Reproductive Health in Nursing

Patient Situation 1

Options Counseling in Unintended Pregnancy and Prevention Care

Ivy's Choice
(Patient Situation #1)

The Patient

Ivy is 16 years old and her last menstrual period was 11 weeks ago. Sometimes she uses oral contraceptives and sometimes condoms, but neither consistently. She has never been pregnant before.

The Setting

A large health center with a Family Planning Department for contraceptive services and comprehensive reproductive health care.

What Happened

Ivy and her mother, Jody, come into the health center to confirm the pregnancy test Ivy took at home. While Ivy is in the bathroom, Jody reveals to the nurse that she was 17 years old when she gave birth to Ivy, and she knows how challenging it can be to be a young mother. She does not want this life for Ivy and would like the nurse to focus on abortion or adoption options if the test comes back positive.

What can the nurse say to Jody?

It is the nurse's job to describe all of Ivy's options in neutral, non-directive and non- judgmental language. The article *Caring for Women with Unintended Pregnancies* by Simmonds and Likis (2011) highlights the nurse's professional responsibilities in providing care to women with unintended pregnancies, which includes appropriate assessment, options counseling, referrals and care coordination, and prevention efforts. This nurse is comfortable with her role. She has worked in reproductive health for years and routinely counsels women and couples on their pregnancy options. She could say to Jody: "It is so wonderful that Ivy has you with her here today to support her. We always encourage family involvement in reproductive decision-making with minors. After we run a pregnancy test, and if it is positive, my role will be to describe all of Ivy's options, if she wants me to. We will discuss abortion, making an adoption plan, and continuing the pregnancy and parenting. Once I've provided information on these options, you and Ivy can discuss her plans together. I will be able to give you more information and give you a referral for whatever decision Ivy makes."

Ivy's Intake Form

PREGNANCY TEST HISTORY

Name: _____**Ivy**_____ Age: _____**16**_____

I identify as: **X Female** __Male __Transgender __Specify: _____

Gender pronoun: **X She** __He __Specify: _____

Would you like a companion in the room with you for your visit?
X Yes __No If so, whom? _____**My mom (Jody)**_____

With whom can you talk with for support?
X Partner(s) **X Parent(s)** __Family Member(s) **X Friend(s)** __No One

Pregnancy History:
Pregnancies _____**1**_____
Births _____**0**_____
Miscarriages _____**0**_____
Abortions _____**0**_____

Have you already taken a pregnancy test? **X Yes** __No
What were the results _____**positive**_____

When was the first day of your last menstrual period? _____**11 weeks ago**_____

Are you using any form of birth control? **X Yes** __No
If so, what are you using? __**Sometimes COCs, sometimes condoms**_____

If you are pregnant, which options would you like to discuss?
X Adoption **X Abortion** **X Parenting**

Case: Ivy is a 16-year old girl brought to the health center by her mother (Jody) for confirmation of pregnancy and options counseling after Ivy took a positive pregnancy test at home. Ivy is feeling ambivalent about the pregnancy. She thinks having a baby will bring her and her boyfriend closer together. Jody is concerned because she gave birth to Ivy when she was 17. She knows how hard it is to be a young mother and doesn't want that life for her daughter. Ivy is open to discussing parenting. Jody is hoping to focus on adoption or abortion.

Common Concern: "I've heard abortion causes infertility."

Personality: Loves fashion and hopes to go to design school.

What Happened (continued)

Jody waits in the waiting room and when Ivy returns from the bathroom the nurse leaves to run the test. It is positive. Ivy and the nurse are alone together in the exam room.

Nurse: Ivy, your pregnancy test is positive. This means that you are pregnant. (Pauses to let this information sink in).

Ivy: That's what I thought.

Nurse: How are you feeling about this? Many women have mixed feelings about a pregnancy.

Ivy: I think Brian would be a great dad. Maybe having a baby would be great for us, bring us closer together. I don't know.

Nurse: Tell me more about what you are thinking. (Pause. Ivy does not respond). Ivy, this is a really important decision for you and sometimes it can be helpful to get support and talk it through with family or friends. Would you like me to ask your mother to come in here to be with you?

Ivy: Yes.

The nurse leaves and returns with Jody who sits next to Ivy.

Nurse: Ivy, you have several options to consider. You could choose to continue the pregnancy and parent the child, you could chose to have an abortion or you could continue the pregnancy and plan an adoption.

Non-directive, patient-centered options counseling

Innovating Education in Reproductive Health provides exercises and presentations on providing quality options counseling to adolescents, and other related sexual and reproductive health issues such as *Caring for Challenging Patients* and *A Counseling Model for Ambivalent Patients*. Completing these tools will help learners develop necessary skills to provide unintended pregnancy prevention and care.

The nurse estimates that Ivy is approximately 11 weeks pregnant. She asks Ivy if she would like information on her options regarding the pregnancy, and Ivy agrees. The nurse explains that Ivy could have a first trimester abortion procedure, she could continue with the pregnancy, or she could make an adoption plan. When working with patients to help them understand their options the most important points to remember are:

1. The patient has the answers.
2. Any choice a patient makes is the right one for her.

Our role as nurses is to be a mirror and a map for the patient: as a mirror we reflect back what we hear the patient saying, and as a map we provide information regarding the different paths a patient can take and it is up to the patient to choose the path that is right for her. Training in Early Abortion for Comprehensive Healthcare (TEACH) details the fundamentals of presenting all options to women including counseling techniques using open-ended questions, dealing with ambivalence and moral conflict in Chapter 2, *Counseling and Informed Consent* of their "Early Abortion Training Workbook." The workbook is an extensive comprehensive resource on abortion care with recommendations and guidance on issues ranging from confidentiality and consent procedures to medications and pain management for different abortions procedures.

First Trimester Abortion

The chart, *First Trimester Abortion: A Comparison of Procedures* from the National Abortion Federation shows a side-by-side comparison of early abortion procedures: Mifespristone, Methotrexate, vacuum aspiration. The chart details how they work as well as the advantages and disadvantages of each. In addition, the National Abortion Federation has *Clinical Policy Guidelines*, which are evidence-based guidelines and standards on abortion care. They include clinical practices on patient care and counseling and different types of abortions. These guidelines, which are revised annually, are based on rigorous review of medical literature and known patient outcomes to support and educate providers on the most current information, standards, and recommendations. The following modules are specific to this competency:

- Module 5: Limited Sonography in Abortion Care
- Module 6: Early Medication Abortion
- Module 7: First-Trimester Aspiration Abortion
- Module 9: Abortion by Dilation and Evacuation
- Module 10: Second-Trimester Induction Abortion

Making an Adoption Plan

If Ivy were to make an adoption plan, she would likely place the baby for adoption shortly after birth. In a domestic infant adoption there are several options for how the process could work for Ivy and the adoptive family. *The Basics of Adoption Practices: A Bulletin for Professionals* from the U.S. Department of Health and Human Services' Administration for Children and Families via the Child Welfare Information Gateway, details types of adoption, family and child assessments,

birth parent involvement, and how the placement and adoption process works including post-adoption services. In addition to prenatal care, the nurse would need to refer Ivy to a social worker who would work with Ivy to find an optimal match in an adoptive family. Ivy could chose to have an open adoption, where identifying information is shared between families with an agreed-upon level of contact, or she could opt for a closed adoption with no shared identifying information. The nurse could also direct Ivy and Jody to view *Open Adoption: Could Open Adoption be the Best Choice for You and Your Baby?* a resource from the U.S. Department of Health and Human Services' Administration for Children and Families for expectant parents. There is a specific section on open adoption which details how it works, the benefits, legalities and action steps for this type of adoption. With the choice to make an adoption plan, Ivy commits to continuing the pregnancy. Her prenatal care must focus on maintaining optimal physical and emotional health, with a focus on continuing her education.

Continuing the Pregnancy and Parenting

If Ivy chooses to continue the pregnancy and to parent the nurse would provide her with some basic prenatal health information, including the importance of taking daily folic acid, and provide her with a referral for prenatal care services. In addition, the nurse could show Ivy and her mother several online resources for teens that provide unbiased support for teen parents including the following:

Backline
This website offers information and provides contact information for a support "talkline" that offers unbiased, nonjudgmental counseling on pregnancy, abortion, adoption, and parenting.

Girl-Mom
A support website written by and for young mothers.

TeenHealth
This website offers advice for teens dealing with pregnancy and provides guidance on talking with parents and doctors about sexuality and pregnancy.

According to the National Institutes of Health, teens are at a higher risk for developing medical complications during pregnancy than pregnant females older than 20 years of age. Infants born to teens are also at a higher medical risk for low birth weight, prematurity and inadequate fetal growth. The Mayo Clinic indicates that pregnant teens are at higher risk due to a lack of knowledge about the kind of prenatal care required for healthy pregnancy. Teens are also more likely to be unaware of the health risks associated with substance use or unprotected sex. Pre-eclampsia, a condition in which the pregnant mother experiences dangerously high blood pressure, and high protein in the urine is a common complication in first pregnancies. Pre-eclampsia may result in early delivery of the baby due to the risk of harm or potential death to the mother or

baby. According to the Centers for Disease Control and Prevention, there are often high social and economic costs of teen pregnancy and childbearing. As an example, teen pregnancy and childbirth contribute significantly to drop-out rates among high school girls: only about 50% of teen mothers receive a high school diploma by age 22, compared with nearly 90% of those who did not give birth during adolescence. The CDC also states that children who are born to teen mothers also experience a wide range of problems and are more likely to:

- Have fewer skills and be less prepared to learn when they enter kindergarten.
- Have behavioral problems and chronic medical conditions.
- Rely more heavily on publicly funded health care.
- Be incarcerated at some time during adolescence.
- Drop out of high school.
- Give birth as a teenager.
- Be unemployed or underemployed as a young adult.

While options counseling is a critical component to high quality health care, not all health care workers have the knowledge and skill to provide effective options counseling. Simmonds and Likis address the conflicts that nurses may experience when providing unintended pregnancy prevention and care, and examine the intersection of personal values with professional responsibilities in their 2005 article *Providing Options Counseling for Women with Unintended Pregnancies*. The article also provides epidemiological data on unintended pregnancy and strategies for providing options counseling.

In some cases, it can help nurses to identify their values and beliefs that might affect their ability to provide the highest quality of care to patients. A set of exercises in *The Abortion Option* from the National Abortion Federation supports health care workers to identify their values and define their boundaries related to abortion care and the role of health care workers in providing abortion services.

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What Happened (continued)

Ivy: But doesn't having an abortion mean I can't have kids later? What if this is my only chance to be a mom?

What are the risks to having an abortion?

There are many myths about the dangers of abortion. Literature reviews (Boonstra et al. 2006) have found that first-trimester abortions have no long-term risks on future fertility, including any increase of ectopic pregnancy, miscarriage or birth defects. The scientific evidence suggests that abortion is one of the safest outpatient procedures available.

Raymond et al. (2014) conducted a literature review and compared mortality rates of abortion to other outpatient procedures commonly performed on healthy young women. The mortality rate associated with abortion between 2000 – 2009 was 0.7 per 100,000 abortions, lower than the rate for plastic surgery (0.8 – 1.7/100,000) and dental procedures (0 – 1.7/100,000 procedures). In comparison with other risks in life, induced abortion may be safer than running marathons (0.6 – 1.2 deaths/100,000 marathons run). Another study by Raymond and Grimes (2012) found that legal induced abortions had a lower mortality rate than birthing live neonates, which was 8.8 per 100,000 cases between 1998 and 2005. This fact sheet from the National Abortion Federation details the safety of abortion and the uncommon, but possible complications from aspiration abortion. In addition, according to the 2013 Guttmacher Institute report, *Still True: Abortion Does Not Increase Women's Risk of Mental Health Problems*, there have been numerous scientific studies which conclude that abortion does not pose an additional threat to women's mental health compared with women who continue with a pregnancy.

What Happened (continued)

Nurse: No matter what you chose to do, making a decision like this is often very difficult even when you know what the right choice for you is.

Jody: Thanks so much. I am thinking about an abortion. I have some questions. Do you perform these procedures here, or do we need to make an appointment somewhere else?

Making effective referrals

To provide high quality patient care, it is vitally important that nurses are either able to participate in the care of the patient or to provide effective referrals so the patient can receive the health care she needs as soon as possible. When a woman chooses to have an abortion, and if the health center cannot do the procedure on site, it is essential to provide her with a referral that will facilitate accessing care quickly. One major barrier to providing effective referrals is that clinicians are often unaware of where adoption and abortion services are offered. In this case, the nurse is familiar with the local facilities and even knows which one will be able to schedule an appointment the soonest. This web page from the National Abortion Federation includes an interactive map that gives state-specific information on abortion services and clinic contact information for each state. Another barrier to providing abortion care and/or referrals is nurses' willingness to participate.

What If...

This section offers a twist or a different perspective on "What Happened" to guide and encourage learners to tease apart various aspects of the Patient Situation.

Ivy wanted to terminate the pregnancy but Judy doesn't believe in abortion?

Maradiegue (2003) provides a detailed historical overview of privacy and confidentiality laws for minors obtaining contraception and abortion, and discusses the clinical implications for practice: *Minor's Rights Versus Parental Rights: Review of Legal Issues in Adolescent Health Care*.

Each state has different laws regarding a minor's right to consent to health care services without parental permission. The Guttmacher Institute (2016) brief, *An Overview of Minors' Consent Law*, provides background information and includes a chart with laws by state on minors' right to consent without parental permission to contraception, STI, abortion, prenatal care, and medical care for minor's child.

Ivy was 8 weeks pregnant?

Ivy's options remain the same: she could have a first trimester abortion procedure, she could continue with the pregnancy, or she could make an adoption plan. The difference here is that at only 8 weeks gestation, Ivy could choose to have a medication abortion which would be more private and wouldn't require an in-clinic procedure. When mifepristone was first approved by the FDA in 2000, it was recommended for pregnancies up to 7 weeks (49 days) after LMP. Since then, the FDA has approved the use of mifepristone up to 10 weeks of pregnancy.

In the article *Mifepristone for Medical Abortion: Exploring a New Option for Nurse Practitioners*, Taylor and Hwag (2003) introduce Mifespristone, commonly referred to as RU-486, and provide clinical considerations including a chart comparing regimens and a chart comparing medication abortion with vacuum aspiration. The fact sheet *What is Medical Abortion?* from the National Abortion Federation (NAF) defines and provides details of medication abortions including how the medications work, how long they take, possible complications, and follow-up care. NAF also defines Mifepristone, a medication that blocks the action of progesterone, discusses how it works, effectiveness as an abortifacent when combined with Misoprostol, possible side effects, and what women can expect when using it in the fact sheet *Facts About Mifepristone (RU-486)*.

In *Care for Women Choosing Medication Abortion* Taylor et al. (2004) discusses the nurse practitioner's role in providing medication abortions and uses case studies to present counseling, complications and potential sides effects, and confirming complete abortion in the article.

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