Sawbones 419: Answering Your Questions About the Roe Verdict
Published July 5th, 2022
Listen here on themcelroy.family

Intro (Clint McElroy): Sawbones is a show about medical history and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello, everybody, and welcome to Sawbones, a marital tour of misguided medicine. I'm your cohost, Justin McElroy.

Sydnee: I'm Sydnee McElroy. Justin, this is a little different, this episode, and I think we already put out a tweet requesting these questions. So you probably know what we're talking about today.

In light of the overturning of Roe v. Wade, which I think everyone is aware of, which now removed our national right, our American right to autonomy over our own bodies and our reproductive health and turned that over to states to decide individually resulting in many states now restricting abortion access in a variety of ways. Either completely or based on weeks or based on methods. Or they haven't, but we think they're going to. So...

Justin: If you're not familiar with, sort of, this history and you did not listen to that episode, I would encourage you— This is sort of a piece I would say, there's a lot of background and context that we won't necessarily be covering today, I would say.

Sydnee: No, because we did that.

Justin: We did that, like, two weeks ago. So if you want to give that a listen, it might be a good place to start if you missed it, and then come on back and we'll do our best. Any other sort of, like, preambles or anything before you deliver? Because this is, like, this time period, as you've said to

me many times, is just kind of defined by flux and not knowing and shifting, and, um...

Sydnee: I think one thing to know— Well, first of all, I wanted to do this episode because our listeners started spontaneously sending me these questions before we requested them. I started getting your questions, and then I started getting those questions from my friends and neighbors and colleagues saying, "What do you think this looks like right now?"

And I'll be honest, the answer to a lot of these questions is gray because there are a lot of— And I am not a lawyer, but I can tell you that lawyers agree there are a lot of legal gray areas right now. There are a lot of areas that this might be true today, but we don't know what will be true next week. And so I will say that if you're listening to this show anytime other than now, the answers could be different.

So a year from now, everything I'm saying will probably have changed, and it also varies greatly depending on what state in the United States you live in.

Justin: Yeah.

Sydnee: So I know West Virginia very well. I will do my best to sort of generalize my answers. But honestly, it's different state by state. And obviously we're going to be discussing reproductive health and abortion throughout this episode. I know that for some people those aren't topics you want to engage with all the time. So just be aware of that.

Justin: Um, "Hello, I was wondering if there are any other ways to deal with ectopic pregnancies other than abortion. Sincerely, a girl who wants kids but is now terrified I won't get medical attention if I need it during pregnancy."

Sydnee: Absolutely. Well, I got a lot of questions about ectopic pregnancy. So, this may not have been your question, but if you asked one about ectopic pregnancies, I tried to lump in a lot of answers under one question.

So an ectopic pregnancy is basically when... Are you trying to—

Justin: I'm trying to—

Sydnee: You want to answer?

Justin: Is it when the zygote implants in the fallopian tubes?

Sydnee: That is one example of an ectopic pregnancy. Basically if it implants somewhere other than inside the uterus, which is where it should.

So a fallopian tube is the most common example. But it can implant other places, like, for instance, old, like C section scars, they can implant. So there are lots of places. The point about an ectopic pregnancy, this will not develop into a viable fetus.

Justin: Right.

Sydnee: Because it is implanted in the wrong place, this— and to put it in very lay terms, this will never become a baby. It just won't. And for a lot of people who undergo this, they may very much desire pregnancy.

Justin: Right? There's a lot— For a lot of people, there's a lot of trauma associated with it.

Sydnee: Yes. And so when you find out—

Justin: Beyond the risk to the person carrying the baby.

Sydnee: So those are the two things to know. This is never going to be a viable pregnancy. It's just not. There is no way, because this was other questions, there is no way to implant that embryo into the uterus. There is no way to do that. It's not medically possible.

Justin: Several states, right, put laws in the books?

Sydnee: Have tried to put laws on the books. I don't know if any have ever passed to say that we have to attempt to do that. You can't— It would be like saying you have to attempt to fly. You can't. You just can't. This is not something we can do. And that's, for some people, they wish we could. In

that moment, they wish we could do that because they desired that pregnancy. So one, this will never become a viable pregnancy.

Two, it is a medical emergency that it be dealt with, maybe not in that exact moment. Maybe the person presenting with an ectopic pregnancy does not need medical attention within the next five minutes or something terrible will happen. But it absolutely has to be managed immediately because if you allow that to continue to develop, it will rupture whatever structure, the tube most commonly, it's in and that can be, will be that case, fatal to the person carrying that pregnancy.

So it has to be managed. It is absolutely a medical emergency. It has to be diagnosed and treated or else the person will likely die. So when we manage those, we actually don't— I think that's an area a lot of people are confused about. We actually don't perform what we would call an abortion in that case. So there are two ways to manage it. If it's early enough and small enough, you can take a medication. It's actually a shot that they give you there on site that will induce, basically, a miscarriage.

Which we can use that term, or an abortion, an induced abortion, but it's different because this isn't a viable pregnancy. So we can treat an ectopic pregnancy. That's how I would say it. We're treating the ectopic pregnancy that way with the medication. It's called methotrexate, which you can take— I know some people do take it by mouth for other things. This is a shot, it's different, it works differently.

Or secondly, a surgical approach. And it really depends on exactly where it is and how far along to determine which one is most appropriate for that patient. When it is a surgical approach, there's always a risk, because basically, especially, let's take a tube, for example. They may be able to just remove the ectopic pregnancy, but often they end up having to remove the whole tube. Not always, but that is a risk which can put future fertility, if you desire fertility, at risk as well.

So these are serious emergencies that have to be dealt with medically. If you are concerned, if you— Please do not hesitate in seeking care in light of this new law, and that is the bullet point I want to get across. Do seek care.

I see no reason right now that a physician in that position would delay your care or deny you care in that circumstance. Now, I know there are a lot of doctors talking, because I'm part of these conversations, about could— Is that something you could get sued for in the future? Is that something I could be prosecuted for? Could you make a case that I should have waited longer until the person was more unstable? All of that.

Right now, the reality is, if you have a concern for that, please go seek care immediately. There is no reason that you should be denied care. This is a different procedure. It's coded differently. This is not the same as what Roe v. Wade was talking about. So please seek care for these things. They are different.

Justin: "Hello, Sydnee and Justin. My question is, does this mean now that miscarriages can be penalized? If so, does that include past miscarriages? I reported a miscarriage to my OBGYN that happened before my most recent pregnancy and I'm worried that could be used against me somehow. Thank you, Erin."

Sydnee: Right now, I see no way, again, that a miscarriage could be penalized, because that's a different— It's different. And I think a lot of this has to do with how we code things. Like, a lot of times in— Well, what I would say as a physician, what would be recorded in your records would be a spontaneous abortion. So I think our language is what gets confusing about this. A miscarriage is the sort of colloquial term for what we call medically a spontaneous abortion.

Justin: Okay.

Sydnee: That would not be the same. And again, there's no reason that if you disclose that to me, you'd be criminalized in any way for that, because I have no duty— And this answers a lot of other questions. I have no duty to report that. The only thing as a physician I would ever violate your confidentiality for is if you told me you were going to go murder someone.

That's really the only reason I can ever break that privacy, that confidentiality, is if I know someone else is going to die because of what you just told me, then I have a duty to report that to save that other person's

life. If you told me that in the past you had a miscarriage, you had an abortion, I have no duty to tell anyone that. And in fact, I can't.

Justin: Right. It's protected.

Sydnee: Please still be honest with your medical providers and discuss these things with them and if they violate your privacy and do report that, they are breaking patient confidentiality.

So at this point, again, it's important that we recognize the reality and also dispel dangerous myths that would lead us to make decisions that could harm us, right? Like not telling people or not seeking care and that kind of thing. Right now, these are situations that there should be no problem disclosing.

Justin: So, "What are the expected effects of the decision on medical training? What happens if prospective doctors can't, you know, they're in an area where there's bans and they can't get the real world experience? Like, what happens?" That's from CJ.

Sydnee: Okay, this is a great question because here's what I'll tell you. I never received any information or training about how any of this happens.

Justin: Nor did I.

Sydnee: In my medical school training, and of course, I was a family physician, so I did not go through an OBGYN residency, but a lot of programs don't— Aren't able to train their residents in these things because they don't perform them at the hospital where the residents are being trained.

So there are— This is already a problem, I would say. Now, will this problem become worse? Certainly I think it will, because they're going to be state like ours, in West Virginia, where we only have one place where you could receive an abortion in the entire state, and it is no longer performing abortions.

So if I wanted to go train in the state, the one place where I could go train is now closed. Now, some of these procedures are the same, and I'll get into that, what a DNC is and why it's the same procedure, whatever the indication is. So all OBGYNs are trained in those. I mean, for the most part, generally speaking.

Justin: The DNC?

Sydnee: Dilation and curettage, which is the same sort of procedure that we use for an abortion, or for other reasons for heavy menstrual bleeding, could be a reason you might get a DNC, for after a miscarriage if there is still concern that there are still products inside the uterus, you might get a DNC.

So there are other reasons you would get these. So physicians are already trained in those. Am I concerned that we will see less of this training nationwide because of these bans? Certainly. And, I mean, I was never taught about the medications. I taught myself about— I learned myself.

And we'll get into medication abortion, but I had to read those articles by myself. No one ever told us about that.

Justin: Mm. "Hi, Sawbones, with this decision, very young people 11, 12, 13 years old will be forced to carry pregnancy term and give birth. What specific complications or issues would result from having very young and not fully developed people carry a pregnancy and give birth?"

Sydnee: So this is an area of grave concern. All of this is of grave concern.

Justin: Of course. It's kind of like ranking the worst crap.

Sydnee: Right. I know—

Justin: The least worst bad.

Sydnee: And that is why the American Academy of Pediatrics specifically came out to condemn forcing children to give birth, because you shouldn't force anyone to give birth. But beyond that, specifically, young people whose bodies aren't fully developed can have trouble with delivery.

I mean, we're getting into very gruesome— How wide is the pelvis? Can the baby fit through, these sorts of issues. And so you're at higher risk for complications during the delivery. You're at higher risk for needing C-sections. Beyond the every bit as important emotional and psychological effects of being forced to give birth as a child, which already being forced to give birth has trauma associated with it.

And then if you add to that, someone who is still developmentally early when it comes to emotional development and cognitive development. So there are absolutely even more negative health consequences in this age group than when we look at adults who are being forced to give birth, who are also going to suffer negative health consequences.

Justin: "Hi Sawbones. How does the abortion pill work? How late in a pregnancy can it be used? What does it feel like to go through a medically induced abortion? And if it comes down to needing to do this at home without doctor supervision, how do you know it worked or if you're having complications that need medical attention? Thanks again, Erica."

Sydnee: Okay, so the abortion pill is an important thing to talk about. It's mifepristone RU-486 is what everybody called it when it first came out. I mean, that's still an accurate term, but I remember that being widely publicized in 2000, back when it was first approved. You can use this up to day 77, 11 weeks.

So you got to get really specific when it comes to pregnancy and dates. There are time frames and you can look at the specific windows where, like, weeks seven to eight, it is slightly more effective. Weeks eight to nine, it gets a little— I mean, still, though, we're talking up over 90% effective at inducing an abortion. So a very effective pill.

It is something and again, anytime you're considering it, it's like any other medical decision, which is why this should be made between a patient and their provider. Whether a medication induced abortion or a surgical abortion is right for you, is a conversation between you and your doctor and no one else needs to be involved in that conversation.

You will— I mean, you will feel cramping. I have had— and I encourage you to read abortion stories. There are people out there, abortion storytellers, who specifically share their experiences so that people will know why they made the decisions they made, who want to share that.

And no one should have to, but there are people who do that and I encourage you to seek out those stories to learn more what is this like. I've never taken this medication, so I can't tell you exactly what it feels like from personal experience. I can tell you that we counsel patients.

There will be cramping and bleeding associated with it. It can take longer than a surgical abortion. So for some people they opt the surgical route just because it's a quicker procedure. And in some ways the recovery then can be faster because you can immediately start recovering while this would be a longer process.

You can do this at home without a doctor's supervision. Self-administered medical abortion is a thing that people have been doing all over the world for a while now. In countries and places where this has been restricted, where they already have abortion bans in place.

There are— So there are a couple of different resources that I wanted to put out there. There's one organization, Abortion on Our Own Terms, and there was someone who reached out. They didn't specifically say I could mention their name, so I don't want to mention someone's name if they don't want me to. Who sent us an email with some resources. Abortion on Our Own Terms can tell you about self-managed abortion and how that works.

This is something that people do. There is a safe way to do it. You can talk to people via telemedicine if you need to be admitted and be mailed the pills, or you can go somewhere and receive them, depending on where you are, and do this at home. And there is a process. There are two medications that you take. First, the mifepristone, followed by misoprostol.

And there's a process for all of this. There is a way to do it with misoprostol alone as well, which is a process. But I would highly recommend that you check out that resource, Abortion on Our Own Terms. If, When, How can talk

to you. Those are lawyers who can talk to you about issues related to this as well. And there's also We Testify, which are abortion storytellers.

There's a network of people who will tell you about their experience and that can help you understand exactly when you have that question, 'What does this feel like?' Someone who's experienced it is the best person to answer that for you.

Justin: "People seem to think you can get in trouble for traveling to get an abortion. Would HIPAA not protect you if you went to a different state for a procedure?" Currently, I don't know of any way the law could be used to prevent you. I know that there's been a lot of talk that there are states who want to do that, like make you get a pregnancy test before you leave the state and then a pregnancy test when you get back and then prove that you had a—

Justin: Things could always get worse. But.

Sydnee: Right now we can't restrict interstate travel in that way. Like that's—

Justin: Yeah, that's a federal thing.

Sydnee: Yeah, that's outside of anything to do with reproductive rights. That's just...

Justin: The law.

Sydnee: The law. And so I don't see of any way that could be restricted at this time. And in fact, traveling out of state is going to be essential for a lot of people who are seeking this care right now. And finding ways to help those people travel out of state is going to be essential.

Justin: "I recently saw that IUDs and Plan B are technically illegal in Missouri now. Do you think this could happen in other states? Should I avoid getting an IUD now? I'm an American living in Canada until 2024 on the chance that I get prosecuted for it in five years when I need it taken out. Thanks, Natalie."

Sydnee: So I will say that there are— I don't know about Missouri state law myself. I know that in West Virginia currently, those things are legal. But we are concerned, those of us who are concerned about such things. A lot of us in West Virginia are concerned that this could become illegal in our state as well. And there are, I think, up to 20 states who will probably possibly ban Plan B at least in the next month or two.

So I definitely think that Plan B is something we should be concerned about going away, state by state of course. And then IUDs I don't know. That's a little— It is a form of contraception, but Plan B is as well. So I think it's going to depend on how the law is written in your state.

If they start talking about when life begins, if there are laws written about conception being the moment life begins, then I think that these things become a risk. Because even though Plan B cannot abort a pregnancy, it still is a contraception that prevents a pregnancy. Same with an IUD, because there is this possibility that somewhere in that time frame something gets fertilized. I don't know.

I can see these being court cases. What it'll be. It'll be a case, but I see no way that you could get prosecuted for something you did when it was legal.

Justin: Yeah.

Sydnee: I will say that is a concern I had for people with IUDs. If it's banned in the state, I don't see any reason we couldn't remove them. But getting a new one put in place, you'd have to travel for. But I don't see any reason that presenting to a medical provider and saying, I've had this IUD in place, it's time for me to get a new one.

They may now be banned from putting a new one in, but there would be no part of the ban that would prevent them from removing it, which you need to do for your own safety once your time, you know, once it's been in there a certain amount of time.

Justin: We have more questions. I think we'll try to get through them faster after so we can get to as many as possible, but we will answer as many as we can after the break.

[theme music plays]

[ad break]

[Max Fun ad]

Speaker 1: Hi, I'm looking for a movie.

Ify: Oh, I got you.

Drea: There's that new foreign film with the time travel.

Alonso: There's an amazing documentary of our queer history on streaming.

Ify: Have I told you about this classic where giant robots fight?

Alonso: Or there's that one that most critics hated, but I thought it was actually pretty good.

Drea: Ooh, I know, the one with a huge car chase. And then there's that scene where...

Everyone: The car jumps over the submarine!

Speaker 1: Wow. Who are you eclectic movie experts?

Ify: Well, I'm Ify Nwadiwe.

Drea: I'm Drea Clark.

Alonso: And I'm Alonso Geraldi. And together we host the movie podcast Maximum Film.

Drea: New episodes every week on MaximumFun.org.

Ify: And you actually just walked into our recording booth.

Speaker 1: Oh, weird. Sorry, I thought this was a video store.

Drea: You seem like a lady with a lot of problems.

[Max Fun ad]

Ross: Carrie, is it?

Carrie: Oh, yes. Hi, I'm Carrie.

Ross: I am psychic Ross and I will be reading you this evening.

Carrie: Oh, interesting. Well, okay. I cohost a podcast. It's called Oh, No, Ross and Carrie.

Ross: Yes. I'm sensing that, the spirits are telling me it is a show about poodles—

Carrie: Well, it's about fringe science and spirituality and claims of the paranormal. Oh, you knew that?

Ross: You do research online, you...

Carrie: But more importantly, like, we do in person investigation....

Ross: [overlapping] In-person investigate as well.

Carrie: Oh, my God. That's amazing!

Ross: See?

Carrie: Me and my friend, this is so weird, my friend Ross, same name as you.

Ross: Weird.

Carrie: He and I just go and try them all out. And actually, we've gone to a number of psychics, and to be honest with you, it's a lot like this. It's called Oh, No, Ross and Carrie. They can find it at MaximumFun.org.

Ross: I could have told you that.

[ad break ends]

Justin: Joyce asks, "Are there old-time remedies for abortion that are safe?"

Sydnee: Please— I wanted to highlight this because I have seen a lot of very well-intentioned people offering, like, herbal—

Justin: Pretty much the same way the baby formula debacle has sprung up, I guess, in answer to anything, right? I mean...

Sydnee: We used to get by, and I think that's always the thing to remember when you started thinking about...

Justin: ...ancient wisdom.

Sydnee: Yes, we used to get by without modern methods of abortion. Can't we do that again? Well, we didn't do very well. That's why we have these modern methods, is because there was still a huge risk and people died. So I would not turn to any sort of unregulated old time remedies for any of this. Just like we would never recommend somebody do a surgical procedure in their own home.

Justin: Right.

Sydnee: Please don't do that. Please seek care. Please continue to. There will be organizations, and we'll mention some more, that can help you find safe services. Um, please do that. Don't turn to any home remedies.

Justin: We have a question here about things that people who can't get pregnant can do, and this person is actually asking if they should have their sons get vasectomies in high school, so.

Sydnee: Okay, first of all, I don't—

Justin: Is that reversible?

Sydnee: Right. Well, technically. I do not believe any providers would do this. I can't see that happening, like, for that purpose, because it's not currently, like, doing it with the intention of reversing it someday when you're ready?

Justin: It's still— Yeah.

Sydnee: There is no, like, indication for it in that way. If you had told your doctor that you intend to get it reversed, he wouldn't have done it, is my thought.

Justin: Right.

Sydnee: Will that change in the future? I don't know. But right now, the problem is that even though technically it's reversible, I mean, things can— There are complications.

Justin: It's surgery. There's a risk.

Sydnee: It's surgery, there's a risk, there's a chance that yours specifically is not reversible. So I've seen a lot of that sort of language and rhetoric being used, like, let's force everybody to get a vasectomy who can.

Justin: Hey, listen, I'm doing my part, but...

Sydnee: I would not— I think everyone should have the right to control their own reproductive health, whatever parts they have, whether they can carry a pregnancy or whether they carry sperm needed to fertilize an egg. I think that cannot be the answer.

Now, if you are an adult who would like a vasectomy because you don't want to have any more children, certainly seek that out, just like if you're an adult who has ovaries or tubes or a uterus or all of the above and would like to seek some sort of surgical procedure to ensure that you never have children, I think that's fine. I think that's all fine.

But doing it with thought, like, someday I'll reverse this, I would not. I would not do vasectomies in that way and no one would recommend that.

Justin: We have a question about weight limits and the morning after pill, you know the—

Sydnee: Plan B.

Justin: Plan B. And it's also asking, timing pregnancy. Like if I miss my period and my pregnancy test comes back positive, I'm actually four weeks pregnant. Like, when does the timer start, I guess, would be the question.

Sydnee: So, first of all, this is a great point about Plan B or My Way— There are numerous brands of emergency contraception. It's levonorgestrel is the generic medication and they are less effective. Specifically, 165lbs has been the cut off.

I actually looked and there's like a little wiggle room between 165 and 172 or something where it might or may not be less effective. And then there is a weight past that where it is definitely less effective. And there are—

I could not find easily accessible higher doses, because taking two won't fix that. I looked into that, will taking two fix it. No. So that is a problem and it's a gap in our care—

Justin: Medicine is so weird, by the way. Medicine is so weird that there's like... I don't know.

Sydnee: Yeah, this is a gap in care. This is definitely a place where I have concerns because it was really easy for me to, thinking about this law being passed and like my patient population, the people I take care of, could I go

and buy some Plan B or something like this, a generic form of this to stock at my clinic to have available, should people need it for free.

And I didn't have an easy solution for okay, but what if they don't fall within that weight range? So I don't have a great answer for this right now and that is definitely a big problem. The second thing about timing of pregnancy and periods, I think this is really important for us to all understand because a lot of people who make laws do not understand this.

So the earliest you could ever find out you were pregnant is when you've missed a period. Unless you're just testing yourself. I guess in that sense you could just test yourself every single day because there are pregnancy tests that can identify, you've seen the commercials, can identify it up to five days before your missed period.

Justin: Sure.

Sydnee: So technically, if you are checking yourself every single day, you could identify it even earlier. But generally speaking, the earliest you're ever going to notice is, "Uh-oh. I should have started my period today. I didn't start it. I'll take a pregnancy test. I took it." At that point, you're at least four weeks pregnant.

And if there's some cycle variability, I mean, most people don't know they're pregnant until five or six weeks. That's just the truth. Or later. If you're someone like me who never knows when their periods are going to happen, it may be later for me because I wouldn't think anything of it if I went eight weeks without a period. And that's true for a lot of people.

So I think knowing that is really important because the idea that you could restrict abortion to six weeks and that would still give people a reasonable time frame to make an informed decision about their healthcare, it's totally ridiculous. Most people wouldn't even know they were pregnant.

So you don't have six weeks. At that point, you would have at best two weeks and most people wouldn't have two weeks. So I think that's important. It also highlights the fact that we're technically pregnant for ten months, not nine, which is a weird thing we never talk about.

Justin: There's a question from Hannah about what doctors are planning to do. Like, I guess what the discussions are in your community right now, what those are looking like.

Sydnee: I think that's a great question because, I hope that people will find this comforting. The vast majority of physicians that I either know personally or associate with through groups or organizations are working to try to find ways to continue to provide care to patients, the full spectrum of reproductive health care to patients while not breaking the law.

I will say that is a concern of mine too. And I know that— I know I try to be an activist and that doesn't sound very activisty, but at the same time, if I don't have a medical license, I can't take care of anyone.

Justin: Right.

Sydnee: And I think that that is a concern of all of us is we want to operate within the bounds of the law so that we can continue to take care of people, but at the same time, we don't want people to go without the care they need. So the efforts that I have been involved in is, one, making sure that for patients that it's appropriate, Plan B.

And there are organizations, like in our state, for instance, in West Virginia, Holler Health Justice is a wonderful organization that helps to get emergency contraception to you for free. So if you're in West Virginia, Holler Health Justice is a great place to go. Go to their website and you can find out how to get free emergency contraception. So that is one effort that we have been involved in, especially locally, like with some of the organizations I work with. How can we get a hold of that and have it available to patients for free so that they can access it?

Other things we've talked about are, because we do not want people attempting to use herbal or self-induced abortions without any sort of medication help or anything. How can we transport people to places where they can access safe care? In our state, and this is true. This is something to think about. And I think there are other questions about this.

Telemedicine has been asked a lot. Can you just call, like, for instance, we're in West Virginia, where it's now effectively illegal, the law we're operating under is from 1882. It's currently being challenged in court by the ACLU. I don't— There was also this other injunction that was passed in 1975, everything is sort of up in the air. But if you live in West Virginia, you can't have a doctor, let's say in Maryland, where it's legal. You can't have a doctor prescribe you mifepristone over the phone through telemedicine. That is illegal. You cannot do that in this state.

I think about 13 states have rulings like that in place where you actually physically have to see the provider to get it. And then, of course, if it's banned, it's banned. So that workaround of telemedicine, that physician in that other state, if they prescribe the abortion pill in a state where it's illegal, will lose their license. So that's not going to be a workaround.

So it's going to be about getting patients to the places they need. We're going to have to create networks, and they are already something that exist, depending on where you live, to transport people, to put people up in hotels as needed during recovery, to have people, if they're available, to help them, to be their sort of abortion dualas. That is a position that exists to help them through that process, to help guide them to appropriate clinics and partnerships with providers outside of our state. That's going to be key.

And we are all having these conversations, not just me in West Virginia, but all over the country. I guarantee people are having these conversations.

Justin: "My sister-in-law is very worried because she used IVF for her first child. But now it's uncertain if that's going to continue to be an option in some states, given how it is done." That's from Kensley.

Sydnee: I think that, again, while right now there's nothing that would inherently prohibit that. I think that these are— [sighs] These are going to be restrictions we will see happen, because that is a fertilized— I mean, that is an embryo now. And, I don't, you know, the embryos you don't implant in IVF are traditionally stored or destroyed.

I don't know what the future— I think this is a legal question. I would say right now, I would continue to, if that is care you're seeking, continue to go

to your doctor. There is no law that's going to criminalize. Please don't stop seeking care right now.

I think that's an underlying— Of all of these. Please don't stop seeking care right now. There may be things that change in the future. I hope they don't. But right now, I would continue to if there is a provider who's doing IVF, continue to do that, there is no reason to think all of a sudden we're going to say, "Ha ha, we caught you, you're going to jail."

Justin: Straight to the point. "I was wondering what the best long term birth control options are for trans masculine people, especially those on testosterone. Thank you, Noah."

Sydnee: That's a great question.

Justin: Thank you, Sydnee.

Sydnee: [laughs] You're welcome. There has been a lot of concern, and there's not enough research, and this is true for trans healthcare in general. There's never enough research or evidence to tell us all of the answers. But there is always concern, if you're already on testosterone and then you take an oral contraceptive that has estrogen in it, is that— You know, are you sort of— Is that going to counteract what you're trying to do with the testosterone to begin with, right?

So, one, there are progesterone-only oral contraceptives, if that's something you desire. Some people prefer a pill. There are progesterone only that should not, will not in any way interfere with the testosterone. That's one option.

Probably better for most people, is something longer acting. Like, there's the depo-provera shot, which is progesterone. There are the implants, like Nexplanon, which are progesterone. There are IUDs, which contain progesterone, and there's the copper IUD, which doesn't contain any hormones whatsoever.

Those are all options that would not in any way interact with testosterone and would be incredibly appropriate for a trans masculine person to seek

out. Um, the implant in the arm, the nexplanon, or an IUD, those both last a lot longer. So if you're looking for something long-acting, those are probably your best long-acting options.

Justin: This is a question. Looks like there's another question about the legality of the mail order abortions. Ask if Biden protected those through USPS, or...

Sydnee: Okay, so there's a question right now where the FDA has approved these pills, so... And specifically Mississippi, their law's being challenged, like, if this is approved for a medical indication, how can you stop it?

Justin: Yeah.

Sydnee: I don't know how that flies, because abortion is approved for a medical indication, period.

Justin: Right.

Sydnee: But in terms of mail order pills, this is the thing about the abortion pills. Again, you can't order them from a state where it's legal. A doctor will be prescribing it. They're not allowed to do that. It is not legal to order them from overseas, from other countries.

Justin: Okay.

Sydnee: People do that with medications all the time, though. We know that. But it is not legal.

Justin: Okay.

Sydnee: That is happening. I mean, if you read about it, it is happening. It is not legal to do that.

Justin: But it is happening.

Sydnee: But it is. And not just with mifepristone and misoprostol, with lots of medication.

Justin: This person wants to know the difference between DNE and DNC abortion, which I know you touched on a second ago. When are those methods used?

Sydnee: So, again, this has to do with how far along the pregnancy is as to which, um, which method of abortion you can use, whether it's pill or DNC, dilation curettage, which again, we used for other indications. It is not solely used for abortion, but that is when you would dilate the cervix.

And you can either use a suction, like a vacuum to basically evacuate the contents of the uterus, or you can remove with instruments. And that is where we get into the dilation and extraction. You would use more instruments in the process. And it has to do with how far along the pregnancy is.

That is the only difference between these two procedures is how far along and which procedure is most appropriate at that stage of pregnancy. These are also the same procedures that are used if a spontaneous abortion, or colloquially miscarriage, has occurred. In order to ensure if it does not pass on its own, you have to make sure all the products of conception are gone because it can be life threatening to the patient otherwise.

Justin: "I just saw a Twitter thread where someone said their SO's rheumatologist was taking all their patients who could potentially get pregnant off of meds with teratogenic risks in case of miscarriage. Um, what is that? And should patients be concerned their treatments for autoimmune conditions will be taken away too?"

Sydnee: I don't know of any— I'm not saying— Obviously someone is saying this is happening and I don't know this person or the situation. So I'm not going to dispute a Twitter thread that I haven't read. I don't know the person. I don't know of any physicians, certainly personally, that are taking patients forcibly off their medications.

There are lots of medications that have risks to, if you become pregnant while you're on the medication, it could either cause problems for the developing fetus or put you at higher risk of miscarriage. Both of those

things, that has always been true with different medications. Certainly, I think you're going to have a lot more conversations about that because of the implications now.

For instance, if you should become pregnant and you find out that there is some sort of life-threatening condition with the developing fetus, your options may now be limited as to how you can approach that, depending on where you live. So I think that there are going to be a lot of conversations, but this, to my mind, would all fall under informed consent.

I would be having that conversation with every single patient, not just blanket forcing everybody off a medication for that risk. Again, if you are prescribing a medication for a rheumatologic condition to a patient and that patient happens to get pregnant and that pregnancy happens to end in a spontaneous abortion, no crime has been committed.

There is no law that criminalizes anything I just said. And so I see no reason that patient should be forced off the medication. Obviously, we're going to have to have a lot more of these conversations, though, just for the patient to make the best decision for their own body.

Justin: So that is the questions. Do you want to talk about this last..?

Sydnee: So, a couple people— Like I said, I already referenced one listener who reached out with information and I named a couple of organizations they recommended. Someone else reached out that runs an organization, this is from Marissa, runs an organization that builds tools and resources for practical support for organizations that are helping people travel. So this listener, their organization is, and let me spell it, APIARYPS.org.

So that could help. And then there's also Abortion Finder, which is just AbortionFinder.org, where you can find verified providers so that you ensure where you're going is a place where you will receive appropriate, medically indicated, safe services. So that's a great resource just to find a place.

One thing that this listener pointed out is that euphemisms are not necessarily helpful. I think a lot of— and this is where there's a lot of well intentioned, like, "Hey, you can always come camping in my state," kind of

thing. I think that right now we need to be really open and honest with what we're talking about.

I think that will help because also there are a lot more people who agree that we need to fight back. We need to push for federal legislation that will protect our reproductive health and we need to do it openly. It doesn't have to be something we do quietly.

We can't push abortion back into the shadows. It has to still be something we talk about openly and help patients access openly so that they know they can come to me and I might say, "We don't have a place in West Virginia, but here are ten different resources that I can help you access so you can go somewhere where you can get a safe, legal abortion in the United States."

And hopefully we can have federal legislation that will change that so that every state has those options. But in the meantime, I think it's really important that we talk openly about this. Please do not— tell people privately, "Hey, if you want an abortion, my friend, you can come stay with me in my state where it's legal." I would not publicize that.

One, it's really hard to know. I'm sure you are a wonderful, well-meaning person. How in the world would anyone else know that? Two, now we know where people go to stay when they're having abortions.

And that's— I think the less of that, the better. But forming grassroots, working with grassroots organizations are already doing this. Like in our state, there's Holler Health Justice, West Virginia Free, and Planned Parenthood have both been working in our state for a long time. And in a lot of states they're sister organizations, brother organizations, sibling organizations, I should say partner organizations that do the same sorts of things to help people access safe, legal abortion care, to get transportation, to get lodging, to get access to medications, to get access to surgical abortions. All of those things.

Work with those organizations and know resources in your community so that if somebody calls you and says, "I'm scared, I just got this positive pregnancy test, I don't know what to do." You can be a good friend and advocate by knowing how to help them access those resources.

Justin: Okay. Thank you so much for listening to our podcast. I'm so sorry about everything, which is going to be my new sign off, I think, for the foreseeable future. [sighs] Thank you, to The Taxpayers for the use of their song Medicines as the intro and outro of our program. Um...

Sydnee: Don't just— All of these grassroots efforts to help people access care are essential right now. And as a physician, that's a lot of what I find myself immediately trying to do. But we can't give up the greater goal, which is there needs to be legislation passed that protects our reproductive rights. That has to happen on a federal level.

And we all— And voting, of course, is part of that, but voting is not enough. We need to be calling our representatives. We need to be vocal about what our values are and what we want out of our representatives and what we expect them to do for us. Because the majority of people in this country believe in full access to reproductive healthcare for everyone.

The majority believe in that. And our Congress should be reflecting that with legislation that protects it.

Justin: That is going to do it for us for this week. Be sure to join us again next week for Sawbones. Till then, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]