

Commentary

Denial of abortion care due to gestational age limits[☆]

Many women are denied wanted abortions in the US. This happens for medical, personal and financial reasons and because women are just too far advanced in pregnancy by the time they present at the abortion facility near them. In the US, each abortion facility sets their own gestational limits, based on physician training, clinician and staff comfort, facility regulations, institutional policy and legal restrictions. Although the phenomenon of women presenting at an abortion facility beyond the gestational limit is not uncommon, it has not been well documented or studied.

The Title X Family Planning Program, the only dedicated source of federal funding for family planning services in the US, requires all subsidized facilities to provide “factual information...on each of the [pregnancy] options, and referral upon request” [1]. While many professional health care associations offer more specific guidance for pregnancy options counseling [2–5], only very rarely do they advise clinicians to assess gestational age prior to making referrals for abortion [6]. For a clinician, the experience of counseling women who are past the gestational limit can be memorable. In her first year of the family nurse practitioner program at the University of California, San Francisco, Loren Dobkin remembers counseling a teenaged woman about her pregnancy options, overlooking the possibility that the woman might be too far along to receive an abortion.

During my first year of training as a primary care provider, I received a lecture about how to counsel women about their options for continuing or terminating an unintended pregnancy. That same week, my last patient, “Rachel,” presented for pregnancy testing. She had tested positive. Rachel was 17 years old, publicly insured through Medi-Cal and had requested and received birth control (a Depo-Provera injection) at her last visit 1 year ago. Rachel appeared to be a typical patient in many ways but one: she also had a serious case of an intestinal disease called Crohn’s, for which she was taking mercaptopurine, a Food and Drug Administration Pregnancy Category D medication thought to cause birth defects.

After I told Rachel that she was pregnant and outlined her options of raising the child, adoption or abortion, I asked how she felt about it. Eyes wide, the first word she offered was “angry.” During the past year, she had been attending another health care facility and insisted that she had not missed any appointments for her birth control. She felt betrayed and wanted to request her medical records to see why it had failed. Then, without any additional prompting, she declared, “I need to get an abortion. My father’s gonna kill me.”

I explained that there were good clinics she could go to nearby and described how to set up the appointment and what to expect when she arrived — glad to be able to offer a solid referral. I thought that the hard part of the counseling was over when I eventually asked her whether she was feeling any pregnancy symptoms. Already overweight, Rachel felt like she was gaining weight faster than usual. She did not think much of it until last week, when she started to feel “zooming in my tummy.” It turned out that she had not had sex in about 4 months. My stomach turned as I realized that I had spoken too soon about the availability of abortion services and recalled the limit for abortion in our state — 24 weeks. I left to report back to my supervising doctor, nervously converting months to weeks in my head as I passed between rooms. Rachel was at least 18 weeks pregnant and possibly much more.

Our clinic did not have ultrasound equipment so the best approximation of gestational age we could offer was to size her uterus by measuring fundal height, which suggested 24 weeks, ± 2 weeks. It was late afternoon on Friday, just a half hour until closing at the only facility that does later abortions. I reached the nurse manager, who offered to keep the clinic open late for her first step — the ultrasound. But Rachel’s father was waiting for her to return home, and the 30-min drive to that clinic was too long to take that night, she said, setting up an appointment for Monday afternoon instead. “Isn’t there anywhere closer she can go?” her older sister pleaded disbelievingly when she came to pick Rachel up. During my prior rotation at that clinic, I had understood and appreciated the great distances women traveled from across the state and from other states to get to that facility. However, I never considered the special barriers that younger and more disadvantaged patients may face in getting to the facility

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and that it might be hard for Rachel to reach it even from a neighboring city.

Rachel returned to the teen clinic the following week. She had been 26 weeks and 2 days when she arrived at the abortion clinic, well past their gestational limit. With the support of the counselors there, she had told her family and decided against adoption. That was the last time I saw her, as we inserted her name into a long waitlist for the only local prenatal care provider who accepted Medi-Cal and could also manage her chronic disease during pregnancy.

1. Why do women present for abortion after the first trimester?

Loren's patient has many characteristics associated with delay in seeking care — youth, obesity, poverty and late recognition of pregnancy. And she experienced common barriers to accessing abortion care — a shortage of providers who accept public funding and a shortage of providers who provide abortions later in pregnancy. Several recent studies have examined risk factors for late presentation for abortion. Women report a number of delaying factors including late detection of pregnancy, difficulty deciding whether to continue the pregnancy, difficulty locating a provider, difficulty getting state insurance, inappropriate or delayed referrals, taking a long time to make arrangements and cost and access barriers [7–9]. The major factors associated with late detection of pregnancy include obesity, abuse of drugs or alcohol, prior second-trimester abortion, being unsure of last menstrual period and emotional factors such as being in denial and fear of abortion [9].

Loren's story is also typical in that the clinician doing pregnancy options counseling usually does not learn what happens to the women or their children. What outcomes can women who are denied an abortion expect for themselves and their families?

2. The Turnaway Study

The Turnaway Study is a longitudinal prospective study of women who receive an abortion and women who are denied an abortion because they present for care after the provider's gestational limit. The study was uniquely designed to follow women like Rachel, investigating the consequences of carrying an unwanted pregnancy to term versus receiving a wanted abortion. The Turnaway Study examines the effects on women's well-being, including short-term physical health, mental health, socioeconomic, substance use and exposure to intimate partner violence.

The Turnaway Study's innovative design involves comparing two groups of women who have had unintended pregnancies: women just over and just under the gestational limit at 30 abortion facilities across the US where no

provider within 150 miles has a later gestational limit. The Turnaway Study follows turnaways ($n=231$) and their abortion-receiving controls ($n=452$) as well as a first-trimester group ($n=273$) via telephone interviews every 6 months for 5 years. We have recently presented preliminary results on the consequences of receiving an abortion compared to having an unwanted birth at the 2012 American Public Health Association meeting, and the publications of our findings are forthcoming.

Our interviews with women in the Turnaway Study demonstrate that a myriad of factors delay seeking of abortion services. Anecdotally, we know that clinicians do not always consider gestational age when counseling patients about their pregnancy options or when referring them to abortion care. Several improvements in pregnancy option screening and referrals may reduce the incidence of women being denied wanted abortions.

3. Recommendations for reducing the incidence of women presenting ineligible for care due to advanced gestational age

- Improve referral procedures. When making referrals, consider gestational age, provider limits, sources of funding and less expensive providers who may be farther away.
- Maintain a current list of abortion providers with contact information and corresponding gestational age limits in your area to which clinicians may refer. Generally, you may obtain contact information online (see www.laterabortion.org#resources).
- Estimate patients' pregnancy gestational age (by history, exam or ultrasound) relative to clinic limits prior to providing referrals to help facilitate access to care. Eliciting sexual and menstrual history before disclosing pregnancy test results may be a part of a patient-centered counseling strategy [10].
- Help patients set up appointments and obtain directions to appropriate clinics.
- Inform patients who desire an abortion that costs usually increase with increasing gestational age. The average cost of abortion in the US is US\$543 for an abortion at 10 weeks compared to US\$1562 for an abortion at 20 weeks and varies widely among clinics [11].
- When providing care for adolescent girls, provide additional support for contraceptive continuity and pregnancy testing as needed. Tailor pregnancy options counseling to their unique circumstances (e.g., legal restrictions, limited transportation and psychosocial developmental stage) [12]. Be familiar with any parental notification or consent laws for minors in your state (see <http://www.plannedparenthood.org/health-topics/parental-consent-notification-laws-25268.htm>).

- If possible, routinely follow up with your patients and make referrals as needed so that they receive care in a timely manner, including prenatal care if abortion was not selected or is no longer an option [2,3,12].

The problem of being denied an abortion due to gestational limits is likely to become worse in the years to come. New laws aim to lower the state legal gestational limit. In recent years, six states have reduced the upper gestational limit to 20 weeks from fertilization and one state to 18 weeks [13]. These laws will make it more challenging for women to obtain a wanted abortion and will likely increase the number of women carrying unwanted pregnancies to term.

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