, in particular by studying the literature cited and by forming connections with local organizations that can offer these patients resources.
2. It is important for physicians counseling abortion-minded patients to listen to the patient and ask her about her own feelings about life, adoption, and abortion.
3. Physicians counseling abortion-vulnerable patients should avoid negativity, marginalizing emotions, and any paternalism.
4. Experience has shown that many women choose to continue their pregnancies when

they see their baby on an ultrasound monitor.

5. Women whose unborn child is diagnosed with a serious or lethal fetal anomaly should be aware of the availability of perinatal hospice.
6. Pregnancy Care Centers should be used whenever possible.
7. Physicians counseling abortion vulnerable patients should be aware of signs of human trafficking.

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