Destigmatizing abortion in primary care settings

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Many nurse practitioners (NPs) in primary care settings are feeling lost or helpless since the Supreme Court decision in the case of Dobbs v Jackson Women's Health Organization.[1] We share these feelings. We believe NPs are key in destigmatizing abortion and can develop strategies to serve patients in primary care settings in this challenging time. Patients who might normally successfully self-refer to abortion clinics or to telehealth abortion services may find themselves facing new difficulties as they try to find their way through the United States' rapidly changing patchwork of abortion laws, regulations, and social norms to connect with a legitimate abortion service. NPs in the primary care setting often assist their patients in navigating the health system, and it is critical that we do not implicitly or explicitly demonstrate that they cannot come to us with abortion-related needs. When we silo the discussion of abortion care to abortion clinics, we risk adding to the stigma and shame that patients seeking abortions experience, and such stigma harms them.[2]

The fact is that abortion is common. Approximately 1 in 4 individuals in the US who are capable of giving birth will have at least one abortion by the end of their reproductive years.[3] When people cannot access safe abortions, their likelihood of negative outcomes increases.[4] The Dobbs v Jackson Women's Health Organization Supreme Court decision necessitates that NPs reexamine current standards of practice in their clinical settings.

Nurse practitioners in primary care settings can affirm to patients that abortions are common and safe, and an essential component of comprehensive sexual and reproductive healthcare. When NPs are willing to discuss abortion in the exam room, vocally acknowledge the ways that abortion can contribute to a patient's wellbeing, and seek to close relevant gaps in their knowledge, they promote equity, reduce stigma, and dispel misinformation about abortion care. They are educated to provide patient-centered care with compassion and factual and evidence-based resources. Unfortunately, many NP academic programs provide little or no information about abortion and abortion care. A first step, then, for some NPs will be to obtain this important information through credible sources (*Box*). They can then review the reproductive healthcare practices in their clinical setting to better integrate abortion-related considerations.

Early pregnancy recognition can make a difference in access to abortion care. If a patient's period is just a few days late and the NP is practicing in a state with a 6-week abortion ban, it is worth investigating the chance of early pregnancy via a thorough menstrual history and a urine pregnancy test. Nurse practitioners can also remind patients that in-office urine pregnancy tests are generally no more accurate than home tests and they should not delay scheduling an abortion to obtain an office-based pregnancy test.[5] A delay of only a few days in confirming a pregnancy and beginning the process of obtaining an abortion could be the difference between accessing a legal in-state abortion and dealing instead with the significant costs of traveling out of state to do so, in addition to further legal and health risks.

Incorporating an unbiased discussion of abortion in contraceptive counseling can provide patients with the knowledge they may need to achieve their reproductive life goals. When discussing contraception, failure rates and efficacy are generally mentioned. This presents an excellent segue to discuss what might happen in the event of an unplanned pregnancy. Patients who have information on abortion care are better equipped to access safe and timely abortion services if ever needed. During contraception consultations, NPs can provide a brief, factual summary of the basics of abortion access and care. We suggest asking patients for their consent so they can opt in or out of receiving the information. Nurse practitioners can discuss gestational limits and

Box. Abortion care resources

National Abortion Federation Clinical Policy Guidelines for Abortion Care. 2022. prochoice.org/wp-content/uploads/2022-CPGs.pdf[A]

Training in Early Abortion for Comprehensive Healthcare (TEACH curriculum) teachtraining.org/training-tools/abortion-training-curriculum/[B]

World Health Organization. 2022. Abortion care guideline. apps.who.int/iris/handle/10665/349316[C]

what to anticipate during both medication and in-clinic abortions. This is also an opportune time to discuss the difference between a crisis pregnancy center (CPC) and an abortion clinic, and to advise on steps to safeguard reproductive privacy. As well, NPs can consider how to best structure this discussion in the context of their particular practice setting.

As contraceptive counseling is forced to evolve in a post-Dobbs world, it is crucial to recognize and ameliorate unnecessary delays in the initiation of birth control. These delays leave patients open to risk of unintended pregnancy. One common pitfall is waiting to start hormonal contraception until the first day of the next cycle, when instead patients could be counselled to start contraception right away and use a backup method for 7 days. In most cases, the risk of hormonal contraception harming a pregnancy is smaller than the risk of waiting until a patient can be proven not pregnant.[6] Waiting to start any method other than intrauterine devices when it cannot be proven a patient is not pregnant is unnecessary. Same-day long-acting reversible contraception (LARC) insertions reduce hurdles for patients, but stocking LARCs for same-day insertion is an ambitious goal for many practices. Comprehensive online toolkits provide suggestions for turning this goal into a reality.[7]

Thorough contraceptive counseling should include a discussion of emergency contraception (EC). Confusion about the legality of EC post Dobbs partially stems from a knowledge deficit about the medication's mechanism of action. Also, NPs are key to dispelling myths around EC. It is important to clarify that EC is not an abortion pill but affirm that medication abortion is an effective resource if ever needed.

Two options for oral EC are available. Most providers are familiar with levonorgestrel 1.5 mg Plan B, which was approved by the US Food and Drug Administration (FDA) in 1999 and is available both over the counter (OTC) and by prescription. Less commonly known is ulipristal acetate, which received FDA approval more than a decade after Plan B and is only available by prescription. The only contraindication to either medication is allergy or known pregnancy. Age restrictions for prescription or purchase of these medications have been abolished nationwide. Given the safety profile, the threshold for prescribing either medication should be very low. Requiring an office visit for established patients as a prerequisite to obtaining an urgently needed prescription presents another unnecessary hurdle. Renewed interest in availability of EC has led to recent reports of pharmacies limiting the quantity of EC an individual can purchase, due to real or anticipated shortages. By anticipating patients' needs, NPs facilitate access and lessen the time for obtaining these medications. They can consider prescribing EC with multiple refills to patients of reproductive age, particularly those using a nonhormonal method as their primary contraception.

All NPs should be cognizant of potential financial hurdles in obtaining EC. Both oral ECs are covered by most health plans.[8] Ulipristal acetate is more effective than Plan B, but its cost for patients without insurance may be prohibitive. Also, NPs should be aware that a patient may pay approximately four times as much for Plan B should they need to purchase it OTC. A prescription for generic levonorgestrel 1.5 mg is the most cost-effective option.

Having a plan for how to respond if a patient expresses a need to access abortion care with attention to preventing stigmatization can help patients feel welcome, valued, and unashamed. It is important to know where the nearest facility for safe abortion care is, how to verify it is not a CPC, and be able to efficiently and privately refer a patient there. Nurse practitioners must carefully consider laws and regulations within their state regarding abortion, and document patient encounters that include mention of pregnancy and abortion in an appropriate manner to ensure safe continuity of care while protecting privacy.[9] They will also need to consider how to respond to a patient who needs to discuss or follow up on a self-managed abortion (SMA), as SMAs are expected to increase post Dobbs. A full discussion of SMAs is beyond the scope of this article, but we encourage NPs to refer to further resources (*Box*).

Some NPs may want to integrate abortion services into primary care to expand access and reduce stigma. Because of legal regulations, the rising threat of violence, and any number of other restrictions, directly providing abortion care may not be safe or feasible for every NP. We encourage NPs who are considering adding abortion care services to their practice to consult with trusted

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peers, mentors, advocacy groups, and legal advisors to determine the best course of action for their particular situation and practice, and to take steps to safeguard their physical and digital security.

Nurse practitioners can express their support of each patient's pregnancy choices, whether that is continuing the pregnancy and pursuing parenting or adoption, or obtaining an abortion. This is essential to patient-centered care that promotes autonomy and respect. A reproductive justice approach that values abortion access, equity, and considers the broader context of family planning, birth, and parenting is critical for NPs and patients. The Dobbs v Jackson Women's Health Organization decision is not an event that any NP can ignore. Clinical practice will need to evolve to recognize its impact. The suggestions here are by no means comprehensive or groundbreaking but are rooted in concepts of reproductive justice and equity that have been pioneered by many others, especially people of color.[10] We hope these suggestions provide a starting point to reconsider your practice and role in the abortion care landscape. ■

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