Combatting Abortion Misinformation and Disinformation in Medical Education

Jaya Prakash  
*Harvard Medical School, jaya_prakash@hms.harvard.edu*

Deborah Bartz  
*Department of Obstetrics and Gynecology, Brigham and Women's Hospital, dbartz@bwh.harvard.edu*

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Background

Abortion regulation, coupled with societal stigma, has resulted in abortion care delivery being relegated largely to independent clinics outside the standard medical system. An estimated 16.4 to 18.9 million U.S. Google abortion-related searches are conducted annually—many of which disseminate abortion misinformation and disinformation (MI/DI) (Turk et al., 2018; Prata & Guendelman, 2019). Up to 80% of websites created by crisis pregnancy centers convey MI/DI, widening the gap between the public’s perception of and patients’ lived experience with abortion care (Bryant et al., 2014; Patey & Hood, 2021; Rowlands, 2011). As medical students are exposed to the same anti-abortion messaging employed within the current sociopolitical landscape, they must understand mechanisms of abortion MI/DI. Further, medical trainees are uniquely positioned to serve as health advocates for correcting abortion MI/DI as they 1) understand medical aspects of political issues, 2) observe links between social issues and health, 3) are trusted by the public, and 4) have access to leaders (Harris Interactive, n.d.; Earnest et al., 2010).

How Does Abortion MI/DI Intersect with Medical Education?

MI/DI leveraged by the anti-abortion movement influences medical students’ understanding of abortion when they walk into medical school. The blame lies in part with the medical community—not out of overt malintent but rather because most medical professionals are informed by the same abortion MI/DI as the general public. Unless medical education is utilized to deliberately correct inaccurate messaging for the entire medical school class, abortion MI/DI will continue to perpetuate within the medical community. There are three main tactics employed to spread health-related MI/DI.

Distorted Storytelling

Narratives are effective at communicating MI/DI given their capacity to 1) build off one another to develop a collective narrative and 2) incite emotional resonance that can reinforce the story within our memory (Dahlstrom, 2021; Polletta & Callahan, 2019; Toscano, 2020). As an example, one pervasive myth argues that most women regret their abortions. Its power to create a collective narrative “lies in its ability to create meaning from the scattered facts of reality and attach normative evaluations toward evaluating that meaning” (Dahlstrom, 2021). Simultaneously, the emotional engagement and reactions incited by stories create a sense of narrative realism that enables acceptance of this messaging—whether true or false (Dahlstrom, 2021). The anti-choice movement promotes gendered narratives that advocate for regulating reproduction that are predicated upon the themes of protecting women from regret, sensationalized imagery of the fetus, immoral providers, and patient atonement for wrongdoing (Allen, 2015; Hopkins et al., 2005; Lentjes et al., 2020; Toscano, 2020). The protagonist in these pro-life narratives is typically a woman who affirms traditional gender roles, unconditional support for the male head of household, as well as faith in God and ultimately denounces abortion (Allen, 2015). Students’ exposure to these reductive, sensationalized narratives has adverse implications for the future health care workforce’s understanding, sympathy, and provision of abortion care (Coeytaux et al., 2003; Rivlin et al., 2020; Stewart & Darney, 2003).
Co-opting of Medical Language

Co-opting language is wielded to gain traction and credibility for more controversial stances (Bartlett & Miller, 2010; Evans & Narasimhan, 2020; Ganesh & Zoller, 2012). The anti-abortion movement has successfully co-opted clinical language to infiltrate federal and state abortion policy by leveraging social diagnoses. Given that social diagnoses exist at the intersection of social structures and manifestations of illness, they provide an opportunity for additional social actors (i.e. government, corporations, social movements, legal practitioners) to influence creation of these diagnoses (Brown et al., 2011). For example, ‘Post Abortion Syndrome’ exists as a social diagnosis that was constructed from the inaccurate interpretation of existing data or methodologically flawed studies (Kelly, 2014). This co-opted medical terminology transmits MI/DI not only to pregnant people but also to medical trainees by masquerading as an unconditionally accepted diagnosis.

How Can Feminist Pedagogy be Implemented in Medical Education to Intervene Upon Abortion MI/DI?

With its emphasis placed on lived experience, shared narratives, empowerment, community building, and challenging traditional views, feminist pedagogy is uniquely positioned to intervene in spaces fueled by MI/DI (Webb et al., 2002).

Interventions Combatting Distorted Storytelling

The challenge with combatting inaccurate information—especially when derived from a distorted, reductive narrative—is that people conceptualize the world around them by subconsciously filling in content to complete gaps in observations and almost universally filling in those gaps with patterns they already believe to be true (Ecker, 2017). The solution lies in countering reductive imagery with authentic patient stories layering the myriad of personal, medical, and social factors that patients balance in pregnancy decision-making. Patient storytelling in abortion medical education situates a patient and her narrative in front of learners so students can conceptualize her decision and circumstances. The “#ShoutYourAbortion” movement is meant to destigmatize the issue of abortion in this way by providing relatable in-person or written stories of people who accessed abortion care (Mauldin, 2019). The same storytelling features used in MI/DI tactics can be leveraged to first identify the misconceptions and second fill the gaps with a representative story (Murphy et al., 2015; Wojtowicz et al., 2020). Exposing students to abortion patient stories and perspectives challenges pre-existing beliefs, promotes self-reflection, and improves students’ capacity to counsel patients on pregnancy decision-making (Rivlin et al., 2020; Rivlin & Westhoff, 2019). This intervention can be applied to professionalism competency development in medical education (Merz et al., 2022). Class-wide sessions centering on abortion patient narratives can be implemented and followed by facilitated reflective discussion among students (Jha et al., 2013).

Interventions Combatting the Co-Opting of Medical Language

Medically accurate, evidence-based abortion information taught in the same way and with the same rigor as other reproductive health topics not only corrects misperceptions but also normalizes abortion as standard healthcare (Sirr, 2007). Empowering students to call out MI/DI and disseminate accurate information can be particularly helpful in combatting co-optation of progressive language (University of Washington, 2018). Medical students can be taught to recognize medically inaccurate rhetoric in the anti-abortion movement. First, in classroom-based sessions, students would together analyze a case of abortion MI/DI (i.e. Post Abortion
Syndrome) for its accuracy and validity. Librarians can be involved in these lessons to help students navigate the identification and evaluation of accurate sources. Second, students would be assigned a project to apply these health communication skills by 1) identifying a current real-world manifestation of MI/DI, 2) analyzing its mechanisms for the class, and 3) disseminating accurate information to the public combatting the MI/DI. Social media campaigns with this function have already been successfully leveraged by medical students to combat COVID MI/DI (Tesema et al., 2022; University of Minnesota, 2020).

Conclusion
It is important for students to recognize and combat the plethora of false abortion medical messaging. In the short term, innovations that train students in this skillset can improve their realistic understanding of bodily autonomy, reproductive justice, pregnancy decision-making, and abortion care as it relates to the real abortion patient experience. When framed within a feminist pedagogical lens, our curricular innovations can inform the development of students’ healthcare communication both inside and outside the exam room. In the long term, these improvements can equip future physicians to engage in more equitable, accurate, and nuanced conversations with patients, colleagues, and communities, especially when there is a value-conflict within those conversations.
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