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A qualitative exploration of women's experiences discovering pregnancies in the emergency department☆

Sarah C.M. Roberts *, Erin Wingo, Katrina Kimport

Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, University of California, San Francisco, Department of Obstetrics, Gynecology & Reproductive Sciences

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ABSTRACT

Objectives: The few studies examining pregnancy testing in emergency departments (EDs) address pregnancy-related physical risks. Here, we examine experiences of people who discover pregnancies in EDs.
Methods: Between 2015 and 2017, as part of a larger study, we conducted interviews with 29 women in Southern Louisiana ($n = 13$) and Baltimore, MD ($n = 16$), who reported discussing their pregnancy during an ED visit. We analyzed these interviews for content and themes.
Results: Respondents reported diagnosis of pregnancy as a routine and straightforward component of care received in EDs. They reported receiving diagnostic studies and therapeutic interventions to rule out and treat complications of pregnancy and care for what brought them to the ED to begin with, such as treatments for nausea and vomiting; education about physical symptoms and nutrition-related needs during pregnancy; and referrals to prenatal care. However, we find evidence of unmet needs related to patient-centered communication, such as providing emotional care to women discovering pregnancies in EDs and lack of support for transitions to abortion care.
Conclusions: While diagnosis of pregnancy in the ED may be routine for ED clinicians, it is not necessarily routine or straightforward for people receiving the diagnosis. ED clinicians should not assume that all people who discover their pregnancies in the ED want to continue their pregnancy. People who discover pregnancies in EDs may benefit from patient-centered communication and support for the range of transitions to care people might need in addition to the routinely provided diagnostic and therapeutic interventions.
Implications: ED clinicians may need additional training and support to ensure that they can meet the range of needs of people who discover their pregnancies in the ED.

1. Introduction

Multiple U.S.-based studies examine diagnoses and treatments for pregnancy in the emergency department (ED), including diagnoses of ectopic pregnancy, treatment of miscarriage and treatment of abortion-related complications [1–3]. With the exception of miscarriage treatment literature, this research focuses on medical diagnoses and treatments related to pregnancy complications rather than emotional and lived experiences of pregnant people receiving care in the ED. Recent research has documented that pregnant people visit EDs not only for urgent and emergent reasons and that those who visit EDs during the perinatal period tend to have publicly funded insurance or lack insurance, miss more prenatal appointments and have multiple health risks such as partner violence and higher risk for postpartum depression [4,5]. This research suggests that pregnant people who visit EDs may have needs beyond urgent medical diagnoses and treatments.

Another way researchers have examined pregnancy in EDs is in the small body of literature addressing the question of to which patients to give pregnancy tests [6–8]. Implicit in this literature is that some people discover their pregnancies in EDs. Yet, this literature focuses narrowly on an assumed shared understanding that use of pregnancy tests in EDs is necessary to avoid causing pregnancy-related physical risks, such as inadvertently giving teratogenic medications to pregnant people or exposing developing fetuses to radiation [9]. The literature related to pregnancy testing (and thus discovery) in EDs, like the larger literature related to pregnancy-related care in EDs (except miscarriage treatment) [1,2], has been primarily medical and epidemiological and

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* Corresponding author.
E-mail address: sarah.roberts@ucsf.edu (S.C.M. Roberts).

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focused on health care professional perspectives related to diagnosis [10]. It has not examined the range of emergency medicine care that might be relevant for people receiving the pregnancy diagnosis in EDs. While normal pregnancy does not need immediate medical care or treatment [10], people diagnosed with and who thus discover pregnancies in EDs may have particular health care needs related to communication, education or referrals. This study examines in-depth interviews with women who discovered pregnancies in EDs with a goal of beginning to identify opportunities to improve the range and types of care provided when ED clinicians diagnose pregnancy.

2. Material and methods

We analyzed in-depth interview data collected as part of the Multistate Abortion Prenatal Study, which examines pregnant people's experiences living in a state with multiple versus few policies restricting abortion [11,12]. The University of California, San Francisco, and Louisiana State University Institutional Review Boards granted ethical approval for this study.

2.1. Study procedures

Between June 2015 and June 2017, we recruited participants at four university-affiliated prenatal care facilities in Southern Louisiana and Baltimore, MD, that primarily serve patients who have or are eligible for Medicaid. We describe study details elsewhere [11,12]. At each recruitment facility, research coordinators approached all patients over 18 years who spoke English or Spanish and presented for their initial prenatal care appointment. Eighty-six percent of eligible individuals consented to participate in in-clinic quantitative portions of the study, for a total of 589 participants [12]. We remunerated participants with a $30 gift card for in-clinic data collection.

We invited a subset of in-clinic participants to complete an in-depth interview by telephone with K.K., a qualitative sociologist. We designed in-depth interviews to address overarching study questions of (1) how state abortion policies matter for obtaining a wanted abortion and (2) how pregnant people experience obtaining pregnancy-related services at pregnancy resource centers. Pregnancy resource centers, also called crisis pregnancy centers, typically offer free pregnancy testing and dating, counseling, patient education or referrals to resources. They are staffed mostly by volunteers who do not have medical training. Most pregnancy resource centers do not refer for abortion, and many are affiliated with evangelical Christianity; part of their mission is to dissuade pregnant people from obtaining abortion care. We purposively sampled from the quantitative participants to develop an in-depth interview sample likely to inform our overarching study questions. We adapted eligibility criteria over the course of the study to recruit appropriate respondents to achieve adequacy in addressing these overarching study questions and to produce similar populations across geographical areas. Criteria included patients who reported that their pregnancy was unintended, that they had considered abortion for this pregnancy or that they had visited a pregnancy resource center.

Eighty-three respondents (43 Louisiana and 40 Maryland) completed in-depth phone interviews 1 to 4 weeks after initial recruitment, at a time convenient to them. We ceased recruitment for interviews when the in-clinic quantitative portion of the study reached its prespecified sample size [12]. Interviews were semistructured, following a general interview guide but allowing respondents to introduce topics they found relevant. Pertinent to this analysis, interviews included discussion of respondents' discovery of pregnancy, feelings about the pregnancy, pregnancy decision making and pregnancy-related services sought or received as well as demographic information. K.K. completed extensive field notes after each interview, summarizing content, identifying initial patterns and reflexively accounting for her own social location and experience of the interview. Interviews averaged 1 h in length; length did not differ by recruitment site. We audio-recorded all interviews with permission of respondents. A professional transcription service transcribed interviews verbatim. We offered respondents who completed an in-depth-interview a $50 gift card to remunerate them for their time.

2.2. Analysis

The methodological orientation was modified grounded theory [13]. In her initial review of the transcripts, S.R. identified discovering pregnancy in the ED as a common experience. This finding led us to analyze the subset of interviews ($n = 29$) that included reference to this experience. Although experiences in EDs was not a motivating question for the study, a number of respondents reported experiences in EDs in their accounts of seeking and receiving pregnancy-related services, prompting this emergent area of inquiry. Using Dedoose, E.W. then read all transcripts and tagged all content that described ED visits during pregnancy, both current and previous pregnancies, creating a dataset of excerpts. S.R. and E.W. reviewed nine of the excerpts together and identified preliminary themes based on open coding and note taking. We then created a preliminary codebook to capture these themes. S.R. and E.W. separately coded transcript excerpts from 15 interviews based on this codebook and then met to discuss and resolve discrepancies, identify emergent codes and update the codebook. Then, S.R. and E.W. applied the updated codebook to the excerpts from these 15 interviews, reviewed discrepancies and finalized the codebook. Using the final codebook, S.R. applied the codes to all transcript excerpts related to ED visits. As a validity check, S.R. reviewed ED visit descriptions in context of the rest of the interview. To orient findings, we examined the identified emergent themes about ED experiences in light of Emergency Medicine competencies, defined by the Council of Residency Directors in Emergency Medicine [10]. We present findings using these competency domains as an organizing structure.

All names are pseudonyms. While we did not explicitly ask about respondents' gender identity, the semistructured interview format, especially during questions about pregnancy discovery, allowed respondents to introduce the topic of gender identity. No respondent did so. In the results below, as most pregnant people identify as women, we use she/her pronouns and refer to respondents as women.

3. Results

Twenty-nine respondents mentioned visiting an ED during their current ($n = 26$) and/or a previous ($n = 4$) pregnancy: 13 from Louisiana and 16 from Maryland. Reflecting demographics of the overall quantitative sample [12], most identified as Black ($n = 24$), four as White, and one as Hispanic. The youngest participant was 18 and oldest 38, with most ($n = 17$) in their 20s. Most ($n = 23$) had been pregnant previously, with most currently parenting and close to half ($n = 12$) reporting previous abortions. We organized women's descriptions of their experiences into the following Emergency Medicine competency categories: Diagnosis, Patient-Centered Communication, Diagnostic Studies and Therapeutic Interventions, Transitions of Care and Education.

3.1. Diagnosis of pregnancy during the ED visit

One group of women in our sample reported visiting an ED already aware that they were pregnant. They went to get care that might typically be provided in an outpatient prenatal care setting, such as seeking and getting confirmation they were pregnant, asking for advice around feelings of dizziness and fainting and getting care for health conditions (such as fibroids) that placed their pregnancy at high risk. They also went for urgent/emergent issues, some of which were pregnancy related, such as unexplained bleeding, and others they perceived as nonpregnancy specific, such as severe depression and symptoms that were diagnosed as a pulmonary embolism.

Another group of respondents ($n = 19$) went to the ED not knowing that they were pregnant, though, and were diagnosed as pregnant during an ED visit. Most of those who went to the ED not knowing that they were pregnant had gone for care related to possible pregnancy-related symptoms, such as nausea, vomiting, other gastrointestinal upset, pains in the abdomen and unexplained bleeding. When they went to the ED, though, they were diagnosed as pregnant. April said,

"I was having a lot of digestive problems, like over the period. I was eating a lot of Chinese food, and I thought that maybe that was it, or maybe I ate some bad sushi. And it was just terrible. […] And I was like, […] I've got to see what's wrong with me. You got to tell me if I have like a stomach bug or whatever." And so I went [to the ED], and then [they] like did a little CT test, and then I found out."

Less commonly, respondents who went to an ED not knowing that they were pregnant went for reasons not related to possible pregnancy symptoms, such as a knee injury or a cold. Two reported having gone to the ED in the past for unexplained bleeding and discovering that they were having a miscarriage when they had not known that they were pregnant. Some who discovered pregnancies in the ED reported having an inkling that they might be pregnant. Others reported having no idea that they might be pregnant.

Two respondents reported clinicians explicitly asking if they could conduct a pregnancy test, and one noted that ED clinicians did the pregnancy test without asking. Others were not specific about how the process of pregnancy discovery was initiated, simply mentioning in the interview that a pregnancy test was done.

3.2. Patient-centered communication

Respondents who discovered their pregnancy in the ED reported various emotional and coping responses. While some reported positive emotional responses such as "excited" and "happy" and others reported neutral emotions and reactions such as "surprised," "mellow," "so-so" and "wasn't worried," most described negative emotional responses. Respondents described feeling "overwhelm[ed]," "devastated," "upset," "confused," "froze[n]" or "scared" upon learning that they were pregnant. Several sourced these negative reactions in not wanting to be pregnant or have and parent a baby. Taylor went to the ED after experiencing an ache in the bottom of her stomach. While she reported knowing that being pregnant was a possibility, she still reported feeling shocked upon learning that she was pregnant in the ED. She explained the shock she felt upon being told that she was pregnant in the ED, saying, "I wasn't really ready [for another child]."

Others identified health-related concerns as undergirding their negative emotional reaction to pregnancy discovery. Stephanie had thought that she could not become pregnant due to a physical health condition she had and had resisted taking the pregnancy test that her primary care doctor suggested because she was scared of finding out the result. After 2 months of feeling unwell, Stephanie eventually went to the ED, where they did a pregnancy test, and she learned that she was pregnant as well as that she also had another severe medical condition. For Stephanie, who had severe health problems that required surgery during her previous pregnancy, concerns about her future health conditioned her emotional response to pregnancy discovery: "I was devastated when I found out…I was upset. I just — I was just really, really upset because I told myself that I knew my body couldn't handle it."

Chloe had never been pregnant before, and it did not occur to her that the intense nausea and vomiting that prevented her from going to work for 3 days could be symptoms of a pregnancy. She went to the ED, where she found out that she was 9 weeks pregnant. Similar to Stephanie, Chloe was worried that her pregnancy would not be healthy because she had not been eating right or taking prenatal vitamins: "I wasn't eating a lot. I couldn't, like, really keep anything down is all. And then I wasn't sure, like, is that […] okay for me to not be eating as much as I was supposed to?"

Still others explained their negative emotional responses to discovering pregnancy as related to social and interpersonal concerns. LaToya went to the ED because she was not feeling well and, in the ED, found out that she was pregnant. She had not thought that she was pregnant because she h still had her period. LaToya said she felt overwhelmed to discover her pregnancy, especially because she had no ongoing relationship with the man involved in the pregnancy: "My partner wasn't really my partner. It just was something that happened. So, I knew I would go through it alone. And I just wasn't prepared for it." After learning that she was pregnant, LaToya reported being in denial; she did not disclose her pregnancy to anyone else for 2 months.

Broadly, these reactions to pregnancy discovery were not specific to having discovered pregnancy in the ED; these respondents likely would have felt the same upon learning of their pregnancy in different settings. But the experiences of these feelings did occur in the ED. When respondents experienced these feelings in the ED, they typically reported processing their feelings on their own, although some reached out to a family member or the man involved with the pregnancy by phone or, if in the ED with them, in person to process the news. Their immediate reactions included involuntary reactions like letting emotions out through shaking or crying. Stephanie, described above, explained: "I cried. I cried. And I just cried." Stephanie went on to describe having to stay overnight because of severe dehydration; even with this long time in the hospital, Stephanie described getting emotional support only from her mother, who had taken her to the ED. Despite the emotional reaction of shock that Taylor had, she described her experience in the ED as not including clinician attention to her emotions, that "after they were done with the [medical] care, I left."

Describing another instance of inadequate patient-centered communication, LaToya, described above, reported being so overwhelmed by both learning of her pregnancy and the nurse's presumption that she would be happy about it that she left the ED before she was discharged:

"When the nurse told me,[…]she was smiling, I guess like a woman would smile if they found out they were pregnant[…]But we didn't really have a conversation about it. She asked me was I excited. I didn't really answer. I just looked at her and did a little smirk or something because I'm a crybaby. So, I had already started crying[…].She took some more information. And she told me to go back into the waiting room and that they would call me so I can get some blood work done. Then that was when I left."

The ED nurse involved in LaToya's care not only failed to anticipate that LaToya might not be happy about the news that she was pregnant but, based on LaToya's account, also failed to respond to and even account for the negative emotions LaToya was communicating.

3.3. Diagnostic studies and therapeutic interventions

In the ED, respondents described receiving multiple diagnostic studies and therapeutic interventions. Specifically, they reported receiving diagnostic studies to make sure the pregnancy did not require urgent/emergent treatment, including ultrasounds and checks of fetal heartbeats to date pregnancies, rule out ectopic pregnancies and diagnose or rule out miscarriages. They also reported receiving therapeutic treatments for nausea/vomiting and dehydration and treatments for miscarriage. A few described receiving non-pregnancy-related care, including treatment for urgent/emergent issues that brought them to the ED (such as pulmonary embolism) and treatment for nonurgent issues such as colds, urinary tract infections, rashes and mental health disorders.

3.4. Transitions of care

A key component of care respondents recalled related to receiving linkages to help them transition to other forms of care. By respondents' accounts, ED clinicians were effective in linking them to prenatal care. Courtney described: "I went there when I went to the emergency room and they scheduled me an appointment for the next two weeks and I went to that one and now they scheduled me another one."

Not all respondents, however, were certain that they wanted to continue their pregnancies at the time; 24 reported considering abortion for this pregnancy, some while in the ED. Linkage to abortion care, however, was extremely rare. Indeed, only one respondent, Michelle, received information about abortion and only after specifically requesting it. She found the materials produced inadequate to enable her to obtain abortion care: the handout the clinician gave her listed only an abortion clinic 5 h away. She explained, "I had to bring it [abortion] up, and it was only — and I brought it up at the end of the appointment, because she hadn't said anything. And she basically just handed me a printout about an abortion clinic in […] Shreveport, Louisiana, which, I mean, that's in North Louisiana, and I can't even afford to use their services, let alone get up there."

At the time of Michelle's ED visit, there were two abortion clinics in Southern Louisiana open, although even those closer clinics would have been difficult for Michelle to get to as she lacked transportation. While we cannot know from what Michelle reported the reasons the provider gave her a handout to an abortion clinic 5 h away rather than the local abortion clinics, from Michelle's perspective, this linkage was not provided in a way that met Michelle's needs. Receiving a handout to an abortion clinic 5 h away contrasted with what the prenatal care referral looked like for Michelle and for other participants: "Yeah, they just said follow up at the women's clinic. So, I came up here to the fifth floor and made an appointment, and then was seen."

One participant, Chloe, who had severe nausea and vomiting (described above) and did not consider abortion for this pregnancy, reported that an ED clinician referred her to a pregnancy resource center because the clinician asked her what help she needed and she had "a lot of questions. I was just unsure about a lot of things." The clinicians explained that she could go and meet with a group at the center where she could get "free things and [where] they had programs and meetings for new mothers." Chloe, who went to the pregnancy resource center the very next day, described it as a place where "I can talk with them every Tuesday about anything. You know, the emergency room is just, I guess, where you come in for emergencies." Chloe described positive experiences with free items offered by the pregnancy resource center and the center's programs and meetings for new mothers and mentioned it to two other pregnant people she knew.

3.5. Education

Respondents recalled receiving advice and health education about their diagnoses and pregnancy and that, in most cases, the care was helpful and answered questions. Concerned about her ability to keep food down, Chloe, who was excited about her pregnancy, reported having a lot of questions, particularly related to nutrition and prenatal vitamins. She was able to ask questions about nutrition and got answers that were helpful. Taylor found out that the stomach pain that initially prompted her ED visit was due to the "egg" against her ovaries and that if she stayed hydrated, it would go away and that this pain was normal. Knowing that the pain was not "something else" and knowing that "[the pain] would go away" helped her be okay with the pain until it subsided the next week. Abigail began spotting a few days after having a positive home pregnancy test and went to the ED. There, she learned that "I had just had like a mini-period or something like that because they said while you're pregnant, you can get your period. I didn't know that."

Respondents did not, however, offer examples of receiving education with basic information about abortion. Among respondents who discovered pregnancies in EDs, other parts of interviews revealed a lack of knowledge about what it would take logistically and financially to obtain an abortion, that abortion funds might be available to help them pay for the abortion and what having an abortion entails in terms of procedures or medications.

4. Discussion

While the idea that people get diagnosed as pregnant in EDs is in scholarly literature [6–8], our study is the first that we are aware of to explore what that experience is like for people who are discovering they are pregnant. Consistent with what has been described in literature about pregnancy-related care in EDs in general [1–4], women described experiences with ED clinicians as primarily providing diagnostic and therapeutic interventions for assessing complicated pregnancy and treating normal pregnancy. They also described receiving support for transitions to prenatal care and education relevant for people wanting to continue their pregnancies.

Women's descriptions of their experiences discovering pregnancies in EDs, however, suggest that the care they receive when they discover pregnancies may not take into account that this is the first time they are interacting with a health care provider around what, in many cases, is an unintended and, in some cases, an unwanted pregnancy. These descriptions also reveal missed opportunities for education, patient-centered communication and referrals for people who may be considering abortion. Specifically, echoing reports of miscarriage treatment in EDs literature [1,2], multiple women reported needing emotional support that they did not receive. A few also reported experiencing clinician communication that was not receptive to or not reflective of their emotional state, such as when they were not happy to discover pregnancies. Respondents did not typically report having emotional needs considered or even inquired about in EDs and, in at least one case, described a situation in which the response of ED clinicians may have exacerbated the negative reaction the respondent was having. This pattern suggests that there may be missed opportunities to use patient-centered communication to support people who discover pregnancies in EDs. However, that one participant received a referral to a pregnancy resource center in the ED suggests that some ED personnel may recognize support needs beyond what can be provided in the ED in patients planning to continue pregnancies and thus help them get support in places that they believe will meet those needs.

Also, respondents typically described ED clinicians as arranging transitions to prenatal care, with arrangements either provided without an exploration of interest in continuing pregnancy or providing basic information about how to obtain an abortion. Support for transitions to abortion care appears inadequate in our sample. Respondents who considered abortion in EDs did not receive referrals to abortion care, save for one instance of a handout that the respondent found impractical and unusable. There also appear to be gaps in education regarding what obtaining an abortion entails.

We note, though, that barriers to ED clinicians providing more robust care related to pregnancy discovery and abortion in EDs could relate to Emergency Medicine competencies rather than views of individual providers or institutions. These competencies do not specifically address unintended pregnancies and address abortion as a complication of pregnancy [10]. Scholarly literature on abortion in EDs is similarly limited in that it focuses on EDs as sites of treating abortion complications or places where people seek care after an abortion [3,14] rather than a health care location that can support people in obtaining treatment for an unwanted pregnancy.

4.1. Limitations

There are a number of limitations. First, we do not have access to medical records or perspectives of providers with whom respondents interacted. Providers may have offered other care including referrals that respondents do not remember. Providers may also have had reasons for why they did what they did about which respondents are unaware. Second, by virtue of recruiting in prenatal care, women who were referred to abortion clinics in the ED and were able to obtain an abortion would not be included. Thus, the lack of descriptions of this experience may be a reflection of the sample rather than an indication that referrals are not provided. However, by virtue of eligibility criteria for in-depth interviews, most respondents had considered abortion for this pregnancy. This suggests there are at least some women in the in-depth interview sample for whom a referral to an abortion clinic might have been appropriate. Future research with abortion patients should explore whether women who obtained abortions visited EDs before presenting at the abortion clinic and whether they received referrals from the ED. Third, the sample is from two states; women in other states and regions of selected states may have different experiences. Fourth, the sample is primarily Black, low income and urban. Their experiences may differ from women who identify as other races, higher-income women or women in more rural areas. Fifth, none of our interviewees reported identifying as transgender or nonbinary. As transgender and nonbinary individuals report high levels of discrimination in EDs [15,16], their experiences could differ from experiences reported in this sample.

4.2. Conclusions

While diagnosis of pregnancy in the ED may be routine for ED clinicians, it is not necessarily routine or straightforward for people receiving the diagnosis. ED clinicians should not assume that all people who discover their pregnancies in EDs want to continue their pregnancy. People who discover pregnancies in EDs may benefit from patient-centered communication and support for the range of transitions to care people might need in addition to routinely provided diagnostic and therapeutic interventions.

References

[1] Punches BE, Johnson KD, Gillespie GL, Acquavita SA, Felblinger DM. A review of the management of loss of pregnancy in the emergency department. J Emerg Nurs 2018; 44:146–55. https://doi.org/10.1016/j.jen.2017.11.001.

[2] Chrestiana D, Cheng AB, Panebianco NL, Dean AJ. Pitfalls in cervical ectopic pregnancy diagnosis by emergency physicians using bedside ultrasonography. Am J Emerg Med 2014;32:397 e1–3 https://doi.org/10.1016/j.ajem.2013.10.055.

[3] Upadhyay UD, Desai S, Zlidar V, Weitz T, Grossman D, Anderson P, et al. Incidence of emergency department visits and complications after abortion. Obstet Gynecol 2015;125:175–83. https://doi.org/10.1097/AOG.0000000000000603.

[4] Kilfoyle KA, Vrees R, Raker CA, Matteson KA. Nonurgent and urgent emergency department use during pregnancy: an observational study. Am J Obstet Gynecol 2017; 216:e1–7. https://doi.org/10.1016/j.ajog.2016.10.013 181.

[5] Malik S, Kothari C, MacCallum C, Liepman M, Tareen S, Rhodes KV. Emergency department use in the perinatal period: an opportunity for early intervention. Ann Emerg Med 2017;70:835–9. https://doi.org/10.1016/j.annemergmed.2017.06.020.

[6] Strote J, Chen G. Patient self assessment of pregnancy status in the emergency department. Emerg Med J 2006;23:554–7. https://doi.org/10.1136/emj.2005.031146.

[7] Stengel CL, Seaberg DC, MacLeod BA. Pregnancy in the emergency department: risk factors and prevalence among all women. Ann Emerg Med 1994;24:697–700. https://doi.org/10.1016/s0196-0644(94)70280-2.

[8] Minnerop MH, Garra G, Chohan JK, Troxell RM, Singer AJ. Patient history and physician suspicion accurately exclude pregnancy. Am J Emerg Med 2011;29:212–5. https://doi.org/10.1016/j.ajem.2009.10.017.

[9] Goyal MK, Hersh AL, Badolato G, et al. Underuse of pregnancy testing for women prescribed teratogenic medications in the emergency department. Acad Emerg Med 2015;22:192–6. https://doi.org/10.1111/acem.12578.

[10] EM Model Review Core Content Task Force II. 2016 Model of the clinical practice of emergency medicine. https://www.cordem.org/globalassets/files/misc.-files/2016-em-model—website-document.pdf; 2016.

[11] Kimport K, Kriz R, Roberts SCM. The prevalence and impacts of crisis pregnancy center visits among a population of pregnant women. Contraception 2018;98:69–73. https://doi.org/10.1016/j.contraception.2018.02.016.

[12] Roberts SCM, Kimport K, Kriz R, Holl J, Mark K, Williams V. Consideration of and reasons for not obtaining abortion among women entering prenatal care in Southern Louisiana and Baltimore. Maryland Sex Res Soc Policy 2019;16:476–87. https://doi.org/10.1007/s13178-018-0359-4.

[13] Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. Thousand Oaks: SAGE Publications; 2006.

[14] Upadhyay UD, Johns NE, Barron R, Cartwright AF, Tape C, Mierjeski A, et al. Abortion-related emergency department visits in the United States: an analysis of a national emergency department sample. BMC Med 2018;16:88. https://doi.org/10.1186/s12916-018-1072-0.

[15] Chisolm-Straker M, Jardine L, Bennouna C, Morency-Brassard N, Coy L, Egemba MO, et al. Transgender and gender nonconforming in emergency departments: a qualitative report of patient experiences. Transgend Health 2017;2:8–16. https://doi.org/10.1089/trgh.2016.0026.

[16] Chisolm-Straker M, Willging C, Daul AD, McNamara S, Sante SC, Shattuck DG, et al. Transgender and gender-nonconforming in emergency departments: what physicians know, think, and do. Ann Emerg Med 2018;71:183–8. https://doi.org/10.1016/j.annemergmed.2017.09.042.