Emily Kumler: I'm Emily Kumler and this is Empowered Health. Before we get started this week: we're about six months into this project and we've realized that we're not completely comfortable taking money from sponsors. This is the work of journalism and the integrity of the podcast is really important to us. But we are taking Patreon donations which you can make through our website[1]. This is sort of a shout out to say if you've been enjoying the podcast, if you are a regular listener, if you want to support our pursuit of getting really good information on women's health out to a wide audience, we would really appreciate your financial support through Patreon so we can ensure that we can keep continuing the content and the level of care that we're providing and the time that it's taking us to do this ongoing because we have hundreds of more topics listed already that we want to cover and I think you know, just as you might subscribe to a magazine or something else, we would really appreciate your support. There are really three ways you can support us. When you listen to an episode, if you enjoy it, please send it to your friends. You can send them a link, you can tell them to sign up for the newsletter. If you go to empoweredhealthshow.com[2] you'll find links to all of our social, which you can follow us on. Just so you have it, our Instagram is at @empoweredhealthpod[3], just pod at the end. Twitter is @empoweredpod[4], and if you follow us, that's great. It's also a great way to share it with other people and subscribe to the newsletter because what we're doing with all these sponsors that want to advertise, instead we're saying that we'd like to get free products and discounts for all of our listeners. So what we'll do is anybody who subscribes to the newsletter, will also get emails from us. We're not going to share your emails with them, but from us, that basically say, hey, here's a code for a discount, or here's a code for a free product. And the products are all really good and they are things that Jill and I are testing and that we like. So we're being really, really picky about any kind of financial incentives that we're getting to pass them on to you. And in exchange, we're asking you all for your support for this project. Thanks so much.

Emily Kumler: Abortion[5] is one of these issues that people feel strongly about no matter what side they're on. And we've seen recently how in the last year, as more states are trying to ban abortion[6] at certain term limits, and we also saw how Texas was able to push forward a law that required admitting

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[1] https://empoweredhealthshow.com/insider/
[2] https://empoweredhealthshow.com/
[3] https://www.instagram.com/empoweredhealthpod/
[4] https://twitter.com/EmpoweredPod
[5] https://www.guttmacher.org/fact-sheet/induced-abortion-united-states
[6] As of June 2019, 26 states have placed some sort of ban on abortion. https://www.guttmacher.org/article/2019/03/surge-bans-abortion-early-six-weeks-most-people-know-they-are-pregnant?gclid=EAIaIQobChMI1bWDw_-M5QIVGm6GCh0T0AIlEAAYASAAEgIkKPD_BwE

privileges[7] for anybody who performed an abortion. And this is a big deal because not only is it expensive to have admitting privileges, but basically everybody agrees that when you perform an abortion, it's a relatively safe procedure and you don't send people to the hospitals so you don't need to pay to be a part of that hospital. That law ended up resulting in two thirds of all abortion clinics in Texas closing[8]. Louisiana had a similar law. When the Texas law went to the appeals court, it was knocked down, saying that it was causing an undue burden to women in terms of limiting their access to abortion care. That was actually something that Sandra Day O'Connor[9], when she was on the bench, touted as like that was the sort of test for whether an abortion law would be legal or not was if it caused an undue burden to women. That language itself is like pretty loose. But people kind of knew that what she meant was that if you didn't have access to an abortion because there weren't any abortion facilities near you, that was too much of a burden on women. She's obviously not on the high court anymore and the high court is now made up of new and different people and so things like this Texas law, which was struck down by the appeals court has now popped up in Louisiana. Rumors are that the Supreme Court is likely to take this case on[10], which we'll probably hear about in the next week or so. So, we wanted to do an episode on abortion, but we did not want to get into the sort of, I mean I think it's an emotional issue, so there's no way to not make it emotional, but I think we really wanted to just sort of look at what is the effect on women, what is the effect on society, when abortions are limited. And so we looked at a lot of different research. We tried to find something that we felt like was really fair and well done and we came across a study that's called the Turnaway Study[11], that's a longitudinal study, that looked at 30 different abortion facilities across the country and took into consideration women who showed up wanting an abortion and were turned away versus women who showed up and wanted an abortion and got it. And they followed those women. And so, they actually have some conclusive information about the impact of being denied an abortion, which we are going to see happen more and more in the United States.

Diana G-F: So my name is Diana Greene Foster[12] and I'm a demographer at the University of California, San Francisco in the Bixby Center

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7 https://reproductiverights.org/press-room/Texas-Abortion-Providers-Admitting-Privileges-Reinstated-in-Lawsuit-Settlement

8 https://www.texastribune.org/2016/06/28/texas-abortion-clinics-have-closed-hb2-passed-2013/

9 https://www.newyorker.com/news/news-desk/how-the-supreme-court-justice-sandra-day-oconnor-helped-preserve-abortion-rights

10 https://www.texasobserver.org/abortion-laws-2019-amy-hagstrom-miller/

11 https://www.ansirh.org/research/turnaway-study

12 https://bixbycenter.ucsf.edu/diana-greene-foster-phd

for Global Reproductive Health.[13] I have a couple of decades worth of research studying women's access to contraception and attitudes about contraception and reasons why people become pregnant when they don't want to become pregnant. Fifteen years ago or so, I started a new study of what are the consequences for women when they want an abortion and can get the abortion or they want an abortion and they can't get the abortion. I have a PhD in demography from Princeton, but most of my background is studying contraceptive use, unprotected intercourse, and access to abortion.

Emily Kumler: I feel like a good place to start is will you just explain to us what a demographer is?

Diana G-F: A demographer is a kind of statistician that studies fertility and mortality and migration, which maybe sounds boring, but in fact it's everything interesting having to do with human life because there's nothing that can't be included in those three. It's employment, it's marriage, it's sex, it's pregnancy, it's having kids.

Emily Kumler: And I think since we're going to be concentrating mostly on the work that you've done around abortion, it's also important to sort of talk a little bit about the difference between advocacy or advocate work and what you do.

Diana G-F: Yeah, so my goal is to bring evidence to a topic that is so full of blind belief in whatever one's side is, without questioning any of the evidence. My goal is to bring real evidence to the question of what is the impact of abortion on women's lives and on children's lives.

Emily Kumler: And so you have this longitudinal study[14] that was over five years. Is it completed now or is it still ongoing?

Diana G-F: It is completed. We recruited women from 30 abortion facilities across the United States between the years 2008 through 2010. So three years of just gathering women into the study and then five years for each woman to try and follow up with them every six months to ask them about their health and their economic well-being and their households. So the data collection was done in early 2016. It's now 2019 and we're still publishing papers because it takes a really long time to get through that much data.

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[13] https://bixbycenter.ucsf.edu/

[14] https://annals.org/aim/fullarticle/2735753/health-women-who-did-did-terminate-pregnancy-after-seeking-abortion

Emily Kumler: And to publish, right?

Diana G-F: Yeah. So we have almost 50 academic papers that are out about the Turnaway Study[15].

Emily Kumler: That's fantastic. I always like to ask researchers in the course of the work that you were doing, what was the thing that sort of stuck out to you as the most, you know, and it doesn't have to be something that was like the most statistically significant, but something that you were surprised by or something that you felt like was a really strong result that was maybe less known than it should be.

Diana G-F: Yeah, so separate the strongest from the most surprising? The strongest result is that at the very beginning we asked women why they wanted to end this pregnancy[16]. You know, abortion is not easy to get. It's often expensive. You have to drive a long way. You have to get through protesters, you are possibly stigmatized by your family, maybe by yourself. You know, why would a woman want to have an abortion? Women gave us a whole bunch of reasons and we wrote a paper trying to describe the reasons that women give for wanting an abortion. What was the strongest result was how much the consequences for women who are unable to get their abortion matched the reasons women gave for wanting to have one. The most common reason women give for wanting to have an abortion is that they don't feel that they can support, can provide for a child or for, in many cases, another child. We find very large economic differences between the women who receive and who are denied an abortion. About 60% of women having abortions are already moms. [17]Often their reason for wanting to have an abortion is to take care of the children they already have. When we followed women over time, we see that their existing children, you can measure the difference in their well-being, whether their mom received an abortion or were denied. And there are various other examples. Women who say that their relationship with the man involved isn't strong enough and we see over time that those relationships dissolve whether or not they have a child.

Emily Kumler: Just to pick up on that point about the effect that it has on the other children in the family?

Diana G-F: Yeah.

Emily Kumler: It seemed like your results were saying that it not only affected the child who was born, even though the woman attempted or wanted

[15] https://www.ansirh.org/research/global-turnaway-study
[16] https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-13-29
[17] https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext

to have an abortion, but was turned away, in terms of developmental milestones, but also it sounds like the family, was more likely to be below the poverty line, so it has an economic impact on the family unit also?

Diana G-F: Yeah. The largest results have to do with economic well-being [18]and that's because it's really hard to work full time when you're eight nine months pregnant or have a newborn. Employment goes down and although public assistance goes up, it's not enough to keep the family from going into poverty. We don't have a system that's generous enough or that's even humane enough to just provide for basic living needs for women and children. There are other countries that do support women around the time of child bearing and the United States is definitely not one of them.

Emily Kumler: I mean, I feel like this is an important point to make for a number of reasons, but I think it's definitely interesting to think about the idea that a lot of the women who are below the poverty line are probably working at like a minimum wage type job so they don't get any paid time off, right? And they are on a fixed income. So like they're not going to move up the corporate ladder in some way whereby they're going to start making more money as they, you know, have more kids, right? So like if you have two mouths to feed and then you have three mouths to feed, like you're trying to do that on the same amount of money.

Diana G-F: Yep.

Emily Kumler: And I think one of the big things that people talk about in our current sort of political climate is this idea of if the laws are changed or states start imposing these bans on abortion, how it's really disproportionately affecting the poorer, younger women.

Diana G-F: So you're right, we have a situation where abortion is increasingly concentrated among low income women and it's partly that wealthier women, it's not that wealthier women decide necessarily to carry pregnancies to term, but they're less likely to become pregnant. And when they have an unwanted pregnancy, wealthier women are actually more likely to have an abortion. But getting an abortion is not easy and we have laws like the Hyde Amendment[19]. Even if you have your health insurance through a federal program because you are on welfare or Medicaid, you're an employee of the federal government or you are in the armed forces, your abortion won't be covered as part of your health care. Whereas if you had private insurance, in most states, it would be covered. Who does that hurt? It disproportionately

[18] https://www.ncbi.nlm.nih.gov/pubmed/29345993
[19] https://www.plannedparenthoodaction.org/issues/abortion/hyde-amendment

hurts low income women. And so we have a situation where among women seeking abortion in the United States, half are below the federal poverty line.[20] And at the time of entering our study, three quarters of women said they don't have enough money to pay for food, housing, transportation, and food. So it's not like they can afford another $500 to pay for an abortion or more for a later abortion. We just published a study on the five year physical health trajectory. So, what happens to women's physical health when they receive an abortion versus are denied an abortion? I think many of your listeners will be very surprised to know that in terms of just the safety of childbirth versus abortion, there is no question that having an abortion is safer than carrying a pregnancy to term and delivering it[21]. In fact, your odds of dying are about 14 times higher if you deliver a pregnancy than you abort a pregnancy. And that's because pregnancy is associated with all sorts of physical health risks. So there's eclampsia[22] and hypertension and diabetes and a slew of risks of chronic conditions that are made worse by pregnancy. So by being pregnant for less time, you're exposed to less risk. And then just the physical experience of childbirth is a much greater risk activity than having an abortion, especially an early abortion. And so that was known before this study. Before the Turnaway Study, we confirmed that women were more likely to have a life threatening complication from birth than from abortion. And we just published whether those health differences actually persist[23]. And so my colleague Lauren Ralph, who's an assistant professor with me at University of California San Francisco, published a paper[24] in the Annals of Internal Medicine showing the five year trajectory of women's health by whether they were just over the gestational limit and were denied an abortion or just under the gestational limit and received an abortion and found that at five years women who gave birth were more likely to report poor or fair health compared to women who received an abortion. It's not just the end of the pregnancy, it's the next five years of living a life that's a little bit harder probably, you know, taking care of kids and dealing with any complications that came from the pregnancy and birth.

Emily Kumler: And that was comparing those two cohorts that are within your research. But did you also compare that to the cohort of the general population?

Diana G-F: We didn't in this study.

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[20] https://www.ncbi.nlm.nih.gov/pubmed/29345993
[21] https://www.ncbi.nlm.nih.gov/pubmed/22270271
[22] https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745
[23] https://www.ncbi.nlm.nih.gov/pubmed/26576470
[24] https://annals.org/aim/article-abstract/2735869/self-reported-physical-health-women-who-did-did-terminate-pregnancy

Emily Kumler: Do those groups look similar? I mean, have you ever sort of compared the population of people who delivered the babies and like sort of their five year feeling or physicality or health or however you're measuring that to something similar. I mean, I'm just, I would assume that they are similar but I don't know.

Diana G-F: I don't have the data on the top of my head. I don't have the data here so I don't, I can't really answer it. We did look at how many women died after delivery. So died from maternal health reasons. Their cause of death was directly linked to having just given birth. And we actually had two women out of about 200 who died after childbirth[25], which is compared to the U.S. Rate of maternal mortality is many times higher. So there is, it may just be a fluke. This is my most surprising finding. You know, it may be a fluke that we just happened to have a sample of women with just absolutely terrible luck. But there also maybe something about, you know, having to carry a pregnancy all the way to term and deliver when you didn't want to have a birth that is associated with greater risk.

Emily Kumler: What I think would be fascinating would be to compare that, I don't know what the racial makeup is of your subjects, but I think it's like 18 per 100,000 deaths for African American women in the United States in terms of maternal mortality.[26] The lower you are on the socioeconomic ladder, and certainly race, seems to play a big part in maternal mortality rates in general. And it would be really interesting to see if that was comparable to what you guys found, but also compare it like if it was more. I think one of the things that's not as well understood is the sort of psychology behind some of this stuff, right? Like pregnancy is hard even if you really want to have a baby. You know, the idea of basically showing up, wanting to have an abortion and being told like, sorry you missed the cutoff and then having to sort of regroup. I mean, one of the other findings I want to talk to you about is the idea of happiness, which you've published on[27] and how, you know, it seems like over time women sort of come out the same in terms of their happiness. I think happiness is obviously very hard to study, right? But I also think it's interesting because you've said that in your work you have found that it is certainly an economic hardship to have an additional child, especially one that wasn't, you know, we could say wasn't wanted. It's also a burden on the other kids in the family in terms of, you know, sort of their developmental milestones. But, as a mother, I can definitely say anecdotally, even if I didn't want to have my kids, it would be very hard after

[25] https://www.ncbi.nlm.nih.gov/pubmed/26576470

[26] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

[27] https://www.ncbi.nlm.nih.gov/pubmed/27973641

they were born to say they're the cause of my unhappiness, right? And so like how do you sort of tease that apart?

Diana G-F: Yeah. So when we started the Turnaway Study, really the question that was most common in the narrative around abortion was does abortion hurt women? We wanted to know the answer to that question and we didn't measure happiness per se. What we measured were all the pathologies of unhappiness. So depression, anxiety, loss of self esteem. We looked at the differences between women who were otherwise similar, but one group got the abortion they wanted and the other one didn't. And what we found was no evidence that abortion hurts women in terms of a mental health harm[28]. There was a short term harm from being denied an abortion. And we saw that the women who were denied an abortion had an immediate hit to their anxiety levels. So, they were much more anxious than women who received an abortion and they had lower self esteem and lower life satisfaction. But over the course of the five years, the two groups converge. So there isn't mental health harm from receiving an abortion, but there's also not long-term mental health harm from being denied an abortion. The issue around having a baby that you weren't ready to have and didn't feel like you could provide for is not so much a story of mental health but of physical health and economic well-being, achievement of life goals, and ability to have wanted kids later. So, I think that abortion hurts women has been thoroughly refuted, but there are lots of ways in which being denied an abortion might actually hurt women and families.

Emily Kumler: Are most of the abortion clinics that you were doing this project with still open?

Diana G-F: Wow, that's a good question. I don't know.

Emily Kumler: Because there were some in Texas, right? And I feel like a lot of those have closed.

Diana G-F: Yeah, definitely one of them in Texas closed. They're definitely not all still open, but I think most of them probably are.

Emily Kumler: And so then I think one of the other things I wanted to make sure we talked a little bit about was the idea of viewing an ultrasound, which is, you know, law in some places, right? That women have to sort of look at the ultrasound as a method of trying to deter them from having an abortion. Can you talk a little bit about that?

Diana G-F: Yeah, so we were doing this study that was intended to look at long-term consequences for mental health and physical health and we

[28] https://www.ncbi.nlm.nih.gov/pubmed/27973641

were wondering and also decision certainty. So the one thing I didn't mention that seems really important from the study is the finding that the vast majority of women who have abortions say that they are glad that they had the abortion, that it was the right decision for them. Over 95% at every point said that it was the right decision for them.[29] But, we were interested in women's decision making and whether things that they experienced at the clinics affected how certain they were, affected their emotions about having had an abortion. You know, these ultrasound viewing laws, I think they presume that women don't realize what they're doing, and that they don't realize that growing inside of them is an embryo turning into a fetus that will eventually be born into a baby if they don't do something about it. Sixty percent of the women having abortions are already mothers. They know very well what's going on inside, but these ultrasound viewing laws, the hope was that if women saw the image they would bond with the baby and decide not to have an abortion. I think that's the motivation behind them. And so we looked at whether viewing the ultrasound image had any effect on how women felt. About 20% of the women in the study were actually in states, I'll have to check that number, were in states where they were required by law to be offered a view of the ultrasound. Many more were in clinics where it was just the practice of the clinic to offer a view. It turns out that about half the women were offered a view. About two thirds of them chose to view the image[30] and who chooses to view are disproportionately women who haven't been pregnant before, which makes sense because they're actually curious about, you know, what it's like to be pregnant and what does it look like? Whereas the women who've had babies before know well what the pregnancy looks like as it goes on. And then we studied whether viewing or not viewing changed how they felt about the abortion and we found absolutely no effect[31]. So women who viewed or didn't view felt the same way about their decision to have an abortion later.

Emily Kumler: And so that sort of, that idea is nullified. I mean like it doesn't seem to have any impact at all on a woman's decision to go forward or not.

Diana G-F: This wouldn't be the right study to assess that because it could be that there were women who viewed and decided not to go through with it, but we only had women who decided to have an abortion. Some of them were denied and some of them received.

Emily Kumler: Oh, I see. Okay.

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[29] https://www.contraceptionjournal.org/article/S0010-7824(16)30410-3/fulltext
[30] https://www.ncbi.nlm.nih.gov/pubmed/24028750
[31] https://www.ncbi.nlm.nih.gov/pubmed/24463667

Diana G-F: I am an author on a separate paper[32] that looked at whether being offered a view and viewing affected people's decision to have the abortion. And it found a very small fraction of women viewed and decided not to go through with the abortion, but they were entirely among the sample who weren't sure they wanted to have the abortion to begin with. So it may be that women who are not sure whether they want to have an abortion decide to view as part of their decision making. So it's a little hard to say that it was the view that changed their mind. It may be that they were undecided that they chose to view.

Emily Kumler: Just to go back for a second to the sort of the five year mental health question or checkup, because I think this is really interesting, the idea that being denied an abortion, which we're probably going to see a lot more of in the coming years, has an impact on the family unit, has an impact on the socioeconomic well-being of the family or health of the family, but may not have a direct impact on the mom's mental health. Again, like this feels hard for me, because I sort of feel like if they're economically having a harder time and the other kids are having a harder time, I mean maybe they don't know what the information that you know that the other moms are not having as hard of a time, right?

Diana G-F: Yeah.

Emily Kumler: How do you explain that? Because I think a lot of times when people, I guess, you know, the idea is that like the more you are in poverty, the harder life is, right? And that the hopes and dreams that maybe you had as a younger, ambitious or interested person, that idea of like those life goals not being achieved because now you're, you know, sort of saddled with kids and like the work that you have and all that stuff that doesn't feel like a prescription for anti-anxiety. That's a really interesting finding and I think people could potentially take that and make all kinds of associations with it, which I don't really want us to do because I feel like that's not so helpful. But just sort of telling me a little bit about like, you know, what do you make of that?

Diana G-F: I think that we all make the best of the life that we have and we are. We don't realize that if we had just, you know, married a different person or conceived a baby at a different time or whatever, that we bought a different lottery ticket that we would somehow be much better off or worse off. We just don't know these things. We move through life trying to make the best. There are things that happen to people in their lives that are very strong predictors of feeling terrible, of being depressed, of having major psychological problems, and those are things like childhood abuse, sexual abuse. They're not

[32] https://www.ncbi.nlm.nih.gov/pubmed/24463667

things like just being poor. You know that people make the best of their lives and are resilient to lots of hardship. Yes, there are kinds of hardship that are very difficult to transcend and yet some people still do transcend very difficult childhoods and abuse in terms of psychology later. Those are bigger events than deciding to have an abortion, having an unwanted pregnancy, getting the abortion, not getting the abortion, struggling. Those are not nearly such strong predictors of mental health as other more traumatic events.

Emily Kumler: The other thing I thought was really fascinating was that one third of the subjects in the Turnaway Study said that they wanted the abortion or they were seeking the abortion at least in part because of something to do with the man involved. We can, you know, sort of assume that maybe that's like an abusive relationship or the man is encouraging them to have the abortion because he doesn't want to be a father yet. But I think that's also really important because I think so often this issue is put on women as though it's like this is a women's issue, right? Or this is like, women have all the control over this and that's a big number. Were you surprised by that?

Diana G-F: I'm not surprised and people are, women are trying to decide whether they want to have a baby and you know, whether the man involved is a man who would be a good father and is excited about having a baby. It just has to be a big part of it, a big part of their decision making. A third of women say relationship issues were part of why they wanted to have an abortion[33]. So a third said that it was a poor relationship or a new relationship and they didn't think the relationship was strong enough to support a child. About a quarter said that the partner wouldn't support the woman having a baby. So the partner was unable or unwilling to help them raise a child. And a very small minority said that the partner was explicitly abusive as their reason. So 8% of the women said yes, that they were seeking an abortion because the partner was actually abusive so that they had been hit, harassed, raped by the men involved in the pregnancy.

Emily Kumler: If you were to look at the data of the women who were turned away, when you go back to their original interview questionnaire data, is there anything that sort of is an indicator that they're going to have more trouble later or that this isn't going to be a positive outcome? You know what I mean? Like that they're not going to be able to turn it around or that they are and they'll figure, you know, that then they have to get out of the relationship and they have to figure out how to do all those things.

Diana G-F: I mean, we definitely thought that one area in which the outcomes of the two groups of women, those receiving an abortion and those

[33] https://www.ansirh.org/content/role-intimate-partners-womens-reasons-seeking-abortion

denied, would diverge would be in whether they stayed with a man involved in the pregnancy[34]. Because we've all seen all the romantic comedy movies where the surprise pregnancy brings two otherwise incompatible people together. But, real life doesn't work like that. In fact, the women said their relationships weren't strong enough to have a baby and we found that the relationships dissolved whether or not the woman carried the pregnancy to term. So whether or not she got the abortion, over time, eventually she was equally less to be with the man involved in the pregnancy. So the pregnancy carried to term doesn't necessarily make the couples stay together. It does, on the other hand, result in the man involved in the pregnancy staying in the picture. So she's much more likely to have contact with him, even if it's not a romantic relationship. One of the most concerning findings of the study was that when women are denied an abortion, they're more likely to continue to be exposed to intimate partner violence compared to women who receive an abortion. So the violence decreases for people who received their abortion and it doesn't increase for the people who are denied[35], but they continue to be exposed whereas the women who have abortions are able to make a break.

Emily Kumler: I feel like there's actually really troubling statistics on pregnant women and domestic violence that like women are more likely to have violence happen against them during pregnancy than in other times in their life. So sort of interesting if a woman was going into an abortion clinic saying, you know what, this partner's already abusing me and then to be turned away like that, she's actually in a really vulnerable position, statistically, for more violence or an escalation of the violence.

Diana G-F: Yeah, we didn't find that. We didn't find an escalation of violence. We just found it stayed steady where the other women were able to escape.

Emily Kumler: Yeah, that makes a lot of sense. You know, the people who sort of make the argument that women are using abortion as a form of birth control, considering that you've also done a lot of research on contraception and unintended pregnancy, like do you follow any of these women to see if they had multiple abortions or like what you know, is there any research behind that?

Diana G-F: Well, first what it would mean to use abortion as a method of birth control, people are at risk of pregnancy sometime from the first time they have sex to menopause and if you use abortion as a method of birth control for that entire period, you would need like 25 to 30 abortions. And I've

[34] https://www.ansirh.org/content/role-intimate-partners-womens-reasons-seeking-abortion
[35] https://www.ncbi.nlm.nih.gov/pubmed/25262880

never heard of anyone having anywhere near that many abortions. So it is not a thing like there is not a big population of people who use abortion as a birth control method. And if you're talking about women who have two or three abortions, that's how many you would expect if you used condoms as your main method or used withdrawal as your main method. That's still abortion as a backup, not abortion as the main method of birth control. In fact, I think you'd need more abortions if you are relying on withdrawal as your main method.

Emily Kumler: I mean, because of an error that happened or like the, you know, the chances of getting pregnant on those forms of birth control?

Diana G-F: Yeah, no method of birth control is entirely 100% effective. If you use something for 30 years, that's a long time when you're trusting that it's going to prevent pregnancy and methods just aren't perfect. So most abortions, most unwanted pregnancies don't happen because of method failure. Most happened because people aren't using a method of birth control, method of contraception, and that's because we make contraception just about as difficult to get as possible. And lots of people don't like the methods that are out there. You know, their bodies react to hormones in a way that they don't like. The method is expensive. Their insurance doesn't cover it. We as a society make contraception just about as unpleasant and difficult to use consistently, and then we're horrified when people don't use it consistently. I don't think we need to blame women for unwanted pregnancies or even to blame men for unwanted pregnancies, although they're certainly heavily involved. When women are forced to carry an unwanted pregnancy to term, it does not produce necessarily an unwanted child. By the time that people deliver, women deliver, they have adjusted to the idea that they're mostly going to parent this child. Of the 160 women we followed over time, only 15 actually placed a child for adoption,[36] and that's because there are women who don't feel like adoption is right for them. They don't feel like they could give birth and place a child for adoption and have the child out there and if they're going to go all the way to delivering, they decide they're also going to parent. So it was very uncommon for people to choose to place a child for adoption. When women deliver that child, we looked at all sorts of outcomes, child health outcomes, birth outcomes, and child development. And we found very few differences in the well-being of that child, born from a pregnancy that the woman didn't want, to the next child born to women who received an abortion in terms of health. But we did find big differences in two areas. One is that when the woman was forced to carry a pregnancy she didn't want to term, the child was more likely to be raised in poverty[37] and raised in a house where there was not enough money to pay for basic things like food and housing. And then the other area in which

[36] https://www.ncbi.nlm.nih.gov/pubmed/28153742
[37] https://www.ncbi.nlm.nih.gov/pubmed/30193363

differed was actually in maternal bonding.[38] So that's how the woman feels about the child. If she preferred to have an abortion, but instead was denied that abortion and carried the pregnancy to term, she was more likely to report poor bonding with that child. It wasn't that 100% of them were poor bonding, but was 9% of the women who were denied an abortion had poor bonding with their child compared to 3% of the subsequent births to women who had an abortion, which is statistically significant. And also pretty concerning because when I showed these data to pediatrics medical students and residents, they weren't so concerned about health outcomes as they were about the bonding because a woman's attachment to her child is such a strong predictor of that kid's well-being over time.

Emily Kumler: Yeah, absolutely. This is just really more of a thought experiment for us to talk about, but I have two kids and in the course of my pregnancies everybody was like, you know, try to reduce your stress level. Like there's all kinds of, you know, research to indicate that being stressed has a negative impact on the long-term health of the child. And I wonder if being, you know, turned away for an abortion, the increased cortisol levels, you know, the risk for delivery. All of those things seem kind of logical, right? Like, your body's already stressed and then you add this extra level of anxiety about what life is going to be like with a child that you didn't think you could have, right, like didn't think you were capable of caring for financially or otherwise. And I wonder if somebody will do a follow-up study on something like that, to sort of look at the long-term health of kids who are born, to women who are turned away. Because I wouldn't be surprised at all if there is something about the in utero experience for that child that you know, the child is born and most mothers see their babies and love their babies, right? And even if they're, you know, and that's like, I don't want to make any generalizations that women are rejecting their kids, but I think there is something about that, you know, that people are looking more and more into about the utero environment for the fetus. That would be interesting to look at, too.

Diana G-F: Yeah, one of the indicators of child health where they were significantly worse off was maternal child health experts like there to be a certain amount of spacing between pregnancies. Remember that this whole study is about women who show up too late for an abortion compared to women who show up just under the gestational limit and get it. And you could ask, well, why are women so late in wanting an abortion? One of the major reasons is they didn't realize they were pregnant and one of the reasons people don't realize they're pregnant is because they just delivered. The finding is that these children born after abortion denial are much more likely to be born after a

[38] https://www.ncbi.nlm.nih.gov/pubmed/30193363

short birth interval of a previous child[39]. So now the woman is coping with two kids where she wanted to spend her time raising just the infant. Now she has another infant. In terms of people being born after a short birth interval, 17% of these children born because abortion was denied, were born within 18 months of a previous birth.

Emily Kumler: I'm so glad you shared that because I think there is a real stigma against sort of this idea of later abortions and women being irresponsible. And that narrative is obviously, you know, flawed.

Diana G-F: Yeah, I mean, there's a huge range of physiological responses to pregnancy. You know, some women throw up for the whole first trimester and some women feel rosey and sweet and happy for the whole first trimester. You know, we don't judge the people who don't have nausea, but if you don't have a bunch of symptoms until you don't realize you're pregnant, somehow that's your fault. And there are people who bleed for the first trimester. So they easily think that they're having their period.

Emily Kumler: If one in three[40] American women have an abortion, then we need to sort of focus in on this idea that a lot of those women may not have access to an abortion in the future if the states keep sort of regulating or overregulating or the Supreme Court decides to overrule Roe v. Wade[41]. I wanted to talk to two doctors who perform abortions and have dedicated their life, sometimes at great risk, to allowing women to have the opportunity to terminate a pregnancy. And as you'll hear from them, this is, you know, a sort of a calling in a way because it's a kind of activism that really reminds me of some of the work that's done around C-sections where people are sort of saying like, we have to pay more attention to women and we have to help women have access to the proper medical care. And politicians should not really be involved in making these kinds of decisions. So we're going to talk to the co-host of the V word podcast, they're abortion practitioners, they're OB/GYN doctors, their podcast is great if anybody's interested in exploring issues around sort of gynecological health and they're going to talk to us about what it's like to be a provider of abortions. And in some cases they're providing abortions to women who are pro-life. And how does that go? And how do they sort of move forward knowing that somebody outside picketing one day and the next day they're coming in and getting an abortion?

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[39] https://www.ncbi.nlm.nih.gov/pubmed/30389101

[40] In 2017, this figure changed to one in four women. https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042

[41] https://www.britannica.com/event/Roe-v-Wade

Dr. Conti: My name is Dr. Jennifer Conti[42] and I'm an OB/GYN at Stanford. I'm also the co-host of the V word podcast[43] along with Erica and I'm a generalist OB/GYN, but I also am specialized in family planning, which means that any of the complex abortion cases or contraception cases come through us. So this is like training we've done above and beyond. And I feel strongly that people are either really out there in the media talking about abortion, but also feeling that they're in a safe bubble. So to say, meaning the landscape is such right now that if you're talking about abortion pretty openly in the media, you almost have to sort of worry about your own safety and your family's safety. But for me, the reason I decided to be more active in the media is because I realized in medical school that people were paying more attention to what they read online or, you know, heard on TV than they were their own physicians. At that point I decided to take a break from medical school, go get a degree in journalism, and just really hone up on media and communication skills and figure out how I could use this really as a public health service to help educate people on a bigger level.

Dr. Cahill: So my name is Erica Cahill[44]. I'm an obstetrician gynecologist or an OB/GYN at Stanford university. And my specialty is also in family planning. I have a generalist practice, so I deliver babies, I do surgery in the operating room, I see patients in clinic and take care of women all throughout their reproductive life cycle. And I see abortion care as a really important piece of that health care. We know in the U.S. one in three women [45] will have an abortion at some point in their lifetime, which makes it the most common procedure that we do, as common as a C-section. And I think sometimes that's mind blowing for people to think about, but it's something that comes up all the time in the health care of women and their families. It feels really important to be able to have women who are going through vulnerable times in their life for whatever reason have the best doctors provide for them. And that's part of why I wanted to make sure that abortion provision was part of my practice.

Emily Kumler: So like, I have two children and when I was pregnant with them, I very much was, you know, excited when I could feel them moving around inside of me. And like that, you know, sort of initial realization that there's this sort of alien thing inside of you is really magical. But the idea that they were their own person, I feel like they're not their own person if they're living off of my blood supply, like that's my body. They become their own person

[42] https://stanfordhealthcare.org/doctors/c/jennifer-conti.html
[43] https://vwordpod.com/
[44] https://med.stanford.edu/profiles/erica-cahill
[45] In 2017, this number changed to one in four women.
https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042

when you can remove them from my body and they can live on their own. And I know that's, you know, maybe that's controversial but that to me just sort of feels right. But I don't really know when that is. And I got into an argument with somebody on Facebook awhile ago about, you know, third trimester abortions. And I was like, I think a third trimester abortion is called a C-section, not an abortion, right? If you can take the baby out and it's alive, no one's like killing the baby. And I think that like if you guys can talk a little bit about that, just to like sort of squash that idea. That seems so crazy to me that that's even circulating.

Dr. Conti: To start with, I just want to say that it is more nuanced than it seems and that the other side is trying to make it. So, just talking about when life begins, when you ask and if you pull, you know, 10 different people, you're going to get different answers because there's a lot that weighs into that question. And one of the things that I like to remind people is that you can't answer scientific questions with moral answers and you can't answer moral questions with scientific answers. The two just are completely different and oftentimes go together, especially for people who have a religious component in their life. But I think a really good example of exactly why we can't answer that question so clearly or in the way that would be so satisfying to the anti-choice side is something we saw happen around the time that Roe v Wade was passed. So when you look back at 1973 and when they passed that decision, Justice Blackmun,[46] who was the one who gave the committee opinion or the Supreme Court opinion, he said very clearly that when you have these different worlds of philosophy and medicine science law, all unable to agree on one point or one definition of when exactly life begins, then they as the court should not be the finalizing decision, right? You have all these different schools of thought saying different things. Then how come you know the law feels superior to all of that and it feels like they can be the final judge? And I think that the question of when does life begin, again, it's harder to answer. I think something that we're seeing a lot more frequently in the news in the media right now is this question of viability, which is also not as black and white as people would think. But it's something you're seeing thrown around, especially with like the, you know, "born alive[47]" bills that we're seeing tossed around. And what I'll say about that is that even viability does not occur at a fixed date and can vary between pregnancies. For example, every woman's pregnancy is going to be unique and has to be evaluated individually. And if you consider a fetus that's anencephalic, for example, meaning it's missing part of its brain and its skull, well that's never going to be viable. So it's just incredibly, incredibly nuanced and also a reflection of where we are in time and in science. You know, what is viable today, you know, sometimes we hear 24 weeks being thrown around, right? And that's

[46] https://www.britannica.com/biography/Harry-A-Blackmun
[47] https://www.congress.gov/bill/116th-congress/senate-bill/311/text?r=3

because there's this idea that at 24 weeks in a non-anomalous fetus, you have about a 50% chance of the fetus making it[48]. That does not mean you know without consequences or without major medical problems, but you know, but the making it, should they go to the NICU. It's called surviving to discharge. That's not the same as what they would have called viability in 1970 for example, because science advances in technology advances, it's so nuanced and I know that it would be very, very convenient to have a black and white answer. A very clear answer. Certainly the other side would want that, but we don't have that.

Emily Kumler: Part of what I'm fascinated by is this idea that if a third of women will have an abortion in their life, why aren't women more comfortable or more vocal about saying like this is our issue, not yours. Or kind of taking the reigns of it a little bit more. Is it just because like birth and sort of like vaginal health and all of these things are considered private? I mean, I honestly don't what the answer is.

Dr. Cahill: I think it's a few different dimensions and like we're not lawyers or policy experts. So we obviously like the policy intricacies are beyond us, though we can speculate, I guess, about that. But I think that we can be clear that the other side is being very transparent in their goals here of restricting women and increasingly more transparent, right, with Kavanaugh and Trump what their goals are in terms of restricting women's autonomy. And I hope we can agree that politics should not drive standards of medical care, that politicians aren't medical experts and have no place in the exam room and that we just say this over and over again. But it does sometimes feel like it's on deaf ears of politicians, I would say. We have tried to do things with the data where we have great data to support sort of all the interventions that we've talked about, but that doesn't seem to be the most useful piece right now. I feel like there are a few different directions that we can sort of tack back from our side, but it's sort of like the liberal version in general of like we are a party of nuances and we like to have things be accurate and accurate isn't always simple and nuanced isn't always simple, which makes it much harder to have basic talking points that everyone can repeat non-stop about. And I think reproductive health is one of the most nuanced and complex concepts in all of human existence really. We think of all the things that go into it. I think that's been challenging with messaging. And the other side has like really captured that and just jumped on all over that not having to have any nuance basically.

Dr. Conti: But, I mean like to go back to what you were saying, too, and like what Erica is saying, too, is that we keep, it's almost like we're a broken record. We keep saying over and over and over again, politicians should

[48] https://www.ncbi.nlm.nih.gov/pubmed/11753511

not be an exam room. They should stop pretending to be doctors and stop pretending to understand the medicine and science, especially with something so nuanced as pregnancy termination. And the other thing that's just like baffling to us is that there is so much you can do to improve the health and well-being of women, their children, their families, and why aren't our elected officials focusing on passing policies that make these people's lives easier, such as expanding access to health care, ensuring that all children have quality health insurance. Like why isn't this the focus?

Dr. Cahill: And I feel like that's what we need to keep doing is just like anytime anyone is talking about some like BS non-medical term about pregnancy termination is to be like, actually, the conversation should be about maternal mortality. What are you doing about maternal mortality? Or like what are you doing about pre-natal care? What are you doing about access to health care in general? Like why are you restricting reproductive health care and cutting all of Medicare?

Emily Kumler: Well. Yeah, and I mean, I think just to add on to that too, there's an instinctual part of me that feels like there is a claim to the higher moral ground on the pro-life side. And that feels very clearly to me, like, we just don't value pregnant women, right? So like there's something about like, oh, you get knocked up, it's your problem, right? And like, oh, well you're going to have to suffer the consequences of that. But it's actually like, no, like if we're a community or a tribe, we're all going to actually pay the consequences of that when there is a woman who can't graduate from high school, right? Or there's a woman who now has a child that she can't afford to pay for and who's going to take care of the child? And you know, the, the downstream effect from all of that, which I think is what you guys are saying. We have that right now, right? That's not a future. That's a current situation where we have a lot of people who aren't being properly cared for and like, why isn't that the focus?

Dr. Conti: I mean it's false that one side is the moral side and one side is, you know, cold, however they're trying to paint us, you know, uncaring. And I think we feel this doubly so as physicians who provide abortions as part of our spectrum of care because we feel this for our patients and for ourselves. Like when you think about we're the only doctors who are afraid going to work and still we are caring for women and we're still caring for women in pregnancy and we're still advocating for things that reduce maternal mortality and access to care and access to contraception and access to routine health screenings. We're advocating for all these things and somehow the like protester that is screaming at me as I walk into my office is morally superior. Like, I don't know if you've seen this Erica, but I have more than once seen someone come in and say to me, as they're getting their abortion, I actually don't believe in this, I

don't believe in abortion. Or even, one time I actually picketed an abortion. Like you know, I was one of the people out there holding the sign. Yet they're still coming in and getting their abortion.

Emily Kumler: What do you say back in that situation?

Dr. Conti: Well it's hard cause you need to be respectful, right? Like at the end of the day, I am the medical provider. I am the person who's going to care for you regardless of how you feel. I can see a politician, you know, talking to the media about how they would never have an abortion. But then if their daughter gets pregnant and needs an abortion and comes to see us, I mean we're going to provide that abortion compassionately and with care and love in the same way we would anyone else. Because even though you are ugly about abortion online and in the news and you know, making everyone else feel terrible about their decisions, it's still accessible for you and it's a hard place to be in as a provider.

Dr. Cahill: And like at the end of the day we became doctors and not politicians because we're compassionate people who want to provide good care for women.

Emily Kumler: Oh my God, yeah, but I would have to sit down with that person and be like, okay, so listen, that's cool that you like that before. But now that you've had this experience, let's talk about how you're going to change your views moving forward, right?

Dr. Cahill: Well, it's an interesting thought to explore, right? But that's also, you could argue, not our role, right? Like you aren't going to provide care and then try to like school them in their belief system or say, hey, you're not walking out of here until you change your mind.

Emily Kumler: No, but I would even think like from a mental health perspective, like you can't, you're not going to be healthy if you've had this and you go back to picketing and don't tell anyone, you know what I mean, and don't talk about it and don't feel like, oh, now you've seen another side to this and you've realized it's more complex than you thought it was when you were picketing.

Dr. Cahill: But, Emily, it is like you're saying. That cognitive dissonance is so crazy thick, like denial is incredibly thick and it's not just abortion. You see it with all kinds of different health issues. People can, like, you can sit there with them and be like, are you not connecting the dots? Like what?

Dr. Conti: But I mean, people have to walk out of our office and back into this world of politics that we're discussing, you know, and back into their life and the opinions of people in their life and the judgment of people in their life. And so I feel like some, one of the kindest things that we can do as providers besides providing safe, effective, and compassionate care is providing a space where we are just supportive, where we are not judgemental, you know? And so I think coming into that space with any other goals about what they should or shouldn't feel is, feels really not great.

Emily Kumler: Yeah, no, I mean, of course I completely respect that approach and I'm sure that's the right one. It would just be really hard for me.

Dr. Conti: The picketer, though. The one time the picketer like outed herself as a picketer, I did say, I respect your views, but I'm so happy that we were able to provide legal and safe care to you today. And it was sort of like my like burn, you know?

Emily Kumler: Yeah, I mean I just, I guess I sort of feel like that's why it's a double whammy, right? Because it's like not just is it threatening in terms of medical care and access to future possibilities for a lot of women, but it's also this shaming thing that happens. And so when, you know, you hear a story like that, it really feels like, wow, that's a lot of self hate to walk around with. Right? To go through this kind of an experience and then to feel like you're going to fall back in line with the old way of thinking about it as an evil, terrible thing to do. Then you're saying that you've done something evil and terrible and that's just like a step away from, I don't know, I think really dangerous kind of mental thought process about yourself.

Dr. Conti: Yeah, the mental gymnastics that are going on there I just, I don't know how to rationalize, you know?

Emily Kumler: There are obviously two stark views when it comes to abortion issues, but I hope that this episode has provided food for thought for all of us to sort of consider some of the data points that we've addressed this week.

Emily Kumler: I'm Emily Kumler and that was Empowered Health. Thanks for joining us. Don't forget to check out our website at empoweredhealthshow.com[49] for all the show notes, links to everything that was mentioned in the episode as well as a chance to sign up for our newsletter and get some extra fun tidbits. See you next week.

[49] https://empoweredhealthshow.com/