AN ABSTRACT OF THE THESIS OF

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Title: An Abortion Service Provider as Political Activist.

Abstract Approved: _____

Susan M. Shaw

The feminist beliefs of abortion service providers and the effects of these beliefs on the delivery of health care to patients is examined by the author who is herself a feminist and member of an abortion clinic staff. Discussion includes abortion rates, abortion safety, characteristics of patients, and accessibility of abortion, particularly as affected by legislation and anti-abortion activism. The research consists of the author's personal experiences as a counselor and patient advocate, conducting patient health history interviews, supporting patients in the operating room, and attending patients during recovery. The data is presented in a personal narrative including autobiographical material, a methodological style supported by feminist theories which question the supposed objectivity and neutrality of conventional scientific methods. Three means by which feminist beliefs are expressed in the delivery of abortion services to patients are identified: the language used to refer to abortion and abortion-related services, the choice of abortion related topics adressed during clinic visits, and the reconfiguration of the conventional provider/patient relationship.

An Abortion Service Provider as Political Activist

by

Gloria Willis

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Gloria Willis, Author

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I do much of my reading, writing, postulating and pontificating at home, so I must express thanks for the patience of my family -- Marius, Mary-Alice, and Neil. Loving them challenges both my cynicism and idealism; they make me strong and keep me honest. I am indebted to Susan, Sara, Ashley, Jeff, Jane, and Earlene who have taken charge of my children on various occasions so that I might have more time to write. Neil Kvern, Sara Moon, Jim Newhall, and Jane White assisted in proofreading. Additional thanks to Neil who broadly supports my academic endeavors, and has been instrumental to the completion of this work in document production, childcare, caffeine support, and bandying of ideas.

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This thesis is dedicated to my mother, Alice Lee, and to my daughter, Mary-Alice.

An Abortion Service Provider as Political Activist

Chapter 1

Introduction

Abortion is both a medical procedure and a political issue, a pointed example of the intersection of private and public domains. The conflict over abortion has raised questions concerning the beginning of life, biological and psychological definitions of personhood, sex, reproduction, biomedical and feminist ethics, family values, sexual equality, and liberties of privacy and bodily integrity. These questions are discussed and debated through a wide range of institutional forums including the media, academia, religion, legislature, law, and most markedly for the purposes of this paper, medicine.

The goal of medicine is to preserve and protect our physical and psychological well being. Medicine as an institution plays a central role in categorizing health and disease, determining which methods of diagnosis and treatment are appropriate, and establishing frameworks for relationships of a medical nature (e.g., physician/patient, specialist/general practitioner, doctor/nurse, psychiatrist/social worker). In this sense, medicine not only effects our bodies directly through physiological means, but also influences how we perceive our bodies, and how we live within the very physical context of our bodies.

Abortion is political in that it is an issue of legislation and government control, and more widely speaking because it is central to broader social issues of health, gender, and power. The medical procedure that is abortion is widely

practiced and safe. However, political forces by means of legislation, public and academic debate, and abortion clinic violence have effectively reduced access to abortion. Abortion is a highly dynamic political issue in that advocates and opponents are actively engaged in debate which continues to affect and shape legislation and public opinion. Those who participate in abortion, including doctors, clinic support staff, and patients, participate in political controversy to varying degrees -- tangentially, directly, unconsciously, or deliberately. Abortion service providers who intentionally act to shape the controversy of abortion are acting politically and can be considered political activists.

Health care workers are also principal conduits of the medical information we receive. Considering the ethical issues, public debate, and potentially violent opposition surrounding abortion, health care workers who provide abortion services are to some degree political. Their work-related actions take place within the context of an evolving political debate. Their willingness to provide access to abortion in the face of oppositional hostility is practical testimony to the belief that abortion, far from being unethical and sinister, is a constitutionally protected choice and reproductive right available to women.

Despite the broad social implications, political activism, like abortion itself, is also an individual experience. In order to present a personal perspective on abortion, abortion services, and the political aims of one abortion service provider, I herewith relate my experiences as an abortion clinic counselor by means of personal narrative including autobiographical material. While this type of data is not substantially generalizable, it uniquely describes abortion, abortion services, and the abortion controversy from an

"insider" perspective, a perspective of which the personal nuances are not easily expressed by statistical methods.

Because I am a feminist and consciously hold feminist beliefs -- the transformation of social structures toward the empowerment of women and the end of sexist oppression -- I examine my experiences for evidence that these beliefs affect the health care I provide to abortion clinic patients. Reflection on my experiences has led me to delineate three areas in which my political beliefs are expressed in the services I provide patients: 1) the language used to refer to abortion and abortion services, 2) the choice of abortion-related topics discussed, and 3) the reconfiguration of the conventional provider/patient relationship. Each of these areas shapes our perceptions and actions regarding abortion, women, and power.

Chapter 2

Literature Review

Incidence of Abortion

For all the controversy involved, abortion does not occur infrequently. Since the 1973 Supreme Court decision in *Roe v. Wade* which established a woman's constitutionally protected right to have an abortion during the early stages of pregnancy, more than 35 million legal abortions have occurred. It is estimated that of the more than 6 million pregnancies each year in the United States, about half are unintended, and more than half of those end in abortion (Henshaw, 1998b). While each year in the United States only 2% of women between the ages of 15 - 44, the age range typically used to represent women of childbearing age, have an abortion (Henshaw, 1998a), projections based on 1992 abortion rates indicate that 43% of women will have at least one abortion before they are 45 years old (Henshaw, 1998b).

Patient Characteristics

The majority of women who obtain abortions used some form of birth control during the month they became pregnant. However, 11% of women who obtain abortions have never used contraception. Nonuse of contraceptive methods is highest among women who are young, poor, unmarried, Hispanic, black, or have limited formal education (Henshaw and Kost, 1996). Unintended pregnancy is directly linked to nonuse of contraception. In fact, 53% of unplanned pregnancies occur among the

smaller portion of women who do not wish to be pregnant, but who do not use birth control methods (Henshaw, 1998b).

Most of the women who have abortions in the United States are young, (below the age of 25 years old), unmarried, or white (Koonin, et. al., 1998). While most abortions are obtained by white women, the abortion rate for minority women is disproportionately high. Hispanic women are about twice as likely as white women to have an abortion, and black women are more likely still to have an abortion. The higher abortion rate of minority women, as is the case with young and unmarried women, is directly related to higher rates of unintended pregnancies (Henshaw, 1998b).

Three reasons are commonly given by women to explain their decision to have an abortion: about three-quarters say that having a baby would significantly disrupt responsibilities of work, school, and family; roughly two-thirds indicate that they cannot afford a child; and one-half do not want to raise a child as a single parent or within a troubled relationship. There are also about 14,000 women each year who choose to terminate pregnancies which are the result of rape or incest (Torres and Forrest, 1988; Hoshiko, 1993).

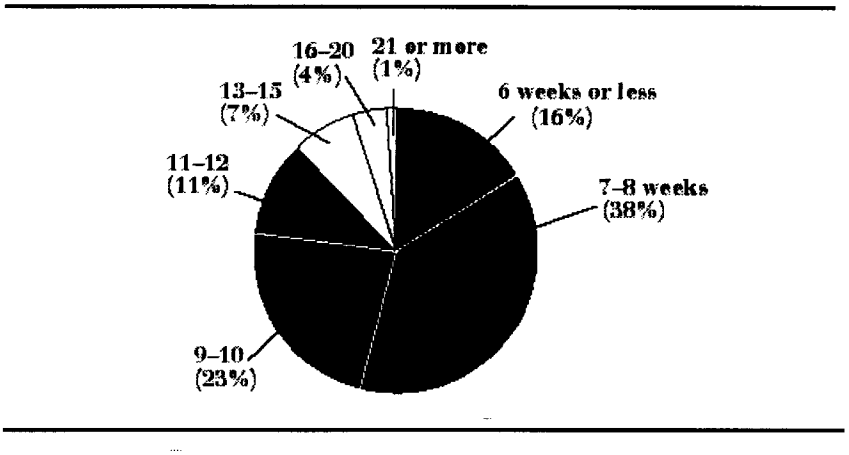
Abortion Safety

Legal abortion is one of the safest surgical procedures practiced today. Incidence of significant complications associated with abortion such as serious pelvic infection, hemorrhage requiring blood transfusion, and unintended major surgery, are uncommon, occurring in less than 1% of all abortions (Lawson, et. al., 1994). Risk of death from having a legal abortion is minimal -- one death in every 150,000 abortions, having decreased steadily since shortly after *Roe v. Wade*, when the death rate was one in every 34,000 abortions. In

fact, full term pregnancy and delivery are significantly more dangerous than abortion, the risk of death being more than ten times as high for childbirth than that associated with abortion (Grimes, 1994).

The primary factor contributing to risk of death from abortion as well as other associated health risks, is length of pregnancy. Abortions performed at eight or fewer weeks result in one death for every 530,000 abortions, compared to a death rate of one in 17,000 for abortions performed between 16 and 20 weeks, and one in 6,000 at 21 or more weeks. The overall low death rate associated with legal abortion is largely due to the fact that 88% of abortions take place during the first 12 weeks of pregnancy (Fig. 1).

Figure 1: When Women Have Abortions (in weeks).



Eight-eight percent of abortions occur in the first 12 weeks of pregnancy.

Source: The Alan Guttmacher Institute, 1998.

Access to Abortion

While abortion is widespread and relatively safe, several factors, including the legal and illegal activities of anti-abortion groups, have limited women's access to abortion.

Legislation and Funding

Legislation limiting abortion has reduced access for some women, particularly those who are young or poor. State and federal restrictions which deny public funding of abortions, require parental involvement, or mandate waiting periods effectively delay access to abortion thereby increasing the health risks associated with the surgical procedure (Fried, 1997; Henshaw, 1995).

Between 1973 and 1977, federal Medicaid paid for about one-third of all abortions in the United States. Since then, the U.S. Congress has passed numerous versions of the Hyde Amendment which prohibits use of federal funds for abortions except for cases in which the pregnant woman's life is endangered, and more recently, cases of rape or incest. Public funds, virtually all from state health plans, pay for about 14% of all abortions (Sollom, 1996). Sixteen states, including Oregon and Washington, provide funding for the abortions of some poor women. It is estimated that 20-35 percent of women who are eligible for Medicaid have carried pregnancies to term when they would have had an abortion if funding had been available (Henshaw, 1995).

The Alan Guttmacher Institute, a reproductive health research organization, reported in 1998 that parental involvement laws requiring minors to notify or obtain consent from parents before having an abortion are

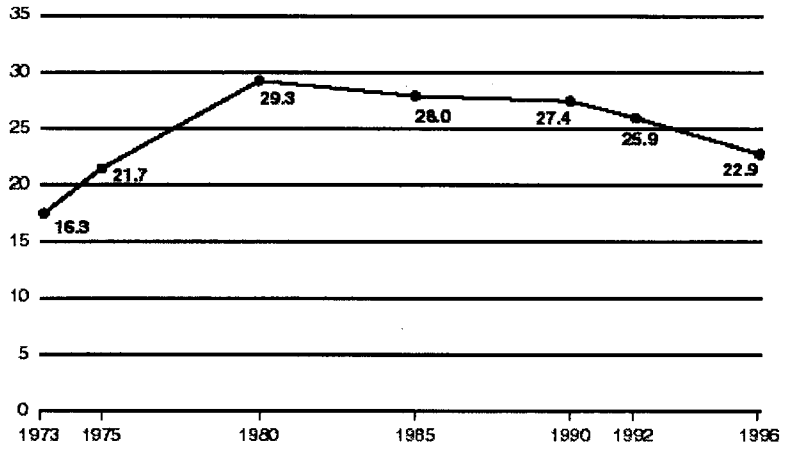
enforced in 30 states. In the 1992 decision of *Planned Parenthood v. Casey*, the Supreme Court mandated provisions for judicial bypass for minors who can not or will not involve their parents, and court permission is usually granted. However, the judicial bypass process often requires additional time, money and travel, thereby delaying and sometimes preventing abortions for some teens (Fried, 1997).

Providers

The number of abortion providers has decreased since the 1980s, falling 14% from 2,380 to 2,042 between 1992 and 1996. A corresponding shift in the distribution of abortion providers to metropolitan areas left 86% of U.S. counties without a known abortion provider. Thirty-two percent of women aged 15-44 lived in these predominantly rural areas. Still, more than one-quarter of the 320 U.S. metropolitan areas had no known abortion providers (Henshaw, 1998a).

Abortion rates have similarly declined. During the same period, the abortion rate fell from 26 to 23 per 1,000 women of childbearing age, declining in number from 1,529,000 to 1,366,000 (Fig. 2). A study involving data from 1987 to 1994 (Henshaw, 1998b) indicates that the abortion rate for women aged 20 and over remained relatively stable, while the respective rate of unplanned birth declined. However, while the abortion rate for younger women decreased 24%, the rate of unplanned birth for these teens remained steady.

Figure 2: The Number of Abortions per 1,000 Women Aged 15-44 by Year.



Source: The Alan Guttmacher Institute, 1998.

Also, there may not be enough medical students trained in abortion techniques to replace the older abortion providers who have or soon will retire. While the percentage of Ob-Gyn programs which offer some abortion training to medical students remained steady at about 70%, there has been a decline in the proportion of these programs requiring routine abortion training (exempting students with religious or moral objections). Only 12 percent of Ob-Gyn programs required routine training for first-trimester abortions in 1991-1992, down from 23% in 1985. The percentage dropped from 21% to 7% for routine training for second-trimester abortions. About 30 percent of Ob-Gyn programs, including 94% of Catholic hospitals and all military programs, do not provide abortion training at all (MacKay and MacKay, 1995).

Anti-abortion Violence

A contributing factor obstructing access to abortion is anti-abortion activism. Health care providers are less motivated to train for and provide abortion services in the face of virulent opposition and potential violence. Clinics and providers have long been targets of threatening or violent acts including blockades, bombings, arson, death threats, bomb threats, assault and battery, and murder. Since 1993, in five separate incidents, anti-abortion activists have murdered five clinic workers -- three doctors, two receptionists, a volunteer escort, and a security guard. Many others have been injured, threatened, or harassed for seeking or providing abortion services (Fig. 3).

In 1993, the U.S. Congress voted into legislation the Federal Access to Clinic Entrances (FACE) Act which prohibits blocking of abortion clinic entrances and intimidating abortion providers or their patients who seek abortion services. The number of clinic blockades has decreased dramatically since passage of the FACE Act. However, anti-abortion activism continues in many other forms, some violent. In the discourse of abortion, anti-abortion violence is portrayed in a variety of guises including terrorism, misogyny, free speech, civil disobedience, and justifiable homicide. The discourse by which the abortion controversy is shaped and defined is enacted through the institutions of medicine, the media, academia, legislation, and the courts.

In 1999, Planned Parenthood of the Columbia/Willamette, along with another Portland, Oregon abortion clinic and five physicians, brought civil suit against American Coalition of Life Activists (ACLA) and 12 of its members for violations of the FACE Act. The abortion providers claimed in part that the anti-abortion activists had threatened their lives by distributing "wanted" posters directed at specific doctors. Similar posters had been distributed prior

Figure 3: Incidents of Violence and Disruption Against Abortion Providers (1).

VIOLENCE	'77-83	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Murder	0	0	0	0	0	0	0	0	0	0	1	4	0	0	0	2	7
Attempted Murder	0	0	0	0	0	0	0	0	2	0	1	8	1	1	2	1	16
Bombing	8	11	2	3	0	0	1	1	1	0	1	1	1	2	6	1	39
Arson	13	14	9	7	8	5	8	10	8	19	12	11	14	3	8	4	153
Attempted Bombing/Arson	5	6	10	4	7	3	2	3	1	13	7	3	1	4	2	5	76
Invasion	68	34	47	53	14	6	25	19	29	26	24	26	4	0	7	5	363
Vandalism	35	35	49	43	29	29	24	26	44	116	113	42	31	29	105	7	795
Assault and Battery	11	7	7	11	5	5	12	6	6	9	9	7	2	1	9	4	111
Death Threats	4	23	22	7	5	4	5	7	3	8	78	59	41	13	11	25	315
Kidnapping	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3
Burglary	3	2	2	5	7	1	0	2	1	5	3	3	3	6	6	6	55
Stalking (2)	0	0	0	0	0	0	0	0	0	0	188	22	61	52	67	13	403
TOTAL	149	132	148	133	75	53	77	74	95	196	437	162	159	111	223	112	2,336
DISRUPTION																	
Hate Mail & Harassing Phone Calls	9	17	32	53	32	19	30	21	142	469	628	381	255	605	2829	903	6425
Bomb Threats	9	32	75	51	28	21	21	11	15	12	22	14	41	13	79	31	475
Picketing	107	160	139	141	77	151	72	45	292	2898	2279	1407	1356	3932	7518	8037	28611
TOTAL	125	209	246	245	137	191	123	77	449	3379	2929	1802	1652	4550	10426	8971	35511
CLINIC BLOCKADES																	
No. Incidents	0	0	0	0	2	182	201	34	41	83	66	25	5	7	25	2	673
No. Arrests (3)	0	0	0	0	290	11732	12358	1363	3885	2580	1236	217	54	65	29	16	33825

(1)Numbers represent incidents reported to NAF as of 12/31/98 and classified by the ATF; actual incidents are most likely higher.

(2)Stalking is defined as the persistent following, threatening, and harassing of an abortion provider, staff member, or patient *away from* the clinic. Tabulation of stalking incidents began in 1993.

(3)The "number of arrests" represents the total number of arrests, not the total number of *persons* arrested. Many blockaders are arrested multiple times.

Source: National Abortion Federation, 1999.

to the murders of Dr. David Gunn and Dr. John Bayard Britton in Florida. The anti-abortion activists argued that the posters made no explicit threats and were thereby expressions of free speech protected by the constitution. The district court ruled in favor of the abortion providers. *Planned Parenthood, et. al. v. ACLA* is currently in the appeals process and will likely continue for years.

Fetal Rights

Anti-abortion activists often argued that from the moment of conception the fertilized egg is a human being, a full person, deserving of the same rights and protections as other persons (Joyce, 1992). Abortion, therefore, is equated with murder, and is considered immoral, criminal, and repugnant. Anti-abortion activists use this moral perspective as a vehicle for shaping public opinion and policy, as is evident in the rhetoric advocating restrictive legislation and reduced funding.

> For example, in the area of public funding, they have made appeals such as: 'Abortion may be legal, but why should we be forced to pay for something that is morally repugnant (to us)?' They have been increasingly successful in suppressing the parentheses, and in portraying the matter as if there were a universal consensus that abortion is morally illegitimate (Fried, 1997:40).

From this moral perspective, extremist in the anti-abortion movement demonize both women who seek abortions and those who provide abortion services. Patients having abortions are depicted as selfish, vain, sexually immoral and irresponsible women who kill their children out of convenience. Doctors are portrayed as butchers who commit crimes against humanity. The

supposed illegitimacy of abortion is used to justify violent acts, including murder.

Anti-abortion discussions of the personhood of fetuses and fetal rights tend to be philosophically abstract. Women and women's rights are rarely mentioned, as if pregnancy and abortion do not take place in women's bodies. Ellen Willis brought this issue to light in her incisively titled essay "Abortion: Is a Woman a Person" (1979).

Feminist theorists have long questioned this claim of concern for fetal rights, suggesting instead that it is simply an aspect of men's desire to maintain control over women's bodies. Shulamith Firestone (1970), in her feminist critique of Marxist historical materialism, argues that the original class struggle was between men and women, the original divisions of labor were based on these biologically determined class distinctions, and that the relations of procreative reproduction (rather than of material production) have shaped history and the economic development of society. Women are subordinate to men in patriarchal cultures, and men preserve their power by maintaining control over women's bodies. The relatively recent acquisition of abortion rights and other reproductive rights has improved the situation of women. The fetal rights movement, as characterized by Kate Murphy, "seems like a last-ditch attempt to wrest control of women's reproduction out of their hands....an effort to control women's lives in general, not only reproductively and sexually but economically and socially as well" (1998:11).

Chapter 3

Methodology

Underlying the high esteem with which conventional scientific method is regarded in western culture is the premise that the researcher and the research process alike remain untainted by values. It is traditionally held that by means of "value neutral" methods, facts are unveiled rather than produced, and knowledge is acquired rather than created. Consequently, traditional science dictates clear distinctions between facts and values, objectivity and subjectivity, positivist statements and normative assertions. These long held assumptions have more recently been called into question.

Objectivity

The scientific principle of objectivity has been critically addressed by both "hard" and "soft" scientists. Based on nuclear experiments he conducted in the 1920s, physicist Werner Heisenberg (1962) concluded that the objects of his scientific investigations -- subatomic particles -- are necessarily affected by the methods of observations utilized by the researcher; consequently, objects of knowledge are determined in part by subjects of knowledge. In her anthropological studies, Ruth Benedict (1934) explored cultural relativism and the subjective nature of cultural beliefs. In the 1940s, Ruth Herschberger (1993) examined male bias embedded in the descriptions of biological occurrences. Ecologists Kristin Schrader-Fenchette and Earl McCoy (1994) discuss the integral role of unacknowledged values in the

practice of environmental science, and the political and ecological implications of these biases.

Some theorists, particularly feminists (Haraway, 1988; Harding, 1993; Hartsock, 1983; Longino, 1990; Stanley & Wise, 1990), have argued that the traditional conceptualization of objectivity which depicts the researcher as detached from the research process omits significant data from scientific investigation, i.e., the researcher. Much as object and subject are related and shaped by the act of scientific investigation, so there is a constant interaction between scientific practice and cultural beliefs. Scientists and researchers are vectors of these interactions; their values and beliefs are the largely unexamined maps by which data is collected and interpreted. As such, researchers and their cultural beliefs function as evidence to be considered as contributing factors of the research process.

Rather than deny our presence in the research process, we as researchers must develop awareness of our belief systems and their influences in order to provide more complete data. Values, which are drawn from our experiences and underlie our motivations, can no more be removed from the practice of science than from any other practical aspect of our lives. Traditional objectivity -- that based on the elimination of personal and cultural values from the research process -- is partial and, therefore, weak and not wholly reliable. "Strong objectivity," argues Sandra Harding, is attained instead by the integration of the researcher and her values into the research process.

> Strong objectivity requires that the subject of knowledge be placed on the same critical, causal plane as the objects of knowledge. Thus, strong objectivity requires what we can think of as 'strong reflexivity'. This is because culturewide (or nearly culturewide) beliefs function as evidence at every stage in scientific inquiry....

> The subject of knowledge -- the individual and the historically located social community whose unexamined beliefs its members are likely to hold'unknowingly', so to speak --must be considered as part of the object of knowledge from the perspective of the scientific method. All of the kinds of objectivity-maximizing procedures focused on the nature and/or social relations that are the direct object of observation and reflection must also be focused on the observers and reflectors -- scientists and the larger society whose assumptions they share (1993:244).

Reflexivity

Strong objectivity involves a reflexive stance by which the researcher, like the researched, is open to scrutiny. As with other integral elements of the research process, the researcher is obligated to analyze her own actions as well as the underlying experiences, beliefs, and motives supporting those actions. To further maximize objectivity, research results, based on interpreted data, are acknowledged as interpretations of observations made through the lens that is the researcher herself. This explicates the context in which the findings have been reached allowing the reader to judge this knowledge in relation to her own experience.

Autobiography

In the practice and theory of conventional science and research, personal experiences, particularly those involving emotions, are considered fundamentally subjective. First-hand accounts of personal experience are regarded as only slightly, if at all, more objective than the experiences themselves. Hence, the use of autobiographical material in the presentation of research is widely regarded as inappropriate (because it is irrelevant or, worse yet, biased), and many mainstream research journals discourage or even

prohibit the use of first-person narratives. While personal experience is undoubtedly the underlying cause of much mainstream research, it is expected to be presented in a highly abstracted style, as far removed as possible from individual thought and action.

In feminist research, however, personal experience is widely and explicitly considered a valuable asset, and first-hand accounts of personal experience are commonly and variously utilized in feminist research. It is somewhat acceptable now in mainstream research, especially in the "softer" sciences, for a researcher to relate personal motives for engaging in a particular area of research, though this practice is typically confined to preface and postscript. These explanatory personal narratives are more prevalent among feminist researchers who are also more likely to use them throughout the research process and presentation. Indeed, in feminist research, the researcher's personal connection to the research topic is so widespread that it is almost expected (Reinharz, 1992).

Another means of using personal experience in association with research is in writing works about research or elements of research -- design, methods, theory -- including text books and other instructional materials. For instance, Ann Oakley (1981), by detailing her own experiences as a researcher interviewing women, was able to provide a practical critique of standard interview principles.

Some social researchers, especially feminists, utilize more extensive autobiographies as a means of research. Such works examine a range of topics including Latina life in the United States (Espin,, 1997), the profession of social work (Grobman, 1996), and the struggles which confront faculty wives who work on campus (Hughes, 1973). An autobiographical approach is especially

appropriate when the author is a member of the researched group, thereby providing an "insider" perspective (Reinharz, 1992).

As a woman who has experienced abortion both as a patient and as a member of the staff of an abortion clinic, I have undertaken an examination of the effects of feminist political beliefs on the quality of care provided to abortion patients. The autobiographical method which I have adopted is particularly suited to the data, which is also personal and subjective in nature. By clearly situating my perspective in relation to the object of my research (i.e., I am a feminist advocate of abortion rights studying the implications of political beliefs applied to abortion services) my personal narrative attains a stronger measure of objectivity, and contributes to the body of knowledge which informs our understanding and interpretation of abortion.

Project Methods and Data

The bulk of my fieldwork consists of more than 800 hours during a 20-month period, acting as a counselor and patient advocate at Downtown Women Center (DTWC), a Portland, Oregon abortion clinic. In conjunction with my assigned duties at the clinic, I have conducted health history interviews with more than 100 patients who have come to the clinic seeking abortion services. Interview topics include reproductive, gynecological, psychosocial, as well as general aspects of patient health. During the interview process, I provide patients with information pertaining to abortion, abortion procedures, after care instructions, contraception, and I also refer patients to social service agencies when appropriate. Also in association with my responsibilities at the clinic, I have attended and supported more than 1,000 patients in the operating and recovery rooms. In my personal narrative, I

describe the nature of these interactions with patients. The object of my research is the means by which I deliver abortion services -- my intentions and objectives, my interpersonal style, the things I say or don't say. This comprises my data, and is the basis of conclusions I draw pertaining to the effect of political beliefs on health care provided to abortion patients.

My first encounter with DTWC was as a patient myself. At the age of 36, five months before I entered graduate school, I unintentionally became pregnant. I chose DTWC over another abortion clinic for two reasons: 1) the recommend-ation of a teacher who had been a patient at DTWC, 2) the respectful attitude of the DTWC clinic staff over the telephone (when I phoned the other clinic, the person I spoke with was curt and patronizing). One year later, as a graduate student at Oregon State University, I approached DTWC in order to arrange an internship at the clinic. As a matter of policy, the clinic does not use volunteers (except for physicians who occasionally donate their services). However, one of the owners of the clinic agreed to propose my internship to the staff. Subsequently, I was interviewed by the staff and a two-month internship was approved.

The staff of DTWC currently consists of 23 women (including, but not limited to, five registered nurses, two medical assistants, one chiropractor, and a bookkeeper), as well as 10 physicians (six women and four men). Most of the staff are employed part-time. Most of the doctors work one day each week, though some work only once a month. The clinic regularly operates six days of the week, Monday through Saturday, with a daily staff of nine, including the doctor and bookkeeper. Approximately 100 to 120 patients are seen each week at DTWC -- 60 to 65 for abortions and the remainder for follow-up services. Roughly one-quarter of the patients receive medical coverage from

state health plans (both Oregon and Washington state health plans provide funds for abortion services). Another quarter of the patient services are covered by private health insurance plans, and the remaining one-half of clinic patients pay in cash (personal checks are not accepted).

The clinic is located on the ninth floor of a downtown medical office building. Abortion providers which operate from free-standing clinics are considerably more visible and, therefore, more vulnerable to anti-abortion activities such as demonstrations, vandalism, arson, or bombings. Nonetheless, between 1986 and 1990, DTWC was the focus of ongoing anti-abortion demonstrations involving clinic entrance blockades. After DTWC obtained a restraining order against several of the most ardent and tenacious anti-abortion activists, the demonstrations became smaller and fewer in number until they were irregular and infrequent events.

In 1994, two of the doctors associated with the clinic were identified in "wanted" style posters distributed by the American Coalition of Life Activists. Similar posters had been distributed the previous year shortly before the murders of two abortion providers in Florida. The FBI notified DTWC and the doctors, and assisted in determining security measures to be implemented including bullet-resistant glass in the clinic operating room and reception area, and a 16-gauge steel, bullet-proof door between the waiting room and the clinic area. Additionally, video monitors and security access intercoms were installed in the clinic entrance area. The FBI also recommended bullet-proof vests, alternate routes to work and home, disguises, and in-home alarms for the doctors themselves.

While DTWC is in many ways similar to other abortion clinics (e.g., patient base, contact with opposition groups, security measures, financial

status), it is distinctive in many ways. The clinic is woman-owned and -operated, the personnel are cross-trained to provide a number of different services, employees participate in profit-sharing, policy and procedures are dependent on staff input, patient interviews are relatively extensive, and nitrous oxide gas is offered for patient comfort during surgery. Therefore, my findings are not intended, and should not be considered, generalizable to abortion clinics overall.

This project does not include any specific or identifying information of any individuals other than myself and the entity of DTWC.

Chapter 4

Health History Interview

Women who call the Downtown Women Center can usually schedule an abortion within a week. The clinic staff members who answer incoming calls collect enough information to estimate the length of pregnancy, previous births, drug allergies, recent infections, and insurance information. They explain to the patient how long she can expect to be at the clinic (depending on length of pregnancy), transportation arrangements that may need to be made, directions to the clinic, and the amount of payment which must be paid in advance.

My day begins at 9:00 am. I briefly look over the patient's chart. At this point, the information in the chart is skeletal -- name, address, age, insurance, occupation, contraindications for oral contraceptives, surgical history, and the first day of her last menstrual cycle. I usually take note of three items in particular -- age, the distance she has traveled to come to the clinic, and how far along the pregnancy is.

I open the locked bullet-proof door that separates the waiting room from the clinic area and call the patient's name. As the patient stands, I make a mental note whether she is alone or with someone, male or female, possible boyfriend or parent. If the person accompanying her rises to come in with her, I inform that person that they might join us later, but that for the time being, I will speak to the patient alone.

Inside the clinic area, I introduce myself to the patient and explain that I will be asking her some questions and getting some information and that I

hope also to answer questions and provide information. I usher her into a consultation room which measures approximately five feet by ten feet. The room contains three chairs and a small desk. Atop the desk sits a hanging file holder with a variety of forms, a translucent plastic model of the female reproductive system, a promotional display of an actual IUD placed on a cross-sectional illustration of a uterus all encased in a square of Plexiglas, and a box of Kleenex. On the wall above the desk is a schedule of the doctors for that month, and a promotional calendar for a particular brand of birth control pills. Colorful art prints, mostly landscapes and floral still lifes, hang on the remaining walls.

I indicate a chair for the patient, and before I seat myself I ask her how she is feeling. Generally, she replies that she is fine. I am not simply being cordial when I inquire how she is feeling. Occasionally (and this is why I ask), she slumps in the chair, her head drops, and her eyes roll lethargically to the side as she explains that she has not been feeling very well. Women typically experience some degree of nausea when pregnant, especially during the first trimester. It is common for patients to feel nauseous, even to vomit, while at the clinic. In these first minutes of contact with the patient I want to make her feel as comfortable as possible, and this includes her stomach. If her stomach is upset, I will get saltines and water for her. It is a caring and nurturing act, small yet significant -- it is an early indication of my motives and objectives, namely, that I intend to care for her by means which are physically and psychologically practical.

Interview

Once seated at the desk, I begin the interview by asking the woman to be patient with me as I will be asking a good number of questions, mostly health history-type questions, some of which she has already answered on the telephone or on the initial paperwork, and others to which the answers will seem completely obvious. Patients always respond agreeably, though there are some who will glance at their watches. (See Appendix A - Health History Interview Form.)

My first question falls into the category of completely obvious -- Are you here because you want an abortion? Yes. Have you examined your choices and are you clear about your decision? Yes. Is anybody forcing you to do this? No. These are the answers I have always received to these opening questions. However, once I saw a co-worker come out of a consultation room after only three minutes with a patient. The fourteen year old patient had stated flatly that she herself did not want to have an abortion, that her mother had insisted. It is the policy of this clinic not to perform an abortion on any patient who does not personally consent to the procedure, regardless of age or parental directives.

Current Pregnancy

Pregnancy Test

I proceed with the health history by asking if the patient has had a pregnancy test, where it was done, and if the result was positive. Most patients have had a pregnancy test before scheduling their appointments. If a

patient has not had a test, we perform one before we go any further with the interview. I have spoken to women, women who have been pregnant before, who are utterly convinced that they are pregnant when in fact they are not. Sometimes, they are experiencing pregnancy-like symptoms which are actually the side effects of hormonal contraceptives such as Depo-Provera.

Occasionally, a patient reports that she was tested at a Pregnancy Crisis Center, a Christian organization which offers free pregnancy testing, adoption information, and anti-abortion counseling. I have had no personal contact with Pregnancy Crisis Center; my knowledge is derived solely from second-hand reports, primarily from clinic patients. It is my understanding that Pregnancy Crisis Center does not advertise its pro-life, anti-abortion stance. The first indication of their position may be the moment when the patient is congratulated on her positive pregnancy test. I have been told of patients receiving hand-knitted booties for her new baby and being asked about name choices. If the woman indicates that she has not decided to continue the pregnancy or that she definitely intends to terminate the pregnancy she is shown anti-abortion materials including enlarged photographs of aborted fetuses and a film designed to persuade her that an abortion is the equivalent of murdering a baby.

After such an experience, some women who come to our clinic tell me that they think the Pregnancy Crisis Center should be more forthcoming concerning their anti-abortion position. Others are irritated because they believe that the choice regarding pregnancy, contraception, and abortion is personal and "none of their business." Most of the women I have met in this situation, however, have said something to the effect that they felt sorry for the pro-life advocates at the Pregnancy Crisis Center because her decision to keep

the pregnancy seemed to be so important to them and they tried so hard to convince her not to have an abortion when she knew full well, based on the circumstances of her life, that she had no intention of staying pregnant. This latter reaction sometimes seems to me admirably generous and tolerant; at other times, it seems another indication of the social conditioning of women to be caring and sympathetic rather than contentious.

I always remind women who have been tested at a Pregnancy Crisis Center that the people who work there are biased, they are against abortion and provide information which depicts abortion as murder. I remind these patients that I am likewise biased -- I believe that women should have access to safe and legal abortions, that they should not be stigmatized for accidental pregnancy, and that abortion providers should not be vilified.

Last Menstrual Period (LMP)

Next, I ask the patient for the date of the first day of her last menstrual cycle. I determine the approximate gestational date of her pregnancy with the use of a pregnancy calculator, a small circular, calendar device also known at the clinic as the "wheel of misfortune." Gestational age begins on the first day of the menstrual cycle, the first day of a woman's period, even though conception takes place approximately two weeks later, give or take a few days. Ovulation usually occurs about two weeks later, and conception usually occurs within a couple days after ovulation. If all this sounds vague and indeterminate, it is. Even a woman who has a very regular menstrual cycle experiences variation in her cycle. Moreover, while the egg is viable for only 48 hours after ovulation, sperm generally remain active for 72 hours after

ejaculation, and can sometimes hide out in the nooks and crannies of the female reproductive organs for four to five days.

By measuring gestational age from the first day of the last menstrual cycle, a woman cannot be less than two weeks pregnant, and is not usually aware that she is pregnant until at least four weeks into the pregnancy, about the time when her next period would typically begin. Most patients I talk to are between 5 and 12 weeks pregnant. "Of course," I explain to the patient, "Dates are notoriously unreliable, so after we finish the interview we'll do an ultrasound exam to determine the exact length of pregnancy."

Pregnancy Symptoms

Most patients experience a variety of pregnancy symptoms, and I ask them to describe these to me. Nausea, unusual food cravings or aversions, breast tenderness, and fatigue are the most common symptoms patients report. Nausea can be an extremely debilitating pregnancy symptom. I have spoken to patients who suffered such severe nausea and vomiting during previous pregnancies that they required regular IV treatment for dehydration from the first trimester until labor and delivery. Hyperemesis is one of the primary conditions referred to when speaking of endangering the pregnant woman's health. Naturally, this type of pregnancy history can influence a woman's decision regarding abortion.

Gynecological History

I ask the patient if she has ever been pregnant before. I estimate nearly one-quarter to one-third of the women I counsel have never been pregnant

before. I record her reproductive history including the number of full term pregnancies (para), miscarriages (spontaneous abortions or SABs), and induced abortions (also known as therapeutic abortions or TABs). Numbers at the clinic have not been analyzed, but DTWC seems unremarkable in this respect and it would not be unreasonable to assume that the patients served by this clinic are similar to the broader population of women seeking abortions throughout the United States. National findings indicate that of the women who seek abortions, 47% have had a previous abortion, and 55% have had a previous birth (Henshaw, 1998a).

If the patient has had a previous abortion, I ask her what it was like. If she has had a bad abortion experience, I assure that we will do everything we can to make this abortion a better experience. My job, I explain to her, is to make her clinic visit as pleasant as possible. I feel I can do this best by answering her questions, providing her with information, and taking care of her.

In general, the reproductive history of a patient is used to determine pre- and post-abortion procedures and care. For instance, if a woman has had several full-term pregnancies with vaginal deliveries, her cervix probably will be fairly flexible and easy to dilate. If, on the other hand, a woman has never been pregnant before, her cervix will likely be firm and tight. If a woman has had full-term pregnancies and deliveries, she may need more of a particular medication, a vasoconstrictor, to decrease bleeding after the abortion procedure. This information is also useful for counseling the patient. A woman who already has children may feel differently about her abortion than a woman who does not have children. The situation will naturally be different for a woman with teenagers at home compared to a woman who has a six

month old baby. It is in addressing this question that I will discover if the woman has gone through a full term pregnancy and adopted out her infant. All of these circumstances create individual situations to which I need be sensitive.

Many of these experiences I have had myself, and this serves me well when counseling patients. My very first pregnancy occurred shortly after I was married. It was a planned pregnancy and I was thrilled. I chose an obstetrician and had an ultra sound which detected a normal, healthy heartbeat. Twelve weeks into the pregnancy I had a miscarriage, what is known medically as a spontaneous abortion. There was very little bleeding with my miscarriage, but it was exceedingly painful. My doctor performed a D&C, dilation and curettage - the same procedure used for therapeutic abortions. My doctor recommended that I avoid trying to get pregnant for a few months. I unintentionally became pregnant 30 days later. I carried the pregnancy full term and delivered by cesarean section my son Marius.

Within a year, I was pregnant again. I had just started work at a job that did not offer insurance benefits. My husband was just leaving his job and the health insurance provided by his employer would terminate at the end of the month. Scheduling our work hours and childcare was difficult. Working outside the home, caring for my baby, and maintaining a home was overwhelming. These reasons, which were real and pressing, I shared with my friends and my physician, but I also had other reasons, more private. I had serious doubts about my relationship with my husband, yet I still believed that a traditional marriage offered me and my son the greatest security and happiness. I thought that if I would just try harder to be a better wife and mother the marriage would work.

The marriage never worked, except in that it was a passage of my life during which I learned to say, "No." As a young woman, I had not developed much confidence in my own knowledge, did not even regard it as such. I was more comfortable relying on the expertise of others. I found it difficult to say, "No," and I married a man who found it difficult to accept, "No." Though he was never physically abusive, he would pressure me incessantly for sex (and other wifely behavior). Sometimes his late night tirades would last for hours, usually when I needed to wake early the next morning. I would literally beg him to leave me alone, to no avail. I often gave in. I was embarrassed and ashamed. I thought I was a strong, smart woman, yet my situation indicated otherwise. I did not want to be pregnant under these conditions. This was one area of my life in which I could exercise some control. I chose not to be pregnant. The doctor who had delivered Marius performed the abortion. I was under general anesthesia during the procedure. Afterwards, I went on the pill.

One year later, I decided to have another child. Things were better at home financially and in the marriage (though we eventually did divorce). I now had a job that provided insurance benefits. Despite my previous c-section, I delivered Mary-Alice vaginally without complications or medication.

When Mary-Alice was three and Marius six, their father and I separated. Two years later, I began a relationship with Neil who lived 200 miles away. Six weeks into the relationship I scheduled an appointment at Planned Parenthood to get a prescription for birth control pills. Planned Parenthood requires a pap smear before prescribing oral contraceptives and the next available appointment was six weeks later. We used condoms

until then. I must have gotten pregnant only shortly before the appointment day. The pregnancy test I took at the time of the pap smear was negative. I was instructed to begin taking the pills after my next menstrual period which was due to start about two weeks later. Instead, I discovered that I was pregnant.

Neil and I examined our lives and our relationship. We were both in our late thirties. I was finally completing my BA; the commencement ceremony was scheduled for the following month. I was planning to attend graduate school in the fall. I already had two children who were (and remain) fabulous and frustrating, wonderfully rewarding and educational, and demanding a sizable investment of time, money, and emotion. I had realized for some time that I regarded my two children as the extent of my family, that I did not intend to have any more children. I had even been considering sterilization, but the cost of a tubal ligation was beyond my financial means at the time. Neil had no children and did not plan to have any. In fact, this was the first time to his knowledge that he had impregnated a woman. I decided to have an abortion and, based on the recommendation of one of my teachers, I chose the Downtown Women Center, the clinic where I now work. After the abortion, Neil moved to Portland, and we became a family together. Six months later, he got a vasectomy.

Women should have pap smears regularly, at least every two years. I ask each patient when she last had a pap smear and if the results were normal. Most patients are aware that they should have regular pap smears and try to have them done annually. However, there are a good number of women who have not attended to this aspect of their health care and have let several years

go by since their last pap smear. We do not usually provide pap smears at this clinic; still, one of my responsibilities is to remind women of the purpose of regular pap smears - to detect diseases such as chlamydia, gonorrhea, pelvic inflammatory disease, and cervical cancer, and to prevent related death and disability. When indicated, I refer patients to clinics and doctors where such services are offered.

Some of the patients, typically teenage women, have never had a pap smear. It is not only imperative that I explain the purpose and importance of pap smears, but that I also describe what a pap smear entails since the pelvic exam they will have at this clinic will likely be their first ever. A pelvic exam is a fairly intimate procedure. The patient lies on her back with her legs raised and her knees apart with a metal instrument holding open the walls of her vagina. If a woman has developed feelings of intimidation or fear associated with sex or sexual intimacy, these feelings may arise during a pelvic exam. Knowing beforehand what to expect does much to alleviate anxiety. During an actual pap smear, the procedure itself can be physically uncomfortable. The doctor must collect a specimen for the lab tests, a procedure which is typically explained as "scraping some cells from your cervix," a rather euphemistic way to describe removing some of the mucous membrane which is the surface of the cervix, not unlike skinning a knee (granted, there are far fewer nerves in the cervix than the knee). I provide the patient with as much information as possible, from a description of the gynecological exam table, to showing her the speculum, the stainless-steel instrument which looks like a duck bill and is used to hold open the vaginal muscles in order to provide a view of the cervix. Providing a woman with information is providing her with control - she is no

longer simply the object of a medical procedure, but a participant who is responsible for seeking care to maintain her health.

When I was thirty-three years old, I scheduled an appointment with my doctor for my annual pap smear. My regular doctor was on maternity leave and one of her partners was filling in for her. After having collected the necessary specimen, she rose up from the low exam stool and, standing there between my raised legs asked, "Would you like to take a look." I was momentarily dumbfounded. In the fifteen years I had been dutifully having pap smears done, no one had ever considered my interest in my body as this woman did. "Sure," I answered. She took hold of a mirror connected to the wall by an extension arm and positioned it between my legs. She moved around the table so that we could look into the mirror together. Pointing, she began to explain, "See that indentation there, that's the opening where your baby came through. I can tell by looking that a baby has been through there, otherwise that indentation would be much smaller, more like a dimple. Your cervix looks very smooth and healthy, but we need the test results to be sure." Years later , as I think back, I am filled with emotion by this simple, respectful act on the part of a doctor.

General Health History

Next, I move from the patient's gynecological health to her general health. I ask if she has ever had any surgeries or other hospitalizations. I also ask about major illness such as cancer or diabetes, or chronic conditions such as high blood pressure. Since all of our patients are in their childbearing years and relatively young, teens to forties, and the majority are at the younger end of this spectrum, I hear few reports of diseases typically associated with aging

such as diabetes, stroke, heart disease, and cancer. I usually hear reports of broken bones, knee surgeries, appendectomies, tonsillectomies, and surgeries related to motor vehicle accidents.

I ask specifically about heart problems -- irregular heartbeat or heart murmur. Occasionally, a patient will report a mitral valve prolapse, a condition which could lead to a heart infection. These patients usually take a prophylactic antibiotic before dental work to reduce risk of subsequent infection. The physicians at the clinic sometimes recommend the same procedure for the abortion.

I also inquire about respiratory conditions such as asthma or chronic bronchitis. It is not uncommon for a patient to have an inhaler prescribed for asthma attacks. I always instruct these patients to bring their inhalers, but I have never witnessed an occasion when a patient felt it necessary to use an inhaler.

While on the topic of respiratory health, I ask patients if they smoke. About half of the women I interview admit to smoking, though most claim to smoke less than half a pack each day. Co-workers have told me that this is a classic example of under reporting a bad habit, but as a person who actually smokes three to four cigarettes a day (really!), I tend to be more generous and am inclined to believe patients. Of course, the phenomenon of under reporting negative behaviors applies to all areas of the interview and I am always aware that little of the information provided to me by patients is objectively verifiable. I must rely on my own skills of establishing reciprocal trust, and assessing the reliability of patient responses.

Allergies

It is critical to inquire and to chart any medications, foods, or other substances to which the patient has ever had an allergic reaction. We also want to know the type of reaction the patient had as this information can determine whether the reaction was allergic in nature, or simply a bad side effect of the substance. An example of a true allergic reaction would be one of the good number of patients who informs me that she is allergic to penicillin or sulfa. The type of reaction is commonly some or all of the following: red and itchy skin, hives, swelling, increased heart rate, sweating, and difficulty breathing. These physiological responses are indicative of a local or widespread release of histamines, which are powerful constrictors of blood vessels. Histamines are commonly released to counteract viruses and other foreign matter which have invaded the body (hence the red, itchy eyes, and swollen nasal passages associated with colds, flu, and hay fever). Exposure to the offending substance (e.g., penicillin, sulfa, pollen, nuts, bee venom, latex) can cause an over release of histamines, which in turn initiates anaphylaxis, a condition of symptomatic responses which is sometimes severe enough to cause the collapse of one physiological system after another, and can lead to death. In the eventuality of a patient going into anaphylactic shock, a "crash cart" stocked with antidotes and other emergency medicines, is located in the operating room. To prevent such an occurrence from happening in the first place, I place highly visible orange allergy labels on the outside cover and the name flap of the patient's chart folder, as well as on the health history form, and the OR form of the chart.

An example of a non-allergic reaction would be a patient who tells me that she is allergic to codeine, and that the reaction was stomach pain and

vomiting. I will note on the chart that the patient has a sensitivity, rather than an allergy, to codeine since it is in the chemical nature of codeine to irritate the digestive tract.

The next question on the patient health history chart refers to the psychosocial well-being of the patient. I personally prefer to address this issue at a slightly later point in the interview. Discussing psychosocial issues has the potential to raise painful and emotional experiences. I feel that such a discussion will be more comfortable if I prepare more groundwork establishing rapport with the patient. I generally discuss the next two topics of health history -- health history of family members, and drug abuse history -- before returning to psychosocial health.

Family Health History

Delving deeper into possible medical issues, I ask about the patient's family health history. Are there any major illnesses such as cancer or heart disease in your family? Does anybody suffer from diabetes or high blood pressure? If there is any indication of genetic predisposition for certain conditions I inquire whether the patient has been appropriately screened. For instance, if there is a family history of breast cancer, I ask the patient if she regularly checks her breasts for lumps. Most breast cancers are first detected through self-examinations. Nearly all of these women answer that they do check their breasts. However, based on my own experience, I persist -- Do you know what you're looking for when you're checking your breasts?

I began self-examining my breasts when I was 18 years old. The nurse from the student health clinic visited our dorm and provided us with information and instructions. When I was 38 years old I had a pap smear

done by one of my co-workers at the Downtown Women Center. She asked if I regularly checked my breasts, I confessed that even though I dutifully went through the motions each month I wasn't certain I really knew what I was looking for. She examined my breasts with me and explained the different textures of the various tissues such as the muscles of the chest wall and the milk ducts. Now, each month in the shower, I lather up with confidence and search out my lymph nodes.

I have been encouraged by reports received from several patients. Apparently, in some high school health ed classes, the curriculum includes breast cancer education complete with a dummy torso bearing life-like breasts -- lumps and all! Students palpate the breasts in order to locate and identify lumps and other unusual tissue. These women assure me they know what they are looking for.

During the discussion of family health history a patient may relate facts which, though not directly related to her own physiological health, play an important psychological role in her current situation. A patient may lack knowledge of her biological family's health history because she was adopted or her father's identity is not known (as in the case of some rapes), or there may be other reason she does not have contact with one or the other of her parents. Discussion of family health issues may provide other pertinent family dynamics. For instance, if a member of the family is currently ill, the patient may be experiencing worry and concern as well as additional caretaking and financial responsibilities. If someone in the family has died recently, the patient may be in the process of grieving. This grief is compounded when such factors as suicide or violence are involved.

Drug Abuse History

My next question for the patient is again specifically personal in its scope -- Do you have any personal history of drug or alcohol abuse? Usually the answer is a simple "No." Sometimes the response is a hesitant "I used to drink a lot in college / high school, but not now," or "I smoke pot, does that count?" Occasionally, patients report drug addictions and other drug-related problems, usually framed within the context of rehabilitation or recovery. Sometimes it is this question that opens the discussion of problems with the police or Children's Services Division.

The purpose of this question is to provide more information regarding both the patient's physical and emotional condition. We will administer several drugs to the patient at the time of the abortion procedure. The patient has several choices of drugs, or combinations of drugs, provided for her comfort during the procedure. In addition to Ibuprofen, we usually recommend a combination of Valium (mild tranquilizer) and nitrous oxide gas (the "laughing gas" used at many dentist offices). If a patient is very sensitive to pain, or extremely anxious about pain we can offer her an injection of Nubain, a synthetic morphine. If the patient has been using heroin, she may react to the Nubain and become very ill. When a patient has decided to use the Nubain it is noted on her medical chart and is administered to the patient when she first comes into the operating room. Immediately prior to injecting the drug, the nurse asks the patient if she has recently used any street drugs or has recently ingested any alcohol. Addressing the issue of drug abuse and illegal drug use beforehand, in the private and confidential setting of the health history interview can avoid the shame and vulnerability of admitting illicit drug activity to the group of people in the operating room. This group could

include any or all of the following: the doctor, the technician, the counselor, the patient's support person - most commonly her male partner or mother -- and the nurse administering the drug. Likewise, by discussing drug use and drug abuse during the health history interview, the patient can avoid the painful physical experience of a bad drug interaction should she feel unable to reveal her drug use in the less confidential setting of the operating room.

If a patient informs me that she is a recovering or recovered addict I take this into consideration in making recommendations to her regarding the drugs we provide for her comfort. In addition to Ibuprofen, I typically recommend both Valium and nitrous oxide gas. For any number of reasons, a patient may choose to use Valium, nitrous oxide, neither, or both. If she will be driving a car herself after the abortion, we cannot give her Valium as it would not be safe for her to operate a vehicle while under the influence of this tranquilizer. Nitrous oxide, however, wears off quickly and we can allow patients to leave the clinic unescorted and even drive soon after the procedure. If a patient has had a prior adverse reaction to nitrous oxide - this is most often an emotional reaction such as fear or anxiety - we recommend the Valium alone. Of course, a good number of women choose to use neither Valium nor nitrous oxide. Often, these women tend to avoid mind altering substances altogether and sometimes drugs in general, though only rarely does anyone refuse the antibiotic we offer. There are many different reasons for this choice. Some women have cultural or religious beliefs about pain and pain endurance, or about the morality of being "high." Some women, through spiritual or physical practices such as yoga, have developed a heightened awareness of their bodies and are quite capable of managing pain or discomfort without the use of drugs. Some women avoid all mind altering substances because the sensation may trigger a

traumatic memory or an addiction related craving. A patient's drug abuse history is one of several factors which helps me counsel her on her use of medication in association with an abortion.

Psychosocial Health

Throughout the interview, I have broached several personal topics. To do so effectively, it is imperative that I maintain a friendly, professional demeanor, embodying a sense of caring and understanding together with competency and responsibility. Ideally, the patient should feel comfortable confiding in me, realizing that I have her best interests at heart. All this must be established in a relatively short period of time. The order in which I ask the questions during the interview is crucial in developing trust. The types of questions and the topics they cover create a rhythm. The interview is not unlike a poem or piece of music. There are moments of tension and relaxation, bursts of activity, periods of dry, clinical description, points of irony, surfacing of emotions, and moments of understanding and insight.

Personally, I find the interview to be smoother and more productive when I first address issues concerning family and substance abuse before asking questions about physical and sexual abuse, experiences which may prove to be more emotionally charged. The flow and rhythm of the language used also contribute to the psychological ease with which the patient responds to inquiries. A lulling and engaging pattern, created by the repetition of words and phrases used in asking questions, allows the patient to easily slip into a natural, reflexive counter-rhythm of response, even as the questions become progressively charged.

"Is there any history of major illnesses in your immediate family?'

"Is there any history of mental illness in your family?"

"Is there any family history of drug or alcohol abuse?"

"Do you have any personal history of drug or alcohol abuse?"

"Do you have any personal history of being physically abused? Has anyone ever hit you?

"Have you ever been sexually abused? Has anyone ever forced you to have sex or sexual contact?"

Usually the answer is a simple, "No." However, childhood neglect and abuse, domestic violence, childhood sexual abuse, sexual assault, and rape are rampant in this country (Finklehor, et. al., 1990). They are also considered risk factors for future unwanted pregnancy (Johnsen and Harlow, 1996; Stock, et al., 1997). It is not surprising that I hear a variety of responses from women -- reports of child abuse both physical and sexual, domestic violence including verbal abuse to attempted murder, date rape, acquaintance rape, marital rape, rape by unknown assailant, and gang rape. These stories are usually told in a slow, steady delivery with little indication of emotion. This lack of emotion is a characteristic means by which the patient protects herself from the pain of the experience, and a means of protecting the listener, me. The significance of my ability to sit with a story and not be overwhelmed by it cannot be overstated. The interview is not intended as a psychotherapy session, though it can establish a foundation for positive self-reflection and an examination of one's life and circumstances. In this sense, the interview has psychotherapeutic value.

As it pertains to the abortion, history of abuse is a significant factor regarding the patient's ability to manage situations which may be experienced as stressful or even threatening. Those women who have faced and resolved

to some degree issues of abuse usually do not have serious problems of stress and fear in connection with the abortion. Women who have broadly suppressed their feelings and emotions related to abuse tend to experience greater anxiety, fear, and discomfort during the abortion procedure, and sometimes will exhibit signs of dissociation especially in the operating room.

Of course, not every patient wants to reveal such intimate details of her personal life to me, though I must confess, I am often surprised by how much patients do tell me. I have consciously used my role as a counselor to build rapport with the patient, and to create as relaxed an atmosphere as possible considering the circumstances. The more comfortable the patient is the more likely she will respond openly and honestly to my inquiries. However, while direct and candid replies may prove useful in assisting the patient, it is not my ultimate goal to obtain complete and honest answers. My primary objective is the patient's well-being, and towards this aim, by means of the interview process, I articulate the matrix of personal and social factors which are correlated to unwanted pregnancy. Awareness of these interrelated factors provides a perspective to the patient which may allow her to acquire more control in her life, her relationships, and her patterns of behavior. If the patient feels comfortable not revealing certain elements of her personal history, this, too, can be seen as beneficial. At the very least, she is exercising control in this particular aspect of her life.

In assessing psychosocial well-being, I also ask the patient if she has support for having the abortion. Almost always, they do. I explain that I am asking for two reason: 1) if no one is with the patient, particularly to drive her home, it will affect the types of medication we can give her; 2) it is an entirely different situation for a woman who must keep her abortion secret from

everyone -- she may find the experience more difficult needing assistance with childcare, scheduling, transportation, and errands; she may simply feel lonelier and more shameful.

Contraception

"What kind of birth control do you want to use after the abortion?" Until recently, I deliberately used the word "abortion" in asking this question, having used the terms "abortion," "procedure," and "termination" interchangeably, without specific intent, during the earlier part of the interview. Using the word abortion drives home the point that contraception is the best method of preventing unwanted pregnancy. However, I came to realize the subtle hypocrisy underlying this manipulative maneuver. On the one hand, I was denouncing the shaming of women who accidentally become pregnant; on the other hand, I was taking advantage of the cultural stigma surrounding abortion to instill a sense of responsibility *grounded in guilt.* For a long while, I did not think much beyond the effectiveness of the technique. When I began to reflect on the possible contradictions inherent in my methods, I could easily rationalize this counseling behavior by reminding myself that I had, earlier in the interview, used my skills as a counselor to gradually deconstruct the shame associated with the word "abortion," therefore, the guilt factor was negligible. Likewise, I would bear in mind my honorable objectives -- responsible contraception -- telling myself that this would be good for the patient. I would also focus on how very subtle and minimal is this shift of terminology. After all, the patient's reply would likely be the same if I were to ask, "What kind of contraception do you want to use *after the procedure*?" or "*after today*?" or even "*from now on*?" But I realize that

this type of strategy, however subtle and well intentioned, is ultimately counterproductive to a more foundational objective -- enhancing the patient's ability to control her life. By deliberately manipulating her feelings, at least attempting to do so, I wrest away control from the patient when my stated goal is to provide her with enough information and resources so that she may exercise greater control in her life. Though I continue to use the word "abortion" when asking about contraception, I do not do so to the exclusion of other terms. I also find myself placing greater emphasis on my role as a resource -- providing information and choices -- rather than arbiter of morality.

Contraception is rarely a simple choice for women. Each type of birth control has advantages and disadvantages which likely change over time depending on the physiological and social circumstances of the woman. When I ask about contraception, some patients already know what form of birth control they intend to use. Oral contraception is the most common choice. Most of our patients are young women and this is often the most appropriate form of birth control for them. The Pill is a reversible form of contraception, it is coitus-independent, so can allow more spontaneity during sex, and it is highly effective when used properly. However, proper use is the key and the catch. Missing just one pill in a series of twenty-one can render this form of birth control less effective. This rigid regularity is not practical for many women. In fact, it is reported that almost half of the women who use oral contraceptives miss at least one pill per cycle, and nearly one-quarter miss two or more pills per cycle (Oakley, et. al., 1991, Rosenberg, et. al., 1998).

Because The Pill is a hormonal contraceptive, there can be side effects which some women are not willing to or should not tolerate. Possible side effects include breast tenderness, nausea, moodiness, decreased sexual

appetite, weight gain or loss, dermatological changes, migraine headaches, increased risk of stroke, and intermenstrual bleeding. About 22% of women report side-effects with oral contraceptive use (Rosenberg, et. al., 1998). Long-term hormonal contraceptives such as time-released surgical implants like Norplant which last up to five years or injections like Depo Provera which lasts for three months eliminate the regimen of daily pills and provide stable levels of daily hormones thereby reducing the occurrence of some side effects. However, the possibility of many hormone-related side effects remains and, in fact, long-term hormonal contraceptives may cause additional side effects such as cessation of menstruation. Certain health conditions may contraindicate the use of hormonal contraceptives all together -- high blood pressure, age, smoking, and breast feeding to name a few. Also, hormonal contraceptives do not protect against the transmission of STDs or the HIV virus.

Nationwide, the overall most common form of contraception is sterilization (about 28% tubal ligation, 11% vasectomy), particularly for women aged 30 and over (Bachrach and Mosher, 1996; Piccinino and Mosher, 1998). In the U.S., most women have given birth to all the children they will by the time they are 30, leaving approximately 15 more years of preventing pregnancy. Sterilization is highly effective, coitus-independent, non-hormonal, and cost-effective. It is also entails the risks of surgery (tubal ligation more so than vasectomy), should be considered irreversible, and it does not protect against STDs or the HIV virus. Furthermore, if vasectomy is a woman's method of birth control, it is only effective for intercourse with the sterilized partner.

The intrauterine device (IUD) is another highly effective, non-hormonal, coitus-independent birth control method which, unlike sterilization, is reversible. During the 1970s, there were serious problems associated with

one model of IUD, legal suits were filed, and the brand was removed from the market. Since then, however, IUDs are much safer. Several of the women who work at DTWC have used the IUD and highly recommend it. Appropriate candidates for IUD use are women who have already had children, do not experience especially heavy bleeding and cramping during their periods, and who do not have a history of pelvic inflammatory disease (PID). Though initially relatively expensive ($200 to $300), they can last up to eleven years. IUDs do not protect against the transmission of STDs or the HIV virus.

Figure 4: Percentage of Women Experiencing an Unintended Pregnancy within the First Year of Use.

Method	Perfect use	Average use
No method	85.0	85.0
Spermicide	6.0	30.0
Withdrawal	4.0	24.0
Periodic abstinence	9.0	19.0
Cervical cap	9.0; 26.0*	18.0
Diaphragm	6.0	18.0
Condom	3.0	16.0
Pill	0.1	6.0
IUD	0.8	4.0
Tubal sterilization	0.5	0.5
Injectable	0.3	0.4
Vasectomy	0.1	0.2
Implant	0.05	0.05
*9% for nulliparous women; 26% for parous women.		

Source: The Alan Guttmacher Institute, 1998

Figure 5: Numbers and percentages of Users of Contraceptive Methods

Method (in ooos)	No. of users	% of users
Tubal sterilization	10,727	27.7
Pill	10,410	26.9
Male condom	7,889	20.4
Vasectomy	4,215	10.9
Withdrawal	1,178	3.0
Injectable	1,146	3.0
Periodic abstinence	883	2.3
Diaphragm	720	1.9
Other	670	1.8
Implant	515	1.3
IUD	310	0.8
TOTAL	38,663	100.0

Source: The Alan Guttmacher Institute, 1998

Latex barrier methods of birth control, such as condoms and diaphragms, can also be effective when used correctly, and their effectiveness increases when used in conjunction with spermicidal lubricants. For those people who are allergic to latex, vinyl condoms and diaphragms are available. Some people suffer an allergic reaction to spermicides. To patients who choose barrier methods of birth control, I always recommend they test the spermicide on the underside of the wrist or the inside of the elbow before using it on the sensitive mucous membrane of the vaginal walls. Another physiological factor to assess when considering a diaphragm is the patient's

susceptibility for developing urinary tract infections. The use of a diaphragm can exacerbate this tendency. A woman with an established history of recurring urinary tract infections is generally not considered a good candidate for diaphragm use.

While physiological factors are important when considering diaphragm and condom use, social factors are actually the predominant consideration in determining the appropriateness of condoms as the primary method of birth control. Due to power dynamics in male-female relationships, condom use is distinctly different for men and women. It is one thing to choose to wear a condom, and a distinctly different thing to persuade your partner to wear a condom (Amaro, 1995). The same power dynamics are true of withdrawal and periodic abstinence as contraceptive methods. However, in relationships characterized by effectual communication, trust, and responsibility, birth control methods which rely on mutual cooperation can be reliable, though in general, these methods tend to be the least effective.

Procedures, Alternatives, and Risks Discussion

Once we have discussed contraception, it is time to conclude the interview. I inform the patient that the last item we attend to will be the consent forms and aftercare instructions (Appendices B, C). But first, I assure her, "I'll tell you everything else that will happen at the clinic today. I figure, the more you know what to expect, the less stressful it will be. So, I'll tell you as much as I can. And I tell you this from experience -- from my own personal experience, because I was a patient at this clinic before I started working here, and from my experience helping hundreds of patients. And I'll answer any

questions I can. So, if you have questions, please ask, me or anyone else here. After I explain everything, you can sign the consent forms."

"As soon as we have those completed," I tell her, "I'll take you out to the lab area and get a drop of blood from your fingertip so that I can check your iron level and your Rh factor. Do you know what your blood type is?"

Most people are unaware of their blood type. We need to know only whether the blood is positive or negative for the RH factor, not the A, B, O type. If a woman has a negative blood type, she must receive a Rhogam injection with each incidence of pregnancy or her body will develop Rh antibodies which could complicate future pregnancies. Only 14% of the population has negative type blood, so most of our patients will not need the Rhogam injection. However, all of them will get a finger poke so that we can run the test.

"After that," I continue, "I'll take you to an exam room where a technician will do an ultrasound. We do internal ultrasounds here. Have you ever had an ultrasound before?"

Since most of my patients are relatively young and have had full-term pregnancies, most have had some form of ultrasound examination. When I was pregnant, external ultrasounds were the norm. I was instructed to drink at least a quart of water in order to completely fill my bladder. Then a device like a small iron was pressed against my belly just above the pubic bone so that sound waves were sent through the fluid in my bladder to the uterus where they bounced off of solid objects like the fetus. An image could be created and sounds detected so that development of the fetus could be tracked. If a woman has never had an ultrasound or has never had an internal ultrasound, I describe the procedure for her.

"The device we use to send out sound waves looks something like a microphone. The technician will slip a condom over it and insert it into your vagina so that it can get close to the cervix and that way get a really good picture of the inside of your uterus. She'll see the image on a monitor, but you won't be seeing that."

Many women grimace when I mention the microphone-like device being inserted into the vagina. "Will it hurt?"

"No. It's not exactly comfortable, but it shouldn't hurt. I mean, it's not any bigger than a penis, well, than most penises."

"From doing the ultrasound, the technician will determine how far along the pregnancy is. And by the way, I'm not using the term pregnancy just to be vague or delicate or evasive. I refer to the pregnancy because what we're talking about is more than just the embryo. The pregnancy includes the amniotic sac, the yolk, the placenta, as well as the embryo. So anyway, after the technician measures the pregnancy and determines the gestational age, she'll decide what will be the best method of dilation. That will either be by using a seaweed laminaria or direct dilation."

The mention of seaweed usually causes some reaction, if nothing more than a look of curiosity.

"Yeah, seaweed. It's pretty weird, but it works." I pull a sample laminaria from the drawer of the desk. The laminaria is two inches long and about an eighth of an inch in diameter, and is the shape and color of a small twig.

"This is made from dried sterilized seaweed from Japan or Norway. The technique was devised in Japan. I know it sounds weird, but it's very effective. The seaweed is very, very absorbent. It draws in all these fluids from

your body and it expands. It'll more than double in size and remains very firm. When it's completely expanded, it'll look like a tampon. That's how it opens the cervix.

"Now, I can't tell you exactly what to expect from the laminaria, I mean, as far as what it will feel like, because everybody's body is different. But I can give you an idea of what the range of experiences is from talking to a lot of different women. Some women, it just doesn't bother them at all, or they notice only mild menstrual-type cramps. That was my experience, kind of like the beginning of my period. Other women have stronger cramps, especially as it expands. For other women, the insertion is very crampy, but then their bodies adjust and they don't notice it so much. One woman told me she only noticed it when she sat down, so she would either lie down or stand up. For a very few women, this is the worst part of the abortion -- it makes them really crampy and nauseous...but that's a very few. I can tell you this -- it should be quite tolerable.

"If the pregnancy is fairly early, we'll probably decide that direct dilation is the better way to dilate your cervix. That means the doctor will dilate your cervix immediately before the abortion itself. It will be part of the procedure in the operating room, and I'll describe the whole operating room scene in just a moment.

"After the ultrasound technician has decided on the dilation method (and inserts the laminaria, if that's the way we're going to go), then she'll put you on the schedule for this afternoon and tell you what time to return. She'll also give you some pills to take with you, an antibiotic and the Ibuprofen, and she'll tell you what time to take them, usually about a half hour before you're due back here. While you're gone, we want you to eat lunch, because when

you come back we're going to give you more pills, and they're less likely to make you nauseous if you've eaten."

I then review the medications that the patient will be taking before the abortion procedure. These usually include Valium (a mild tranquilizer) and Ergonovine (a vasoconstrictor), as well as the Ibuprofen and Amoxicillan (an antibiotic) that the patient will take with her to lunch. We also discuss whether she wants to use nitrous oxide gas during the procedure. I almost always recommend the gas -- it is safe, it is widely effective, it wears off quickly, and I like the high (this last bit of information is optional, depending on my assessment of the patient). If the patient has never used nitrous oxide gas before, I do my best to describe the sensation to her.

"It makes most people feel numb and relaxed, and kind of dreamy -- like you're dreaming while you're awake. You're still aware of where you are and what's happening, but you tend to get more involved with the dreaming process that's going on inside your head. I remember the first time I had nitrous. I was at a dentist's office getting a filling, and I was having a weird dream about an ancient civilization where they made statues of dentists and everyone had big celebrations to worship dentists. And the whole time, while the dentist was drilling a whole in my tooth, I was thinking, 'Of course, they worship dentists, dentists are so cool.'"

Most patients decide to use the nitrous oxide. In fact, most patients are concerned about pain and discomfort, and want all the pain medication we can give them.

When all the arrangements have been made for the afternoon, I provide the patient information about downtown Portland, nearby places to eat or

shop, and if the patient is from out of town, convenient lodging if she has not yet made plans.

"When you return to the clinic after lunch there will be more waiting. There's a lot of waiting throughout the day. You've already experienced some of that this morning. You'll wait in the exam room for the technician to come in to do the ultrasound, though that usually doesn't take too long. When you return to the clinic, you'll wait to talk with the doctor. The consultation with the doctor is so that you can meet her and can ask any questions and address any concerns that you have, and just so you can make sure you feel comfortable having her as your doctor. After you talk to the doctor we'll give you some more pills. We give you the pills *after* you meet with the doctor because it's just more comfortable and productive to talk to the doctor when you're straight headed and have all your clothes on. It's got to be more ethical to have you consult with your doctor before we drug you.

"Anyway, after you take the medications, you'll be waiting again, this time for the drugs to take effect. We usually allow about thirty minutes for the Valium to kick in. Some of that waiting will be in the waiting room, but most of it will be in one of the pre-op rooms which are adjacent to the operating room. The pre-op rooms each have a soft, cushy bed so you can lay down and relax, just rest, before we bring you into the operating room. The key to being comfortable during the abortion procedure is being relaxed. That's why we give you the Valium and the nitrous oxide. But there are other things that you can do to help yourself relax. The most important factor in relaxation is breathing. So while you're waiting in the pre-op room it's a good idea to practice your breathing. It might sound silly, but it's really helpful. Slow, steady breathing is the key, so practice breathing in through your nose to the

count of four, and breathe out through your mouth to the count of four. That slow deep breathing really keeps your muscles relaxed, and that makes you more comfortable.

"In the operating room, there will be three people with you -- the doctor, a woman assisting the doctor, and a woman helping you with the nitrous oxide. It might be me helping you with the gas if I'm on the schedule. If it's not me, it will be someone pretty much like me. If I don't see you in the operating room, I'll see you in the recovery room.

"You'll probably be in the operating room for only eight to ten minutes; it's a very brief procedure. Most of that time is preparation time -- getting on the examination table, getting the nitrous going, getting your legs in the leg rests. Oh, by the way, the table in the operating room is sort of like most gynecological exam tables, but, you know how most of those exam tables have the foot stirrups at the end for your feet to sit in? Well, instead of foot stirrups, this table has leg rests which fit behind your knees, so that your legs just kind of hang there. I tell you this only because I notice that almost everybody, when they first lie back on the table, their feet start circling around, searching for that foot stirrup. No need to do that. Just lie back and relax, and once the nitrous is going, we'll place your legs in the leg rests.

"When you're all situated on the table and you're feeling the nitrous, then we'll get started. The first part is very much like a pelvic exam -- the doctor will exam your uterus with her hand, then she'll insert the speculum into your vagina. If you have a laminaria for dilation, she'll remove it at that time. Then she'll give some shots of the local anesthetic into your cervix. The numbing medication we use here is Lidocaine, like the Novocain they use at the dentist office. Have you ever had any dental work done, like for a filling,

when the dentist gives shots into the gum? This is very much the same, except it has the advantage of not being in your face. That's a big advantage. There are a lot fewer nerves in your cervix than in your mouth. Besides that, since our cervixes aren't used to being touched, they don't differentiate much between sensations. For instance, in your mouth it's easy to tell the difference between a pinch and a poke and a prod. With the cervix, these tend to all feel the same -- you might not notice at all, or it might feel like a stinging or a cramp. Those are the reactions I notice most often from patients. At any rate, within a minute the cervix goes numb.

"If we're going to use direct dilation to open your cervix, the doctor will do that as soon as the Lidocaine has taken effect. The cervix is opened with a dilator -- a stainless steel surgical instrument about a foot in length, and about the diameter of a pencil. Both ends come to a blunt point, with one end slightly wider than the other. The doctor first inserts the narrower end of the dilator into your cervix, then the wider end. This is usually crampy, but the combination of Valium and nitrous oxide is very effective. And the key is to be as relaxed as possible. So the counselor who's helping with the nitrous will be reminding you to breathe slowly and deeply."

From the drawer of the desk, I remove a slender plastic tube.

"After your cervix is dilated, the doctor will insert a tube, like this, through your cervix and into your uterus. This tube is called a cannula, and it's what the doctor uses to perform the actual abortion. The other end is attached to a surgical hose which is then connected to the suction machine. The doctor will run the suction for about one-and-a-half to two minutes. The suction removes the lining of the uterus including the pregnancy. While the uterus is being emptied is when you'll probably have the strongest cramping,

like a really hard menstrual cramp or a medium-strength labor contraction. But it's short, and the Valium and the nitrous oxide are very helpful."

"Right after I had my abortion, I told the doctor, 'That hurt.' But it wasn't like they were peeling me off the ceiling, I just told him matter-of-factly, 'That hurt.' And then I told him something that I hear women say all the time after the abortion, 'That's not as bad as I thought it was going to be.'

"I'm kind of a weenie though. I don't want to make you think that it will necessarily hurt, because I've done that before, then afterwards some patients told me that it actually didn't hurt. There's a wide range of experience.

"After the abortion is finished, we'll take you immediately into the recovery room where there will be a bed and a heating pad. For the first ten to fifteen minute you'll probably have cramping like fairly strong menstrual cramps. The uterus is gradually relaxing and the cramping eases up, too. In fact, by the time women leave the clinic, they're usually having mild menstrual-type cramps or no cramps at all.

"You'll stay in the recovery room until you feel strong enough and steady enough to be up and walking around. The average length of time in the recovery room is twenty to thirty minutes. Of course, everybody is different, so there is a wide range of what is considered normal. Some women barely sit down. They're out of there in five minutes. They just bounce out. Some women, particularly those that have been very sick with the pregnancy, lie down, fall asleep, and stay for an hour. Most women are in between. It's totally up to you.

"After you leave the clinic, we want you to be certain to take care of yourself, so we have these aftercare instructions for you. Please keep this

sheet of instructions handy -- you should read over it again because there's too much information here to memorize in one sitting. Also, it has our phone numbers on it, our regular office number, the toll-free number, and our after hours number; so if you have any questions or any problems at any time, you call us.

"We list in the instructions how to avoid problems and what problems to you should call us about. There are two basic kinds of problems that you can actively avoid: 1) unnecessary bleeding, and 2) infection. To avoid unnecessary bleeding, I want you to refrain from lifting anything for the first two days. The instructions say not to lift anything over twenty pounds, but you lift that all the time without even thinking about it. A bag of groceries almost always weighs over twenty pounds. A lot of purses weigh more than twenty pounds. Backpacks for sure. Toddlers. Cast iron skillets. The chair you're sitting in weighs twenty pounds, so pulling a chair out from the table would be lifting too much. After the first two days, the lifting restriction goes up to fifty pounds, which is easier to avoid. At least, you're usually aware that you're lifting if it weighs that much. Don't lift anything over fifty pounds for two weeks. Are the lifting restrictions going to be a problem? Do you have any obligations that require you to be lifting?"

Most of the women I counsel are able to avoid all lifting for a couple days. Some have toddlers, but most of these women have some assistance, especially for the first two days. Some patients, however, have jobs that require lifting: waiters, farmers, nursing aides, gardeners, welders, and dog groomers, to name a few. We provide work and school releases for those women who otherwise would be unable to rearrange their job-related responsibilities.

"The second precaution you can take to prevent unnecessary bleeding is to avoid aerobic or strenuous exercise for the next two weeks. Any problems there?"

Not many women indicate a problem with refraining from exercise, the exceptions being student athletes, aerobic instructors, and exotic dancers. While a work or school release is helpful for athletes and athletic instructors, exotic dancers are usually more interested in returning to work than taking time off from work. If they don't dance, they don't get paid. Dancers are not the only women who will ignore certain aftercare instructions. I have found that women who hold traditionally male jobs such as construction workers or firefighters, are more likely to return to regular work duties even when these duties conflict with aftercare instructions. They explain to me during the interview, and upon returning to the clinic with problems caused by overtaxing their bodies, that they don't feel that they can reduce their workloads strictly for reasons related to "female" problems.

"Those guys already hassle me all the time," one patient informed me. "If they found out the reason I was taking off from work, I'd never hear the end of it."

She was back at the clinic in less than a week with problems of severe cramping from clotting associated with heavy bleeding.

The second problem women can actively avoid is infection. Patients are instructed not to put anything in their vaginas for a period of time. That means pads not tampons for the first week, and no sex for two weeks. Usually, women simply nod, indicating that they understand. Occasionally, I hear the incredulous, "Two weeks!" I am most surprised, though I suppose I should not be, by the large number of women who express relief when I inform them

of the two week sex moratorium. I realize that the majority of women I talk to at the clinic are in the midst of suffering the painful consequences of sex; most of them are emotionally distressed, and many of them are physically ill, so it is understandable that sex might be distasteful. Still, there is something more in their responses. I often hear remarks like, "No problem, I don't really like sex that much, this will be like a vacation," or "That's okay, I only have sex because it's so important to him." History of sexual abuse is a conceivable explanation for the negative feelings some of these women have toward sex. When I asked my co-workers for other possible causes, they presented me with several feasible ideas: some women are not sexually attracted to men but end up in heterosexual relationships because that's the norm, sex may be a low priority compared to other activities in a person's life, and sometimes sex is not very enjoyable because some people are not very good at sex.

The next part of the aftercare instructions lists the types of problems for which the patient should notify the clinic.

"The very first item on this list is fever. If you have a fever, even a slight fever, give us a call. Fever can be an indication of infection. We don't usually have a problem with infection because we give an antibiotic just before the procedure and instructions on how to prevent infection. But if there is any sign of infection, we want to be right on top of it. Fever is not an absolute sign of infection, but we don't want to take any chance, so if your temperature is elevated, call.

The other three problems to call us about are symptoms that are commonly associated with your period: cramping, clotting, and bleeding. These are perfectly normal, but if they are excessive, if they're more than you usually experience on the heaviest day of your period, then give us a call.

There are some general guidelines for each of these symptoms. For instance, with cramping, if you take 800 mg of Ibuprofen and you're still in pain, call us. Your recovery should not be painful. If it is, we want to know about it. Clotting is very normal. Lots of women experience clotting during their periods. This is the rule of thumb on clotting: if the clots are bigger than a quarter, give us a call. Bleeding is perfectly normal, though some women don't bleed after an abortion, so don't be alarmed if you don't bleed. But here's another reason to wear pads instead of tampons. I want you to watch how much you're bleeding. If you're bleeding heavily enough to fill a pad in an hour, or even two hours, that is too much bleeding. It's not hemorrhaging, so you don't need to panic, but it is heavy bleeding, so call us because we'll want to slow it down.

"All three of these problems are usually associated with your uterus not contracting down enough, not constricting the blood flow. There are several things we can do to help if this happens to be the situation. We can instruct you on massaging your uterus (sometimes it just needs a jump start). Or we can phone in a prescription for a medication that will stimulate the uterine muscles to contract which slows the blood flow. And if worse comes to worse, and this does happen for about one in fifty women, you can come back in for a resuction. But I must tell you, for most women, the recovery process is uneventful.

"In fact, I only mention the one in fifty women who return for a resuction because that statistic won't be listed on the consent forms you're going to sign next. The clotting and cramping don't actually threaten your health or endanger your life, so they're not considered significant risks. But let's take a look and see what the significant risks are."

Before we can proceed further, the patient must sign copies of the aftercare instructions (Appendix B) and consent form (Appendix C). After the forms have been signed, I take the patient to the lab area where I test a drop of her blood for iron and Rh factor. If her blood is Rh negative, she will need a Rhogam shot, so I highlight her health history sheet, two entries on the OR sheet, and the insurance form.

I then offer the patient the use of the restroom so she can empty her bladder as this will make her more comfortable during the ultrasound exam. When she is ready, I show her to an exam room where I check her blood pressure. Then, I provide her with a lap sheet, and instruct her to undress from the waist down. I place the patient's chart in a slot on the wall next to the exam room door and notify technician that the patient is ready for her ultrasound exam. Then I return to the nurses station where I pick up the next patient's chart and begin again.

Chapter 5

The Operating Room

If I am scheduled to work OR, my first responsibility after lunch is to set up the operating room. This entails checking the nitrous oxide gas and oxygen tanks to make certain both active tanks and back-up tanks are not empty, preparing wet wash cloths and emesis basins (just in case), and stocking supplies such as paper towels, latex gloves, and disinfectant. When the OR is set up, I change into scrubs.

There was a time when I preferred to wear street clothes in the OR. I thought street clothes created a more comfortable, less clinical atmosphere. Also, wearing scrubs required extra time for changing, and besides, I viewed scrubs as the uniform of medical professionals, and while I am indeed in a medical setting, I am not a medical professional, and I did not want to mislead. All that changed one day. Immediately after an abortion procedure, while the patient was still lying on the table breathing the nitrous oxide, I noticed the tale-tell throat muscle motion indicating that the patient was suppressing the gag reflex. I removed the breathing mask from her nose and reached for the emesis basin while I instructed her to roll onto her side. This particular patient was heavy-set and had quite some difficulty turning onto her side, especially since she was still rather high from the nitrous and cramping from the abortion procedure. She was just starting to turn towards me when she began vomiting. I was hit from head to toe. The patient immediately and profusely apologized. We, in turn, hurriedly assured her that she had done nothing

wrong. In fact, the doctor explained, the only problem was that I was not wearing scrubs. So, now I wear scrubs.

After changing into my scrubs, I call the first patient from the waiting room into the clinic area where I escort her to a consultation room. I notify the doctor that the patient is ready for PARDs (Procedures, Alternatives, and Risks Discussion). I call the next patient and repeat the procedure. When the doctor has finished consulting with the first patient, I escort her to the medication counter and chart the time she took her Ibuprofen and antibiotic (usually one-half hour before arriving at the clinic). I give her two small cups, one containing water, the other containing two pills.

"The green pill," I tell her, "Is Valium, to help you relax. The white pill is Ergonovine, a drug that helps your uterus contract back down."

I chart the time these pills are taken as well. We cannot start the procedure until 30 minutes after the patient has ingested the Valium. I show her back into the waiting room and assure her that it won't be long before she is called into a pre-op room.

After the first two or three patients have met with the doctor, we begin "loading" the pre-op rooms. Those patients who took Valium earliest and those not using Valium at all, are the first to be shown into one of the two pre-op rooms which are located adjacent to the operating room. Each room contains a twin size bed, a chair, a small table, a stack of gray Rubber-maid tubs, and some magazines.

"Undress from the waist down," I instruct the patient. "Put you clothes and other stuff in the gray tub. You can use this sheet to wrap around your waist like a skirt. It'll be about fifteen minutes before we're ready, so just

lie down and relax as much as possible. And if you need anything, just let us know."

When the doctor and the tech (the technician assisting the doctor) are both ready, I bring in the patient's chart. From the information on the OR sheet (see Appendix D), I report to the technician the gestational age and the type of dilation indicated. "Eight DD," means that the patient is 8 weeks pregnant and direct dilation is the method to be used to open her cervix. "Ten with a lam," means that the patient is ten weeks pregnant and a seaweed laminaria has been inserted in her cervix to effect dilation. This information allows the technician to set up the appropriate surgical instruments. I will also announce any notes which have been made on the chart by the staff member who conducted the health history interview. These usually include one of the following: survivor, lots of TLC, very nervous, needlephobe, no descriptions of any medical procedures, run water during suction, or First Pelvic! Next, I note which injections if any the patient will need -- Rhogam if the woman has a negative blood type, or Nubain if the patient has requested this additional pain medication. I also inform the OR staff if the patient is allergic to anything with which she may come into contact in the operating room such as the latex gloves we wear, or benzene, an antiseptic. I make a personal note of the patient's occupation, where she lives, if she is in school, how many children she has. These last are facts which may be useful in quickly establishing a pleasant and relaxed connection with the patient -- in other words, for making chit chat.

I also inform the OR team if anyone will be accompanying the patient. Sometimes a translator will attend in the OR if the patient speaks neither English nor Spanish (we have a bilingual staff member to attend Spanish

speaking patients). More often, if someone is accompanying the patient, it will be a support person. About ten percent of our patients request to bring someone with them to be present during the procedure. Most commonly, this will be the patient's male partner, though sometimes it is her mother or a close friend. As a matter of course, we do not suggest that the patient bring a support person -- clinic staff are trained and prepared to provide professional and personal support in order to meet patient needs. However, if the patient requests to have a support person in attendance during the procedure, we take steps to meet this request.

The first consideration in determining if the presence of a support person is appropriate is whether or not the patient herself will feel better with that person present. I explain to the patient that the job of the support person is to focus entirely on the patient in order to give unwavering emotional support so that the patient can feel more comfortable. The support person is not in the operating room as a spectator to a medical procedure. If the support person is likely to cause stress, due to tensions in the relationship or feelings the person has regarding the pregnancy and abortion, this is counterproductive to the comfort of the patient. Together, we examine the patient's objectives in having this person with her, the nature of their relationship, and the ability of the individual in question to be supportive. We also discuss at which points during the clinic visit the presence of the support person will be most beneficial to the patient.

Usually the patient wants to have a support person with her simply in order to feel more at ease. People feel more secure in the company of friends, less threatened, more casual. It has been my observation that girlfriends are especially good at this aspect of the support role. Friendships tend to be more

flexible and relaxed, less culturally dictated than the ties of family and marriage. The tension and expectations characteristic of romantic or familial relationships are generally not as pronounced in the less formal structure of friendships. For some patients, particularly younger women, the reliable and consistent dependability of a familial bond (i.e., Mom) provides a solid base for confidence and calm. However, the majority of women who want a support person with them in the operating room choose their male partner. A woman's relationship with her boyfriend or husband is one she has chosen and is, in this sense, distinct from familial relationships. Unlike most other friendships, her committment to the man is explicitly implied by the nature of the relationship. The quality of the relationship is a reflection on her judgement, security, and happiness. As a support person, the partner can share the woman's abortion experience in a respectful and deeply meaningful way. Being cared for or taking care of someone during a difficult situation can strengthen a relationship whether it be with a partner, family member, or friend.

Occasionally, the patient's purpose in having the man as her support person is to have him witness the ordeal to which she must be subjected. This motive is indicated by statements like, "He's the one that got me into this and I'm going to make him see how much it hurts," or "He won't believe how bad it is unless he's there." In these cases, I discourage the presence of the man during the clinic visit. If this is her sentiment, she is committed to having a painful and terrible experience. While it may well benefit the couple to openly address issues of trust, respect, and responsibility within the relationship, the operating room is not the place to seek emotional redress.

Once we have determined the presence of the support person will be beneficial to the patient we must next consider the suitability of the person she

has chosen. Some people are uncomfortable with clinical settings such as the operating or examination rooms, or with physiological symptoms of illness like vomiting. People who are squeamish under these circumstances may not be able to offer helpful support in such settings. In fact, they may actually detract from the support of the staff, especially if they themselves require assistance. Though it rarely occurs, it is a real concern that the support person may become physically ill, may even faint or vomit. Not all loved ones are able to remain calm and collected in the setting of the operating room, though their presence beforehand or afterwards can be greatly reassuring and appreciated. Sometimes, loved ones provide the greatest help outside the clinic altogether -- paying expenses, taking care of children, preparing meals, running errands, talking about the experience, or just being there.

As well as considering the support person's reaction to medical settings and procedures, we also discuss his or her attitude toward the patient, and feelings about the abortion. If the person in question has been abusive toward the patient or is otherwise highly critical of her, this person is not suitable as a support person. Likewise, if the support person is against abortion in general or this abortion in particular, she or he may have difficulty being supportive. Again, there are many ways to be supportive of the patient without being physically present during the abortion.

Some of the most touching moments I have witnessed in my role as counselor have been between the patient and her support person. Words of endearment and encouragement whispered by a mother as she strokes her daughter's hair. The unexpected maturity of a teenage boy who is able to express respect and affection for his girlfriend. The shaky smile and steady

gaze shared between a woman and her husband. Girlfriends giggling over an irreverent joke.

Some of my most frustrating experiences at the clinic have involved the patient's support person. When there is a problem, it is most often because the chosen support person simply is not emotionally prepared to take on this responsibility. The person who cannot bring himself to look at or touch the patient (like the man who stares out the window and pushes the patient's hand away when she reaches for his) usually does more harm than good. Likewise, the person who is more involved with her own feelings and reactions during the abortion (like the mother who covers her eyes throughout the procedure and gasps at every sound) does the patient little service. Only rarely does the support person fail to be supportive due to obvious disregard for the woman and her experience, though I have witnessed such situations. Once, a very anxious patient brought her husband with her into the operating room. She was extremely nervous, particularly about experiencing pain. As we positioned her on the table, she was jumpy, but co-operative. She had a difficult time relaxing. Her husband rolled his eyes and said, "She's always like this." He made other comments to the patient such as, "You're not helping any," and "I knew you'd be like this." Each time his voice was tinged with smug impatience. During the actual abortion, he turned away from his wife and craned his neck so that he had an unobstructed view of the doctor's hands. I attempted to draw his focus back to his wife who was moaning softly between inhalations of nitrous oxide. I leaned across the patient's prostrate body within a few inches of his face. "Are you with us," I asked, glancing down at his wife. He looked at me from the corner of his eye for a brief moment, then returned his gaze to the activities of the doctor.

When the operating room team is ready I inform the patient. I knock on the door of the pre-op room as I open it, and pop my head in. I make certain that I use her name when I ask if she is ready. I introduce myself and explain that I will be with her in the operating room, helping with the nitrous oxide if she chooses to use it. I show her into the operating room and introduce her to the tech who will be assisting the doctor. While the tech is instructing the patient how to position herself on the table ("Open up the sheet so that you're sitting on your bare bottom. That's it. Now drape the sheet across your lap and scootch towards me about six inches. Okay, about another two inches. Okay, now scootch back about an inch. There we go.") I return to the pre-op room, remove the sheet from the bed and put it in a gray RubberMaid tub in which the patient has placed her belongings. I take the tub to the recovery room which is located through a door at the other end of the operating room and I place the tub on a stand just inside the door. This indicates to the recovery room attendant that the patient is beginning the surgical phase of her clinic visit, and will be ready to enter the recovery room in about ten minutes. During this time, the recovery room attendant will prepare a bed for the patient using the same sheet the patient had in the pre-op room (this reduces laundry by about one-third, saving money).

It is philosophically important at DTWC to provide abortion services that are both compassionate and affordable. We take many small steps to ensure that the clinic operations are efficient and humane. In any given afternoon, an average of eight to twelve abortions will be performed. It is essential that we make the most effective use of time (and money) without rushing the patient.

For instance, while I am carrying the gray tub of personal belongings across the operating room, the tech is helping the patient situate herself on the table. As I pass by, I ask the patient if she will be using the nitrous oxide. If she says yes, without even slowing my pace, I reach over to the gas distribution mechanism and turn the dial which allows gas from the tanks to be released into a reservoir bag. After placing the tub in the recovery room, I seat myself on a low stool next to the operating table. By this time, the reservoir bag has filled sufficiently to begin administering the gas to the patient. Many such actions in the operating room are taken in order to use time most efficiently.

Before administering nitrous oxide gas to the patient, I ask if she has ever had nitrous before, "Like at the dentist office, or something." I always throw in the "or something" because some people have only used nitrous oxide recreationally and the specific purpose of my question is to ascertain if the patient has previously used nitrous, not whether the use was licit or illicit.

If the patient has used nitrous oxide before, I confirm that the experience was helpful and that the patient was comfortable with the use. If the patient has never used nitrous oxide before, I increase the percentage of oxygen in the nitrous oxide mixture so that the patient initially will breathe in a relatively low dose which I can gradually increase to an effective yet comfortable level. I explain to her why we, like dentists, use nitrous -- it generally relaxes people, it makes the entire body numb, and it usually induces a dreamy sensation which tends to be more engaging than what is happening in the physical world. Nitrous oxide is metabolized very quickly, so the effects are felt only as long as the gas is being inhaled. For this reason, I will hold a small mask over the patient's nose during the entire procedure. Moreover,

because the effects wear off quickly, if for any reason the patient does not like the effects of the nitrous, I will remove the mask and the gas will dissipate directly. I always inform the patient, however, that most people enjoy the effects of the gas, and that, in fact, we regularly get requests from patients to take the gas home with them (and that it will not be possible to honor this request, should she make it).

As I place the mask over the patient's nose, I instruct her to breathe slowly and deeply, inhaling through her nose, completely filling up her lungs, and exhaling through her mouth, completely emptying her lungs. I explain that this slow, deep breathing itself helps muscles relax. I recommend that she count to four with each breath, in and out. I ask the patient to be aware of the initial effects of the gas such as numbness in her fingers or feet, numbness of her face especially around her mouth so that her lips might feel tingly, ringing in the ears or other sound distortion, and, of course, the sensation of being "high." I also warn her that, due to the effects of the nitrous oxide gas, I or other OR staff might appear to be more amusing than we actually are.

As soon as the patient is feeling the effects of the nitrous oxide, the tech places the patient's legs in the leg supports at the foot of the table. The leg supports are about twelve inches long, eight inches wide, and are angled to fit behind the patient's knee. Most gynecological examination tables have foot stirrups rather than the leg supports of the operation table. The leg supports are more suitable for surgical procedures because a patient may involuntarily clamp her knees and thighs together during an operation and this is exactly where the doctor's head is positioned.

I am seated on a low stool near the patient's head so that I can hold the nose mask in place, speak directly into the patient's ear, and hold her hand if

she likes. I can also better observe the patient's body signals such as breathing, skin tone, and muscle reflexes, as well as the nitrous oxide apparatus. The doctor, stands between the patient's raised legs, and explains that she will now do a brief examine. She inserts her gloved, lubricated hand into the patient's vagina and manually examines the cervix and uterus to determine size, texture, and position. With this portion of the procedure completed, the doctor seats herself on a wheeled stool at the foot of the table between the patients legs. The tech stands immediately to the doctor's right, behind a stainless steel tray on which are arranged the surgical tools which will be used in performing the abortion. The doctor and tech are focused primarily on the patient's lower body, specifically her reproductive organs, while I am focused exclusively on her upper body, particularly her breathing.

Unless otherwise instructed by the patient, the doctor explains each step of the procedure as she performs it. "I'm inserting the speculum into your vagina. I'm washing your cervix with a cottonball soaked in antiseptic. Now, I'm giving the numbing medication." The numbing medication is Lidocaine. It is part of the local anesthetic process referred to as the paracervical block and is standardly administered in three injections. The syringe used to administer the paracervical is formidable in appearance with a three-and-one-half inches long needle. The length of the needle is misleading. The purpose of the extended needle during an abortion is not to deeply pierce tissue -- the needle actually penetrates a mere fraction of a centimeter beneath the surface of the tissue in order to inject the Lidocaine. The extended length of the needle is necessary only to traverse the vagina.

Not surprisingly, the long needled syringe is kept out of the patient's view. Likewise, doctors and staff usually refrain from using terms like

"injection" and "shot." It is generally held that the psychological associations to needles can cause considerable stress, enough to counteract the benefits of knowing exactly what is going on. Some patients explicitly request that no mention of needles or certain other medical descriptions be made. If the patient expresses an interest in these details, they are, of course, provided. Because our cervixes are not accustomed to being touched, sensations of touch often are not clearly differentiated. Also, there are considerably fewer nerves in the cervix than in parts of the body that are more commonly touched, like the face and hands. Some women do not notice the injections. Some feel an injection as a pinch, a stinging, or, more commonly, as a cramp. I remind the patient that, just like injections from the dentist, the shot might hurt at first, but will shortly go numb.

After the injections are completed, the doctor sits back and waits for one minute while the anesthetic takes effect. During this pause, I remind the patient to focus on her breathing, and to remember that anytime she experiences any discomfort or pain that she should inhale deeply to immediately intensify the effects of the gas. (Nitrous oxide is an interactive drug. Compared to other mind altering substances, nitrous oxide allows the patient a great degree of control. Simply closing her eyes allows her to slip deeper into a dreamlike state. Opening her eyes can shift a patient to a more sober mental state by visually reorienting her to her surroundings.)

If the patient's cervix is to be opened by direct dilation, that process begins as soon as the local anesthetic has taken effect. The doctor explains that she will be stretching the cervix and that this will likely cause cramping. I remind the patient to breathe in deeply and exhale completely. The doctor first determines the angle of the cervix with an instrument called a sound, then uses

a dilator to widen the opening of the cervix. The dilator is a stainless steel surgical instrument about a foot in length and varies in diameter from the size of a pencil to the width of my pinkie finger, depending on the length of the pregnancy. Each end of the dilator, about an inch from the tip, is angled approximately forty-five degrees. One end is slightly wider than the other end. The doctor first inserts the narrower end of the dilator into the os of the cervix, then the wider end. Depending on the gestational age of the pregnancy, the doctor uses either one or two dilators (if two dilators are used, one is slightly larger than the other). If a laminaria was inserted either the day before or several hours prior to the abortion, the doctor simply removes the laminaria and assesses the degree of dilation that has occurred.

Once the cervix has been sufficiently dilated, the doctor proceeds to insert the cannula, the tube by which the suction curettage is performed. The cannula is a clear plastic tube, angled like the dilator about an inch from the tip. The cannula is attached to a surgical hose which in turn is connected to the motorized mechanism which provides the suction. The doctor informs the patient that she will soon hear the noise of the suction machine for about two minutes, and that she will probably experience hard cramps while the uterus is being emptied. Then the doctor signals the tech who starts the suction.

The noise of the suction is mostly from the motor. It is not so loud that it can not be drowned out by the sound of running water in the sink, but it is loud enough that those in the operating room must speak more clearly and firmly than usual in order to be heard. Positioned next to the patient's ear, I can still speak softly and be heard clearly. I follow the rhythm of her respiration, guiding her gently in a pattern of slow, deep breaths. Throughout the procedure, I continually comment on the patient's breathing. If her

breathing is shallow or rapid, so there is the possibility she might hyperventilate, I instruct her to breathe more deeply or slowly. When giving these instructions to the patient, I speak with a soft and soothing cadence. Doctors and patients have commented on the hypnotic quality of my voice.

"Blow all the air out," I say. "Nice and slowly. That's right. Very good. Now, slowly and completely fill up your lungs. Good."

Ideally, patients have already fallen into a pattern of relaxed and effective respiration. I facilitate this breathing by offering positive feedback in a quiet and encouraging manner.

"You've got excellent lung capacity. Very good. Now, breathe in deeply. That's it. Perfect. You're right on top of it. Beautiful, that's exactly how you should be breathing. And exhale. Excellent. You're doing fabulously. Good job. Very good job."

These instructions may seem obvious and the method of delivering them excessively cheerful or even patronizing. However, inhaling nitrous oxide, or simply focusing specifically on breathing, brings about an altered state of consciousness in which guidance of this sort proves to be a useful and effective means of maintaining the patient's comfort.

During the suction curettage, the doctor guides the cannula along the inner walls of the uterus, from side to side, and up and down. Emptying the uterus causes the uterine muscles to contract, and this is usually experienced as cramps by the patient. In fact, this is the hardest cramping the patient will experience during the procedure. It lasts about one-and-one-half to two minutes. After the first minute, when the uterus has contracted quite tightly, the suction is turned off and the doctor explains that there will be a routine thirty second break. I inform the patient that we are now 90% done, and tell

her once again that she is doing a good job. This break is taken because it allows the uterine muscles to relax. Once the uterus has opened up a bit the doctor makes a final pass through the uterus with the cannula, assuring that all the tissue has been removed. This usually takes about 15 seconds.

Even before the suction is turned off, I inform the patient that the procedure is finished. I begin increasing the oxygen in the gas mix so that the patient will gradually come back to a normal state of consciousness. The tech turns off the suction and checks the tissue to determine that the abortion is complete. If the gestational age of the pregnancy is nine weeks or less, the tech is looking specifically for the placenta -- the rest of the pregnancy, including the embryo, is too small to be seen with the naked eye. After nine weeks, the tech is also looking for fetal parts of which some are now visible. At 11 weeks or more, cranial and spinal parts have developed, and the tech assesses that these are present. If there is any question about the thoroughness of the abortion just performed, an ultrasound examination is made to ascertain what tissue, if any, remains in the uterus.

When it has been determined that the abortion is complete, the doctor places dry gauze in the patient's vagina (to act as a tampon), and removes the speculum. The patient's legs are moved from the leg holders onto the table. By this time, I have adjusted the nitrous-oxygen mixture so that the patient is breathing straight oxygen. I remove the mask from her nose, and speak directly to her, face-to-face.

"How are you doing? I imagine you're feeling pretty crampy, and kind of groggy still from the gas, huh? Well, that's really normal. Those cramps will ease up a lot in the next ten minutes or so, and the gas will wear off even sooner. In about a minute, I'm going to take you into the recovery room.

We've got a bed for you there and a heating pad. The heating pad is going to feel really good on those cramps. You're going to be feeling much better very soon."

I am not simply trying to employ the power of positive thinking -- cramps usually subside relatively quickly. Once the uterus is empty, the contracted muscles begin to relax, and the cramps diminish. Some women feel very little, if any, pain. When I ask if they are feeling crampy, they shake their heads and say, "No, not really. Not any more than with my period, maybe less." Others experience substantial cramping, but no more than a medium-sized labor contraction (which, if you have never had one, is indeed substantial).

I note on the chart the strength of the nitrous oxide used as well as the patient's general response to the abortion. If the patient was calm, responded well to the nitrous, and experienced minimal discomfort, my comments may read, "Date: (Patient's name) did excellently during TAB w/ N2O & valium." If the patient experienced more difficulty, but coped well, I may note that she "did fine during TAB w/ N2O & valium." When the patient does not use nitrous oxide or valium, this is indicated in my comments. If the nitrous caused anxiety, the support person created stress, or the patient had difficulty remaining still, I note this on the chart. I might also make recommendations concerning any future abortions the patient might have at DTWC such as "Next time use nubain," or "Highly sensitive to N2O. Use very little." The comments I chart most often include "did beautifully / very well / great / wonderfully / fabulously during TAB w/ N2O & valium."

When the abortion procedure has been completed smoothly and relatively comfortably or when the patient has been notably valiant, I make a

point of telling the patient what a good job she has done. No matter how skilled the doctor and staff, without the effort of the patient, the procedure can not be performed easily. I usually tell patients, "You did a really good job. I know this isn't easy. You're crampy, plus you're high from the gas, yet you stayed very focused, you were right on top of it. You really did a good job. Thanks."

With that, I help the patient walk into the recovery room. I introduce her to the staff person who will be taking care of her while she rests, and in doing so usually comment again on how the patient did during the procedure -- "She was very brave," or "She was awesome," or "She's feeling kind of pukey." As the recovery room attendant helps the patient climb into bed, I return to the operating room and set up for the next patient.

Chapter 6

Recovery Room

The door separating the operating room from the recovery room opens, and the OR counselor emerges with a gray RubberMaid tub containing the patient's belongings. She sets the tub on a stand just inside the door and slips back in, closing the door behind her. This is my sign that in about ten minutes the patient will enter the recovery room.

The recovery room is fairly large, measuring approximately fifteen by twenty-five feet, the largest room in the clinic (except the waiting room). There are four gurneys, each supplied with a pillow and a heating pad, where patients rest during their immediate recovery. At one end of the recovery room is a door which leads to a small area with sinks, an autoclave for sterilizing the surgical instruments, and a washing machine for laundry. At the other end of the recovery room is a rest room which includes the usual amenities plus a dryer for laundry. Along one length of the room are large windows which provide a wide view of west Portland including the St. Johns, Broadway, and Fremont bridges, Council Crest, Forest Park, and the ornate steeples of several downtown churches.

As recovery room attendant, my duties are many and varied. My primary responsibility is twofold 1) the immediate comfort and well-being of the patients as they make their transition from the experience of the abortion clinic to the outside world, and 2) support and service of the operating room, primarily by maintaining the supply of sterile surgical instruments. Periodically, the OR tech will bring out "dirty" instruments -- speculums, forceps,

tenaculums, and dilators -- which have been scrubbed and soaked in antiseptic. I will rinse these, wrap them in sets, and "cook" them for thirty minutes in the autoclave. It is imperative that the operating room staff does not exhaust its supply of instruments.

I also have several secondary functions which include washing, drying and folding laundry, record keeping, assembly of charts, providing work excuses, and occasionally sending tissue to an outside lab. However, my first responsibility is the well-being of patients.

When the OR counselor deposits the gray tub in the recovery room, I take the bed sheet and prepare a gurney for the patient. I slip a sanitary pad in the tub with her belongings, then return to my assorted duties. As I listen to the muffled sounds from the operating room, I can imagine what is occurring. There is the initial chit chat and joking between the staff and patient. Then it is quiet -- the counselor has probably started the nitrous oxide. After a few minutes I hear the suction begin. I double check to be certain that everything is ready for the patient. A few minutes later, the OR counselor escorts the patient into the recovery room.

Unless I am actively attending another patient, I move to help the new patient situate herself on the gurney. I place the heating pad on her tummy, and cover her with a thick, fuzzy blanket.

"I imagine you're feeling kind of crampy right now, " I begin. Patient responses range from, "Not really," to "Kind of," to "Oh, yeah."

When patients are not feeling especially crampy, I give the "thumbs up," and reply, "Excellent! You should just continue to get better and better."

If the patient is experiencing painful cramps, I remind her, "Cramping is really normal these first ten minute after the abortion. But it's also very normal for the cramps to ease up considerably in a short time. In ten minutes or so there should be a noticeable change for the better. The best thing right now is for you to lie back and relax, let the heating pad do its job, and those cramps will ease up. Remember to breathe, your muscles need oxygen to relax. Now I'm going to let you rest for a while. I'll check back on you in a few minutes, but if you need anything in the meantime, you let me know. My name is Gloria, and I'll just be hanging out in here."

Some patients are tearful in the recovery room, either sad or in pain. When a patient is suffering from immediate physical distress, I assure her that I want to do everything I can to make her feel better. I help her find the most comfortable position to lie in, usually on her left side. I remind her to breathe slowly. I instruct her not to hold her breath because this will cause her muscles to cramp more. I offer her Kleenex and ask if she is thirsty. Much of my advice is quite practical. Some of my actions do little to directly relieve pain, yet are significant in that they indicate my concern for the patient. My manner is that of a capable mother -- competent and caring. I can be very effective and soothing.

When patients are sad, I am sympathetic, but not alarmed. It is not unusual for a woman to have mixed feelings about an abortion, even when she is certain of her decision. Besides the emotional strain of the general circumstances, the additional physical stress of the surgical procedure, and the effects of the nitrous oxide, can create a less inhibited emotional state in which feelings we typically reserve for private expression rise to the surface and are expressed openly. I understand her reaction as a normal and healthy aspect of

healing, not something that needs to be fixed. I do what I can to make time and space for these feelings. Again, the most effective care is a balance of practical help and compassion -- in this case, Kleenex and kind words.

Most "outsiders" assume there must be a lot of sadness and crying at an abortion clinic. This is generally not the case. Most women have given serious thought to their decision and have spend adequate time examining their feelings. The interview process facilitates these measures. By the time women have reached the recovery room, especially after any cramping has subsided, they usually feel more relieved then anything else. They also often express appreciation for clinic and staff.

More than tears, I see vomit. Hardly a day goes by that not even one patient vomits. Pregnancy often causes nausea, and the additional stress of the clinic visit, particularly the surgical procedure, often triggers vomiting. Staff at the clinic comment that they have become so desensitized to vomit that they can hold an emesis basin for a patient in one hand and eat lunch with the other.

I continually and unobtrusively check the patient to assess how she is recovering. Gradually, the patient will begin to relax, her facial muscles soften, her color returns, and she may even doze off. If a patient has had an injection of the painkiller Nubain, she will usually rest substantially longer. After the patient has rested for ten to fifteen minutes, I approach her and begin asking some of the final questions of her clinic visit.

"How are you doing? Have those cramps eased up at all? Good. They should just continue to get better. Did you schedule your two week follow-up visit? Good. Do you have pads at home for the bleeding? What about Advil or some kind of Ibuprofen?"

Women who don't already have pads and Ibuprofen usually assure me that they can get some on the way home. I tell them that it's not necessary, I will provide them with enough pads and/or pills to get through the day and they can go to the store tomorrow. "Today is a good day not to have to worry about anything. You just go home and rest."

I go over their aftercare instructions one more time (Appendix D), especially the sections on prevention of problems -- no tampons, no sex, no lifting, no aerobic exercise. "Are you going to be able to take it easy for a couple days, just veg out, be a couch potato?"

Most women are confident of their ability to lounge around. Some women are not sincere when they agree with me. If I sense this from a patient, I ask more questions. I might look at her chart to see what her line of work is. Or I will simply ask about her obligations. Many women have young children at home, so we discuss which activities will be acceptable and which will not. Often women have job responsibilities that may interfere with their health needs. We discuss what type of arrangements can be made and I write up a work excuse if needed. Some women live on farms or have horses, and feeding and caring for their animals is a major responsibility. Whatever their responsibilities, we discuss their options and the possible consequences to their health. I usually tell them, "You will probably be feeling back to normal very soon. Just remember -- your uterus is still healing. Be kind to your uterus."

In the recovery room I have the chance to talk to women about many diverse topics. They tell me about their children, jobs, school, proms, travels, jokes, recipes, movies, books. Because I am the last staff person that they usually have contact with before the two week follow-up visit, I am often the

one to whom they express their thanks. I have had more than one woman tell me that this is the best medical experience, regardless of the purpose, that she has ever had.

Since it is the last chance before leaving the clinic, patients often ask questions. I answer all questions as carefully and as honestly as I can. Are there any foods I should avoid? Eat anything you want. Will it be okay to drink? Sure, but I wouldn't recommend getting drunk. Can I have oral sex? On him, yeah; not on you. What do you do with the dead embryos? All tissues are frozen and sent to a biomedical waste company that incinerates them. Isn't it hard working here? I like working here. It's very satisfying to be able to help people who are in a tough spot.

When the patient feels she is ready to leave, I check her blood pressure and pulse to make sure everything is normal. I carry her things into the restroom ('Remember, don't lift anything') where she can get dressed and ready to go.

"When you're done with the skirt-sheet, it goes in this hamper behind the dryer. The doctor left some gauze in your vagina, be sure to pull that out and put it in the red wastebasket over there. When you're all dressed, come back into the recovery room and I'll get you on your way home."

Chapter 7

Conclusions

From a feminist perspective, abortion is viewed as a right by which women exercise physiological, personal, and social control in their lives. This empowerment of women is crucial to the feminist goal of ending sexist oppression. Feminist beliefs and objectives are political in that they advocate transformation of civil and cultural institutions in order to effect the social change necessary to end sexist oppression. Courses of action directed toward social change constitute political activism. Those who, with motive and intent, participate in these transformational courses of action are political activists. In this sense, abortion is a highly political medical service, and many of the women and men who work as abortion service providers are likewise political.

Among the many and varied forms of feminism which are espoused and practiced (liberal, socialist, radical, psychoanalytic, and post-modern, to name just a few), the end of sexist oppression is widely understood to be a feminist goal. If not the defining objective of feminism, the end of sexist oppression is at least a unifying characteristic of feminist philosophies, theories, politics, and practices (hooks, 1984; Tong, 1989; Warren, 1990; Andersen, 1996).

Oppression involves an imbalance of power by which one group forces and enforces the submission of a less powerful group (Young, 1990). The empowerment of women, individually and collectively, is a means to alleviate sexist oppression and is generally recognized as a feminist goal (Butler, 1990; Deveaux, 1996). However, just as there are various feminisms, there are different conceptualizations of power and empowerment. Some post-modern

feminists examine the social construction of beliefs and belief systems and view power as the process by which these ideologies construct our perceptions, particularly regarding women and women's issues (Hartsock, 1990; McNay, 1993) . The locus of power is seats of knowledge -- such as law, medicine, academia, and language -- which construct our belief systems. Power is exercised through the authority of knowledge. In short, knowledge and power are one in the same. In order for women to exercise power, established patriarchal institutions such as law and medicine must be transformed. Beneficial, though limited, social transformation may be achieved through participation within existing ideologies such as the liberal political and legal system of the U.S.. Wider social change, however, necessitates transformation of our fundamental conceptualizations of power.

Within the ideology of liberal political philosophy, the concept of rights is a cornerstone. Likewise, the issue of women's rights is fundamental to the beliefs and aims of liberal feminists. There is admittedly debate among feminists regarding the patriarchal underpinnings of liberal political theory, a debate which at times contests the concept of individual rights altogether (Pateman, 1980, 1988; Wright, 1993). However, the underlying liberal concepts of power -- autonomy, personal and bodily integrity, and self-determination, values which liberal political theory frames within a structure of liberties and rights -- are a means of empowering women and are generally accepted as fundamental feminist goals (Hartman, 1992). Within an existing liberal system, women's rights -- legal, economic, and political rights, including the right to abortion and other reproductive health rights -- are a means of framing, and, consequently, of exercising personal and social power for women, thereby contributing to the feminist effort against sexist oppression.

In providing access to abortion, a constitutionally protected right in the U.S., abortion service workers are providing women a means by which to exercise autonomy, personal and bodily integrity, and self-determination. In this sense, abortion service providers participate in a feminist belief system. However, such participation (which could arguably be described as tangential) does not directly indicate personal feminist beliefs on the part of individual abortion service workers. Indeed, the mere fact of employment at an abortion clinic no more defines one as a feminist than working as a bank teller characterizes one as a capitalist. Neither does the threat of violence at one's place of work in itself determine one's political convictions. There are far more armed bank robberies than acts of violence against abortion clinics, yet we are not likely to assume that the capitalistic beliefs of bank tellers are more fervently held than the feminist beliefs of abortion service providers. There are more crucial factors at play in the relationship between one's occupation and one's political beliefs.

Banks and abortion clinics are both political in the sense that economics and abortion are each issues of legislation and government control. Capitalism, though at times critiqued in theory, enjoys widespread stability, participation, and support. Abortion is more visibly political in that it is the focus of ongoing and prevalent controversy. Even supporters of abortion rights may harbor ambivalence toward certain aspects of abortion -- public funding for abortions, late-term abortions, abortion as a tool in gender selection, abortion as birth control. Opponents of abortion have countered the legitimation of this particular women's right by arguing the personhood of fetuses and fetal rights, specifically the right to life (Hopkins et. al., 1996). Abortion is thus positioned at the center of the conflicting interests of women and fetuses. Due to the

widespread debate surrounding abortion, public perception and governmental legislation regarding abortion are presently in flux. As a focal point of social change, abortion is a site of political activism. Those abortion service providers who intentionally participate in shaping the social perception and configuration of abortion are political activists.

Staff members of abortion clinics are also conduits of health services and information regarding abortion. If abortion clinic staff embrace feminist beliefs these may be expressed through the services provided to the clinic patients by various and related means. In my experience, these include, but are not limited to: 1) the language used to refer to abortion and abortion services, 2) the choice of abortion-related topics discussed, and 3) the reconfiguration of the conventional provider/patient relationship.

Language Use

While we use language to describe objects, occurrences, and events, our choice of words also reveals much about our beliefs and motives as well. Language is political in that it is used to name and frame situations and practices thereby organizing experience to support belief systems and related courses of action (Williams, 1995). For instance, one who actively opposes government policies may be described as either a "dissident" or a "traitor," depending on the perspective of the speaker. Each term provides a vocabulary for identifying motives and allegiances. The same holds true for the abortion controversy (Reicher and Hopkins, 1996).

I found my own use of language to be similar to that employed at DTWC, which is not surprising considering the feminist objectives we share -- the end of sexist oppression through the empowerment of women, in part, by

women's rights including abortion rights. The focal point of terminology -- typically characterized as woman or fetus -- is the significant difference between the language used by opponents of abortion and abortion rights advocates. For my co-workers and me, abortion is not the "murder of innocent children," rather women's "reproductive right to terminate a pregnancy." The doctor is not a "butcher" or "abortionist," but an "abortion provider." We refer to the facility as an abortion "clinic," while it is often described in the opposition literature as an abortion "mill." Anti-abortion activists depict the embryo or fetus as an "unborn baby" or even "unborn child." At the clinic, we prefer medical terminology such as "the pregnancy."

One point of significance in the difference in terminology used by myself as an abortion service provider and that used by anti-abortion activists is that each may reflect the perspective of two different segments of women -- those who intend to carry a pregnancy full-term and deliver a baby, and those who are pregnant and do not wish to be. In fact, anti-abortion language is political in that it tends to normalize and universalize the experience of women who desire pregnancy, birth, and motherhood, while it characterizes as deviant those women for whom pregnancy, or at least *a* pregnancy, is unwanted (Hopkins, et. al., 1996; Tonn, 1996). For instance, when a woman intends to have a baby, referring to the fetus as a "baby," as I did just now in using the phrase "to have a baby," is more in keeping with her desires and perceptions and is more appropriate than using the medical term "the pregnancy" as in "to carry the pregnancy full-term and deliver." However, the use of terminology appropriate for a woman who wants to be pregnant when used to refer to a woman who terminates a pregnancy, portrays a woman who selfishly and

uncaringly sanctions the murder of her own "baby" (she is clearly not maternal). When a woman does not want to be pregnant and decides to terminate a pregnancy, language which does not confer to the fetus the status of personhood more accurately reflects the perspective of the woman and is feminist in that it validates her intentions and decision, as well as her identity as a woman.

Utilizing particular language is also political in a more conventional sense. Debate continues in Congress regarding "partial birth" abortion, known medically as "dilation and extraction" (Fried, 1997). "Partial birth" abortion is a term which confers to the fetus the status of infant, thus personhood and rights. The term "dilation and extraction" describes a legal medical procedure and serves a liberal feminist objective in that the term does not directly invoke concepts of personhood except in as much as the procedure is performed on the person of the female patient.

Medical terminology is generally considered more neutral, therefore, more objective and accurate than less formal, value laden language. However, medical terminology does indeed convey values -- the values of western science -- and often depicts procedures and conditions as if removed from human experience (Bell, 1994; Balint and Shelton, 1996). For instance, the terms "product of conception (POC)" and "contents of the uterus" do not address the potential for human life nor the personal and social implications for a woman having an abortion. Likewise, neither the term "dilation and extraction" nor "partial birth" abortion conveys the multi-dimensional nature of the experience for the woman who has a late-term abortion. Language which validates the knowledge derived from the experience of women is more broadly feminist in that it further empowers women by acknowledging the

authority of the women's perspectives. Many women experience mixed emotions about having an abortion. In my experience it is not uncommon for a woman who has clearly decided to terminate a pregnancy to also feel a sense of loss over not having this particular child. So, while I generally use terminology which reflects the perspective of a woman who does not wish to be pregnant, i.e., "pregnancy," when the situation warrants, I will also use language expressing the experience of a woman who wants to have a baby, i.e., "child."

Topics of Discussion

The choice of abortion-related topics is similar to language use, but is broader in its reference to belief systems. The topics of discussion which anti-abortion activists raise typically involve religion, "family values," and conceptions of motherhood (Hopkins et. al., 1996) The topics of discussion which I raise as an abortion service provider relate to the societal factors which affect the social condition of women, including their health and well-being. These discussions are intended to inform and empower women personally and collectively.

During the interview, I ask about and discuss a number of different social factors related to both health care in general and unwanted pregnancy in particular. Throughout the clinic visit, I ask about the patient's experience of seeking medical care and screening, as in the discussion of past pap smears and breast exams. I involve the patient in a discussion towards deciding on an appropriate contraceptive method. The patient is also provided with information and instructions regarding her care during the recovery phase of

the abortion. In each of these discussions, I emphasize the patient's role as an agent in the health care process. I consciously act to encourage and empower women to actively participate in preserving their health and well-being.

I also ask patients about abuse history and often discuss the relevance of abuse to health, particularly as it affects our sense of power and control (German, et. al., 1990). Abuse includes, but is not limited to, childhood sexual abuse, domestic violence, and rape. These are also considered risk factors for depression, substance abuse, further victimization, and unwanted pregnancy (Finklehor et. al., 1990; Johnsen and Harlow, 1996). These are topics central to feminist analyses of power and sexism in patriarchal culture. Discussing these issues with patients raises awareness of the many social factors which contribute to the condition of women individually and in general.

Patient Participation

Patient participation is solicited throughout the clinic visit with the specific intent of validating and empowering the patient. The interview process is a constant exchange between the counselor and the patient. There is a thorough discussion of medical procedures and aftercare instructions so that the patient will be equipped to take active responsibility for her health. She participates in deciding on pain medication. The staff encourages questions and input throughout the abortion process. The patient, individually and socially, is the focus of services provided.

The paternalistic nature of the patient-provider relationship has endured since the days of Hippocrates and Plato, and is characterized by the authoritative physician who examines the patient, reports his findings, and makes decisive recommendations to the patient and family. Social factors such

as religion, family, and personal and social circumstances might be considered significant, but were not dominant in the relationship (Wolf, 1994). Variations and shifts in the paternalism of the patient-provider relationship have occurred, most notably since World War II when patient autonomy appeared as a visible issue in medical ethics. A libertarian model developed in which the focus of the relationship shifted from the autonomy of the paternal physician to the autonomy and self-determination of the patient with the doctor acting as a presenter of the facts and options involved (Englehardt, 1978). Concerns that such health care might prove too minimal led to discussions of the appropriate degree of paternalism and patient autonomy and these continue presently (Veatch, 1991; Savaulescu, 1995; Wulff, 1995; Balint and Shelton, 1996; Madder, 1997).

Creating a partnership around women's health dismantles the typical power dynamics of paternalistic medical (predominantly male) authority acting on the passive (predominantly female) patient. Similar power dynamics operate throughout patriarchal institutions and are fundamental to systems of oppression. Every day women experience the oppressive dynamics of sexism in which power and control are denied them. Reconfiguring the provider/patient relationship so that the health care provider acts as a knowledgeable resource to be used as a tool by the patient, creates a situation in which the patient is actively engaged in the decision-making regarding her health (Rosenberg, 1998, et. al.; Boughn, 1994).

In this partnership model of providing health care services, the patient's knowledge of herself and her circumstances is crucial to the delivery of appropriate care. Her feelings and opinions are regarded as authoritative knowledge. Especially for women whose self-esteem has been hindered or has

been actively debilitated, respecting the patient's judgments makes it possible for her to take her own judgments seriously, thereby kindling her trust of her perceptions and enhancing her sense of integrity.

While there are many ways in which beliefs and values affect actions in general, and my work as a staff member of an abortion clinic in particular, language use, choice of discussions topics, and the clinic policies and procedures which incorporate patient participation were most apparent from my experience as an abortion service provider. Of course, there are other means by which my feminist beliefs are manifested in the health care I deliver to patients. Some are more noticeable to me than others, some are only dimly apparent, and some I do not yet recognize because of the limits of my perspective.

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APPENDICES

Appendix A

Health History Form

NAME: B.D. AGE: DATE:

REFERRAL LETTER: INS:

CHIEF COMPLAINTS:

OB/GYN HISTORY: G___P___AB___SAB___

PAP:

Pregnancy test
DTWC _____
Other _____

LMP: _____

PG SX:

STDs:

BLEEDING:

PAST MEDICAL HISTORY:

___ Safer sex ed.

___ Partners x 1 year

Heart:

Lungs:

BIRTH CONTROL:

ALLERGIES:

CURRENT MEDS:

F/U / PAP:

REFERRAL LETTER:

PSYCH/SOC HISTORY:

2 wk EXAM HERE:

Other:

FAMILY HISTORY:

B/P Hgb: RH:

SPECIAL NEEDS:

CONSENT:

METHERGINE 0.2 mg_____

AMOXICILLIN 1 gm_____

D&A Hx.

PELVIC EXAM:

DOXYCYCLINE 100 mg #_____

ERYTHROMYCIN 500 mg _____

ULTRA SOUND:

ERGONOVINE MALEATE 0.2 MG _____

Appendix B

Consent Form

DOWNTOWN WOMEN'S CENTER PATIENT INFORMED CONSENT

_____
Patient name

_____ has explained to me in a way I understand, the general treatment or procedure to be undertaken: DILATION AND CURETTAGE SUCTION ABORTION WITH LOCAL ANESTHESIA AND DIRECT DILATION.

Initial each section you have read and understand.

____ I am aware of and have considered all pregnancy options, including childbirth/parenting or adoption, and therapeutic abortion, and I am resolved in my choice of abortion.

____ I understand that pregnancy tests are not 100% accurate, and that I might not really be pregnant.

____ I understand that the purpose of this procedure is to terminate my pregnancy, but that no warranty or guarantee has been made to me as to the results of this procedure. It has been explained to me that in some instances pregnancy is not terminated by this procedure and, if that happens, further treatment or procedures will be necessary. A repeat suction procedure to remove retained fragments of tissue is necessary in 1-5% of cases. I understand that if I am unable to return to this office for this service, the cost of the repeat procedure will be my own responsibility.

____ I have been informed that vacuum aspiration abortion is about 20 times safer than childbirth, and that the death rate for women in the U.S. having vacuum aspiration abortions is less than one for every 100,000 cases.

____ I have been informed that the following possible health problems may result from this procedure:

- infection (1 in 100 cases)
- perforation of the uterus or other structures (1 in 500 cases)
- bleeding requiring transfusion (1 in 500 cases)
- allergic reaction to medicine (1 in 100 cases)
- damage to abdominal organs (less than 1 in 1000 cases)
- incomplete abortion (1 in 100 cases)
- emotional reaction (very rare)
- need for major surgery (less than 1 in 1000 cases)
- ectopic pregnancy, although not a result of an abortion, is a life-threatening condition, and occurs in 1 in 100 pregnancies.

____ I have been informed that, should a complication occur, additional medical procedures may be required to protect my life or health, including hospitalization and/or surgery. I understand that the cost of any additional medical services shall be my own responsibility. To the extent that is considered necessary for my care, I consent to anesthesia, blood transfusions, pathology, laboratory or radiology services, prescription drugs, or other medications or treatments as authorized by my physician. I give authorization for the Emergency Contact person listed in my chart to be notified about the problem.

____ I have had explained to my satisfaction the details of my condition and diagnosis, the procedure/treatment to be undertaken, alternatives and risks involved. I have consented to the treatment, surgery, and any other treatment deemed necessary, as stated above.

_____	_____	_____	_____
Patient signature	Date	Witness signature	Physician signature

Appendix C

Aftercare Instructions

AFTERCARE INSTRUCTIONS

WHAT'S NORMAL?

Most of your pregnancy symptoms will go away within a few days, though breast tenderness can take longer. Call us if any nausea continues. If your breasts leak fluid, call us.

You may bleed afterwards (called "cleansing bleeding"), but some women don't bleed at all. This after-bleeding varies from person to person. It can stop then start again; it can begin days after the procedure, and it usually is brown discharge at the end. Most cleansing bleeding will end by the two week check up. **Your normal menstrual period will start within one to two months after your procedure.**

HOW TO PREVENT PROBLEMS:

-Be sure to take care of yourself by getting enough rest, food, and comfort. You will usually heal quickly, and should be back to normal by the two week check up. If you have a job where you stand all day or do any lifting, **we can provide you with a medical excuse**. This excuse does not disclose confidential medical details.

-Do not lift anything over **20 lb.. for 2-3 days,** and do not lift anything heavier than **50 lb..** until after your two week check up.

-Do not work out aerobically or do strenuous work or exercise for two weeks.

-Limit sexual activity to hugs and kisses for this two week time period.

-Use pads, not tampons, **for the first week** to help prevent infection.

-Tub baths are fine (unless you were 14 weeks or greater in the pregnancy...then wait one week for a tub bath)...but do not share water in a swimming pool or hot tub for the first week. Showers are fine anytime.

-Douching is never recommended as it washes away natural substances that keep the vagina healthy and clean.

PROBLEMS TO CONTACT US ABOUT:

1. FEVER : Call if you have a fever of 99 or greater. Take your temperature everyday. Simple glass thermometers are inexpensive and can be purchased at a pharmacy.

2.CRAMPS: Mild cramps are normal. You may take over the counter pain medications such as Advil (ibuprofen), Tylenol (acetaminophen), or Aleve. If these medications at recommended dosages do not ease the cramps, **CALL US. Do not take aspirin because it can make you bleed more.**

3. BLEEDING HEAVILY: If you are bleeding heavier than your normal period, or changing a pad every hour, or bleeding any amount that concerns you, CALL US.

4. PASSING LARGE BLOOD CLOTS: Blood can sit in the uterus and may form firm clumps called "clots". Bad cramps and/or heavier bleeding can accompany the passing of clots as they exit the uterus. **CALL US** if you are passing clots that are larger than a marble or that cause heavier cramps or bleeding.

Call us at 224-3435 (anytime), 699-5349 (after-hours), or 800-742-9202 (work hours).

MEDICATIONS:

Most women do **not** go home with extra medications. If there is something in your history that requires antibiotic attention, you will probably be sent home with **Doxycycline** to prevent infection. If you have had two or more previous deliveries (childbirth), or if you were greater than 10 weeks in the pregnancy, you will probably go home with **Methergine or Egonovine Maleate** to keep your uterus firm. Methergine and Ergonovine Maleate should not be taken by women who have high blood pressure. If you have questions about this, call.

Aftercare Instructions (cont.)

PROTECTION FROM PREGNANCY AND SEXUALLY TRANSMITTED DISEASE:

Condoms and vaginal spermicide, both available at drug stores, if used together can protect you from both pregnancy and diseases like HIV or chlamydia. Ovulation (the time when pregnancy is possible) can occur anytime after the procedure, so protect yourself. If a condom breaks, call the Downtown Women's Center about the **Morning After Pill**, which, if taken within 72 hours of the condom breaking, may help prevent pregnancy.

Oral Contraceptives (birth control pills) can be started the first Sunday after the procedure. If you were further than 14 weeks in the pregnancy, you should wait until the 3rd Sunday. The first cycle of pills may NOT protect you, so use condoms and vaginal spermicide. Condoms are needed along with the oral contraceptives to prevent sexually transmitted diseases. The Downtown Women's Center is usually able to give two cycles of birth control pills to you and then it is your responsibility to make an appointment with your practitioner for a Pap smear. After your Pap you will usually receive a prescription for a year's supply of birth control pills. If you do not know where to go to for a Pap smear, please call us and we can help you. A nurse practitioner is available to do Paps at the Downtown Women's Center also.

If you have any questions about your contraceptive technique, feel free to call.

PAP SMEAR: You did NOT receive a Pap smear as part of your procedure. Pap smears are done to look for cancer of the cervix, and are very important yearly exams. Most practitioners who do Paps recommend waiting one month after your procedure with us before getting a Pap.

TWO WEEK CHECK UP: If you do not have a two week check up appointment, call us. There is no charge for this brief exam.

REMEMBER!

You can call us...24 hours a day...if you have problems. Calling before 9 PM allows us to call in medications to a pharmacy before they close. Call during working hours if you have non-emergency questions.

PATIENT:_____ WITNESS: _____ DATE:_____

Appendix D

OR Sheet

Name _____ Date _____

Medications		Dose	Time	Init.
Valium				
Methergine		0.2mg		
Ibuprofen				
Acetaminophen				
Vicodin				
Amoxicillin				
Erythromycin				
N_2O				
Ergonovine M.		0,2mg		
Nubain				

Therapeutic Abortion in the Office

Ride Home: _____ Birth Control _____

Special Instructions: _____

_____

Doxycycline 100 BID X _____

Methergine (0.2 mg.) _____

Ergonovine Maleate 0.2mg _____

_____

Current Medications: _____

_____

PO Here ___ Other ___ Referred by _____

G _____ P _____ TAB _____ SAB _____ RH _____ Hgb _____ BP _____ Allergies _____

Surgical/Medical Problems _____

Position _____ LAM(s) _____ Wks _____

Paracervical Block Yes_____ No_____ Anesthetic _____ Cannula Size _____

Dilation Yes_____ No _____ Placenta Seen Yes_____ No_____ Normal Yes____ No____

Est. Wks. Gest. _____ Other:_____

Fetal Parts Yes_____ No _____ Complete Yes_____ No_____ EBL over 100 cc: Yes____ No____

Complications No____ Yes _____

OR Start time _____:_____ OR end _____:_____ Tech: _____

I certify that in my professional judgment, this nonspontaneous abortion is medically necessary because medical and/or emotional problems have been or may be caused or aggravated if the fetus were carried to term, thus endangering the physical or emotional health of the woman.

_____
Physician's signature

RECOVERY ROOM:

Medications		Dose	Time	Init.
Rhogam				
Ibuprofen				
Acetaminophen				
Vicodin				
Aleve				
Toradal				
Methergine		0.2mg		

Medical Excuse _____

BP _____

Pulse _____

Post Op _____

Referral Letter: Yes ____ No ____ HC ____

Birth Control _____

Written Instr. _____

Discharge Meds. _____

Discharged at Time _____:_____

Init. _____