Transcript of “Is Permanent Contraception Always Fool Proof? Find out with Dr. Schwartz and Dr. Treder”

Coming Together for Sexual Health Podcast

Tammy Kremer:

Welcome to Coming Together for Sexual Health. I'm Tammy Kremer, and I'm thrilled to talk with you about the world we are creating by coming together for sexual health, and yes, the pun is intended. My background in thinking holistically about health as a facilitator and a doula helps me talk with our guests about celebrating pleasure, combating stigma, and making sexual healthcare both more accessible and more inclusive of the communities we serve. We're powered by nationally recognized experts in sexual health at the University of California San Francisco, and the California Prevention Training Center. All views expressed are those of the person speaking, and not of the CAPTC or their employer. Subscribe to get our latest episodes, share with your friends, and leave us a five-star review to help more people find us. Thank you for coming together for sexual health.

Welcome to Coming Together for Sexual Health, Dr. Eleanor Bimla Schwarz, and Dr. Kelly Treder, so glad to have you on today. We're going to be talking today about contraception that might be considered permanent. There are probably going to be some surprises in this conversation, there were for me, in preparing for this episode, so I'm looking forward to jumping in with both of you. I'll go ahead and do a quick intro for Dr. Schwarz, MD. She's a professor of medicine at UCSF, and she's the chief of the Division of General Internal Medicine at the San Francisco General Hospital. She has a particular interest in identifying ways to meet the needs of diverse populations, including women with chronic medical conditions, and other underserved populations. Dr. Kelly Treder, MD, MPH is a board-certified OB-GYN at Boston Medical Center, and an assistant professor of OB-GYN at Boston University School of Medicine. She specializes in family planning, and is committed to health equity. So welcome both of you.

Dr. Eleanor Bimla Schwarz:

Thank you for having us.

Tammy Kremer:

I'm so excited to connect. It's been months in the making since Jennifer Carlin, who is a medical consultant with the California Prevention Training Center, wrote to me to connect me with you about your study based on pregnancies that occur after tubal sterilization or having your tubes tied. Jen had previously been on an episode of the podcast that we called Lesser Known Forms of Birth Control and Downplayed Side Effects, and in that episode we talked a bit about access to permanent sterilization, specifically there was a story of a young woman who wanted to have her tubes tied in her 20s, and Mariana Horn, one of our guests on that podcast, talked about how hard it was for her to get that procedure. I kept thinking about this patient as I was communicating with the two of you, and learning about the rate of pregnancy that can happen after tubal sterilization.

I'll let you share the stats yourselves, but in the study that you wrote 2.9 to upwards of 8% of people who have their tubes tied could end up being pregnant later, and that just was very alarming to me, I guess, because the general conversation around tubal sterilization seems to be that people make the assumption that once they've done that they're good to go. They don't really need to be thinking about getting pregnant. It just really drove home for me another area around contraception, where there's a

lack of information or communication of the information that we already have, so I'm really excited to speak with you on these issues today. Just to get us started, I want to give you each an opportunity to share what makes you passionate about your clinical and research work around contraception, and anything specifically you want to share about permanent contraception at this point. Dr. Treder.

Dr. Kelly Treder:

I entered OB-GYN as a field knowing that I wanted to focus on family planning as a specialty, and knowing that I wanted to really devote my career to issues around contraception and reproductive healthcare. I think clinical care and research around contraception really provides this amazing opportunity to be incredibly person-centered and very individualized, both in the care that we deliver and in research that can make reproductive healthcare as a whole just much more attuned and responsive to people's needs and values. Birth control is such a personal decision, and such a preference-specific decision that really depends on people's experience, people's values to find the option that is the best for them. So I really like having the opportunity to be able to support people in making those decisions that are in alignment with their values and their goals for their reproductive lives.

Tammy Kremer:

Thank you, Dr. Treder. How about you, Dr. Schwarz, what's something that makes you passionate about the clinical and research work that you do around contraception?

Dr. Eleanor Bimla Schwarz:

I'm a general internist, I provide primary care, and I also work in the inpatient setting with patients who tend to have complicated lives, and often chronic medical conditions. I have seen the ways in which pregnancies that aren't timed the way a family would like them to be can really be really complicated for patients and their families, and their whole community. So I think that made me start getting interested in how to try to help make sure that patients who wanted to control the timing of their pregnancies had the resources they needed to do that.

I have always been interested in caring for underserved populations, and it became clear to me fairly on in my career that somehow the reproductive health of women with chronic medical conditions was a bit of an underserved area, where women would feel like they went to the doctor all the time, but nobody ever talked to them about their birth control options. We made assumptions that women would already know what they needed to know to take care of themselves, so to speak, in terms of preventing pregnancy. So, I guess some of my passion for making sure that we are talking to women and having these conversations comes from that, of trying to make sure that people don't face those challenges without feeling ready for them.

Tammy Kremer:

Yeah, thanks for sharing that grounding in terms of the impact on people's lives when they have this access and information. Can one or both of you tell me a story about a patient or just an example of some of the kinds of situations you've seen patients in when they come looking for more permanent long-term options for contraception?

Dr. Eleanor Bimla Schwarz:

I feel like I see a lot of patients who have come to the understanding that "birth control is not safe for them" because they have medical conditions that make it complicated for them to use estrogen, which

is commonly in birth control pills, but they haven't gotten a deeper dive of what their options might be. They seem to think that their only option would be to have a surgery to "have their tubes tied" as a way to avoid future pregnancy, which might be dangerous, and avoid the risks they perceive of birth control.

Dr. Kelly Treder:

I'll add to that that I see a lot of people who come to me to talk about a surgery because they're at the point in their lives that they feel very sure that they don't want more children, and they want the method that's the most effective, and they really perceive a surgery to be sort of the, what we would say in the medical world to be the gold standard or sort of the best of the best in terms of pregnancy prevention. I think that's definitely the idea or the perception out there that these sterilization surgeries are the most effective option if you really want to be sure that you're not going to get pregnant again.

Tammy Kremer:

Can you tell me a bit about what does that surgery actually entail or what kind of options exist in the realm of more permanent contraception, and which actually are the most reliable options?

Dr. Eleanor Bimla Schwarz:

I think there's a lot of different concepts floating around there. Just to be clear, permanent can mean it can't be undone, but it doesn't necessarily mean fail-proof or most reliable. So I think we need to be clear, are we talking about ones that are one and done and you never think about it again, or what you're looking for is something that's really fail-proof?

Tammy Kremer:

Can we talk about both? I'm curious to start with fail-proof, what would you consider fail-proof?

Dr. Kelly Treder:

Well, I think, unfortunately, nothing. I don't think we really have any contraceptive option that's fail-proof, maybe other than abstinence, which I always say is fail-proof until it's not. I think that's one of the things that Dr. Schwarz and I are pretty passionate about, is getting that information out, that there are a lot of really effective contraceptive methods, but that nothing is perfect, nothing is a 100%. It seems like the things that probably work the best are things like an implant that goes in the arm or an IUD, particularly probably a hormonal IUD seems to work the best. Then, at least the data that we have, it seems like a surgery, like a tubal surgery for birth control is probably third in the ranking if we were really going to rank things in terms of effectiveness with the data that we have today. Would you agree, Dr. Schwarz?

Dr. Eleanor Bimla Schwarz:

Well, I would say we can't forget the options for our male partners, and vasectomy, the permanent surgery for men is also going to be more effective than the surgeries for women. How a vasectomy compares to a arm implant, we don't have direct data, but it looks like maybe the arm implant comes out ahead there. Yeah, so I might say arm implant number one, vasectomy number two, hormonal IUD number three, and then these surgeries for women number four, based on the data we have at this time.

Tammy Kremer:

It's pretty amazing to hear that. I think what you were talking about before of this assumption that a surgery is going to be the most reliable, it's an interesting example to examine what makes us socially, culturally carry that belief. I think something that I have felt is I have more information about the variety of options available that seems to be somewhat more common knowledge, at least from my perspective, than the rates of pregnancy when using those options. I think some of those methods that you've described, in my mind, I did have the belief that having a tubal sterilization or having your tubes tied would most likely be the most effective option for a female-bodied person, and that those others would come afterwards. I'm wondering, from your perspective, do most providers that you work with seem to have that same information that you do, or is this an area where there's a gap between the research and practice?

Dr. Eleanor Bimla Schwarz:

I think there is a gap between what most clinicians know, and what the studies have actually shown us. I think there's also an issue here where we just don't talk to people about surgeries. When we do our sex ed for young adults, teens, high school, we don't talk about contraceptive surgeries because we think that most of these teens will want to be pregnant at some point, and so what they're looking for is not a permanent option right now, so we don't talk about it when we're talking about birth control the first time. Then as people get older, we don't tend to talk about it because we sort of assume that these are adults who know everything they should know, and we've sort of jumped over this part of who was supposed to ever tell you about any of this. I think that there's a lot of people just relying on what they learned from their peers and the community, and not a lot of actually talking to somebody who's really a specialist in this area about how these options compare.

I think it's important also to be clear, all of these methods we're talking about are very effective. They're more effective than the pills. They're more effective than condoms. There's a good number of clinicians who might say, "Oh, those differences between those methods, they're so small. Who really cares about that small of a difference?" That may be true, it may not be a meaningful difference to some people, but I also feel like we owe our patients the respect of letting them decide how big of a difference matters to them. If what they want is really the most effective, then we need to be clear that from the studies that have been done, the most effective thing a woman could do without her partner's participation would be the arm implant.

Tammy Kremer:

Such important information to get out there. Are either of you seeing an increase in people asking for the most effective forms of contraception and, or specifically for permanent sterilization given the political climate around abortion today?

Dr. Kelly Treder:

I mean, certainly. I think in clinical practice we see that. Yes, I think there's research and data also to show that there's been an increase in sterilization procedures as abortion access has become more restrictive, and specifically in states where abortion is more limited. There's certainly a lot of justified fear in terms of people being concerned that they're not going to be able to access abortion in the case of an unintended pregnancy, and people are seeking really effective contraception, and for some people that has led to a surgical method.

Tammy Kremer:

When it comes to surgery, I know that there's been different versions of procedures available. Are we talking at this point about only one or can you describe the surgical options that exist?

Dr. Kelly Treder:

Yeah, that's a great question. There are a number of different actual procedures sort of grouped under this term sterilization, or tubal sterilization, or tubal surgery for contraception, a lot of different terms. We used to do procedures where essentially we would find some way to interrupt the fallopian tube. The fallopian tube is typically the place where the sperm and the egg meet, and then they travel back down into the uterus, and the pregnancy implants in the uterus, and so any sort of way to interrupt that tubal path. Sometimes we have cut out a little segment of the tube, there have been clips, there have been rings, there have been a lot of different ways that we've done the procedure. Increasingly now, we are actually removing the fallopian tubes completely, which we don't think changes much in terms of the surgical risk or the length of the procedure, and so that has been a newer trend that has not been incredibly well-studied in terms of actual effectiveness for pregnancy prevention, but that has been a shift in practice in many places in recent years.

Tammy Kremer:

That's really interesting to hear because I know that, if we can talk for a second about those who might have any regrets or desires for the reversal of a procedure, that sounds like one that would be irreversible. Can you talk a bit about which of those procedures might be reversible for some time, and whether patients are informed about which version of the surgery will be performed?

Dr. Kelly Treder:

In general, any of these procedures should not be considered reversible. When we talk about the difference between fail-proof and permanent, they should really be considered a procedure that cannot be undone. There are some types of reversal procedures, however they are not guaranteed in terms of how successfully they can put a fallopian tube back together, and especially not guaranteed in terms of how that reversal procedure can result in a pregnancy and a live baby, which is the goal when someone is asking about a reversal procedure typically. I think that's a really important message to get out, that these are not procedures that can be reversed easily or with any guarantee no matter what type of procedure is done, and that reversal procedure is almost always not covered by insurance.

Surgery paid for completely out of pocket is very expensive, and so it sort of underscores the importance of people being really informed before making this type of decision. Because I have had patients come to me and say, "Well, I want the surgery that I can undo in 10 years when I think I might want to have a pregnancy." So that obviously warrants a lot more discussion about maybe then a surgery is not the best option if this is really something that you're wanting to undo at some point in your life.

Dr. Eleanor Bimla Schwarz:

I think we do have fairly widespread misunderstanding of what it means to have your tubes tied. A lot of people seem to have the understanding that that would be something you could easily untie, and that it would be a procedure that you could undo. Unfortunately, if you go to Dr. Google and you just look on the internet about options, it does appear that it's possible to have surgeries that would allow you to get pregnant after you've had your tubes tied. But again, access to those surgeries is really expensive, and for many people ends up really not being a reality that they could then pursue in vitro fertilization, or

some other assisted fertility techniques so that they could achieve a pregnancy after having their permanent contraceptive procedure, even if there are advertisements for such services on the internet.

Tammy Kremer:

Got it. Yeah, that's really significant in terms of information being misleading. I'd love to hear from the perspective of providing this care, what it's like to try to communicate so much information to a client who comes in and is looking for, let's just say the most effective contraceptive method. How do you communicate about statistics, and the possibilities of pregnancy using different contraceptive methods, as well as counsel patients about the scope of possible side effects?

Dr. Eleanor Bimla Schwarz:

I think the first thing is to really get a sense of what is most important to the person you're talking to at this point in their life. I always talk to my patients about the fact that for most people, their sense of what's working well for them will change over time, and that there are a lot of methods, and none of them work perfect for all patients. Unfortunately, we have to have you try them out and see if you like them, and if you don't, then we'll be more than happy to switch to something else. If after you've tried everything you want to go back to the first thing you try, that that is totally fine, and that's what I'm here for, is to help connect you with whatever option you would like. Sometimes when people are thinking they want a surgery, they come in and say, "I want a surgery," and I think part of our job is to really help understand how they've come to that decision, about why it is that they think that's going to best meet their needs. For many people, that will be what best meets their needs.

Again, many people are very, very happy after they've had these surgeries. It is one of the most commonly used form of contraception in the country. I think the thing that breaks my heart is that it's estimated that one of every 10 people who has these surgeries goes on to regret having had it, or to ask to have somebody reverse it and then be told, "No, sorry, I don't know how we could pay for that for you," which is just the most painful thing to have to do. I literally was in a clinic this morning with a woman who was asking, "Isn't there any way I could help have her insurance cover IVF for her?" Unfortunately, there's no way that I know of to write letters to any insurance companies that will get them to cover that.

I think, for me, it's just about trying to make sure that people know everything they need to know to make a good decision for themselves. For some people that will end up being a surgery, and that's a beautiful thing if that's what's going to work well for them. But I think it's just our obligation to make sure that they know about all available options, that they're not arriving at this decision that they need to have a surgery because they think it's the only thing that's safe for them, or the only thing that will work well for them.

Tammy Kremer:

That is a heartbreaking conversation to have to have. I could see how that would be really difficult for someone to accept, and what a striking contrast to those who are just so grateful to have had that surgery performed. Dr. Treder, do you have anything to add about that? Anything that you look out for in terms of indications that particular methods might be a good match for someone?

Dr. Kelly Treder:

I would echo what Dr. Schwarz said, it really is such an individualized decision. I think starting the conversation from a place of understanding someone's values around their contraceptive choice can really help make the conversation really smooth, and really productive, and really feel like you are really

helping to advocate for a person's choice, and help them come to the right choice for themselves. There's sort of a structure to the things that I want to always include in any conversation that I have with somebody before they're going to have a surgery, because I want to make sure that there are some key facts. Many of the things that we're talking about here everyone has heard before, and really feels like they can understand so that they know that it is really the right decision for them.

That's true of all birth control counseling, but I think it's especially important or sort of heavy when you're thinking about an option that really is permanent or is not easily reversible, and so there are some key things that I always bring up to people, and really want to make sure that people feel like they have a good grasp of. I've certainly had people with every one of those things. I can think of a patient who has said, "Oh, this is definitely not the right thing for me because of that," and it sort of speaks to the misinformation or some of the misperceptions that are out there about these types of surgeries, and whether or not they can be reversible. I've had people say that ultimately it wasn't the right choice for them because they didn't actually realize that it was a real surgery that might require time off of work, and would require general anesthesia.

It's sort of enlightening when you do a really in-depth counseling discussion with somebody, and realize how many different ideas they came in with that may have led them to think this was the right option for them, but not for everyone.

Tammy Kremer:

Thanks. What are some more things on that checklist of what you might go through?

Dr. Kelly Treder:

Well, we've talked about a lot of them. One is certainly about the effectiveness. It's really important for me to make sure that people understand that there are other contraceptive methods that work as well, or better than a surgery, and to weigh that comparative effectiveness against the risks of surgery. Because these surgeries for most people are very safe surgeries, but it's still a surgery, and a surgery is always riskier than something that doesn't require anesthesia, something that doesn't require an abdominal incision. So while the complications from surgeries like this are very low, they're still higher than the complications that you might have from an IUD placement or an arm implant, and so it's important that people know that there are some standard risks that come with all surgeries, and that those are probably more common than the risks that might come with placement or use of an IUD, for example. That's one of the big things, is sort of the comparative effectiveness and the comparative safety or risk or complication profile.

The other thing, and Dr. Schwarz mentioned it earlier, but I always have to mention vasectomy. I have rarely have someone take me up on it, but it is important for people to know that that is an option. If somebody has a single male-bodied partner, and that person is interested in vasectomy, it is more effective than a tubal surgery, and it is much lower risk. It is done under local anesthesia with a couple of days recovery compared to a few weeks of recovery for a tubal sterilization surgery. So that's another thing that I'm always mentioning to folks. Then, I also always mention the risk of regret because I think that is a unique risk to a surgery like this, unlike any other types of surgeries that the threat for this surgery can be really profound. Like Dr. Schwarz described, those visits when folks are coming in asking about fertility options after a surgery are really the most painful because the options are just so limited, and it's a really heartbreaking visit to have with folks.

Dr. Eleanor Bimla Schwarz:

One more conversation about those risks that Dr. Treder was talking about, one of the ones that is sort of hidden in some of what she's talking about in terms of recovering from surgery, but I think feels different when we actually put a name on it, is pain and how much pain people have after the procedure. That can be a complicated conversation as well because if you're put to sleep you're not going to feel anything right at the time that you're put to sleep, but in the days after a abdominal surgery many people do have pain. Somehow we have a lot of people who seem to worry about pain with IUD placement, and that can happen, but in the grand scheme of things it's much more common for people to have abdominal pain and pelvic pain after they have one of these surgeries than after they have an IUD placed.

So I think that's another place where it's important for us to make sure we're having the conversation, and talking about what it is that's worrying our patients. For a variety of reasons, it's totally appropriate for our patients to be worried about how much pain they might experience, and for how long they might have pain after they go through a procedure.

Tammy Kremer:

Absolutely. Thanks for raising that. I feel like there's, I don't know if it's just me, but there's also this perception of like, "Okay, you're having your final kid, they can just, while you're doing that, may as well just get your tubes tied." I think my mom did that when I was born, I'm the youngest of three. I haven't considered what additional pain or challenge having a procedure at the time or around the time of birth could cause.

Dr. Eleanor Bimla Schwarz:

I agree with you. Many people in this country do have these procedures done during a hospitalization when they're delivering a baby, and a lot of the pain that they might have from such a surgery will often, I think, get wrapped up under, well, if they were having a cesarean section, they would be recovering from that anyways, so it might not be any additional pain or discomfort than what they were expecting from that abdominal surgery. But I think for the people who are having these procedures at times when they haven't just had a cesarean section, it's important to think about what pain might be involved with recovering from having some cuts made to your abdomen.

Tammy Kremer:

Yeah, thanks for raising that, that's really important to consider. So let's talk about arm implants. What do you think are some reasons that folks are choosing that or not? Do you think anything has changed in the popularity of that option?

Dr. Eleanor Bimla Schwarz:

Their popularity has been growing over time. The biggest limitation to arm implant placement in this country remains that it's somewhat hard to find a clinician who has been trained to place the arm implants, and that is not because it's a complicated procedure at all, but it has to do with the way contraceptives are regulated in this country, and the fact that the Food and Drug Administration put a special requirement on this device, which says that you have to go through a formal training program run by the company to be able to place the device. So that takes a special commitment on behalf of the clinician to have gotten that training, and not all clinicians, unfortunately, have yet done that, not all residency training programs are routinely making sure that all of their graduates are able to place implants.

It's more challenging than it should be to find a provider who can place an implant. There are some websites online, there's a group called bedsider.org where there's a clinic locator and if you know that's what you want, you can put in your zip code, and it will help you find a clinician near you. But ideally, in a world that I will live in at some point, any clinician you would ask would be able to place or remove an arm implant because really it's such a simple clinical procedure

Tammy Kremer:

That's really telling in terms of the structural issues around accessing that procedure. I'm curious your take on some of the research that's been done around these so-called, in our conversation at least, fail-proof or permanent contraceptive methods, what your take is on the research that's been done, and what kind of research we need.

Dr. Eleanor Bimla Schwarz:

The data that we have available comes from a couple different sources. One is what's called the National Survey of Family Growth, and that is a survey of US women that is done every few years, and it is designed to be representative of the experience of all US women between the ages of 15 and 45. One study looked at a number of cycles of that data. In fact, it looked at data from 2002, 2006 to 2010, 2011 to 2013, and then the most recent data that's publicly available, from 2013 to 2015. Across all of those cycles, it found that approximately 2.9% or up to even 5.2% of the women who told those interviewers that they had had one of these procedures that they thought would be fail-proof, and then after that they had gotten pregnant without trying. So we can see there that it seems like it definitely wasn't fail-proof as they might have expected.

In terms of what additional studies might be useful to us from there, it would be really nice to know what the data since 2015 shows, that's from 10 years ago. Unfortunately, that data isn't publicly available at this time, so it requires somebody getting special access, and being able to share that with the world, but I do hope that we'll have that information in the future. As Dr. Treder was mentioning, some of the surgical approaches have changed over the last 10 years, and if in fact salpingectomy is more effective than these older procedures, we would hope to see that that rate had gone down, but at this point we don't honestly know.

The other source of data is claims data, and there was a study that looked at the experiences of many women in the state of California who were getting publicly funded contraception. That study looked only at women who were having these procedures done at a time other than when they had just given birth. So these were women who were having what are sometimes called interval procedures. In that study, again, we saw that the rates of pregnancy in the first year after they had one of these procedures done was about 2.6%. So very similar to what was reported from the National Survey of Family Growth. Again, importantly, in that study of Medi-Cal clients, women who had an IUD placed were potentially less likely to experience a pregnancy within the first year of use.

Tammy Kremer:

Thanks for that overview in terms of understanding where we're at with the research. Can you talk a bit about the research that you specifically are working on related to this?

Dr. Eleanor Bimla Schwarz:

It's always a challenge to get funding to do the projects that one would like to do, but as I was mentioning, I would love to get funding such that we would be able to look at the not publicly available National Survey of Family Growth data, the more recent years of that, as well as to do some additional

analysis of Medicaid claims data. Hopefully, we'll have that and be able to report back on whether there are differences between women who have these procedures, whether that's an IUD placement or a permanent contraceptive procedure done just after delivery, as opposed to at another time in her life.

Tammy Kremer:

Was there a turning point you can point to in research on these methods? If so, can you talk about how that impacted the standards of care?

Dr. Eleanor Bimla Schwarz:

I don't think there's been a major turning point or a change in standard of care. Standards of care vary internationally. I think we have to also spend a little time asking ourselves why we do so many more surgeries than IUD placements in the US compared to other wealthy European countries where IUD placement is much more common than these surgeries. I think some of that has to do with the way healthcare gets funded in the United States as opposed to in some of those other countries. Clearly, we pay more for surgeries. Surgeries are more complicated than IUD placement, so that probably influences rates of provision in the US in fee-for-service situations.

Dr. Kelly Treder:

I do think something that we haven't quite touched on, a bit tangential to what we're talking about now is just the history of these types of surgeries in this country. There is a long history of forced and coerced sterilization in this country, mostly targeted towards certain communities in our society, people of color, people with lower incomes, people with disabilities. I think that the history is ... I shouldn't probably call it a history because it's not in our distant past, it's quite recent, and I think it's an important context too. I don't know if I would necessarily call it a turning point, but I do have some hope that we are shifting towards a much more person-centered model of contraceptive care that is really trying to get away from some of that history, and really trying to restore some autonomy and empowerment towards the folks and the communities that have suffered from that. So that's one of the things also that really excites me and motivates me about this work, is really trying to create a type of reproductive healthcare that is much more equitable and just much more justice-oriented.

Tammy Kremer:

Yes, thank you for centering that in this conversation, and I think that's something folks may know about, but not necessarily always understand the implications or how that has impacted the distrust of a provision of contraceptive care, and aspects of the relationship between the clinician and patient when someone's coming in looking for an option that might work for them. I'm wondering how the training of clinicians, what your take is on how clinicians are being trained around talking about these different options, and what clinicians might benefit from in order to work with patients in ways that are more responsive, both to the history of these methods and the needs of patients.

Dr. Eleanor Bimla Schwarz:

I think one thing that is really shining through is that there's a lot to know about each of these methods, and there are a lot of methods. I think at least in our training of general internists to primary care providers, we're not getting enough time on the topic, and so people end up with fairly superficial understanding of what the range of methods are, and what the range of concerns that would ideally be addressed with each patient. I think the good news is we do have resources out there online, some of

which are very good, and the goal is to try to get people to use the ones that are good, but I think also sometimes on the internet there is information that can be misleading.

Tammy Kremer:

Do you have any favorite resources you'd like to name?

Dr. Eleanor Bimla Schwarz:

My two favorites are, for young people bedsider.org, and I think that is really focused for teens and it works well for teens, but it doesn't do a great job talking about options that many of my patients are looking for, as Dr. Treder was mentioning, those who are just feeling like they're done and they're interested in surgery. For folks who are interested in comparing surgery to other options, we've put together a website that is available at advancingaccess.ucsf.edu, and that website, I guess, is one of my favorites for people considering getting their tubes tied, because it does take the time to go through all the different dimensions that seem to me to be important for people to consider before going through such a surgery.

Tammy Kremer:

Great. We'll make sure to include those in the show notes. Dr. Treder, do you want to add anything on that?

Dr. Kelly Treder:

I agree with all of those. I think Reproductive Health Access Project also has great, more in-depth fact sheets about individual methods for patients, and how to use certain methods. That's something I refer to a lot for people who are choosing between methods, or have chosen something and are wanting some sort of written information as they're trying something out.

Tammy Kremer:

Great, thank you. How can clinicians and researchers work together to make sure that the information that we have is being utilized and implemented in clinical settings?

Dr. Eleanor Bimla Schwarz:

I think most clinicians are trying to. I think it just requires ongoing attention, like we do with so many of our continuous quality improvement initiatives to make sure that we're paying attention to what options are being offered, and making sure that our patients truly do have access to all of their potential options. Because if you're living in a community where you don't have access to all of your options, then people will often settle for an option that may not be their preferred option, just because the barriers of traveling or of obtaining child care so they could go to a more distant clinic really can end up constraining people's choices.

Tammy Kremer:

As we come to a close, I just want to ask, is there anything else that we haven't talked about today that you really want a presence for our listeners?

Dr. Kelly Treder:

I do just want to drive home the point about how personal and individual this decision about birth control, especially about a permanent birth control option is, and how important it can be, the power of that experience, and kind of the honor of that experience as a clinician, to be a part of that, and the responsibility of clinicians and reproductive healthcare as a field to really create a setting, and create a conversation that can allow people to really find the option that works best for them, and also the freedom to take the time to make that decision.

I think Dr. Schwarz said it earlier that birth control is a little bit of a journey, and you might try something and it might not work quite right, and your needs might change as you go throughout your life, and I think that idea can be really helpful for clinicians and patients making those decisions, to know that it's not one size fits all, and it might also shift over time for any one person, and that we really need to give these conversations some space, and give it what it deserves so that people are making the right choices for themselves.

Dr. Eleanor Bimla Schwarz:

I would echo that. My goal is never to talk somebody out of any given method. My goal is to make sure you have all the reasons why you are absolutely right that this is the right method for you, and I just want to make sure you know everything about it so we can both be sure that this is exactly right for you.

Tammy Kremer:

I appreciate that framing.

Dr. Eleanor Bimla Schwarz:

The other thing that we didn't talk about really in explicit terms is where abortion fits in this whole conversation, and access to abortion services, and the way that fear that people may not have access to abortion services can lead people to feel like they need to protect their patients or protect themselves by taking what might otherwise be seen as potentially drastic measures. I was really impacted once upon a time by a conversation with a French colleague, who was talking about how she found it so interesting, the differences between France and the US, where in France everybody was really, really worried that a woman might regret a tubal sterilization, but they had no concerns that she would regret an abortion. Whereas in the US, we have this preoccupation that women may regret their abortions, and we don't think much about whether or not they will regret having a tubal surgery. The data really shows that regrets after abortion are very rare to non-existence.

I think it's important to make sure that we're making sure our patients have access to all of the options that might be useful to them, including access to abortion services when they're thinking about all of what might be useful to them in controlling their fertility.

Tammy Kremer:

Yes, thanks for bringing that forward. I was recently reading the book on The Turnaway Study by Dr. Diana Greene Foster, and there is a figure in the book that shows the number of unintended pregnancies that conceivably, pun intended, could happen if someone is using a particular form of birth control across their entire reproductive years. It was very humbling to see that even folks that are using birth control correctly, as this figure kind of maintains, people could still easily become pregnant unintentionally over the course of the 20 or so years, or more, that they might be sexually active and able to produce a pregnancy. It just really shows the role that abortion has to play alongside, and as part of a suite of options to give people the power to determine when, and whether they want to have children.

Dr. Eleanor Bimla Schwarz:

Indeed. I think we also need to remember that abortion can be so simple these days. It's just a pill. It's not a complicated regimen. It's really not much more complicated than any other pills that people take at other times in their life. There can be complicated abortion procedures that require advanced training, but for most pregnancies that are identified early, ending it can be as simple as taking a pill.

Tammy Kremer:

I like to end each episode asking our guests, what's one thing you hope we can create by coming together for sexual health?

Dr. Eleanor Bimla Schwarz:

For me, it's a world of no regrets.

Dr. Kelly Treder:

I love that. I love the ideals of reproductive justice, and those sort of main tenets of people really being empowered to have children, not have children, parent their children, and live with their families in dignity and safety. That's the world I dream of, and I think we have some work to do, but I think we're up to the challenge.

Tammy Kremer:

We're getting there. Great. Well, thank you both so much for your time, and the work that you do every day. I really am inspired by getting to have this conversation and looking at the areas that are underexposed around contraceptive options. It's always eye-opening how much there is to know on this topic.

Dr. Eleanor Bimla Schwarz:

Well, thank you, Tammy. You did a beautiful job guiding this conversation.

Dr. Kelly Treder:

Thanks, Tammy. Thanks for prioritizing this.

Tammy Kremer:

Absolutely. Thanks for listening, and please follow and rate us wherever you get your podcasts to help more people find us. Hey, how about sharing this with a friend or a colleague you'd like to talk with about sexual health? Check out the show notes for the resources mentioned in this episode and the transcript of the show. Connect with us on Instagram at comingtogetherpod, on X at CaliforniaPTC, and at comingtogetherpod.com. This podcast is produced by me, Tammy Kremer, with our co-producer and editor, Isaiah Ashburn, brought to you by the California Prevention Training Center. We're based at the University of California San Francisco, and would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.