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Adolescent Health in a Post-Roe World

August 12, 2022

In June 2022, the Supreme Court overturned the landmark Roe v. Wade decision that for almost 50 years provided constitutional protection for legal abortion in the United States. Since the decision was overturned, over half of the states in the country have either banned or severely restricted access to abortion. How does this impact how we take care of our adolescent patients? What are the implications of unplanned pregnancy for the adolescents we care for with chronic health conditions? How might this change access to contraception in the future?

Join this conversation with Kid Expert Dr. Kylie Fowler to learn the impact of the recent change in access to reproductive health care, best practices for prescribing contraception, including emergency contraception, and how we can help our patients safely access the full spectrum of reproductive health care, including access to abortion.

Transcript

Dr. Angela Kade Goepferd: Welcome to Talking Pediatrics. I'm your host, Dr. Angela Kade Goepferd. On June 24th, 2022, the Supreme Court in a five-four ruling overturned the landmark Roe versus Wade decision that until then provided constitutional protections for abortion, which have been in effect for nearly 50 years. This ruling gives individual states the power to set their own abortion laws, a right which had been previously protected during the first two trimesters of pregnancy.

Almost half of the states in the US have already or are expected to outlaw or severely restrict abortion as a result of the Supreme Court decision. This not only changes the landscape for reproductive health in this country, it has a significant impact on the health and wellbeing of adolescents overall. Here to talk to us today about the implications for our care of teenagers in this post real world is Dr. Kylie Fowler, one of our kid experts in pediatric and adolescent gynecology at Children's Minnesota. Kylie, thanks for joining me today.

Dr. Kylie Fowler: My pleasure.

Dr. Angela Kade Goepferd: Let's start off, when you and I first discussed getting on the podcast to talk about this, it's not just reproductive health specifically that is impacted or the ability to get an abortion, but really the implications that this will have for adolescent health and adolescent reproductive health more broadly. When you think about adolescents not having access to safe and legal full spectrum reproductive healthcare, what kind of impacts does that kind of have on teen health overall?

Dr. Kylie Fowler: When you have kind of consistent access to sort of the last option when it comes to potential for getting pregnant, it kind of makes it so that you have to think about it a lot less. There's a lot of implications kind of to adolescent health in general from the kind of basic physiology of pregnancy and what that can do to the health of adolescents who have periods and have the potential to get pregnant.

We treat here a myriad of issues where if a pregnancy were to occur, an unintended pregnancy were to occur, that would really significantly threaten the health of that adolescent or child or young adult kind of wherever they are in the spectrum. When you have kind of a fail stop option, that kind of makes it so it's less in your mind. We do still have access in the state of Minnesota, but it's not great and it's not immediate.

I think what happens for pediatricians and general pediatricians as well as specialists is we're really going to have to start being more forward thinking about this and much more preventative since we don't have access to kind of that fail stop procedure anymore.

I also think that there are some coming implications for restrictions that we might see on adolescent autonomy in general, what we are able to provide for them regarding their sexual health, but that's not all. I mean, we're seeing a lot of legislation surrounding trans health, of course, as well. I think this has implications for where other aspects of healthcare are going to have sort of judicial imposition, so that's really kind of frustrating and a little bit scary.

I think it also, from a mental health standpoint, we have to make sure that a lot of the scariness that the teens are reading about all of this is sort of guided through. There's a lot of implications to them as teenagers and kind of their overall health that we have to sort of pay attention to.

Dr. Angela Kade Goepferd: You mentioned Minnesota, one of the things that was somewhat alarming is that there were these trigger laws in place so that as soon as Roe was overturned, several states had laws that went almost immediately into effect once that ruling became final, that essentially made abortion at any stage completely illegal or really difficult to obtain. What's the current situation here in Minnesota and particularly the surrounding states, because even if abortion is legal in Minnesota, if it's not in Wisconsin, then that has implications for our care?

Dr. Kylie Fowler: Well I don't want to be too pessimistic. Minnesota, prior to the overturning of Roe V. Wade, was sort of a moderate access state. We didn't really consider it to be a high access state. The reason for that was several restrictions that were placed on it.

One of the big restrictions was a 24 hour wait. There's also legislation that minors had to tell not just one parent, but both parents. There was and is still a requirement that any tissue following an abortion must be cremated or buried. There was, and I say was because of some judicial updates in our state, but a requirement that the abortion procedures could only be carried out by physicians, so somebody with a physician level license, so no advanced practice clinicians, among others. A lot of those restrictions had been challenged in a 2019 court case that was ruled on about two weeks ago and a judge overturned a significant amount of them.

In Minnesota, as of right now, the 24 hour wait has been kind of put on pause, kind of waiting to see response from legislation and the state. But for right now, that's not in place, which is really helpful because if you think about someone coming from North or South Dakota, that 24 hour wait significantly increases their time off, the cost of the procedure, all of those things.

It also struck down the regulation that you have to be an MD or DO to provide the procedure. There's going to be a lag in training of advanced practice clinicians, but it's great that that can move forward.

It also struck down the minor parental consent. It opened up quite a bit of access.

The other thing that it struck down, which I appreciate, is we also were one of the states that had a script that had to be read giving medically false information and so that is no longer a requirement in the state.

Where do we go from here? Well, the state has the option to appeal this decision and the current person who would do that is Keith Ellison. He is the Minnesota attorney general. He has come out and said that he's not going to appeal. All of those are struck down as of right now, but that's very tenuous. If we have an attorney general who decides to pursue that, and also there are other entities outside of the state who could kind of appeal that decision higher up. Of course, if it goes to the Supreme Court, again, we might see those restrictions come back.

Dr. Angela Kade Goepferd: I was quite relieved, particularly for our adolescents, to see the dual parent notification go away for adolescents. It's really challenging for a lot of reasons for adolescents to obtain that prior to accessing abortion.

With regard to states that are around Minnesota, we think of patients needing to come to Children's or come to Minneapolis to get specialized healthcare, but not necessarily to get primary care, which I would argue reproductive healthcare and access to abortion is really primary care. What's the situation like in the states surrounding Minnesota, in the Dakotas, in Wisconsin, Iowa? What are we expecting or do you know much about what's happening there now?

Dr. Kylie Fowler: This is something that seems to be changing quite rapidly. As far as we know, as of August 2nd, the most up to date that I have, South Dakota has a complete ban. North Dakota is kind of working on that and their ban has had a hold on it, which has been kind of interesting because they have one clinic that's on the border that has been kind of going back and forth between just moving across the border. Then Wisconsin allowed a previous ban and the age of this ban was before women could even vote, so if that gives you an idea of how old that is, to go into place, but again, it has been legally challenged as well. But for right now that is in place.

Then Iowa's been able to pass additional restrictions that I believe are up to six weeks, so anything past six weeks. We did have a slight Midwest change last night in that a ballot measure in Kansas actually overwhelmingly passed to protect abortion rights that are in the Kansas state constitution. But that doesn't necessarily mean that they won't be kind of the same restrictions that we're talking about.

Dr. Angela Kade Goepferd: It feels like now more than ever, it's really important that those of us who are in primary care are providing healthcare to adolescents, including reproductive care, really understand how to do that well. What would you describe as some best practices for providing adolescent contraception for those of us who are wanting to be more proactive in terms of preventing unplanned or unwanted pregnancy in our patients?

Dr. Kylie Fowler: I do think that we have now all moved into the space where we are all reproductive healthcare providers. There are kind of some basic pearls that I think I would want to get across. One is don't let perfection be the enemy of good. At a baseline rates, if a teenager is having unprotected sex, there's an 85% to 90% chance that they'll be pregnant within a year. For the population at general, we call those [inaudible 00:09:52] rates, which is a weird word, but it just basically means pregnancy rates, that's about 85%. Of course, as you get older, you get less fertile. For an adolescent, it's closer to 90%.

Dr. Angela Kade Goepferd: Wow.

Dr. Kylie Fowler: If you can reduce that in any way, that's a win. Just because they're not all running around with IUDs, that's fine.

The other point is that because of the pandemic and even technological developments that were happening before the pandemic, we now have a lot of really good evidence that providing contraception by telehealth is safe and acceptable to patients, so that's really great. There's an excellent actually algorithm and that JAMA published in JAMA Pediatrics. It is like, do you need contraception? Do you have these conditions? It's just, if yes, then, if no, and it just takes you down to what you can provide by sending a script somewhere.

The tools exist. We don't have to reinvent anything. Use of that algorithm has actually been shown to help providers more closely adhere to safety guidelines and prescribing than without it in an in-person visit. Not only can we do it well, but we can do it safely and maybe even better.

I do acknowledge that there has been a big push for LARC, a long acting reversible contraception in this patient population, which that would be IUDs and implants, which of course, need to have in clinic visits. While I do love LARC, a lot of adolescents are not ready for it and we don't have to necessarily limit ourselves just because we can't provide those things. I think it's important to know about them so you can tell patients about them, but if you don't personally put in [inaudible 00:11:46] on or IUDs, then you have all of these other options just as a bridge to getting them to an appointment where they might get something that they like a little bit better.

I would also say just to not have a fear around it. I'm super awkward with adolescents all the time. I talk about sex with them all the time so I'm sometimes surprised at the silly words that come out of my mouth. They don't really care. I mean, they laugh at you and then it's lighthearted and then you just kind of move on. But just letting them know that talking about sex is a thing that we do and even sometimes it's awkward and it's totally fine, so kind of not to have a fear around these conversations.

Dr. Angela Kade Goepferd: I wonder for folks who are thinking telehealth, that might be a good option to do a visit for contraception, what are some of the things that we need to consider there? Typically when I prescribe in the office, I'm thinking about getting a pregnancy test, for example, and then how do you manage that via telehealth? I worry sometimes about the confidentiality of a telehealth visit and doing that with adolescents. Could you talk about some of those things that we might see as barriers that we can get through to be able to prescribe via telehealth for contraception?

Dr. Kylie Fowler: I still find sometimes ensuring confidentiality via telehealth to be an intimidating aspect of things. Sometimes you can't do it and that's when you might need to bring them in for a clinic visit and sort of make up an excuse for bringing them in. But for the most part, what I will do is similar to what I do in the clinic, which is ask if I can talk to the adolescent alone if the parent or guardian is present, a lot of times they just show up on their own, which is kind of cool. I think they actually show up on their own a little bit more with telehealth than in person, and in which case I ask them who is within listening range and they might say my little brother and I will say, "Can you move to a place where no one can hear you and I can ask you some personal questions?" Or I will just ask, "Are you in a place that I can ask you some personal questions," and see what they say.

We don't have a lot of control about whether or not we can get them in a private place when they are at home or wherever they are on the video. Again, we have to be kind of careful about those things and provide things safely. Those are some ways that you can at least try.

As far as the pregnancy test goes, there is an app for that actually. The USSPR, which is United States Specific Practice Recommendations, which is part of the published algorithm, has some basic questions that you can be their standard, which is what they call reasonably sure that a person is not pregnant. It has to do with the date of last sexual activity, what their use of contraception was with that. We have had a lot of conversations in gynecology about how we use reports of consistent condom use. I'll say, "I don't want to start this if there's any chance you can be pregnant. Please tell me if a condom is broken or whatever," and they're pretty upfront about that, so last sex, their last period, any barrier contraceptive use.

Then the other thing is you sort of have to hedge your risks a little bit. We know that birth control pills don't really harm an ongoing pregnancy. We know that because lots of people miss a pill and then get pregnant and then take them for six more weeks before they figure it out. It's sort of a risk benefit thing. If you're on a telehealth visit, the only things you can start are a combined pill, patch or ring, which are probably not going to have significant effects on an ongoing pregnancy.

You can also choose subcutaneous Depoprovera. You can get that in an at home kit, which takes a little bit of insurance finagling. The things that we can provide to them at home have not been shown to interrupt or cause damage to an ongoing pregnancy. I kind of think about that a little bit too. I really want to try to make sure I go through all the questions to be reasonably sure that they're not pregnant, but these things are not going to do a lot of harm.

If I'm concerned about it and I'm like, "You're on the fence and I'm a little nervous about this. I want you to take a home pregnancy test next week and call me." These are some of the things that I've done to get around this.

Again, you're trying to keep the teenager safe. In the majority of the situations, it's really not likely that they're going to be pregnant. The time I absolutely can't do that is if they're in clinic with me and I need to place an IUD because you can't put something in a uterus with a pregnancy. Again, if it's going to interrupt or damage a pregnancy, then that's a little bit different risk than some of these other things that we can use via telehealth.

Dr. Angela Kade Goepferd: Let's talk a little bit about emergency contraception. There's a few things that I'd love to know. One, what are the current rules for adolescents to be able to access emergency contraception with or without a prescription and in what circumstances? Then when do you use it in your practice? I know I have some times where I'm more likely to give a prescription or recommend emergency contraception for an adolescent over others, but I'd love to hear kind of how you interact with that as an option for adolescents.

Dr. Kylie Fowler: I'm going to take just a little step back because one of the things that came up when Roe fell was kind of a group of gynecologists that are very public facing who have written books and have websites and have a social media presence established website called Three For Freedom, basically three ways that we want to protect from hopefully even needing to access abortion. One, we kind of talked about, which is making sure that people have a primary contraceptive method. Then the second one is that they have knowledge of, if not a provision of, emergency contraception. That's a kind of a big part of it. Then the third part of it is accessing abortion medication. But the emergency contraceptive piece is a big piece of this.

Emergency contraception isn't without a bit of controversy, just because the types of pills that are available aren't as effective for different patient populations and things like that. One of the main differences just to know to establish that baseline is emergency contraception is contraception that is to be used after intercourse has taken place. There are three basic options that we have. One is IUDs, which of course, we can't provide that via telehealth or in a lot of pediatric clinic settings. Then the other two options that we have are, again, [inaudible 00:18:40], but a whopping oral dose of it. That's known as plan B. Then the other medication is Ulipristal acetate, which is known as Ella. Plan B is available over the counter and is available. It used to be restricted to age 17 and up, but that is no longer the case. It's pretty ubiquitous. You can get it at Costco, you can get it on Amazon. You can get it at Walmart. I mean, it's in a lot of different places.

The access is great. The efficacy of all of these is it's the least effective so that's kind of the bummer aspect of that. Specifically it's less effective if you weigh more than 160 pounds and that's not very many pounds. One of the things, again, kind of going back to not letting perfection be the enemy of good. It's not not effective. Even patients that are above 160 pounds have fewer pregnancies after unprotected intercourse if they take this, then those who don't. If that's all you have access to, do it. The Ulipristal acetate is both more effective in general, but also has some weight limits. It seems to be a little bit less effective above 200 pounds. It's better on a few different fronts. Even in patients who are not above the weight limit, it still is more effective than plan B.

But the problem with it is that it is prescription only. There's been several studies that show that most pharmacies don't carry it. They can get it in for you within 24 to 48 hours. You can take any of these up to five days after unprotected intercourse, but they all are more effective the faster that you take them.

The way that I've done that is a couple of things, is one, if someone really needs it, emergency contraception, but they don't want an IUD, I just know that Children's pharmacies carry it. I say, "You have to go to this pharmacy. I apologize. I can't send it to your pharmacy today because they won't have it. You need to go to the St. Paul or the Minneapolis pharmacy. I just know that our pharmacies carry it."

The other thing is when you're providing kind of a primary contraceptive method but maybe it's one that is more prone to failure, is saying, "This is a great option for emergency contraception, but I want you to fill the prescription when you can." They have to call their pharmacy, say they want the prescription filled and they'll get it to them within a couple of days.

If you're not doing an IUD, I do think Ella would be the more preferred method, but again, they're all effective. It's just kind of tier of effectiveness. The nice thing about plan B or all the other names, the generic names that they have for it, is that it's just super available all over.

Who to give it to? I give it to everyone. I'm also a little bit liberal with it. These are pretty safe medications. I had a patient the other day who I was like, "I think you should have this." She's like, "I don't think I need this." I was like, "Well, your insurance covers it and you're headed to college. You're in a sorority. Keep it on hand. Somebody might need it." Do I encourage sharing medication? Not really, but also in this instance, maybe a little. We're just kind of in a different environment now.

Dr. Angela Kade Goepferd: There's a lot of misconceptions out there about what to do if you miss one of your birth control pills and how effective is it going to be then if you miss one or don't miss one. I think educating our patients about the medications that we're prescribing them, how they work, when you would need to use emergency contraception, when you can consider their primary contraceptive method a failure if they've missed a dose and for how long so that they can make really good informed decisions about how to take care of their bodies, because many of them don't have any idea about what the rules are.

Dr. Kylie Fowler: We are doing a lot of things as physicians, but when we can educate patients about their bodies, that's really helpful. Sometimes it's just really simple things like when I'm talking about every time you get your period once a month, that means you released an egg a couple weeks earlier. Sometimes they look at me like I'm nuts. But when you think about advertising, you have to hear a message three or four times before it sticks. If I just say that and then breeze right on, I'm not really that concerned about it because if we're all kind of saying the same things, then hopefully some of this starts to stick.

I think people think they need to start drawing everything out. But if we just drop little kind of nuggets of information here and there, even things like the HPV vaccine is safe, even if they aren't getting it that day. All of that I think kind of builds up over time and is a way to kind of both be teaching and also not use up your entire visit. We can't be perfect all the time.

Really, kind of if anybody is using a systemic hormonal contraceptive like a traditional birth control pill and they have to use plan B or the levonorgestrel oral dose or the Ulipristal acetate, they need to use a backup method for two weeks. It throws things off as far as sort of where you are in your cycle. The Ulipristal acetate with progesterone antagonist so it might decrease the efficacy of your birth control when you start it back.

Then the levonorgestrel dose kind of spikes your progesterone and then drops it and you might actually ovulate because of that. You need to be using a secondary method and back on your regular birth control for a couple of weeks before you can kind of stop using that second method.

Dr. Angela Kade Goepferd: You mentioned medical abortions are using pills for abortion. I wanted to talk about that a little bit. The things I want to know is who can do that so who can prescribe that type of medication? Is that something a pediatrician or a primary care provider can do, or do you need to have something special to be able to do that? Then if we have an adolescent for who we think that might be a good option, what should we know about that or what information should we be giving them about that?

Dr. Kylie Fowler: I wish that medication abortion was a little bit more accessible, but the main medication that is part of that is highly regulated. Medication abortion consists of two medications. The first is a medication called Mifepristone, also a progesterone antagonist, but works in a little bit different way. Then the second medication is Misoprostol, which causes uterine contractions. That's the combination of medications that are prescribed in that.

You can use them up to 10 weeks of pregnancy. There is some safety data at more advanced gestational ages, but in the US it hasn't been cleared past 10 weeks. Right now, if you are to prescribe Mifepristone, you have to go through FDA regulatory certification and registration, and then it can only be dispensed by a pharmacist or pharmacy that has also gone through that or a clinic that has gone through that. You could dispense the medications in clinic or with a specialty pharmacy.

I honestly thought about doing this a couple years ago, and then didn't move too much on that as part of Children's because I didn't think that it was necessary. That's something that maybe we might look into at some point. But as of right now, there haven't really been any clinics or pharmacies that have been willing to take that on outside of specific abortion providers. There are a number.

In clinic, you can get medication abortion at any abortion provider and they'd usually dispense the medications in the clinic. That's how Planned Parenthood does it. There are also several telehealth clinics that have been set up just for this, four of which are operational in Minnesota. These names have kind of floated around the internet quite a bit, but Aid Access is one of them. Abortion Delivered is another one. Just The Pill is another one. I believe the fourth one is called The Pill Delivered. These are clinics that have been set up just for this and this is all they do.

Unfortunately, the way a lot of these medications and abortion have been regulated is that there's so much red tape that it's harder for other entities to take it on, especially if that's not the only thing that they're doing. The medication is mailed to patients currently, although there's a lot of even introduced legislation to put some kind of curtails on that. I'm not sure how long this will last. But as of kind of 2020 and beyond, over half of abortions are provided by medication in the country now.

To put this into perspective a little bit, as far as timing goes, we had a 14 year old a couple weeks ago who tested positive for pregnancy in our office. When we called a few different local clinics, they could only get us in four and a half weeks. That's the current wait time for an in person appointment in Minnesota right now.

The telehealth providers could get her in within three days and then she got medication two days after that. It is dramatically increasing access, which is good. You can also get those pills prescribed before you have a pregnancy, which might be something that would be an option if we have a patient who's going to college in a state where things are really restricted. I say that because I think it's a good option. I also want to be wary of people using up the resources before they need them so kind of be judicious about who needs to have that, but that's kind of the third piece of that sort of three for freedom is that it's very safe to have medication abortion even by telehealth and that's probably the best access that we have right now.

Dr. Angela Kade Goepferd: If we were going to be referring a patient for a medication abortion, what sorts of things should we be telling them to kind of expect or prepare for or what that might be like just so we can help them in advance?

Dr. Kylie Fowler: They're going to ask a fair number of personal questions, especially with the telehealth, because they have to be reasonably sure that you are within the 10 week mark, so when your date of last sex was when your last period was missed, what your periods are like at baseline.

I was an abortion provider at Planned Parenthood during my fellowship. I remember our handout had this little guy that was an animated lemon, I guess not animated, but a cartoon lemon. It said, "You might pass a clot as large as a lemon." The bleeding is quite significant and you can pass a clot as large as a lemon. That's kind of one of the things that I say, but also that they will give you bleeding precautions for when to contact your doctor. They will give you precautions about kind of fevers and all of those types of things for which you might need to seek care. But underlying all of this is 97% of them are successful without needing to access any further care. The vast majority of the time, things are fine.

The other thing that I tell them, just so that they don't feel too weird about it, is that if you do need to access care, no expert even in women's health, no gynecologist can tell whether you're having a miscarriage because you're having a miscarriage or whether you're having a medication abortion. If you don't feel like dis disclosing it, you can say, "I'm having miscarriage." If people are worried about disclosure or where they would access care afterwards, then you can just reassure them that nobody has to know.

Dr. Angela Kade Goepferd: Just want to thank you for coming here today. I think it is really important. Prior to June, we really existed in a world where we assumed that all of our patients would have access to full spectrum reproductive healthcare and now we're in a world where that may not be the case. I think just reviewing good guidelines for contraception and how to have these conversations with adolescents, how to help them access emergency care when they need it and including medication abortion is really important. Thanks for joining me today. Thanks for all the work you do with kids and teenagers. We really appreciate it.

Dr. Kylie Fowler: Happy to be here.

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