

PERSPECTIVE

# INTERSECTING WITH ABORTION CARE AS AN INTERNIST

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## Abortion.

Let's get that term out in the open—I've written it, you've read it.

Since the landmark Supreme Court decision in *Roe v Wade* in 1973, abortions have been legal, but not always safe and accessible in the United States, as years of regulation and exclusions have limited women's choice. Abortion rights have remained a polarizing force in politics and healthcare discussions, with many states riding the momentum of the polarizing 2016 election cycle. More than two dozen states have passed or introduced anti-abortion bills, including the recent near total bans passed in Georgia and Alabama.

Why am I now writing a piece about abortion rights and abortion care for *SGIM Forum*? What place does this subject have taking up space in a monthly newsletter for internists? As a physician who is not an obstetrician, how am I possibly qualified to write on the subject?

I am an American woman physician, and I strongly believe advocacy as physicians is a crucial element of our professional calling. I believe that we must use our informed, empowered voices, especially when the debate is fueled by misinformation, stigma, and fear-mongering: "to avoid the political fray through silence is impossible, because silence is now political. Either engage or assist the harm. There is no third choice".<sup>1</sup>

But even more importantly, through my own practice of medicine, I have had a small role in the care of women seeking abortions. I want to share my experience of how a #ProudtoBeGIM hospitalist can facilitate safe, compassionate, patient-centered care through abortions. I also want to use my voice as an internist to amplify how truly difficult and serious these private decisions are, rather than wanton and callous as the conservative media and politicians might portray.

In my role as a hospitalist, I mainly provide outpatient patient care in our pre-operative medicine clinic. In my nearly a decade working in this clinic, I have evaluated dozens of women who are scheduled for abortions—first, second, and third trimester D&Cs or D&Es. (As a brief disclaimer, I use the term *wom-*

*en* throughout this piece. I acknowledge that there are times when transgender men or gender non-binary patients might seek abortions, but I use "women" for consistency.)

Portland, Oregon, has a very supportive family planning professional obstetrician community, and there are multiple venues in the community for women to receive their procedural care. If I am scheduled to see them in pre-op clinic, then that indicates that they have been referred to the university hospital because the community or clinic-based ambulatory setting is concerned that their health care requires a step up in care for the procedure to be performed as safely as possible.

Who are these women? These are the women with underlying medical conditions for whom carrying a pregnancy to term could be life threatening. Maybe this was an undesired pregnancy and they were keenly aware of the risk of conceiving, but their birth control failed. Or maybe this was a desired pregnancy, and she had pursued extensive counseling with her continuity medical team—and the pregnancy originally deemed safe is now made abundantly clear to not be safe.

I think of the woman. . . :

- with previously stable congenital heart disease who is not tolerating the hemodynamic changes of pregnancy as well as anticipated.
- who has recovered from tricuspid valve endocarditis, is stable on methadone for her substance use disorder recovery, and whose birth control failed.
- with a hypercoagulable disorder and a history of a dural vein thrombus who could not safely take hormonal birth control and every form of non-hormonal birth control simultaneously failed.
- whose long-standing stable epilepsy is now practically refractory because the pregnancy so dramatically lowered her seizure threshold.

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These are also women who developed a new medical condition either during or as a result of the pregnancy, and their health is now in jeopardy. For example, she who has acute severe proteinuric kidney disease, spilling grams of protein daily, thought to have some pregnancy induced nephropathy.

The other women I evaluated in pre-op clinic may be healthy, but they are scheduled for second trimester D&Es, a more extensive procedure that might require more extensive anesthesia support in the OR setting. These are the women who almost always learned of some fetal abnormality on the 18-20 week scans—severe congenital abnormalities that are not compatible with life.

The role I'm serving in these women's care struck me during one of the 2016 presidential debates. In response to inaccurate and gruesome language about what second trimester and late term abortions entail, Hillary Rodham Clinton said: "the kinds of cases that fall at the end of pregnancy are often the most heart-breaking, painful decisions for families to make. I have met with women who toward the end of their pregnancy, get the worse news one could get, that their health is in jeopardy if they continue to carry to term or that something terrible has happened or just been discovered about the pregnancy...This is one of the worst possible choices that any woman and her family has to make. I do not believe the government should be

making it...I can tell you the government has no business in the decisions that women make with their families in accordance with their faith, with medical advice, and I will stand up for that right."<sup>2</sup>

I tell you from dozens of experiences of my brief time intersecting with these women's lives—these are not easy decisions. They are heart-breaking, and they have been taken extremely seriously by the women and whomever they have chosen to be involved in that decision making process. Women deserve and must have the right to be shepherded through these decisions with skillful, compassionate, patient-centered, safe medical care. It does not matter to me if it was a planned pregnancy or not, if it was a desired pregnancy or not. These are not easy decisions.

I am also highly cognizant that the language I need to use in my patient counseling needs to be tailored:

*"you have reached this point because you and your physicians are worried about your health, and that concern is why you are seeing me in pre-op clinic. I want to reassure you that, overall, a D&C (or a D&E) is a "minor procedure". I use the word "minor" only to refer to how physically stressful the procedure might be on your body—it's short, it doesn't require an incision, and you likely won't need general anesthesia. However, I do not want you to think that the word minor refers to the*

*significance of the procedure, and I do not want you to think that I'm trying to trivialize how hard the decision to schedule it must have been. Yes, it's a "major" decision, but based on our visit today, I think you are ready for the "minor" procedure as safely as possible through the care of your obstetrician and anesthesia team."*

Compassionate, respectful, medically-informed, privacy-minded abortion-related care needs to be the norm not the exception. I think internists do have a role in this, through physician-advocacy, pre-operative risk evaluations, or peri-procedure support and counseling through the primary care setting. We must trust and support women to make their choice, and we must care for them before and after that choice has been made. As an internist, I will amplify once more, "I will stand up for that right".

**References**

1. Berwick D. Moral choices for today's physicians. *JAMA*. 2017;318(21):2081-2082.
2. Blake A. The final Trump-Clinton debate transcript, annotated. *Washington Post*. [https://www.washingtonpost.com/news/the-fix/wp/2016/10/19/the-final-trump-clinton-debate-transcript-annotated/?utm\\_term=.dee0d2cf49ed](https://www.washingtonpost.com/news/the-fix/wp/2016/10/19/the-final-trump-clinton-debate-transcript-annotated/?utm_term=.dee0d2cf49ed). Published October 19, 2016. Accessed July 1, 2019.