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This publication is designed for use by licensed medical providers. Individuals who wish to provide any of the medical services described herein should obtain appropriate training prior to initiating services. This resource is not intended to provide legal, medical or other professional advice. It is not a substitute for consultation with a healthcare provider or for independent judgment by healthcare providers or other professionals regarding individual conditions and situations. This workbook is protected by copyright; replication for sale is prohibited. For authorization to reproduce the document (whole or in part) for non profit use in your training program, please contact the authors at:

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While this publication was designed for use by licensed physicians during medical training, ARHP recognizes the content has educational content that may helpful to physicians, nurse practitioners, physician assistants, nurse-midwives and other health care providers who read the publication without participating in a hands-on medical training.

Learning Objectives
After reading this guide (without having completed the additional reading and hands-on training), participants will be able to:

- Identify key elements of informed consent counseling.
- Recognize major psychosocial issues of importance for women who seek abortions.
- List the basic steps involved with first trimester vacuum aspiration abortions and early medical abortion service provision.
- Identify common complications related to first trimester abortion care.

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Disclosures
The following CME advisory committee participants have a financial interest or affiliation with the manufacturers of commercial products discussed in this continuing education program. These financial interests or affiliations are in the form of grants, research support, speaker support, and/or other support. This support is noted here to fully inform course participants and should not have an adverse impact on the information provided by these speakers.
Creinin: Dr. Creinin receives compensation from Danco Laboratories, LLC, the distributor of mifepristone in the United States, for providing third-party telephone consults to clinicians who call for expert advice on mifepristone.

Godfrey: Dr. Godfrey is a faculty trainer for the Implanon Clinical Training Program of Organon USA, Inc.

Goodman: Dr. Goodman is a faculty trainer for the Implanon Clinical Training Program of Organon USA, Inc.
CME Post-Test

1. If, at the scheduled time of an aspiration procedure, a patient appears to be ambivalent about her decision to have an abortion, which of the following would NOT be an appropriate response?
   a. Offer the patient a chance for further counseling.
   b. Immediately invite the patient’s partner into the room to discuss the matter further.
   c. Ask the patient open-ended questions that will allow you to assess more fully her concerns or level of discomfort with her earlier decision to have an abortion.
   d. Explain to the patient that up until a certain point the procedure can still be safely halted, but after that point it would jeopardize her wellbeing not to proceed to completion.
   e. Inform the patient that you will not proceed unless she clearly states that this is her choice.

2. Verification of pregnancy through transvaginal ultrasound visualization of the gestational sac should be possible by approximately:
   a. Week 3-1/2
   b. Week 4-1/2
   c. Week 7

3. All of the following statements about mifepristone-misoprostol abortion in the United States are true EXCEPT:
   a. Mifepristone (Mifeprax) is sold only to medical providers directly, not to pharmacists.
   b. Although the FDA approved mifepristone-misoprostol for abortion through 49 days gestation, evidence-based regimens are available that have high efficacy through 63 days gestation.
   c. A decrease of at least 50% from the baseline serum βhCG 48 hours after vaginal misoprostol administration is consistent with successful abortion.
   d. There is a small risk of heavy or prolonged bleeding that may require aspiration.
   e. The patient should wait until her bleeding stops to initiate oral contraceptives.

4. Which of the following would not be among the minimum equipment and medications that must be available to handle a medical emergency in abortion care?
   a. O2 delivery system
   b. Oral airways
   c. Ultrasound machine
   d. Uterotonics
   e. Epinephrine
CME Evaluation

On a scale of 1 to 5, with 5 being the best, please rate this publication in terms of the following:

1. Extent to which stated program objectives are met:
   - Identify key elements of informed consent counseling.  
     Rating: 5 4 3 2 1
   - Recognize major psychosocial issues of importance for women who seek abortions.  
     Rating: 5 4 3 2 1
   - List the basic steps involved with first trimester vacuum aspiration abortion and early medical abortion provision.  
     Rating: 5 4 3 2 1
   - Identify common complications related to first trimester abortion care.  
     Rating: 5 4 3 2 1

2. Relevance to clinical practice
   Rating: 5 4 3 2 1

3. Increased understanding of the topic
   Rating: 5 4 3 2 1

4. Extent to which stated program objectives are met
   Rating: 5 4 3 2 1

5. Effectiveness of teaching/learning methods
   Rating: 5 4 3 2 1

List two applications that can be made to your clinical practice/workplace based on what you learned from this workbook:

1. 

2. 

Do you intend to use the information you have learned from this workbook to enhance your clinical practice in any way?
   Yes  No  N/A

6. Please comment on the scientific rigor, fairness, and balance of the material:

7. What topics would you suggest for future programs?

Participants who correctly answer 70% or more of the questions on the post-test will receive continuing education credit. To obtain credit, return a copy this form with a processing fee of $15 by July 31, 2008 to:

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Name: _____________________________ Please indicate the total time you spent on this educational activity:
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Affiliation: _________________________
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City, State, Zip: _____________________  □ Check enclosed, payable to ARHP.
E-mail: ____________________________  □ Charge my AMEX/VISA/MasterCard
Signature: ___________________________ Card Number: ______________
Expiration Date: _______________
1. ORIENTATION

As you begin your training in reproductive health and abortion care, we hope you will be inspired by the stories you will hear, the clinical skills you will learn, and movement you are joining. We are extremely pleased to provide this opportunity for you in an ongoing effort to assist primary care providers in delivering more comprehensive health care to women.

Before beginning your training program, please read and complete the Skills & Experience Inventory to provide information about your background and prior experience. The Values Clarification Exercise is intended to help you clarify your present personal values about pregnancy options and abortion training, and to help you think about those values in the context of professional judgments you may be called upon to make.

During your orientation, you may meet with the training faculty to review the Skills & Experience Inventory, Training Plan & Checklist, and Trainee Agreement and fill out any other required documentation. The faculty or clinic staff will review the approach to patient care, charting procedures, reporting requirements, and safety policies (e.g., universal precautions, emergency plans, security measures).

On the first day of your training, you will have an opportunity to “shadow” one or two patients through the pregnancy counseling and abortion visit from counseling to recovery. This experience offers you a comprehensive view of clinical operations, and also allows you to observe the process from the patient’s perspective.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

- Identify your personal values and feelings about pregnancy options and abortion training
- Clarify individual training goals and expectations
- Describe the range of constraints on abortion care, and ways this can impact access
- Describe clinic protocols including, charting, reporting requirements and safety policies

READINGS

- Early Abortion Training Workbook: Chapter 1
- Supplemental Readings:
  - Clinic Policies and Procedures (may be provided)
  - State Legal and Reporting Requirements (may be provided)
TIPS FOR SUCCESS

SKILL
It is important to identify and understand the life experiences that have affected your opinions, in order to promote a non-judgmental climate for patient care. When counseling a patient about her pregnancy, abortion, or contraceptive options, remember to use open-ended questions and to listen actively.

SAFETY
Because both aspiration and medication abortion are safe and simple procedures, you will not experience all challenges or complications during the training. When performing procedures, concentrate on good technique, first and foremost. Your efficiency and confidence will grow with experience. When you encounter a tough situation in practice, do not hesitate to ask a more experienced colleague for help or make appropriate referrals. If you decide not to include reproductive health services in your practice, such as prenatal care, deliveries, or abortions, it is still important to know how to refer patients and handle follow-up issues. Keep a list of referrals in your community for your patients.

Regardless of your clinical setting, make sure you know where the emergency cart or supplies are kept and review the procedures for emergencies and hospital transfer.

Your personal safety is also important. Simple security measures include parking in a safe place, not wearing a white coat or scrubs outside a high-volume facility, and remaining alert. Know how to reach security personnel in the event of suspicious activity or emergencies.

ROLE
As a medical provider, you will serve your patients best by providing unbiased information and non-directive counseling. By providing high quality pregnancy options counseling and either services or referrals, you will contribute to broadening the access women have to these services.

At many times in clinical practice, you may be the most senior professional on site. The entire staff will be observing you and doing their best to follow your example. Be a conscientious clinician model and leader.
PROGRAM OVERVIEW

PROGRAM OBJECTIVES

At the conclusion of the program, you should be able to:

1. List key elements of pregnancy options and informed consent counseling.
2. Perform uterine aspiration for first trimester vacuum abortion or early pregnancy loss using local anesthesia.
3. Describe or carry out the steps involved in early medication abortion provision.
4. Describe management options for early pregnancy loss.
5. Describe the management of emergency situations and complications related to first trimester abortion care.
6. Provide patient-centered contraceptive counseling and management.

TRAINING SUMMARY

This program will vary depending on the setting in which it is undertaken. We encourage adaptation as needed for use in residency programs, higher-volume training clinics, or individual practice in the U.S. or abroad. During this training program, each trainee should:

- Review the training program and meet with faculty and staff for orientation
- Participate in values clarification around pregnancy options.
- Follow client(s) through an abortion visit from counseling to recovery.
- Perform routine post-procedure and follow-up care.
- Discuss case studies involving post-abortion complications and manage complications when they occur.
- Discuss case studies involving early pregnancy loss and participate in the counseling, evaluation and treatment of women experiencing early pregnancy loss.
- Complete evaluation instruments to assess your knowledge and to provide feedback about the training program.

Those participating in early abortion clinical skills training will also:

- Practice performing manual vacuum aspiration (MVA) using simulated model and “no touch” method
- Observe faculty performing first trimester vacuum aspiration abortions
- Under the direct supervision of faculty, perform aspiration abortion procedures until assessed as competent
- Perform tissue examinations to identify pregnancy elements consistently and accurately.

To complete the supplemental readings for the training, each trainee will need a copy of selected chapters from the National Abortion Federation (NAF) textbook, A Clinician’s Guide to Medical and Surgical Abortion (Paul M et al, eds. New York: Churchill Livingstone 1999). These chapters are available online with free registration at: http://prochoice.org/education/resources/textbook.html.
LENGTH OF TRAINING

- 1-2 days for orientation, shadowing, observation, and workbook review (for all participants, including alternative curriculum only)
- 2-5 days of simulated and “hands on” training in order to perform 20-50 first trimester abortions, and workbook review.
- Time necessary to complete the Training Plan & Checklist for basic training (including required readings and evaluation instruments)

ADVANCED TRAINING

- Training opportunities exist for individuals interested in gaining more in-depth skill and knowledge. These experiences may include additional elective clinical time and completion of all supplemental readings. They may also include reproductive health fellowship training, or opportunities to transition to training.
- Those interested in becoming trainers should obtain the Trainer’s Workbook, with evidence-based teaching points and chapter on transitioning to training available at: http://teachtraining.org.

ALTERNATIVE CURRICULUM (OUT-OPT) OPTIONS

You may not choose to provide the full spectrum of reproductive health services. This curriculum can be tailored to your particular needs, but we recommend that all primary care clinicians—in-training receive some exposure to the material. If you are not going to provide early abortion services yourself, it will still be important to know how to counsel, refer, and provide follow-up care for your patients. In our experience, trainees choosing Alternative Curriculum Options benefit from discussing these options with their Reproductive Health Faculty after the initial Orientation and Values Clarification session. This allows for both trainees and faculty to arrive at a balanced appraisal of the appropriate training content.

The alternative curriculum recommendation on the following page cover the foundation of values clarification, pregnancy options counseling, contraception, follow-up care, and management of complications of abortion. Additional material can be added based on individual training goals.
# TRAINING PLAN & CHECKLIST

**NAME:** ____________________________________________________________  
**TRAINING INITIATION DATE:** ________________________________  
**TRAINING COMPLETION DATE:** ________________________________

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<td><strong>ORIENTATION</strong></td>
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<td>Discuss Chapter 1 in Training Workbook</td>
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<td>* Review Skills &amp; Experience Inventory &amp; Training Plan</td>
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<td>* Discuss readings and clarify training goals</td>
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<td>Tour facility and discuss policies and safety issues</td>
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<td>Review emergency cart location / contents</td>
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<td>Follow patient(s) through abortion visit</td>
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<td>Review instruments and practice &quot;no touch&quot; technique</td>
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<td>Simulate procedure steps for uterine aspiration (for abortion or early pregnancy loss management)</td>
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<td>Discuss Values Clarification Exercises</td>
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<td><strong>COUNSELING</strong></td>
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<td>Discuss Workbook Readings</td>
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<td>Observe or role play pregnancy options counseling</td>
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<td>Discuss Counseling Exercises</td>
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<td><strong>PREGNANCY DIAGNOSIS AND MEDICAL SCREENING</strong></td>
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<td>Discuss Workbook Readings</td>
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<td>NAF Chapter 4 - Documenting Pregnancy and EGA</td>
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<td>Review pregnancy testing and dating methods</td>
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<td>Review medical history pertinent to abortion</td>
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<td>Observe early pregnancy ultrasound examinations</td>
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<td>Perform ultrasound examinations with observation</td>
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<td>Perform pelvic examinations for uterine sizing with observation</td>
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<td>Discuss Pre-Abortion Evaluation Exercises</td>
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<td><strong>PAIN MANAGEMENT</strong></td>
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<td>Discuss Workbook Readings</td>
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<td>NAF Chapter 7 – Pain Management</td>
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<td>Review pain medications used for oral and IV sedation, patient selection, monitoring</td>
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<td>Review agents and methods used for cervical anesthesia</td>
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<td>Administer effective cervical anesthesia with observation</td>
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<td>Administer IV sedation medication</td>
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<td><strong>EARLY VACUUM ASPIRATION</strong></td>
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<td>NAF Chapter 9 &amp; 13 – Surgical Abortion in the First Trimester &amp; The Challenging Abortion</td>
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<td>Observe procedure and review use of equipment and instruments with faculty</td>
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<td>Review strategies for minimizing complications</td>
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<td>Perform MVA to competency with observation</td>
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<td>Perform EVA to competency with observation</td>
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<td>Perform accurate tissue examinations</td>
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<td>Discuss Aspiration Abortion Procedure Exercises</td>
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Note: **SHADING** indicates additional activities depending on training goals.
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<td>NAF Chapter 15 – Abortion Complications</td>
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<td>Review strategies for management of common complications</td>
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<td></td>
<td>Review post-procedure medications, instructions, and initiation of contraception</td>
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<td></td>
<td>Observe recovery room procedures</td>
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<td></td>
<td>Discuss special follow-up protocols (eg, rule out ectopic)</td>
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<td></td>
<td>Discuss Follow-Up Care &amp; Managing Problems Exercises</td>
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<td></td>
<td><strong>EARLY MEDICATION ABORTION</strong></td>
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<td></td>
<td>Discuss regimens (FDA and Evidence-Based)</td>
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<td></td>
<td>Review counseling, patient information, and patient selection</td>
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<td></td>
<td>Provide regimen and patient information with observation</td>
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<td></td>
<td>Review follow-up to assess completion of abortion; provide if possible</td>
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<tr>
<td></td>
<td>Discuss Medication Abortion Exercises</td>
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<td></td>
<td><strong>MANAGEMENT OF EARLY PREGNANCY LOSS</strong></td>
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<td></td>
<td>Discuss Workbook Readings</td>
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<td></td>
<td>Review counseling for Early Pregnancy Loss</td>
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<td></td>
<td>Discuss management options for Early Pregnancy Loss</td>
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<tr>
<td></td>
<td>Discuss Early Pregnancy Loss Exercises</td>
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<td></td>
<td><strong>OFFICE PRACTICE</strong></td>
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<tr>
<td></td>
<td>Discuss Workbook Readings</td>
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<tr>
<td></td>
<td>Discuss Office Practice Exercises</td>
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<td></td>
<td><strong>EVALUATION</strong></td>
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<td></td>
<td>Complete Skills Assessment</td>
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<td></td>
<td>Complete Training Program Evaluation</td>
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</tbody>
</table>

**SUGGESTED EXERCISES FOR ALTERNATIVE CURRICULUM (OPT OUT)**

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Reading</th>
<th>Exercises</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Orientation</td>
<td>All</td>
</tr>
<tr>
<td>2.</td>
<td>Counseling, Education, and Informed Consent</td>
<td>Part I</td>
</tr>
<tr>
<td>3.</td>
<td>Pre-Abortion Evaluation</td>
<td>All</td>
</tr>
<tr>
<td>4.</td>
<td>Medications and Pain Control</td>
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<tr>
<td>5.</td>
<td>Aspiration Abortion Procedure</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Follow-Up Care and Managing Problems</td>
<td>All</td>
</tr>
<tr>
<td>7.</td>
<td>Medication Abortion</td>
<td>All</td>
</tr>
<tr>
<td>8.</td>
<td>Management of Early Pregnancy Loss</td>
<td>All</td>
</tr>
<tr>
<td>9.</td>
<td>Office Practice</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Evaluations</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: **SHADING** indicates additional activities depending on training goals.
SKILLS & EXPERIENCE INVENTORY

NAME: __________________________________________

I. CONTINUING EDUCATION: Use the space below to list all courses and programs in reproductive health care which you have attended in the last five years.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

II. Have you ever had training in:

   Family Planning/Contraception? ○ Yes ○ No Hours: _______

   Human Sexuality? ○ Yes ○ No Hours: _______

   Cross-Cultural Issues? ○ Yes ○ No Hours: _______

   Interpersonal Sensitivity Issues? ○ Yes ○ No Hours: _______

III. EXPERIENCE - check all which apply:

   ○ Electric Vacuum Aspiration under general anesthesia ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Electric Vacuum Aspiration under local anesthesia ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Manual Vacuum Aspiration (MVA) Abortion ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Dilation & curettage ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Ultrasound dating* ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Management of spontaneous abortion ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ IUD insertion ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Endometrial biopsy ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Prenatal care ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Pregnancy Dating Exams in first trimester ○ 1-10 ○ 11-20 ○ 21-30 ○ >30

   ○ Hysterectomy ○ 1-10 ○ 11-20 ○ 21-30 ○ >30
I. Could you give three reasons why you decided to participate in this Abortion Training Program?

II. Do you have any hesitations (fears) about participating in the Abortion Training Program?
   ○ Yes  ○ No

III. Do you have any hesitations (fears) about providing abortions?
   ○ Yes  ○ No

   If yes, please explain and indicate how we can help you address these concerns.

IV. Describe your current practice situation and location or your future plans for employment upon completion of training:

V. What is your opinion about:
   - Government funding for abortion  ○ In favor  ○ Not in favor  ○ Don't know
   - Parental consent for abortions for women under the age of 18  ○ In favor  ○ Not in favor  ○ Don't know
   - A mandatory 24-hour waiting period  ○ In favor  ○ Not in favor  ○ Don't know
   - Offering medical abortion as an alternative to surgical abortion  ○ In favor  ○ Not in favor  ○ Don't know
   - Spousal consent  ○ In favor  ○ Not in favor  ○ Don't know
   - Sex education in public schools/school-based clinics  ○ In favor  ○ Not in favor  ○ Don't know
   - Contraceptive availability in public high schools  ○ In favor  ○ Not in favor  ○ Don't know

VI. Aside from technical skills, do you anticipate any other benefits from completing abortion training?
VII. Do you anticipate, or have you experienced, negative feedback from colleagues because of your plans to participate in abortion training?
   ○ Yes  ○ No  If yes, please explain.

VIII. Do you plan to utilize abortion training in your future practice?
   ○ Yes  ○ No  ○ Don’t know  Can you help us understand why or why not?

IX. Do you anticipate any barriers to performing abortions?
   ○ Yes  ○ No  If yes, please explain.

X. In your opinion, why do women have repeat abortions?

XI. To your knowledge, is there a shortage of abortion providers in the United States?
   ○ Yes  ○ No
   A) If yes, why do you think this is the case?  

   B) Any suggestions about what should be done?  

   C) Do you think any of the following health care professionals should be trained to provide abortion services? (Please explain your answers if possible)
      - Family practitioners/GPs  ○ Yes  ○ No
      - Physician assistants  ○ Yes  ○ No
      - Nurse practitioners  ○ Yes  ○ No
      - Certified nurse midwives  ○ Yes  ○ No

XII. Is there anything else you would like to tell us?  

TRAINEE AGREEMENT

As a participant in the Clinician Training Program, I agree to:

Review and comply with the medical standards and mandated reporting for my training site, maintain confidentiality, and provide documentation of rubella immunity, lack of infectious tuberculosis, and Hepatitis B vaccination status as needed;

Follow the clinical protocols of my training site;

Be contacted by the training staff periodically for the purposes of program evaluation;

Keep a complete record of all abortion procedures (medication and aspiration) that I perform for the next two years (including records of any complications identified at the time of abortion or during the first 2-4 weeks post-procedure);


SIGNATURE OF APPLICANT: _____________________________________________

DATE: _____________________________________________

* Note: Keeping a log and follow-up information will help you monitor your own practice. Training staff may also use this information on an anonymous basis in evaluating the effectiveness of training.
UNIVERSAL PRECAUTIONS & NEEDLESTICK MANAGEMENT
Adapted from Universal Precautions for Prevention of Transmission of HIV and Other Bloodborne Infections
(OSHA 1996)

DEFINITION
"Universal precautions," as defined by the Centers for Disease Control and Prevention (CDC), are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B (HBV), and other blood-borne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious.

GUIDELINES
Gloves and protective face gear should be worn when touching or working with blood and body fluids requiring universal precautions. This includes mucous membranes, non-intact skin (i.e. when performing bimanual exams, handling products of conception, etc), and items or surfaces soiled with blood or body fluids (i.e. speculums, cervical dilators, etc). To prevent needlestick injuries, bending, breaking, recapping, or removing contaminated needles and other sharps is prohibited unless such an act is required by a specific procedure or has no feasible alternative. After they are used needles, scalpel blades, and other sharp items should be placed immediately in puncture-resistant containers for disposal.

PLEASE REMEMBER THAT CLINICIANS SET AN EXAMPLE FOR THE ENTIRE STAFF; BEING CAREFUL YOURSELF MAY HELP PROTECT OTHERS.

If there is a needlestick or other blood exposure don’t delay, call the PEP-Line (see below) and immediately tell your trainer or supervisor. A decision about medication should be made within a few hours.

PEP-LINE: NATIONAL CLINICIANS’ POST-EXPOSURE PROPHYLAXIS HOTLINE
1-888-HIV-4911 (1-888-448-4911) 24 hours a day, 7 days a week

Offers health care providers around-the-clock advice on managing occupational exposure to HIV and hepatitis B and C. Exposure to blood-borne pathogens requires a prompt, individualized response. Call for immediate expert advice for any health care worker exposed to blood-borne pathogens. PEP-Line is a free service to health care providers.

For additional information please visit OSHA at http://www.osha.gov/SLTC/bloodborenpathogens/postexposure.html, or the National HIV/AIDS Clinicians’ Consultation Center (NCCC) website at http://www.ucsf.edu/hivcntr/ or email the Center at hivcntr@itsa.ucsf.edu or call (415) 476-7070.

Provided by National HIV/AIDS Clinicians’ Consultation Center
The NCCC is a component of the AIDS Education and Training Centers (AETCs) Program funded by the Ryan White CARE act of the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau in partnership with the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians.
### MANAGING EMERGENCIES

#### MAINTAIN CLIENT SAFETY • CALL FOR HELP • ASSESS CLIENT CONDITION

<table>
<thead>
<tr>
<th>Recent Medication</th>
<th>High Pulse</th>
<th>Low Pulse</th>
<th>Low BP</th>
<th>Pulse Over Minutes or Hours</th>
<th>No Pulse</th>
<th>Rhythmic Limbs, Jaw Movements</th>
<th>Anxious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low BP, Cool, Clammy Skin</td>
<td>Low BP, Pale, Sweaty</td>
<td>No Pulse, Absent or Gasping Respirations</td>
<td>Rapid, Shallow Breathing</td>
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<tr>
<td>Peri-Oral Cyanosis</td>
<td>Nausea, Vomiting</td>
<td>Unconsciousness</td>
<td>Normal Pulse</td>
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<tr>
<td>SOB, Hives</td>
<td>May Lose Consciousness</td>
<td>Unconsciousness</td>
<td>Numbness</td>
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<tr>
<td>Coughing/Sneezing</td>
<td>Sudden Onset</td>
<td>Possible Incontinence</td>
<td>Carpal-Pedal Spasm</td>
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### ANAPHYLAXIS

- Call 911
- Ammonia capsule
- Elevate legs, cover head
- Light blanket
- Oxygen

### HYPOVOLEMIC SHOCK

- Call 911
- Elevate legs
- Light blanket
- Oxygen

### VASOVAGAL REACTION (NEUROGENIC SHOCK)

- Call 911
- Start CPR
- Ammonia capsule
- Light blanket
- Oxygen

### CARDIOPULMONARY ARREST

- Prevent injury
- Let seizure run its course
- Oxygen
- Slow breathing

### SEIZURE

- Call 911
- Start CPR
- Prevent injury
- Oxygen
- Slow breathing

### HYPERVENTILATION

- Call 911
- Let seizure run its course
- Oxygen
- Slow breathing

---

If shock developing:
- Start IV LR or NS
- Epinephrine (1:1000)
- Infuse rapidly
- Start 2nd IV

- If continued low pulse, give Atropine 0.4mg IV or IM
- If continues >2min., call 911
- Give Valium 5mg IV
- Reassure patient is stable before she leaves clinic

---

- If no recovery, call 911
- Repeat x1 in 5 min. if needed
REPORTING AND LEGAL REQUIREMENTS

Be aware of the reporting requirements for your state, such as for:

- Abortion
- Domestic violence
- Child abuse
- Infectious disease
- Sexually transmitted infection

Ask faculty or staff at your site to assist with local resources, and see Office Practice Chapter (pages 148-150) for more information.

AN OVERVIEW OF ABORTION LAW

Abortion laws differ, rather dramatically in some cases, from state to state. However, the Supreme Court has issued some key decisions, starting with Roe v. Wade in 1973, which today serve as the basic foundation for state abortion laws.

In the Roe decision, the Court established that:

a. In the first third of a pregnancy (about the first 13 weeks), state laws and regulations may not interfere with a woman’s right to end a pregnancy through abortion. This means that the decision whether or not to have an abortion is left to a woman and her medical care provider.

b. During the second third of pregnancy (about 14 to 24 weeks), state laws may regulate abortion procedures only in order to protect the woman’s health.

c. During the later part of pregnancy (after about 24 weeks), and after the fetus is viable, state laws may prohibit abortion except when it is necessary to preserve the life or health of the woman.

Most states have passed laws to prohibit post-viability abortions under most circumstances and, in practice, there are only a small handful of doctors nationwide who offer this care to women who need it. Until 1992, the framework of Roe v. Wade served as the basis by which the constitutionality of state laws related to abortion was determined. Recently, however, Court decisions, particularly Planned Parenthood of Southeastern Pennsylvania v. Casey in 1992, have established that states can restrict pre-viability abortions, even in the first trimester and in ways that are medically unnecessary, as long as such restrictions do not place an “undue burden” on women seeking abortion services. Thus, state laws requiring waiting periods before a woman can have an abortion, mandatory counseling that attempts to dissuade women from having abortions, and parental consent or notification have been implemented in many states. (See page 18 for more information)

Additionally, individual hospitals and practices can and do impose other restrictions, such as gestational limits or anesthesia requirements, on the abortion services they provide. Thus, even though women have a constitutionally protected right to obtain pre-viability abortions, these medical services might not, in fact, be available or accessible.
ABORTION FACTS AT A GLANCE
Abstracted from Facts on Induced Abortion in the United States 2006 Fact Sheet,
and An Overview of Abortion Law, 2007 Fact Sheet

INCIDENCE OF ABORTION
- 49% of pregnancies among women in the U.S. are unintended; 1/2 of these are terminated by abortion.
- In 2000, 1.31 million abortions took place, down from an estimated 1.36 million in 1996.
- Eighty-eight percent of abortions in 1998 occurred in the first 12 weeks of pregnancy.
- The number of abortion providers declined by 11% between 1996 and 2000 (from 2,042 to 1,819). 87% of all U.S. counties lacked an abortion provider in 2000. These counties were home to 34% of all women aged 15-44 years.

WHO HAS ABORTIONS
- 52% of U.S. women obtaining abortions are younger than 25. Women aged 20-24 obtain 33% of all abortions, and teenagers obtain 19%.
- 43% of women obtaining abortions identify themselves as Protestant, and 27% identify themselves as Catholic.
- 2/3 of all abortions are among never-married women.
- Over 60% of abortions are among women who have had 1 or more children.
- On average, women give at least 3 reasons for choosing abortion: 3/4 say that having a baby would interfere with work, school or other responsibilities; about 2/3 say they cannot afford a child; and 1/2 say they do not want to be a single parent or are having problems with their husband or partner.

CONTRACEPTIVE USE
- 54% of women having abortions used a contraceptive method during the month they became pregnant. 76% of pill users and 49% of condom users reported using the methods inconsistently, while 13% of pill users and 14% of condom users reported correct use.
- 8% of women having abortions have never used a method of birth control.
- As much as 43% of the decline in abortion between 1994 and 2000 can be attributed to the use of emergency contraception (Wind 2002).

SAFETY OF ABORTION
- The risk of abortion complications is minimal; less than 1% of all abortion patients experience a major complication.
- There is no evidence of childbearing problems among women who have had a vacuum aspiration abortion, the most common first trimester procedure.
- The risk of death associated with childbirth is about 12 times as high as that associated with legal abortion.
- Almost half of the women having abortions beyond 15 weeks of gestation say their abortion was delayed because of problems in affording, finding or getting to abortion services.
LAW AND POLICY HIGHLIGHTS

- In the 1973 *Roe v. Wade* decision, the Supreme Court ruled that women, in consultation with their providers, have a constitutionally protected right to have an abortion in the early stages of pregnancy—that is, before viability—free from government interference.

- **Gestational Limits:** 36 states prohibit abortions, generally except when necessary to protect the woman’s life or health, after a specified point in pregnancy, most often fetal viability.

- **Public Funding:** 17 states use their own funds to pay for all or most medically necessary abortions for Medicaid enrollees in the state. 32 states prohibit the use of state funds except in cases of danger to life, rape or incest. South Dakota limits funding to cases of life endangerment.

- Without publicly funded family planning services, an estimated 1.3 million additional unplanned pregnancies would occur annually; about 632,300 would end in abortion.

- **Waiting Periods:** 24 states require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between when she receives counseling and the procedure is performed. 6 of these states have laws that effectively require the woman make two separate trips to the clinic to obtain the procedure.

- **Parental Involvement:** 35 states require some type of parental involvement in a minor’s decision to have an abortion. 22 states require one or both parents to consent to the procedure, while 11 require that one or both parents be notified and 2 states require both parental consent and notification.

- **Federal Abortion Ban:** After the Supreme Court in 2000 and three district courts in 2004 decided this ban was unconstitutional due to a lack of health exception, the Supreme Court reversed its previous decision on the so-called “Partial Birth Abortion” Act in 2007. The ruling construes broadly the range of abortions that the act bans and retreats from an unbroken line of precedent that has held that, in any abortion regulation, a woman’s health must remain the paramount concern.

- See Legal and Reporting Considerations (pages 148-150) in Office Practice Chapter for more information on state and TRAP (Targeted Regulations of Abortion Providers) laws.
ADOPTION FACTS AT A GLANCE

INCIDENCE OF ADOPTION
- 2% of unmarried women place their child for adoption (Moore 1995). This percentage has steadily decreased since the 1970s (National Adoption Information Clearinghouse 2000).

WHO CHOOSES ADOPTION
- Information is limited on women who choose to adopt, but there is some data suggesting that those who choose adoption over parenthood express higher educational aspirations, come from higher socioeconomic backgrounds, and have intact families supportive of the placement (Stolley 1993).
- Birth fathers are actively involved in the decision for adoption in 25% or more of cases according to some agencies (Freundlich 1998).

TYPES OF ADOPTION
Confidential vs. Open:
- In confidential adoption, the birth parents and adoptive parents have no contact. The only information provided about the birth parents is history medically relevant to the child.
- In open adoption, the birth and adoptive families know about each other. This ranges from limited knowledge, such as the birth parents choosing the adoptive family after reviewing applications, to extensive interaction, such as regular contact with the adoptive parents and child.

Related vs Unrelated:
- Related adoptions include those by step-parents and non-parent relatives.

Agency vs Attorney vs Facilitator Adoptions:
- Agency mediated: The birth parents relinquish their parental rights to the licensed adoption agency that places the child. These agencies must meet strict state standards for licensure, generally assuring high quality services.
- Attorney mediated: Independent adoption, also called private adoption. Birth parent chooses the adoptive family and then interacts directly with the adoptive parents and/or their attorney. Some expenses, such as the birth mother’s medical care, can be covered by adoptive parents in this situation. All but four states allow private adoption and have their own set of regulations that must be followed.
- Facilitator mediated: Any adoption arranged by an unlicensed person for a fee. This is the least regulated type of adoption and is not permitted in all states.
- International adoption is also available.
- Temporary foster parenting is another option.

THE ADOPTION PROCESS
- The birth parent selects the type of adoption and who will facilitate the process. Birth parent(s) may interview and choose from various adoption professionals to meet their needs.
- All prospective adoptive parents undergo a home study to evaluate them, which may include interviews, home visits, health and income statements, and references. This process generally takes 3-6 months (National Adoption Information Clearing House 2004).
REFERENCES


EXERCISES: VALUES CLARIFICATION

In spite of our efforts at objectivity, we all hold personal values that can influence how we respond to our patients. Sometimes these values are very clear to us and are easily articulated. Others exist at a deeper level, so we don’t necessarily recognize the influence they have on our behavior and judgments as health care providers. Further, one’s values may change in response to life experiences, and your encounters with patients and colleagues may influence your beliefs without your having much of a chance to reflect on these changes.

The exercises presented here are intended to help you clarify for yourself your present personal values about abortion and abortion training, and to help you think about those values in the context of professional judgments you may be called upon to make. Work through these exercises at your own pace.

EXERCISE 1.1: General Feelings about Pregnancy Options

Purpose: This exercise is designed to illustrate the wide range of beliefs about the acceptability of pregnancy options and to help you clarify your personal views about your patients choosing abortion, parenthood, or adoption.

In general, how do you feel about your patients choosing abortion?

☐ I can accept my patient's decision to choose abortion in certain circumstances including:
  ☐ if the pregnancy threatens her physical health or life
  ☐ if the pregnancy threatens her mental health
  ☐ if the pregnancy involves significant fetal abnormality
  ☐ if the pregnancy resulted from rape or incest
  ☐ if she is in an unstable relationship
  ☐ if she does not want any more children
  ☐ if she is not financially able to care for a child and requires public assistance
  ☐ if a baby would interfere with education or career goals
  ☐ if she is very young
  ☐ if she is in prison and will be unable to provide care
  ☐ if she has AIDS
  ☐ if the pregnancy resulted from birth control failure
  ☐ Other(s)

☐ I can accept my patient's decision to choose abortion in any circumstance when she has made an informed and voluntary choice.

What are the reasons for your beliefs?
In general, how do you feel about your patients choosing adoption?

☐ I would accept my patients choosing adoption in the following circumstances:
  ☐ if the pregnancy threatens her physical health or life
  ☐ if the pregnancy threatens her mental health
  ☐ if the pregnancy involves significant fetal abnormalities
  ☐ if the pregnancy resulted from rape or incest
  ☐ if she is in an unstable relationship
  ☐ if she does not want any more children
  ☐ if she is not financially able to care for a child and requires public assistance
  ☐ if a baby would interfere with education or career goals
  ☐ if she is very young
  ☐ if she is in prison and will be unable to provide care
  ☐ if she has AIDS
  ☐ if she does not believe in abortion for herself
  ☐ if the pregnancy resulted from birth control failure
  ☐ if she feels conflicted about being separated from her baby
  ☐ Other(s)

☐ I would accept my patients choosing adoption in any circumstance when she has made an informed and voluntary choice.

What are the reasons for your beliefs?

In general, how do you feel about your patients choosing parenthood?

☐ I would accept my patient’s decision to choose parenthood in the following circumstances:
  ☐ if the pregnancy threatens her physical health or life
  ☐ if the pregnancy threatens her mental health
  ☐ if the pregnancy involves significant fetal abnormalities
  ☐ if the pregnancy resulted from rape or incest
  ☐ if she is single or in an unstable relationship
  ☐ if she does not want any more children
  ☐ if she is not financially able to care for a child and requires public assistance
  ☐ if a baby would interfere with education or career goals
  ☐ if she is very young
  ☐ if she is in prison and will be unable to provide care
  ☐ if she has AIDS
  ☐ if the pregnancy resulted from birth control failure
  ☐ Other(s)

☐ I would accept my patient’s decision to choose parenthood in any circumstance when she has made an informed and voluntary choice.

What are the reasons for your beliefs?
EXERCISE 1.2: Gestational Age and Abortion

Purpose: For some people, the acceptability of abortion is dependent upon the stage of pregnancy at which an abortion might take place. The following exercise is designed to help you clarify whether your beliefs are influenced by the gestational age of the pregnancy.

1) At what gestational age do you stop feeling alright about your patient choosing to have an abortion? Check all that apply.

- At conception
- At implantation
- At the end of the first trimester
- At quickening (i.e. point of fetal movement)
- At the end of the second trimester
- At viability
- At some point in the third trimester
- It depends on the reason for the abortion
- Other (please explain):

2) Now consider this list again as it relates to your comfort level with varying degrees of your professional involvement in abortion. At what gestational age do you stop feeling alright about:

a. making abortion referrals for patients

b. performing abortions

What are the primary factors that influence your feelings?

EXERCISE 1.3: Women’s Reasons and Your Choice to Provide Abortions

Purpose: This exercise will help you clarify your feelings about some potentially challenging situations that may arise in abortion care.

Consider the following potentially challenging situations:

I would feel uncomfortable providing an abortion for a woman who:

- is ambivalent about having an abortion but whose partner wants her to terminate the pregnancy
- wishes to obtain an abortion because she is carrying a female fetus
- has had what I consider too many previous abortions
- shows little emotion about becoming pregnant and choosing abortion
- has indicated that she does not want any birth control method to use in the future

What factors influenced your choices? How might you handle your discomfort when caring for patients under these circumstances?
EXERCISE 1.4: Abortion access and your choice to provide abortion

**Purpose:** The negative impact on public health when abortion is illegal or otherwise inaccessible is well documented. The following exercise is designed to help you think through the consequences of limited access to legal abortion and help you determine what role you might play in addressing decreasing access. How might your decision to offer options counseling, referrals, and/or provision of abortions have an influence, positive or negative, on the accessibility of abortion?

Read the following passages from Carole Joffe’s *Doctors of Conscience: The Struggle to Provide Abortion Before Roe v. Wade* (Beacon Press 1996).

a. A doctor who was a resident in a New York City Hospital during the 1960’s describing what she called the “Monday morning abortion line-up”:

   ...women would get their paychecks on Friday, and that night they would go to their abortionist and spend their money on the abortion. Saturday they would start being sick and they would drift in on Sunday or Sunday evening, either hemorrhaging or septic, and they would be lined up outside the operating room to be cleaned out Monday morning. There was a lineup of women on stretchers outside the operating room, so you knew if you were an intern or a resident, when you came in on Monday morning, that it was the first thing you were going to do. (from Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*. Boston: Beacon Press 1995, p.60)

b. While the above scenario occurred over 35 years ago before Roe v. Wade, on a smaller scale, similar situations sometimes still arise because safe, legal abortion is still not accessible to many women. A 2001 study by the Guttmacher Institute found that 87% of counties in the United States do not have a single abortion provider. Further, legislative barriers, such as public funding restrictions, parental consent laws, mandatory biased counseling, and waiting periods, make it difficult for women (particularly young, poor, and rural women) to obtain abortions. Consider the following passage from *Doctors of Conscience*:

   On March 27, 1994, Kawana Ashley, a 19-year-old single mother with a three year old son, shot herself in the stomach during the 25th or 26th week of her pregnancy. She was hospitalized but ultimately survived her injuries. Doctors delivered a female infant by emergency caesarean who died 15 days later. Ms. Ashley was a Medicaid recipient, but since Florida’s Medicaid program funds abortion only in cases of rape, incest, or life endangerment, she needed to find a way to pay for the surgery herself. Unfortunately, by the time she got enough money together, she was into her second trimester, and the cost was higher. When she had raised the extra money she needed, she was beyond 20 weeks, the cutoff point at which the clinic stopped providing abortions. Out of desperation to end her unwanted pregnancy, Ms. Ashley endangered her own life.
The values clarification exercise can be challenging, satisfying, and thought provoking for both the trainer and the trainee. The questions are best asked in a neutral and non-judgmental way. You may choose to start with a statement like, “Everyone will have different thoughts about these questions. There is no right or wrong answer.”

Discussing how circumstances have influenced some of your own uncertainties over time may enhance trust and open communication. You may ask where the trainee thinks her beliefs come from and what has influenced these beliefs. You can ask, “How could your feelings potentially affect the interactions you have with a patient seeking an abortion? How could recognizing these feelings prior to the interaction have a positive impact upon patient care?” Ask the trainee how she anticipates her feelings could change with this training experience.

During discussion of this exercise, consider covering the following key points:

- Patients have the right to make decisions for themselves.
- As the health care provider, you serve patients best by providing active listening and unbiased information.
- Every person has her own challenges in life. We can not know what is the best decision for each patient without walking in her shoes.
- Each of us is shaped by our personal life experiences, which in turn may affect our judgments. It is important for health care providers to identify and understand those influences. Self-exploration and understanding help us to promote a non-judgmental climate for patient interaction and care.

Depending on the trainee, you may have to spend a significant amount of time discussing the key points. If it becomes clear that the trainee has ambivalence about the issues, you may have them consider some of the problems at home and return for further discussion about them.
EXERCISE 1.1: General Feelings about Pregnancy Options

**Purpose:** This exercise is designed to illustrate the wide range of beliefs about the acceptability of pregnancy options and to help you clarify your personal views about your patients choosing abortion, parenthood, or adoption.

In general, how do you feel about your patients choosing abortion?

If a trainee expresses ambivalence about one of these scenarios, you may want to humanize the situation with a patient story to see if this changes her view. Or you may want to change the scenario slightly to provoke further thought and discussion. For example, change ‘if the woman is not financially able to care for a child’ to ‘not financially able and feels like she must return to her abusive partner for financial support if she has a baby’. To further complicate the situation, you may add that her partner has previously abused her two small children.

EXERCISE 1.2: Gestational Age and Abortion

**Purpose:** For some people, the acceptability of abortion is dependent upon the stage of pregnancy at which an abortion might take place. The following exercise is designed to help you clarify whether your beliefs are influenced by the gestational age of the pregnancy.

At what gestational age do you stop feeling alright about your patient choosing to have an abortion? Check all that apply.

Ask what happens for the trainee between the gestational age that feels alright and the one that doesn’t. What is the difference for the trainee? Does it have to do with the trainee’s understanding of fetal development, concerns about fetal pain, looking at POC, viability of the fetus, physical risk to the woman, her lack of access to services elsewhere, what it feels like doing the procedure as a provider, or other perceived ethical concerns? If the trainee expresses particular concerns about late abortions, remind her that post-viability abortions are rare, and that they are only allowed if the pregnant woman’s health or life is at stake.

It may be a good time to talk about looking at POC and fetal parts. Has the trainee ever seen a gestational sac or fetal parts? How did she first (or currently) feel about it? Were there any factors that influenced how she felt about looking at POC (i.e. things getting messy, touching POC, placing multiple POC into one container)? Was she influenced by patients’ questions about what we do with POC, or patients wanting to see POC or take POC home?

It may be a good time to ask if the trainee’s feelings would be different if there were no other abortion services accessible to the patient. What kind of patient hardship would motivate them to offer the services?
Now consider this list again as it relates to your comfort level with varying degrees of your professional involvement in abortion. At what gestational age do you stop feeling alright about:

a. making abortion referrals for patients

If a trainee is struggling with the idea of making referrals, consider addressing the following issues:

How is this situation different from other medical circumstances where we value unbiased information and patient autonomy?

The goal is to provide the patient with non-directive options counseling, accurate information, and access to services.

The goal is to learn how to cope with our responses internally, to care for ourselves and our emotional well-being, and to further explore our feelings so that we can provide compassionate, non-judgmental care to patients.

b. performing abortions

Each provider is different and needs to find his or her own comfort level. Many factors may influence a provider’s decision, including personal beliefs and current abortion access in the community where the provider practices.

What are the primary factors that influence your feelings?

Often we have had personal experiences that play an important role in our beliefs. Understanding that can help us evaluate our beliefs and consider other approaches to provide more balanced care.
EXERCISE 1.3: Women’s Reasons and Your Choice to Provide Abortions

Purpose: This exercise will help you clarify your feelings about some potentially challenging situations than may arise in abortion care. Consider the following potentially challenging situations:

I would feel uncomfortable providing an abortion for a woman who:

☐ is ambivalent about having an abortion but whose partner wants her to terminate the pregnancy

While this decision is obviously important for both partners, it is the woman’s right to make the final choice, as she is the one who bears the risk of the pregnancy and the ultimate responsibility for the child.

☐ wishes to obtain an abortion because she is carrying a female fetus

Sex selection brings up many complicated ethical issues. It might be helpful to ask her if there are medical reasons that support her preference (i.e. sex-linked genetic conditions). If her decision is based on social factors alone, discussing these with her may help you better understand her position and decide your comfort or need to refer.

☐ has had what I consider too many previous abortions

Use of abortion as a primary means of birth control is not common. If it were, the large majority of abortions would be repeat abortions. There are many reasons that contribute to repeat abortions including lack of access to healthcare, challenging financial circumstances, and difficulties with birth control. More than half (52%) of abortions are among women who have never had an abortion before. (Henshaw 1998) 54% of women having abortions used a contraceptive method during the month they became pregnant. (Jones 2002) When the latter issue is further explored, obstacles to effective contraception can often be overcome. Consider offering methods that have better adherence rates as well as emergency contraception.

☐ shows little emotion about becoming pregnant and choosing abortion

Emotional responses vary significantly and a patient's outward appearance may not be reflective of her feelings. You may want to check-in with the patient about her decision, what questions she has, and confirm that informed consent was obtained.

☐ has indicated that she does not want any birth control method to use in the future

Women often wish to avoid sex after abortion. Help the patient assess her situation and whether abstinence is a likely reality for her. Tell her you have heard this perspective from women you have seen back later with unintended pregnancy. Proactive planning is an important form of self-care. Discuss birth control options, and what has or has not worked for her in the past. At a minimum, give condoms and emergency contraception, and recommend she return if her situation changes.

Early Abortion Training Workbook
Advanced provision of emergency contraception has been shown to increase its use by 2 - 4 times without changing the use of other forms of contraception, as well as decreasing the rate of unintended pregnancy. (Trussell 2004).

What factors influenced your choices? How might you handle your discomfort when caring for patients under these circumstances?

Recognizing personal discomfort with a situation is a big step towards providing patient-centered and unbiased care. Remember there may be more to the situation than the patient communicates directly.

It will be important to acknowledge which situations cause you discomfort. Sometimes talking with colleagues may be helpful. Sometimes referral will be the best option for your patient. Consider if the issue should be addressed with the patient and how best to provide appropriate support for her.

EXERCISE 1.4: Abortion access and your choice to provide abortion.

**Purpose:** The negative impact on public health when abortion is illegal or otherwise inaccessible is well documented. The following exercise is designed to help you think through the consequences of limited access to legal abortion and help you determine what role you might play in addressing decreasing access. How might your decision to offer options counseling, referrals, and / or provision of abortions have an influence, positive or negative, on the accessibility of abortion?

What is the trainee’s reaction to these accounts? Are there elements in these stories that would motivate them to provide abortion services or make referrals?

This is a good place to discuss the current political situation in regards to abortion limitations and restrictions both regionally and nationally, the public health implications, and what individuals can do to help protect the right of choice.
2. COUNSELING, EDUCATION AND INFORMED CONSENT

This section covers the fundamentals of presenting women with their full range of options, including parenting, abortion and adoption, as well as coaching them through the decision-making process. This section also looks specifically at counseling in abortion care, addressing the issues involved in obtaining informed consent, addressing patients’ questions, and providing support during abortion procedures.

CHAPTER LEARNING OBJECTIVES
Following completion of this chapter, you should be better able to:

- Deliver pregnancy test results in a confidential and nonjudgmental manner
- Describe the full range of pregnancy options including parenting, adoption, and abortion
- Guide and support patients through the decision making process by using specific counseling skills and techniques
- Address issues of ambivalence and ensure that decisions made by patients are informed, voluntary and uncoerced
- Use language that is mindful, sensitive and unassuming

READINGS:

- Early Abortion Training Workbook: Chapter 2
- Supplemental Readings:
    - Chapter 3: Informed Consent, Counseling, and Patient Preparation
    - Chapter 16: Answering Questions About Long-Term Outcomes
  - National Abortion Federation (NAF). Early Options: Counseling the Medical Abortion Patient. 2001 (video)
  - Ferre Institute Pregnancy Options Workbook (http://www.ferre.org/workbook/)
TIPS FOR SUCCESS

SKILL
Nonjudgmental reflective listening is often the key component of successful counseling. A woman’s needs are likely to vary depending on how she feels about the choices before her. The focus of your counseling will differ if a woman is receiving pregnancy test results, considering pregnancy options, preparing for an abortion, or discussing her contraceptive options. Maintain your attention to privacy and confidentiality. To provide unbiased counseling, it is important to separate your individual beliefs from your professional role in the provision of care. Do not hesitate to seek help from experienced counselors or providers when coping with a challenging counseling situation.

SAFETY
It is important that each patient feels comfortable with her decision and has given her informed consent. If necessary, allow extra time for the patient to think, talk further, or ask additional questions; reassure her that she is welcome to change her mind or to delay a few days until she has clarity.

If a patient is particularly anxious about discomfort during the procedure, you may offer different pain management options to help her relax. Occasionally, a referral to a facility that can provide more extensive counseling support or anesthesia may be necessary.

ROLE
Your respectfulness and kindness to patients are essential in your role as a model for staff. While you are in the procedure room, your attention should always be directed to the patient, and the conversation should include her.
CONFIDENTIALITY

Confidentiality means that information disclosed to a staff person in any health care setting will be protected and will be available only to other staff directly involved in that patient’s care. Patient information must not be shared with anyone else, unless the patient has expressly given permission to do so, or an exception to confidentiality is necessary in order to:

- comply with health department laws about required infectious disease reporting.
- comply with required reporting of suspected child abuse to Child Protective Services,
- comply with required reporting of domestic violence to the local police department,
- provide formal subpoenaed information.

Disclosure of any other information without permission is considered a breach of confidentiality.

Telephone authorization for release of information should not be accepted, unless it is a medical record transfer from one site to another site within the same clinical organization.

Written releases authorizing a medical facility to disclose medical information:

- must be kept in the client’s medical records and a copy sent with any transferred files
- must have the signature on the release match the patient’s signature in the medical record

Remember that hallways near exam rooms are not soundproof. Assume the patient and others can hear you.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires medical providers and researchers to adhere to a set of national standards protecting the privacy of individually identifiable health information. Known as “The Privacy Rule,” these standards are enforced by the Office for Civil Rights. A summary of the guidelines is available at http://www.hhs.gov/ocr/hipaa/guidelines/overview.pdf
COUNSELING TECHNIQUES AND CHALLENGES

Portions adapted from:
• A Physician’s Guide to Patient-Centered Care: Providing Support to Women During First-Trimester Abortion Procedures (Joan Mogul Garrity and Mary Ann Castle, PPNYC, 1999), and

I. PREGNANCY OPTIONS COUNSELING

Almost half of all pregnancies in the U.S. are unintended, and over half of women with unplanned pregnancies used contraception during the month they got pregnant. Many of these women will come to you for information about their pregnancy options. As this can be a very difficult and confusing time for women, it is important to listen actively and to provide basic information about all options in a non-directive manner.

In primary care settings the clinician, rather than a trained counselor, often provides patients with options counseling. If you have the opportunity before the pregnancy test is done, talk with your patient about her expectations and wishes. This allows you to focus your conversation on her specific needs. Once you have the test results, the following responses may make good starting points:

- Remaining silent after giving the result allows the patient to respond spontaneously.
- How are you feeling about this pregnancy? Is this the right time for you to have a baby?
- No matter whether you choose to parent, adopt, or end this pregnancy, this may be a hard decision, and women often feel conflicting emotions.
- What part of this situation is most difficult for you?
- Although it can be helpful to talk with friends and family members about this, it is ultimately both your right and responsibility to decide what is best for you.
- I want to look at this situation with you so you can find some peace of mind and come to a decision that you will be comfortable with for the rest of your life.
- What is your picture of the next year or five years of your life? How does this pregnancy change or affect your hopes and goals?
- It can be helpful to look past some of the shock to connect with what you’re really feeling now; can you put words to those feelings?
- How have you made difficult decisions before? Did you feel like the choices were yours, or did someone else decide for you?
- Who in your life can help you in a supportive way, without judging you or pushing their opinions on you?

Validating Feelings Rather than Fixing Them

It’s natural and well-meaning to try to “fix” or “take away” difficult feelings. Faced with a patient’s emotional distress, it is tempting to say things like: “Don’t worry about it,” “Don’t cry,” or “You’ll feel better about this soon.”

Such responses send the message that the provider doesn’t want to know about the patient’s feelings. It’s as if she’s being told, “Don’t have that feeling here. Please be cooperative, and pretend you’re not feeling that way!”
Alternatively, a supportive comment such as: “This can be hard,” may then be followed by an invitation to express more feelings:

“Tell me what’s concerning you the most,” or
“What can I do that would be most helpful to you?”

It is often sufficient to simply acknowledge a patient’s emotions. Validating feelings, in a tone and manner that conveys caring, helps indicate that the provider understands and will accept and respond to the patient, difficult feelings and all.

When a patient’s concerns are unrelated to her choice about this pregnancy (such as financial or housing problems), it is appropriate to assist to the extent you can at this visit, to defer that discussion until you can see her again, or to offer the assistance of another staff person:

“It is not the best time [I’m not the best person] to help you with that right now, as I really want to focus on the issue at hand. After the procedure is complete, we can figure out another time, or I can ask the counselor to talk more with you about...”

If you are not able to solve that problem with her, there is still great value in having asked the questions and acknowledged the patient’s situation. It demonstrates interest in her as a whole person and may reveal influences that are affecting her choice.

**Communication Techniques**

As patients communicate their emotional state both explicitly and through non-verbal cues, attention to both is critical. Open-ended questions help elicit more information, while closed-ended questions, such as “Are you okay?” are too easily answered with yes or no. To invite a more complete response, it is helpful to ask an open-ended question such as:

“How are you feeling about being here today?” or
“What questions do you have for me?”

Making reference to the way others might feel can help to normalize an unfamiliar situation and allay anxiety. Speaking in the third person can validate and normalize the patient’s feelings. It allows both the clinician and patient to look at the situation objectively without triggering defensiveness.

There are, of course, as many ways of expressing feelings as there are women, but providers should be particularly alert to subtle cues when treating women from cultures other than their own.

**Addressing Patients’ Fears**

By asking women what they believe the short and long term consequences are of each pregnancy option, you can uncover and address each woman’s specific concerns.

Common fears include:
- The pain of the abortion procedure, which can trigger you to review options for pain control and relaxation
• The possibility that the fetus may experience pain, in which case it may be helpful to discuss the development of neural structures, explaining that a fetus is not likely to experience pain until later in pregnancy.
• Sadness over the loss of any future contact with a child she adopts out, which can prompt a discussion of open adoption.
• The moral implications of choosing abortion, which may lead to exploration of her personal beliefs and misinformation she may have encountered.

Dealing with Ambivalence

Most life decisions are characterized by a normal degree of ambivalence. If you are not sure that the patient has made a firm decision, however, it is appropriate to allow the patient more time for thought and supportive counseling, even if it means delaying a possible procedure. Conflicting emotions commonly arise from:
• loss of confidence in the decision
• grief over the loss of the pregnancy
• distress over life circumstances surrounding the pregnancy—relationship issues, financial concerns or violence
• the difficulty of handling the situation alone
• the implications of her religious beliefs

Some patients respond well to visual exercises such as completing the table below.

<table>
<thead>
<tr>
<th>Positive consequences of:</th>
<th>Abortion</th>
<th>Adoption</th>
<th>Parenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term</td>
<td></td>
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<td></td>
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<tr>
<td>Negative consequences of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short term</td>
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</tr>
<tr>
<td>Long term</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Baker A. Abortion and Options Counseling: A Comprehensive Reference. Granite City, (IL), Hope Clinic for Women. 1995

Addressing Special Circumstances

Multiple Pregnancies: It is not uncommon to discover a twin gestation during the initial ultrasound evaluation. Occasionally, a patient changes her decision based on this additional information. While many women want to know if they have a multiple pregnancy, routinely asking all patients prior to their ultrasound whether they want this information can help you honor each woman’s wishes.

Early Pregnancy Failure: If a pregnancy failure is discovered during the evaluation, providers routinely offer women that information. It is generally best to be honest with the patient; she has a right to know all the details about her pregnancy. Occasionally,
women opt to defer a procedure and wait to see if they will pass a failed pregnancy spontaneously.

**Sexual Abuse, Incest and Assault:** Patients who have been sexually abused or raped have had no control over the abusive situation and are likely to feel especially vulnerable.

You can help a woman feel safe and supported by saying:
- “This isn’t your fault. I’m sorry this has happened to you.”
- “Is it hard for you to talk about this?”
- “I’m glad you told me; you’re brave to do that.”
- “Many women in this situation feel alone; you don’t have to be alone with us.”
- “No one ever deserves for this to happen to them.”

For an exam or for any procedure, it is helpful to explain each step so the patient is prepared. Acknowledge how difficult this experience may be. A male provider can acknowledge that his gender might be making the experience more difficult. Ask for permission to begin and to touch. Frequently check in with the patient about how she is feeling.

In describing steps of any procedure, consider using the word “gentle.” For example:

“I am going to gently insert the speculum...”

Rape or sexual abuse counseling referrals are essential, and local reporting laws will dictate any legal action the provider is required to take. Be certain that follow-up counseling is offered. Facilitating a process of closure is vital for this patient.
Ask open ended questions
“How are you feeling about being here today?”
“Tell me more…”
“What is the most difficult part for you?”

Reflect
“You seem to be feeling…”
“Am I correct in understanding…”

Validate, don’t fix
“Lots of women feel…”
“What can I do that is most helpful for you?”

Use “If…then” statements
“If now is not the time for you to be pregnant, then it will be important to take your pills regularly.”

Give the patient control
“Which would you prefer?”
“If… then” instead of “You should…”
Keep her informed.

Pay attention to non-verbal cues (Hers and yours)

Communicate acceptance
In your tone. Use eye contact. Sit at her level.

Use silence
Let her finish.

AVOID

False reassurances
“You’ll be fine. This won’t hurt.”

Over-identification
“I know exactly how you feel.”

Medical jargon
“Have you had previous pregnancy terminations?”

Loaded statements
“Have you talked to your family about the decision?”

Giving advice
“I think you should…”
INFORMED CONSENT

Voluntary and informed consent of the patient must be obtained and documented prior to the abortion procedure. State laws, malpractice standards, and the ethical standards of medical practice define the parameters of the informed consent process.

You (or a trained staff member) may obtain informed consent (unless state laws prohibit delegation of this duty to a non-physician). In first trimester abortion practice, the following issues are typically addressed during the informed consent process:

- Pregnancy alternatives, i.e., continuing the pregnancy (and parenting, foster care or adoption) or abortion and potential benefits and risks of each option
- The voluntary nature of the patient’s decision
- The abortion methods available to the patient: medication vs. aspiration, efficacy, potential benefits and risks
- Tests that may be performed (e.g., pregnancy tests, hemoglobin, sonography)
- Available anesthesia options, and the benefits and risks of each method
- The nature, benefits, and risks of any ancillary procedures (e.g., state reporting requirements for sexually transmitted infections)
- Permission to treat the patient in the event of a complication or emergency
- If the patient is a minor, a discussion about involving her parent or guardian in the abortion decision, and if required by law, obtaining permission of the parent or court prior to performing the procedure

Even when the patient expresses certainty about her decision to have an abortion, take care to establish that she is making her choice without coercion from her partner, parent, guardian, or anyone else. Talk to the patient alone at first, before allowing others of her choosing to participate in the discussion, so that she has an opportunity to disclose any coercion.

State laws or regulations may influence the informed consent process. For example, some states require a specific waiting time between provision of the information necessary for informed consent and the abortion procedure. Some states require a discussion of particular topics or regulate who can obtain informed consent. Parental notification or consent laws also exist in many states.

You must assure that the patient receives clear and accurate information on the benefits and risks of abortion. Aspiration abortion complications typically included in the consent discussion include continuing pregnancy, incomplete abortion, hematometra, infection, hemorrhage, cervical laceration, uterine perforation, and the extremely rare occurrence of hysterectomy or death. The patient also needs to know that the risks of mortality or morbidity from pregnancy and childbirth are considerably higher than those associated with first trimester legal, induced abortion. Written information or audiovisual materials may be used to supplement the informed consent discussion.

After the patient’s questions have been answered, she is given a copy of the consent form to read. The form should be signed by the patient and by a witness prior to the procedure and before administration of any medications.
Some situations require special measures to assure that the patient understands the information provided. If the patient speaks a foreign language, use a neutral translator whenever possible rather than a friend or family member. Delay the procedure if substance use or other factors have compromised the patient’s comprehension.

Contraceptive counseling is an integral part of abortion care. You should discuss available methods and explain briefly the efficacy, benefits, potential side effects, and risks of each. More details can be provided once the patient chooses a method. If the patient opts to use hormonal contraceptives or a method that requires a procedure, such an IUD or contraceptive implant, she should review information and sign the appropriate separate consent form.
II. ABORTION COUNSELING

In a recent survey of more than 2200 patients who had abortions at one of 12 clinics in the United States, information and counseling ranked first among the factors correlated with patient satisfaction (Kaiser Family Foundation 1999).

Because questions or the need for emotional support may arise at any point during the abortion visit, a counseling consciousness permeates every aspect of quality abortion care.

Pre-Procedure – Establishing Rapport and Responding to Patients

A friendly introduction and taking a seat at the patient’s level demonstrate respect and support and help ease the anxiety that typically occurs prior to a procedure. The clinician is ultimately responsible for determining that the patient’s decision to terminate the pregnancy was made freely and without coercion. These conversations are best held with the patient sitting up, rather than lying down or in lithotomy position.

Specific issues to cover before the patient is in the procedure room may include:

- Reviewing the patient’s medical history, including contraindications for the procedure (such as uncontrolled asthma or a uterine anomaly), and offering referrals for other services if needed;
- Explaining the steps of the abortion procedure and preparing the patient to manage the physical experience of the procedure;
- Obtaining informed consent, which includes explaining alternatives, risks, and complications, documented by a signed and witnessed consent form.

In some cases, a patient who says she feels sad about having an abortion may genuinely need to reconsider her decision. More often such statements are simply expressions of a normal psychological state—sadness associated with a life situation that has resulted in this decision. Most women who choose to have an abortion are grateful that they can obtain one. At the same time, they are not happy that they have to exercise this option because the pregnancy is unwanted, unintended, or untimely.

Providers can help patients by acknowledging that their feelings are typical or normal responses to such an important decision. For example,

“Many women are nervous about this situation, particularly about feeling pain” or “I think a lot of women feel sad about having to make this kind of decision.”

Some patients are not very responsive, or their verbal statements do not match their non-verbal behavior. For example, a woman may say, “I’m fine” or “okay,” while she is shaking, crying, or appears otherwise distraught. Attention to non-verbal communication is essential. Simply acknowledging these emotions can be helpful. For example,

“This can be a difficult situation.” or “It’s normal to feel sad or scared.”

Disparity between verbal and non-verbal communication does not necessarily indicate ambivalence about the abortion. The patient may not feel well; nausea, dizziness, cramps, or fatigue may account for her appearance. Alternately, she may not be conscious of her internal conflict, she may be able to articulate only some of her
emotions, or she may have significant emotional distress related to circumstances other than the abortion. Regardless of its cause, this incongruence deserves acknowledgment, recognizing that the patient may have emotions other than those she expresses.

Addressing these issues can be difficult. On the other hand, they provide a valuable opportunity for answering questions and acknowledging that these feelings are normal and appropriate.

WHEN IS IT APPROPRIATE TO DEFER THE ABORTION PROCEDURE?

Some patients feel a new sense of ambivalence immediately before the procedure is to begin. This may be another way a patient communicates an unmanageable level of fear, or it may be that the reality of being in the procedure room is making her reconsider her decision.

It is not appropriate to try to facilitate a decision-making process while the patient is sitting on the table. She should be offered supportive counseling and more time to think. If she declines, the provider may explain that she can still ask to safely stop the procedure up until a specific time, beyond which stopping would be dangerous.

In deciding how to proceed, it is appropriate to trust your own instincts. Some patients, who do not want to accept responsibility for their decision, recant in an effort to make the provider or the agency “responsible.” In such a case, the provider must ask for a clear statement of the patient’s intent before proceeding. For example:

“If you want to go ahead with the procedure, then I must hear that this is your choice. I know it may not be a choice you are happy to make, but if you aren’t willing to state it as your own, then I cannot do the procedure.”
Communication During the Procedure

Women experience a wide range of feelings related to abortion, from relief and confidence in their decision, mixed with manageable levels of anxiety, to feelings of fear, guilt, or sadness.

Patients may express fear of:

- anticipated pain of the procedure
- the sound of the vacuum aspiration machine
- reaction of other patients
- humiliation and scorn by staff
- potential complications including infertility or loss of time at school or work
- financial burden
- discovery by one’s employer, friends, or family
- repercussions associated with her religion

Professional knowledge, offered in a soothing manner, may go far to reassure the patient.

"Many women are concerned about being able to have children in the future. In U.S. studies, researchers have found no relationship between the number of abortions and problems in future pregnancies,"

For patients who express fear that, “this is a sin and God will punish me,” you might respond:

“This is a difficult decision. Many women from different religious backgrounds struggle with this decision, even though they know it is the right thing for them to do.” or, “In many religions, people are permitted to ask for and be granted forgiveness.”

Helping the Woman Maintain or Regain Control

When a patient is afraid, a stronger sense of control can help her successfully cope with the procedure. The directive style of traditional provider-patient communication, in which patients are told what to do, can reinforce the patient’s feeling of helplessness. To communicate respect and to improve a patient’s sense of control, it is helpful to provide instructions using an “if…then” statement such as:

“If you want the procedure to go as quickly as possible, then it will help to hold as still as you can.” instead of “You have to hold still.”

In the occasional case when a patient is extremely upset and unable to hold still, it is appropriate for the provider to take control in order to keep the situation safe. Gentle yet firm physical contact and directions given in a kind, steady tone may help the patient regain control and allow the provider to proceed. In most cases, a brief pause is enough for the patient to regain control.

An assistant can provide physical and emotional support during the procedure, offering a hand to squeeze or working with the patient’s partner to help reassure and relax her. Involving all members of the team helps the patient manage her pain and keeps the procedure safe.
Keeping Patients Informed

Some women express a desire to be kept informed about each stage of the procedure, while others do not. Consider asking a woman about her preference before starting:

"Some women like to know what is happening, and others prefer to talk about other things, or to be quiet. Let me know if you have a preference."

If she would rather know what is happening, use gentle descriptions such as:

“I’m numbing up the cervix now. Many women don’t feel this part, though you may feel a slight pinch.” or,

“I’ll now start gently stretching open your cervix. It’s soft and opens easily with a little pressure. Feeling that pressure means that we’re almost finished.”

Some patients, on the other hand, prefer not to know the technical details of the abortion and respond better to diversion and distraction. Engage the patient about her family, jobs or school. Music and pictures in the procedure room can also help.

Patients who are fearful can be engaged about their concerns by asking,

“What do you expect you will feel?” or “What have you heard about the procedure?”

These questions can bring to the surface the myths or negative stories patients may have heard and can guide you in more specifically addressing her concerns. Some helpful statements include:

“Every woman’s experience is different, though most people do very well with the procedure. Some feel almost nothing, others say it hurts a lot. Most are somewhere in between. Generally, the procedure is very quick, so although some women feel like they are having sudden strong menstrual cramps, these usually subsides shortly after the procedure.”

The following relaxation and breathing techniques can help the patient manage pain and anxiety during the procedure:

- Provide continuous verbal support and encouragement.
- Demonstrate slow focused breathing, emphasizing relaxation on the out-breath.
- Explain that releasing tensed muscles can reduce pain. Encourage her to bring attention to her jaw, eyes, lower back or bottom, letting go of any tension there.
- Direct a partner or friend to help support the patient’s efforts.
- Coach a jumpy patient to push her hips into the table. This helps overcome her urge to pull away.
- At the beginning of uterine aspiration, explain that although this is the time women feel most cramping, it is the final part of the procedure and will likely not last long.
- Avoid comparison to labor pains, as they are generally much more severe than cramps associated with abortion.
If a patient wants to know about her progress, you can estimate the time the entire procedure will take and provide cues such as:

“We’re about halfway through,” or “This part just takes another 30 seconds.”

Communicating with Quiet or Silent Patients

Even with a patient who does not verbalize her pain or nervousness, it is necessary to maintain enough verbal communication to monitor her physical and emotional condition. At regular intervals throughout the procedure, it can be helpful to ask the patient to let you know how she is doing.

Following the Abortion—Ending the Visit

As soon as possible after the procedure, the provider may move to the head of the table and reassure the patient that everything went well. Once again, non-directive and “if...then” statements are particularly helpful. They can continue the partnership between provider and patient that was established before and during the procedure.

Rather than, “Don’t have intercourse for the next week” try instead:

“If you want to reduce the risk of infection, then you will want to avoid vaginal intercourse for the next several days. How will this work for you?”

Responding to Challenging Questions

One of the most difficult tasks in communication is responding to tough questions. We will review here some of the most common questions that arise. These questions are especially difficult because of the effects their underlying meanings may have on the patient.

General guidelines for responding to difficult questions include:

- remaining sensitive to both expressed and non-verbal emotions;
- clarifying the patient’s true question;
- acknowledging feelings; and
- providing accurate information.

When a patient asks a challenging question, clarifying what the patient wants to know avoids assumptions about the patient’s intent. For example, a patient may ask,

“What do you do with the baby after the abortion?”

The word “baby” causes the provider to assume that the patient is feeling guilt or regret. To avoid responding based on that assumption, providers might say,

“A lot of women ask about that. Can you tell me a little more about what is concerning you?”
The patient might then tell you that she wants to know what will happen to the fetus. A suggested response would be,

“I examine the pregnancy tissue to make sure that the procedure is complete and that nothing is left inside your uterus.”

Some patients may ask to see the POC. In first-trimester abortion, many providers show the patient the pregnancy tissue and explain the process of embryo-fetal development.

A patient might ask, “Will this hurt the baby?” For patients having a first-trimester abortion procedure, providing facts may alleviate this concern. For example,

“At this point in the pregnancy, the brain and nervous system are still in a very early stage of development. Most brain cells are not developed and without a cerebral cortex pain can’t be felt.”

If the patient persists with her concern after receiving this factual information, you may validate her concerns:

“There can be so many confusing and conflicting feelings when you make this decision.”

A follow-up response by the provider can normalize the feelings. For example:

“I think that a lot of women think that choosing an abortion makes it seem like they don’t care about children. But it often seems that they care so much about children that they want to be sure they have them only when they can provide for all their needs.”
REFERENCES


Maguire DC. Sacred Choices: The Right to Contraception and Abortion in Ten World Religions. 2001


Runkle A. In Good Conscience: A Practical, Emotional, and Spiritual Guide to Deciding Whether to Have an Abortion. 2002

EXERCISE 2.1: Pregnancy Options Counseling

Purpose: Almost half of pregnancies in the U.S. are unintended. It is important that you be able to provide basic information about all options in a non-directive manner. The following exercise is designed to review pregnancy options counseling. Consider using role-play in the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic. How would you approach this?

2. When you ask a patient what questions she has, she wants to know if an abortion will affect her ability to have children in the future.

3. A woman is leaning toward adoption, but is trying to decide, and wants to know more about the process and options.

4. Your 15 year old patient is excited when her pregnancy test comes back positive. She has not told her parents yet because she thinks they will be angry. Her boyfriend wants her to have the baby, and he says he will find a job to support them.

5. Your patient had a brother who died of Tay Sachs disease, and she is worried that she might carry the gene. She is also concerned because she was taking a diet pill until she found out she was pregnant at 6 weeks gestation. She is considering abortion but would like to know about the effects these issues may have on the pregnancy.
EXERCISE 2.2: Abortion Care Counseling

Purpose: Discuss what you might do or what you might say to the patient in each of the following situations.

1. As you enter the exam room you hear the patient's partner criticizing her for “acting stupid” and telling her angrily to “just shut up.” He is looking at the wall and ignores your efforts to introduce yourself.

2. When you come into the procedure room and ask the patient how she is feeling, she starts crying uncontrollably. She has her head turned away from you and does not make eye contact.

3. Before you begin the procedure, the patient asks, “Is this going to hurt?”

4. The patient is a 14-year-old rape survivor who is 7 weeks pregnant. Every time you attempt to insert the speculum, she raises her hips off the table.

5. You have just completed a vacuum aspiration abortion on a patient at 8 weeks gestation. She asks, “Can I see what it looks like?” How would your response differ if the patient were at 12 weeks gestation?
EXERCISE 2.1: Pregnancy Options Counseling

Purpose: Almost half of pregnancies in the U.S. are unintended. It is important that you be able to provide basic information about all options in a non-directive manner. The following exercise is designed to review pregnancy options counseling. Consider using role-play in the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic. How would you approach this?

Before you give the result, ask what result she hopes for. Once you give the result, wait for her to respond. These responses may help you guide your patient:

- How do you feel about this result?
- Is this the right time for you to have a child?
- What has helped you make challenging decisions before?
- Are you aware of all your options?
- If she needs more time, consider giving her the exercise in this chapter on perceived short and long term consequences of her options, or referring her to the online Pregnancy Options Workbook at www.pregnancyoptions.info.

Remember that your role is to listen, support, and frame questions that will help her come to a decision about this pregnancy. You cannot fix her situation.

- When you ask a patient what questions she has, she wants to know if an abortion will affect her ability to have children in the future.

Uncomplicated vacuum aspiration in the first trimester has been shown to have virtually no effect on a woman’s future reproductive health. There is no measurable increased risk of secondary infertility, spontaneous abortion, or pre-term delivery. Available data suggest that multiple abortions pose little or no increased risk compared to a single procedure. For further discussion of other procedures such as dilation and sharp curettage (D&C), dilation and evacuation (D&E), or second trimester abortion, please refer to Paul, page 217.

NOTE: The use of prophylactic antibiotics at the time of the abortion procedure will help prevent against pelvic infection. Abortion care can also provide an opportunity for diagnosis and treatment of pre-existing STDs as well as for education about contraception.
3. A woman is leaning toward adoption, but is trying to decide, and wants to know more about the process and options.

The following concepts about adoption can be useful to discuss:
- Giving birth and raising a child are two different things. You might be ready for one but not for the other.
- It can be a good parenting decision to decide not to parent.
- All birth mothers feel sadness about relinquishing a child, even though it might be the best decision for all involved.
- A birth mother can think of adoption as a way to give parents to her baby, as opposed to giving her baby to adoptive parents.
- She can select the adoptive parents she wants for her baby. (Singer, p. 237)

Introduce various types of adoption and give referrals as appropriate. You can discuss open vs. closed adoption and the various people or agencies that might facilitate the process. Please see the Adoption Facts Section in Chapter 1.

4. Your 15 year old patient is excited when the home pregnancy test comes back positive. She has not told her parents yet because she thinks they will be angry. Her boyfriend wants her to have the baby, and says he will find a job to support them.

Assure her that your job is to help her determine the best decision for her, separating out her own desires from her parents or boyfriend’s wishes. You can ask her to:
- Describe her goals for the future (school, work, social life and relationships), and how becoming a mother would change these.
- Evaluate the pros and cons of each option: parenthood, abortion or adoption.
- Make lists or draw pictures representing how strongly she feels about each option.

To help her explore the question of involving her parents in the decision, you may:
- Ask her what she imagines her parents saying, and how she might respond.
- Explore having the discussion with her parents sooner than later, as her parents will find out eventually.

Help her do more reality-testing around the prospect of parenting:
- How might she manage this financially, logistically, emotionally?
- Provide appropriate referrals for prenatal care and other assistance programs.
5. Your patient had a brother who died of Tay Sachs disease, and she is worried that she might carry the gene. She is also concerned because she was taking a diet pill until she found out she was pregnant at 6 weeks gestation. She is considering abortion but would like to know about the effects these issues may have on the pregnancy.

- There are many hereditary diseases, like Tay Sachs and cystic fibrosis, for which specific testing is now available. Offer to refer her for genetics counseling, after you have considered basic testing such as triple screen, chorionic villus sampling, and amniocentesis.
- For information about risks associated with medications, refer to the Teratogen Hotline (800-532-3749) or Drugs in Pregnancy and Lactation.
- People tolerate risk and uncertainty differently.
- Ask what she would do with the information provided by genetic testing. Would her choice about the pregnancy or her preparation change given this information?
- Keep in mind that she may have reasons other than those she’s stated for not wanting to continue this pregnancy.

EXERCISE 2.2: Abortion Care Counseling

Purpose: Discuss what you might do or what you might say to the patient in each of the following situations.

As you enter the exam room you hear the patient's partner criticizing her for “acting stupid” and telling her angrily to “just shut up.” He is looking at the wall and ignores your efforts to introduce yourself.

- It is essential to talk to the patient without her partner present.
- Explain that you routinely do an exam with the patient alone and have him go out to the waiting room.
- Ask her about the tension you observed and how she is feeling about her decision.
- A domestic violence screen is appropriate, and you should know the reporting laws for your state.

1. When you come into the procedure room and ask the patient how she is feeling, she starts crying uncontrollably. She has her head turned away from you and does not make eye contact.

Crying is normal, but unwillingness to make eye contact is not. Consider asking “What do those tears mean?” Is she fearful? Unresolved? Is she feeling pressured into her decision? It is hard to assess what is going on if you can’t make eye contact. You may add something like “I can’t proceed unless I understand where you are coming from, and that you want this procedure.”
2. Before you begin the procedure, the patient asks, “Is this going to hurt?”

- Each woman is different, but most women tolerate this procedure pretty well.
- Some women have no pain at all. Some women feel cramping but that part is usually quick.
- There are some things you can do to help with the pain. Try to breathe slowing, and relax your muscles.
- I’m going to be as gentle as I can, and we can talk to you during the procedure.
- It’s helpful to give a role to the patient’s partner, by helping her breathe, holding her hand, and reassuring her.

3. The patient is a 14-year-old rape survivor who is 7 weeks pregnant. Every time you attempt to insert the speculum, she raises her hips off the table.

- Use gentle touch
- Have her practice a Kegel during the exam so she makes the connection of how to relax perineal muscles
- To overcome the urge to pull away try having her focus on pushing her hips downward into the table.
- Talk about the importance of her being able to hold still for safety.
- If she is still unable to relax, she may need more medication, or conscious sedation
- Lastly consider the possibility that she needs a referral for general anesthesia.

4. You have just completed a vacuum aspiration abortion on a patient at 8 weeks gestation. She asks, “Can I see what it looks like?” How would your response differ if the patient was at 12 weeks gestation?

Before 9 weeks it is difficult to locate fetal parts, and it can be very therapeutic to show a patient, particularly if she perceives the pregnancy as “a formed baby” (often the impression from the protestors signs outside the clinic).

For later gestations, consider asking tactfully what the patient expects to see. Alert her if recognizable parts will be visible. Some providers are not comfortable showing fetal parts, but would consider showing the placenta, or everything together.
3. PRE-ABORTION EVALUATION

Errors in the evaluation of pregnancy duration are one of the most important causes of abortion complications. Understanding the use of human chorionic gonadotropin (βhCG) tests and diagnostic ultrasound, both independently and in combination, is also important for accurate estimation of gestational age and for the evaluation of pregnancy location and integrity. While the medical evaluation of a woman seeking abortion is seldom complicated, it may occasionally reveal conditions that warrant further management or that modify how, where, or when the abortion takes place.

In this section, you will review interviewing for date information, interpreting laboratory tests (e.g., βhCG, Rh, etc.), reviewing medical histories, conducting physical exams, and evaluating the results of ultrasonography.

The pre-abortion evaluation is also a good opportunity to review the patient’s medical history and preferences for contraception, and to reinforce the importance of condom use when sexually transmitted infections may be an issue.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

□ Use clinical and sonographic findings to accurately estimate gestational age.
□ Differentiate key characteristics of a true gestational sac from a pseudosac on ultrasound.
□ Use sonographic findings to diagnose a non-viable pregnancy
□ List clinical, laboratory, and sonographic findings that would constitute red flags for an ectopic pregnancy.

READINGS

□ Early Abortion Training Workbook: Chapter 3
  o Additional tools and/or handouts for this chapter are available online at http://teachtraining.org.
□ Supplemental Readings:
  o Ultrasound in Abortion Care Training Workbook. Affiliates Risk Management Services, Inc. 2007
    ▪ Chapter 5: Medical Evaluation and Management  
    ▪ Chapter 4: Documenting Pregnancy and Gestational Age
TIPS FOR SUCCESS

SKILL
Pelvic exam skills improve quickly with practice. You will get rapid feedback from your procedure, as well as from comparing exams with an experienced trainer or ultrasound findings.

SAFETY
Make sure to avoid significant underestimation of the gestational age, especially with more advanced gestations.

If you are relying on ultrasound records from the chart, always double check the report form for patient name and date of exam and verify the ultrasound date and exam findings directly from the patient in your history review.

If you are not absolutely certain about the size and position of the uterus with your pelvic exam, do something to become certain. Options include another ultrasound, another pelvic exam repeated after the patient has voided, and consultation with a colleague.

ROLE
Consider working closely with your staff to develop a team approach to each patient. For example, a review of the patient’s basic history with your assistant before entering the room can help you have a common understanding of what the specific needs are for the patient.
# PREGNANCY DATING: TIPS AND METHODS

## PHYSICAL EXAM

### Dating by uterine size in centimeters

- After 4 weeks, uterus increases by approx 1cm per week
- After 12 weeks, uterus rises out of pelvis
- At 15-16 weeks, uterus reaches midpoint between symphysis and umbilicus
- At 20 weeks, uterus reaches umbilicus
- After 20 weeks, fundal height in centimeters approximately equals weeks

### Dating by uterine size in fruit comparisons

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lemon</td>
<td>5-6</td>
</tr>
<tr>
<td>Orange</td>
<td>7-8</td>
</tr>
<tr>
<td>Grapefruit</td>
<td>9-10</td>
</tr>
</tbody>
</table>

### Limitations to manual sizing:

- Leiomyomata
- Multiple gestations
- Marked uterine retroversion
- Obesity

## ULTRASOUND

### Gestational sac

The first ultrasound sign of pregnancy

- Seen at about 4 ½ weeks by transvaginal probe

A normal gestational sac is characterized by: (remember FEEDS mnemonic)

- **F** - Fundal (in mid to upper uterus)
- **E** - Elliptical or round shape in 2 views
- **E** - Eccentric to the midline
- **D** - Decidual reaction (surrounded by a thickened choriodecidual reaction; appears like fluffy white cloud or rind surrounding sac)
- **S** - Size > 4 mm (Criteria sometimes used to distinguish from pseudosac)

Gestational sacs should always be visible when the serum βhCG is:

- ≥ 2000 mIU/ml by transvaginal probe
- ≥ 3600 mIU/ml by transabdominal probe

\[
\text{Mean gestational sac diameter (MSD)} = \frac{L + W + H}{3}
\]

\[
\text{Gestational Age (in days)} = \text{MSD (in mm)} + 30
\]

### Yolk sac

- First confirmation of gestational sac; excludes a pseudosac
- Round, symmetric sonolucent structure (with dark center) in gestational sac
- Appears at approx 5-6 weeks and disappears by 11-12 weeks
- May be seen when the mean gestational sac diameter is 8-10mm
- Should always be seen when gestational sac reaches 13mm (43 days).

### Embryo

- Appears at approximately 6 weeks
- Embryonic pole length (EPL) or crown-rump length (CRL) is longest axis of embryo
- Don’t include yolk sac or limbs in this measurement
- Should be seen when gestational sac reaches 19 mm (49 days)

\[
\text{Gestational age (days)} = \text{embryonic pole length (mm)} + 42
\]

After 12 weeks it is better to use biparietal diameter (BPD)

### Embryonic cardiac activity

- Appears at approx 6 ½ weeks
- Should always be visible when embryo reaches 5mm (47 days)

### “Red flags”

<table>
<thead>
<tr>
<th>For Ectopic Pregnancy:</th>
<th>For Non-viability:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No gestational sac by 35 days LMP</td>
<td>No yolk sac by 13 mm GS (43 days)</td>
</tr>
<tr>
<td>GS not characteristically normal</td>
<td>No cardiac activity by 5 mm EPL (47 d)</td>
</tr>
<tr>
<td>No yolk sac by 38 days (8 mm GS)</td>
<td>No embryonic pole by 49 days</td>
</tr>
<tr>
<td>Free fluid in cul-de-sac</td>
<td>Pain and/or vaginal bleeding</td>
</tr>
<tr>
<td>Risk Factors for ectopic pregnancy</td>
<td>No embryonic pole by 49 days</td>
</tr>
</tbody>
</table>
### ULTRASOUND & POC DATING TABLE

<table>
<thead>
<tr>
<th>Gestational Age (Weeks)</th>
<th>4 wks</th>
<th>5 wks</th>
<th>6 wks</th>
<th>7 wks</th>
<th>8 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational Age (Days)</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td>32</td>
<td>33</td>
</tr>
</tbody>
</table>

#### TRANSVAGINAL ULTRASOUND FINDINGS

<table>
<thead>
<tr>
<th>Landmark</th>
<th>4 wks</th>
<th>5 wks</th>
<th>6 wks</th>
<th>7 wks</th>
<th>8 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational Sac</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yolk Sac</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Pole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Mean Gestational Sac Diameter

- 3 mm: 4-5 wks
- 5 mm: 5-6 wks
- 8 mm: 6-7 wks
- 13 mm: 7-8 wks

#### POC SIZE

- 3 mm: DIME
- 5 mm: NICKEL
- 8 mm: QUARTER

◆◆◆ At the beginning of the time range, each landmark first appears in a viable pregnancy. At the end, the absence of the landmark may indicate a non-viable pregnancy.
SAMPLE EARLY PREGNANCY ULTRASOUND IMAGES

Images from Fjerstad, M, Andrews, M, Gatter, M. *Ultrasound in Very Early Pregnancy and Management Pathways Slideshow*. CAPS, 2004. Gestational sac suggested in the first, but not the second ultrasound. If there is no yolk sac, it is important to confirm features that help rule out pseudosac. See FEEDS mnemonic (developed by D Schneider, personal communication 2004).

Pseudosac:
- Generally lacking gestational sac features
- May not be fundal (Get longitudinal view to demonstrate)
- Tends to fill center of uterine cavity
- Irregular Shaped (beak or flame shaped)
- Minimal decidual reaction
- Smaller size

PREGNANCY LANDMARKS

From *Manual Vacuum Aspiration*, a presentation by Physicians for Reproductive Choice and Health (PRCH) and the Association for Reproductive Health Professionals (ARHP), 2000.
REFERENCES


EXERCISES: PRE-ABORTION EVALUATION

EXERCISE 3.1

Purpose: To distinguish appropriate uses for various types of pregnancy tests. For the following scenarios, please indicate whether you would use a high sensitivity urine pregnancy test, a low sensitivity urine pregnancy test, or a serum quantitative βhCG test and the reasons for your choice.

1. A patient comes to your office requesting abortion. She is 4 weeks 2 days LMP and states that she had a positive home pregnancy test.

2. A patient is 6 weeks LMP and requests abortion. Transvaginal ultrasound examination shows no intrauterine gestational sac. The patient has been spotting intermittently but is otherwise asymptomatic.

3. A patient comes to your office for her routine follow-up visit 3 weeks after early vacuum aspiration. She started taking oral contraceptive pills the day following the abortion. She has some breast tenderness but otherwise feels well.

4. You have just completed an early vacuum aspiration procedure for a patient who is 5 weeks LMP. You see no sac or villi when you examine the tissue with backlighting. No ultrasound machine is available on site.
EXERCISE 3.2

Purpose: To review key information about ultrasonography in early pregnancy. Please answer the following questions:

1. Describe three differences between transvaginal and transabdominal ultrasound and when it is most appropriate to use one or the other.

2. When do the following normally first appear on transvaginal ultrasound?
   a. Gestational sac?
   b. Yolk sac?
   c. Embryonic pole?
   d. Embryonic cardiac activity?

3. Name three characteristics of a true gestational sac (vs. a pseudosac).

4. Calculate the gestational age in days for the following pregnancies seen on ultrasound:
   a. Gestational sac: length 6 mm, width 7 mm, height 5 mm; no yolk sac or embryo present
   b. Gestational sac: length 18 mm, width 16 mm, height 16 mm; yolk sac present; embryonic pole length 5 mm

5. What is the differential diagnosis of the following transvaginal ultrasound findings? What steps would you take to clarify the diagnosis?
   a. Mean gestational sac diameter 14 mm with no yolk sac or embryo visible
   b. Embryonic pole length 3 mm with no visible cardiac activity
   c. 3 mm x 3 mm central anechoic sac in pregnant patient 6 weeks LMP with history of intermittent right lower quadrant cramping
   d. Embryonic pole length 7 mm with no visible cardiac activity
   e. Irregular, flattened gestational sac without embryo, cystic changes present in decidua and myometrium resembling “swiss cheese” pattern in patient who is 8 weeks LMP
EXERCISE 3.3

**Purpose:** To identify pre-procedure conditions that may warrant special management. How would you manage the following case scenarios?

1. A 41-year-old patient presents for abortion at 5 weeks LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows an intrauterine sac consistent with 5 weeks gestation and multiple uterine leiomyomata.

2. A 17-year-old patient has a history of severe asthma. She presents for abortion at 8 weeks gestation. She was hospitalized three months ago for an asthma exacerbation, and she discontinued oral corticosteroids 4 weeks ago. She uses a steroid inhaler daily. The patient appears comfortable with normal vital signs, but pre-procedure examination reveals mild wheezes bilaterally.

3. A 38-year-old woman has a history of mitral valve prolapse with regurgitation. She takes prophylactic antibiotics for dental procedures. She presents for abortion at 11 weeks gestation and wants to know if she will be given antibiotics to “protect her heart.”

4. A 26-year-old patient presents to your office at 7 weeks gestation. She had a chest x-ray and abdominal series after a motor vehicle accident 2 weeks ago. She decided to have an abortion because of concerns about the effects of the radiation on the fetus.

5. You are preparing to perform vacuum aspiration on a patient who is 5 weeks pregnant. When you insert the speculum, you note a cervical ectropion that is hypertrophic and friable, with mucopus exuding from the cervical os.
EXERCISE 3.1

**Purpose:** To distinguish appropriate uses for various types of pregnancy tests. For the following scenarios, indicate whether you would use a high sensitivity urine pregnancy test (HSPT), a low sensitivity urine pregnancy test (LSPT), or a serum quantitative βhCG test and the reasons for your choice.

1. A patient comes to your office requesting abortion. She is 4 weeks 2 days LMP and states that she had a positive home pregnancy test.

   **Key Points:**
   - A high sensitivity urine pregnancy test (HSPT) is the most useful test to confirm an early pregnancy.
   - You want a simple office-based confirmation of pregnancy. The modern HSPT can detect levels as low as 20 mIU/ml. These levels occur in urine as early as a week after conception or before a missed period.

   If the pregnancy test is **positive**, proceed with a pelvic exam or ultrasound

   If the HSPT test is **negative**, have patient return in a week for retesting if her period does not start.

   There is wide variability in βhCG levels from patient to patient at a given gestational age; peak levels range from 20,000-200,000 mIU/ml and occur between 7-10 weeks gestation.

2. A patient is 6 weeks LMP and requests abortion. Transvaginal ultrasound examination shows no intrauterine gestational sac. The patient has been spotting intermittently but is otherwise asymptomatic.

   **Key Points:**
   - Ectopic pregnancy must be ruled out in this patient.
   - A LSPT or serum βhCG can help clarify the diagnosis in this scenario.

   The differential diagnosis includes false positive HSPT, very early intrauterine pregnancy, miscarriage, and ectopic pregnancy.

   - First confirm pregnancy with a HSPT. If this is **negative**, the combination of negative pregnancy test and no IUP on ultrasound indicates she is not pregnant. Address reasons why she may be spotting, and encourage her to return in a week for a repeat urine pregnancy test.
• If the HSPT is positive, you can proceed in one of two ways - by doing a low sensitivity pregnancy test (LSPT) or by drawing a serum βhCG.

**LSPT method:** These urine based tests turn **positive** around 2000 mIU/mL. If the LSPT is positive, an intrauterine pregnancy should have been noted on transvaginal ultrasound; however some of the assays have high false-positive results and a confirmatory stat serum βhCG is advisable. If the serum βhCG is 2000 mIU/ml or greater, or she is **symptomatic**, refer her for evaluation of possible ectopic pregnancy. If the LSPT is **negative** or the βhCG is < 2000, consider seeing her again in 4-7 days for another transvaginal ultrasound, and give ectopic warnings.

**Serum βhCG method:** If no LSPT is available, proceed directly to drawing serum βhCG, and continue as above.

3. **A patient comes to your office for her routine follow-up visit 3 weeks after early vacuum aspiration.** She started taking oral contraceptive pills the day following the abortion. She has some breast tenderness but otherwise feels well.

**Key point:**
• Don’t use the HSPT test routinely in an abortion follow-up visit. The HSPT can stay positive for 4 to 6 weeks (occasionally as late as 8 weeks) following an induced abortion.
• Take history for other signs of pregnancy. Keep in mind that breast tenderness may be a consequence of starting estrogen-containing oral contraceptives.
• Consider checking the abortion record to make sure that abortion was complete and appropriate POC (products of conception) were noted.
• **Do not do a HSPT,** since many women will still have a positive result several weeks after early abortion. One option is to do a low-sensitivity pregnancy test. This test turns positive around 2000 mIU/ml, so a negative result would be reassuring. If she had a positive result on a low-sensitivity test, we would be more concerned about continuing pregnancy or retained POC. Keep heterotopic pregnancy in the differential diagnosis but remember that the incidence is only 1 in 6,500 pregnancies.
4. You have just completed an early vacuum aspiration procedure for a patient who is 5 weeks LMP. You see no sac or villi when you examine the tissue with backlighting. No ultrasound machine is available on site.

Key Point:
- Consider ectopic pregnancy strongly in any case in which you do not get definitive proof of IUP. Draw serum $\beta$hCG today and repeat in approximately two days. Refer out for urgent ectopic workup if $\beta$hCG is not appropriately falling.
- Check to make sure that an initial pregnancy test was done and truly positive.
- Look carefully for evidence of pregnancy tissue. Try a handheld magnifying lens. Look carefully through the equipment. Re-rinse the tissue and separate the clots.
- If still no POC, consider a re-aspiration. Repeat uterine exam to assess for flexion, and consider changing cannula types, e.g. from a flex to a rigid or vice versa, for a different approach.
- If suspected ectopic, treat or refer as appropriate.

EXERCISE 3.2

Purpose: To review key information about ultrasonography in early pregnancy. Please answer the following questions:

1. Describe three differences between transvaginal and transabdominal ultrasound and when it is most appropriate to use one or the other.

<table>
<thead>
<tr>
<th>Transvaginal ultrasound</th>
<th>Transabdominal ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>easier if bladder is empty</td>
<td>better uterine view with full bladder</td>
</tr>
<tr>
<td>easier to detect earlier pregnancy</td>
<td>difficult to see pregnancy of &lt;6 wks</td>
</tr>
<tr>
<td>better resolution but worse tissue depth</td>
<td>better depth but worse resolution</td>
</tr>
<tr>
<td>probe usually 7.5mHz</td>
<td>probe usually 3-5mHz</td>
</tr>
<tr>
<td>considered more invasive by the patient</td>
<td>less invasive</td>
</tr>
</tbody>
</table>

Transvaginal ultrasound is commonly used in early pregnancy. Abdominal ultrasound is commonly used after first trimester or when ultrasound guidance is needed during a procedure.

2. When do the following normally first appear on transvaginal ultrasound?

a. Gestational sac? 4 ½ weeks
b. Yolk sac? 5-6 weeks
c. Embryonic pole? 6 weeks
d. Embryonic cardiac activity? 6 ½ weeks
3. **Name three characteristics of a true gestational sac (vs. a pseudosac).**

   This question introduces the concept of the pseudosac, which is a fluid collection that mimics a gestational sac. Uterine changes can occur even with an ectopic pregnancy.

   The earliest definitive sign of an IUP is a yolk sac within a gestational sac in the uterus. Before the yolk sac appears, it is critical to differentiate between a true gestational sac vs. a pseudosac. The pneumonic “FEEDS” may help you recall the primary features of a gestational sac (Fjerstad 2003)

<table>
<thead>
<tr>
<th>Gestational Sac</th>
<th>Pseudosac</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fundal</strong> (in mid to upper uterus)</td>
<td>Variable location</td>
</tr>
<tr>
<td><strong>Elliptical or round</strong> (as enclosed in a membrane)</td>
<td>Irregular shape or contour of fluid collection</td>
</tr>
<tr>
<td><strong>Eccentric to the uterine stripe</strong> (due to implantation)</td>
<td>Central to uterine stripe (in cavity)</td>
</tr>
<tr>
<td>Decidual (or chorio-decidual) reaction. Appears as “fluffy white cloud” around sac</td>
<td>May be Absent</td>
</tr>
<tr>
<td><strong>Size &gt; 4 mm mean size</strong> (Criteria sometimes used to distinguish from pseudosac)</td>
<td>&lt; = 4 mm</td>
</tr>
</tbody>
</table>

4. **Calculate the gestational age in days for the following pregnancies seen on ultrasound:**

   a. **Gestational sac:** length 6 mm, width 7 mm, height 5 mm; no yolk sac or embryo present

   Mean sac diameter= \((6 + 7 + 5)/3 = 18/3 = 6\) mm. Then use formula for gestational age (days) = mean sac diameter (mm) + 30. Thus in this case 6 + 30 = 36 days = 5 weeks 1 day

   b. **Gestational sac:** length 18 mm, width 16 mm, height 16 mm; yolk sac present; embryonic pole length 5 mm

   When an embryo is visualized, use the embryonic pole length to determine gestational age. You use the formula for gestational age (days) = embryonic size (mm) + 42. Thus in this case 5 + 42 = 47 days = 6 weeks 5 days

      Remember: when the fetal pole appears, it is more accurate to date the pregnancy using the fetal pole than the gestational sac.

5. **What is the differential diagnosis of the following transvaginal ultrasound findings? What steps would you take to clarify the diagnosis?**
a. Mean gestational sac diameter 14 mm with no yolk sac or embryo visible

Key Point:
- A yolk sac may be seen when the gestational sac is 8-10mm and should definitely be seen by the time the gestational sac has achieved 13mm.

If no yolk sac is visible in a 14mm gestational sac, the most likely diagnosis is early pregnancy failure (anembryonic pregnancy), both terms for what we formerly called a “blighted ovum”. Some treatments for early pregnancy failure include expectant management, misoprostol, or aspiration.

b. Embryonic pole length 3 mm with no visible cardiac activity

Key Point:
- Early pregnancy failure can be diagnosed by lack of embryonic cardiac activity in a 5mm fetal pole.

Cardiac activity is usually detectable by “6 ½” weeks. An embryonic pole length of 3mm represents about “6 ½” weeks. You could tell the patient that this is probably just an early pregnancy and explain her various pregnancy options. In she wishes prenatal care and wants to know if she has a viable pregnancy, she could return in a few days to repeat the ultrasound.

c. 3 mm x 3 mm central anechoic sac in pregnant patient 6 weeks LMP with history of intermittent right lower quadrant cramping

This case indicates likely ectopic pregnancy. By six weeks, or 42 days, the mean sac diameter should be 12mm. A normal sac should also be eccentrically placed and not centrally placed in the uterine cavity. Combined with the cramping pain in the right lower quadrant, findings consistent with a pseudosac should make you think of ectopic pregnancy. Refer for workup.

d. Embryonic pole length 7 mm with no visible cardiac activity

As in question b, cardiac activity should be seen by the time the embryonic pole length reaches 5 mm. Normal viable pregnancy is very unlikely in this case. If the patient wants an abortion, you could do the procedure. If she wants prenatal care, you could explain that this probably represents a non-viable pregnancy and refer her for definitive ultrasound.

e. Irregular, flattened gestational sac without embryo, cystic changes present in decidua and myometrium resembling “swiss cheese” pattern in patient who is 8 weeks LMP

This suggests molar pregnancy. Refer out for further workup. Early molar pregnancies may appear with homogeneous or mixed-density echoes resembling
incomplete abortion or early pregnancy failure on ultrasound. The classic “blizzard” or “snowstorm” appearance of molar pregnancy on ultrasound often is not visible until after 10 weeks gestation.

EXERCISE 3.3

**Purpose:** To identify pre-procedure conditions that may warrant special management. How would you manage the following case scenarios?

1. A 41-year-old patient presents for abortion at 5 weeks LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows an intrauterine sac consistent with 5 weeks gestation and multiple uterine leiomyomata.

   Uterine fibroids may inhibit our ability to complete the procedure, and medication abortion is an excellent and likely safer alternative to aspiration abortion. Stop and discuss this with the patient.

   When considering aspiration abortion, use ultrasound to see where the sac is in relation to the fibroids. If a small 5 week sac is high in the fundus of a 17-week size fibroid uterus, it may be very difficult to reach. Referral is appropriate.

   If referral options are limited, consider waiting a couple weeks for the sac to grow bigger and more accessible. Ultrasound guidance is a helpful adjunct to any procedure with fibroids.

2. A 17-year-old patient has a history of severe asthma. She presents for abortion or early pregnancy loss management at 8 weeks gestation. She was hospitalized three months ago for an asthma exacerbation, and she discontinued oral corticosteroids 4 weeks ago. She uses a steroid inhaler daily. The patient appears comfortable with normal vital signs, but pre-procedure examination reveals mild wheezes bilaterally.

   **Key points:**
   a. Make sure you are able to control asthma before starting an elective procedure.
   b. Most temporary adrenal suppression is relatively unimportant for brief outpatient procedures.

   Try an albuterol inhaler. If inhaler clears her lungs, continue with procedure. If wheezes don’t clear, she will need better control of her asthma before proceeding.

   Adrenal suppression can occur when a patient uses exogenous steroids. The extent of adrenal suppression with most steroid regimens is mostly unknown. Stress-dose corticosteroid therapy is probably unnecessary for minor procedures under local anesthesia.

   Although the evidence is unclear, it appears that adults who get up to 60 mg/day of prednisone for 10 days or less were considered at low risk of needing adrenal suppression precautions (Coursin 2002, Prescriber’s Letter;).
3. A 38-year-old woman has a history of mitral valve prolapse with regurgitation. She takes prophylactic antibiotics for dental procedures. She presents for abortion at 11 weeks gestation and wants to know if she will be given antibiotics to “protect her heart.”

The American Heart Association endocarditis prophylaxis guidelines do not recommend antibiotic prophylaxis for procedures that are not likely to cause bacteremia with organisms that would be dangerous to the heart valves. Uninfected abortion, D&C, and IUD insertion and removal are among the low-risk procedures that are not likely to cause bacteremia with endocarditis-causing organisms. (Paul 1999, page 60) Current recommendations can be found at: http://www.americanheart.org/presenter.jhtml?identifier=9459.

4. A 26-year-old patient presents to your office at 7 weeks gestation. She had a chest x-ray and abdominal series after a motor vehicle accident 2 weeks ago. She decided to have an abortion because of concerns about the effects of the radiation on the fetus.

Key Point:
- Many patients overestimate the harmful effects of exposures. It is our responsibility to give accurate information for informed choice about pregnancy options.

Although fetal exposure to ionizing radiation is linked to malformations, most diagnostic plain-film radiographs expose the fetus to radiation far below the threshold thought to be harmful.

A general consensus is that cumulative fetal radiation exposure should be limited to less than 5 rad. (American College of Radiology, National Council on Radiation Protection, ACOG) Consider the exposure associated with the following radiographs.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Radiation Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest x-ray</td>
<td>0.00007 rad</td>
</tr>
<tr>
<td>Multiview abdominal x-ray</td>
<td>0.245 rad</td>
</tr>
<tr>
<td>IVP</td>
<td>1.398 rad</td>
</tr>
</tbody>
</table>

Very small amounts of radiation, such as during most medical radiographs, contribute only a small amount to the average birth defect rate. (See review at http://www.aafp.org/afp/990401ap/1813.html). Also refer to the Teratogen Hotline at 800-532-3749.

5. You are preparing to perform vacuum aspiration on a patient who is 5 weeks pregnant. When you insert the speculum, you note a cervical ectropion that is hypertrophic and friable, with mucopus exuding from the cervical os.

Key Point:
• Have a low threshold for treating cervicitis or bacterial vaginosis, as both have been associated with post-abortion endometritis. As long as you treat the infection at the time of the abortion, there is no need to delay the procedure, unless PID is suspected (Paul 1999).
4. MEDICATIONS & PAIN CONTROL

This section describes methods of pain control as well as routine medications used before, during, and after aspiration abortion. Medications indicated for emergency situations are also reviewed.

CHAPTER LEARNING OBJECTIVES
Following completion of this chapter, you should be better able to:

□ Describe the various options for pain control, including non-pharmacologic, used during an aspiration abortion
□ Identify indications and dosages for medications commonly used in emergency situations
□ Know the location and availability of emergency supplies in your clinical setting
□ Describe the differences between local anesthesia, conscious sedation, deep sedation and general anesthesia in terms of the necessary monitoring and personnel needed for each

READINGS

□ Early Abortion Training Workbook: Chapter 4
□ Supplemental Readings:
  ▪ Chapter 7: Pain Management
TIPS FOR SUCCESS

SKILL
Because pain perception is complex, including both physical and psychosocial elements, it is usually best managed by a combination of pharmacological and non-pharmacological means. Relief of pain and control of anxiety are important determinants of abortion safety as well as the well-being and satisfaction of each patient. In addition to any medications used, reinforce the value of relaxation throughout the procedure.

Most abortions in the U.S. are performed using local anesthesia with or without additional medication, although a spectrum of pain control options can be offered in a primary care office, clinic, or hospital setting. Oral medications such as non-steroidal anti-inflammatory drugs, narcotics or anxiolytics may be used individually or together. IV pain management may be chosen if time, monitoring and staffing are available. Consider when the patient last had liquids or solids by mouth. General anesthesia is still used in some circumstances. Depending on the timing of the procedure, the preferences of you and your patient, and facility resources in your setting, an effective regimen can be chosen.

Clinicians can administer cervical anesthesia with very little discomfort to the patient. Because of the way the pelvis is innervated, cervical anesthesia tends to decrease discomfort from cervical manipulation, but has less effect on uterine cramping. Watch your colleagues, review the options, and vary your technique until you are able to apply local anesthesia effectively. Variations on technique include superficial vs. deep injection, number and location of sites, type of needle used, type and additives to local anesthesia, speed of injection, and time elapsed before initiation of the procedure.

SAFETY
Medications used for pain control are one of the few potentially life-threatening aspects of abortion care. It is important to pay close attention to the medical history, allergies, and concurrent medications that might interact with those you are planning to use, as well as following recommended dose range limits. Know any antidotes to medications used that can cause sedation and respiratory depression. Use caution with local anesthesia to avoid direct intravascular injection and excessive dosing. If you will be using IV medication, make sure that the clinic emergency cart contains the proper drugs to treat adverse reactions, and that treatment instructions are available.

Note: Directions for administration of medications by IV push specify SLOWLY. Time yourself on your watch to recognize how long 30 to 60 seconds really is.

ROLE
In addition to any pharmacologic measures used, the use of support, focused relaxation, and gentle operative technique during the procedure can be invaluable. Guide the patient through breathing techniques to maximize relaxation and avoid hyperventilation with its associated anxiety. Do not underestimate the helpfulness of deep-breathing techniques; the support of a partner, friend or medical assistant; and the reassuring tone of your voice and words.
REASSURANCE AND RELAXATION

Some patients are inordinately anxious about anticipated pain. Providers should honestly acknowledge the possibility of pain. For example,

“I can’t promise that you won’t feel any pain. I can tell you that I will do everything I can to be as gentle as possible. I’ll be giving you a local anesthetic and will show you some breathing techniques to relax. Avoiding clenching your muscles will also help.”

Many patients seem to be more afraid of the cervical injection than of the procedure itself. Some providers find it helps to avoid referring to “injection or needle” but instead, non-specifically mentioning “giving some medicine for the cervix.” One technique to lessen discomfort is to inject the needle as the patient coughs. To relieve anxiety, providers could alert the patient to how the injection might feel.

“You might feel a slight pinch or pressure from the medicine.”

Toward the end of the vacuum aspiration, cramps often become more intense. Remind the patient that the procedure is nearly over.

“If you feel cramping during the procedure—that is not a sign that something is wrong. Cramps are the response of a healthy uterus as it gets smaller and stops bleeding.”

PREDICTORS OF PAIN ASSOCIATED WITH ABORTION

Increased pain
- pre-operative anxiety, depression, ambivalence
- dysmenorrhea

Decreased pain
- previous vaginal delivery

Studies show conflicting results
- gestational age at time of procedure
- maximum cervical dilation
- provider experience

Factors not strongly predictive of pain intensity
- manual vs. electric vacuum aspiration
- prior pelvic exam
- prior abortion
- prior cesarean section

Trials evaluating manual vs. electric vacuum aspiration showed that MVA was acceptable to patients, without a significant difference in satisfaction, pain, anxiety, or vaginal bleeding, although studies were limited by use of IV pain medication. (Nichols, Evidence I/B) In spite of no difference in pain scores, significantly more patients reported that the noise associated with electric vacuum aspiration increased their pain
(Edelman 2001). Some patients were also bothered by the sounds made by the manual vacuum. Women did not note more pain associated with the slightly increased time that manual vacuum required in these trials. (Nichols, Evidence I/B)

Studies on incomplete abortion reveal that suction causes less pain than sharp curettage (Forna 2002). Routine sharp curettage is not indicated following vacuum aspiration.
## BASIC MEDICATION OPTIONS

<table>
<thead>
<tr>
<th>Drug (Class)</th>
<th>Dose Range</th>
<th>Antidotes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Anesthesia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine (0.5% – 1%)</td>
<td>Up to 200 mg (20 cc 1% or 40 cc 0.5%)</td>
<td>NA</td>
<td>Most common in US. Lower concentration as effective but more $</td>
</tr>
<tr>
<td>Bacteriostatic Saline</td>
<td>20 cc</td>
<td>NA</td>
<td>As effective as lidocaine</td>
</tr>
<tr>
<td><strong>Optional Additives to Local Anesthetic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bicarbonate (Buffer)</td>
<td>5 cc / 50 cc anesthetic</td>
<td>NA</td>
<td>Less injection pain</td>
</tr>
<tr>
<td>Vasopressin</td>
<td>5-10 u / 50 cc anesthetic</td>
<td>NA</td>
<td>Decreases bleeding</td>
</tr>
<tr>
<td>Atropine</td>
<td>2 mg / 50 cc anesthetic</td>
<td>NA</td>
<td>Helps prevent vasovagal bradycardias</td>
</tr>
<tr>
<td><strong>Oral Pain Meds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ibuprofen (NSAID)</td>
<td>600 – 800 mg PO</td>
<td>NA</td>
<td>More effective if given 2 hrs before procedure</td>
</tr>
<tr>
<td>Naproxyn (NSAID)</td>
<td>250 – 500 mg PO</td>
<td>NA</td>
<td>More effective if given 2 hrs before procedure</td>
</tr>
<tr>
<td>Lorazepam (Benzodiazepine)</td>
<td>0.5 – 1 mg SL or 1-2 mg PO</td>
<td>Romazicon (Flumazenil)</td>
<td>Shorter acting benzodiazepine</td>
</tr>
<tr>
<td>Diazapam (Benzodiazepine)</td>
<td>5-10 mg PO</td>
<td>Romazicon (Flumazenil)</td>
<td>Longer acting benzodiazepine</td>
</tr>
<tr>
<td>Vicodin / Tylenol 3 (Narcotic with Tylenol)</td>
<td>1-2 tablets PO</td>
<td>Narcan (Naloxone)</td>
<td>Equivalent medications can be used</td>
</tr>
<tr>
<td><strong>IV Pain Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>50 – 100 mcg IV</td>
<td>Narcan</td>
<td>Give over 30-60 seconds</td>
</tr>
<tr>
<td>Versed (Midazolam)</td>
<td>1 – 2 mg IV</td>
<td>Romazicon (Flumazenil)</td>
<td>Give over 2-3 minutes</td>
</tr>
<tr>
<td><strong>Common Antidotes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcan (Naloxone)</td>
<td>0.1 mg – 0.2 mg (0.25-0.50 cc) IV/ IM each 2-3 min. Max dose 0.4 mg</td>
<td>NA</td>
<td>Narcotic antidote</td>
</tr>
<tr>
<td>Romazicon (Flumazenil)</td>
<td>0.2 mg (2 cc) IV each min. Max dose of 1 mg</td>
<td>NA</td>
<td>Benzodiazepine antidote</td>
</tr>
<tr>
<td><strong>Some Emergency Meds</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atropine Sulfate</td>
<td>0.2 mg (0.5 cc) IV push or 0.4 mg (1cc) IM, each 3-5 minutes to max dose of 2 mg</td>
<td>NA</td>
<td>For symptomatic bradycardia</td>
</tr>
<tr>
<td>Benadryl</td>
<td>50 - 100 mg IM/IV/PO</td>
<td>NA</td>
<td>For allergic reaction. Can use oral if rash alone</td>
</tr>
<tr>
<td>Epinephrine (1:1000)</td>
<td>0.3 – 0.5 mg (1 mg/ cc) SQ/IM/ IV each 10 min</td>
<td>NA</td>
<td>For allergic reaction. Reserve for respiratory manifestations or anaphylaxis</td>
</tr>
</tbody>
</table>

Other medication options not listed here include: medications for cervical dilation, medications for bleeding, additional emergency medications, and antibiotics.
**ANESTHESIA: DEFINITIONS AND MONITORING**

Adapted from *Clinical Policy Guidelines* of the National Abortion Federation (2003)

**DEFINITIONS**

**Local Anesthesia:** Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, this almost always signifies intra- or paracervical block.

**IV Pain Management** (also called Conscious or Moderate Sedation): A minimally depressed level of consciousness that retains the patient’s ability to maintain a patent airway independently and continuously, to be easily aroused, and to respond appropriately to physical stimuli and verbal commands.

**Deep Sedation:** A controlled state of depressed consciousness from which the patient is not easily aroused. This may be accompanied by a partial or complete loss of protective reflexes, including inability to maintain a patent airway independently and/or to respond purposefully to physical stimulation or verbal command. Deep sedation can result from sedative and analgesic administration intended to produce only conscious sedation.

**General Anesthesia:** A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

**MONITORING GUIDELINES**

1. When IV Pain Management is used, a person other than the clinician must be present who is trained to monitor appropriate respiratory, cardiovascular and neurologic parameters, including level of consciousness.

2. The personnel administering IV Pain Management must recognize that conscious sedation may lead to deep sedation with hypoventilation and be prepared to provide respiratory support.

3. The practitioner administering general anesthesia or deep sedation must be certified according to applicable local, hospital, and state requirements.

4. When IV Pain Management is used, monitoring must be of a degree that can be expected to detect the respiratory effects of the drugs being used.
PROVIDING EFFECTIVE LOCAL ANESTHESIA

Although several methods of pain management are available for aspiration abortion, local anesthesia is most frequently used in the U.S. in combination with other types of medication. The cervix and lower uterine segment are innervated by parasympathetic nerves fibers S2 through S4. The uterine fundus is innervated by sympathetic nerves T10 through L1, which are not fully accessible by cervical anesthesia since they accompany the ovarian vessels and are higher in the pelvis than local infiltration can reach.

Local anesthetics block nerve impulses, but this mechanism may not be the primary source of pain control in paracervical block. The main action may involve distension or physical pressure on the tissue-containing nerves. Lidocaine vs. equivalent amounts of bacteriostatic saline showed no significant difference in pain intensity, although bacteriostatic saline contains the preservative benzyl alcohol which has anesthetic properties (Miller 1996, Evidence I/A). A slightly less effective block was achieved in a trial using plain saline compared to lidocaine (Chanrachakul 2001; 1/A evidence).

Use caution with local anesthesia to avoid direct intravascular injection and excessive dosing, as adverse effects have been reported with lidocaine used in cervical anesthesia. At low doses, patients may notice peri-oral tingling, lightheadedness, tinnitus, or metallic taste. At higher concentrations, they can have muscular twitching, unconsciousness, seizure, and cardiac instability. Deaths have been associated with intravascular injection and overdose. (Paul 1999) A maximum recommended dose for lidocaine in paracervical blocks for pregnant women is 200 mg (achieved by giving 20 cc 1% (10 mg/cc), or 40 cc 0.5% lidocaine.

TIPS TO MINIMIZE INTRAVASCULAR INJECTION

- Use a combination of superficial (0.5") and deep injections (1.5") which may make paracervical block more effective (Weibe 1992)
- Move the needle while injecting OR aspirate before injecting
- Use multiple sites of injection
- Use a vasoconstrictor mixed with the anesthetic (such as vasopressin) to slow systemic absorption (and reduce blood loss).
- Some clinicians prefer a lower concentration lidocaine or bacteriostatic saline

ADDITIVES TO LOCAL ANESTHESIA

- Lidocaine vs. equivalent amounts of bacteriostatic saline showed no difference in effectiveness (the latter includes benzyl alcohol, which has anesthetic properties). But when compared to plain saline, the lidocaine group showed less pain intensity (Evidence I/A).
- Carbonated vs. Plain Lidocaine showed that bicarbonate decreased pain scores by 8% (Evidence I / B).
- No evidence suggests one local anesthetic works better than any other for paracervical block. Alternatives to lidocaine include chloroprocaine (nesacaine) or bupivicaine (marcaine).
**INJECTION TECHNIQUES**

- Injection locations vary as much as providers. No current data demonstrate one technique is superior.
- Studies evaluating waiting time after cervical injection showed conflicting evidence. Studies showed that with a two-site injection technique, waiting two or more minutes decreased pain scores (Donati 1996), but not when multiple injections sites used (Wiebe 1992)
- Slower injection (60 vs. 30 sec) showed statistically significant decrease in pain (Wiebe 1992 – Evidence I / B)

### Common Mixture for Preparation of Anesthetic

1. Take 50 ml vial of 0.5% or 1% lidocaine and draw off 5 cc (save or discard).
2. Add 2-4 units (0.1-0.2 ml) of vasopressin.
3. Add 5 ml sodium bicarbonate (8.4%) as buffer.
4. About 20 ml of mixture is usually adequate.

If atropine is added to the above mixture for vasovagal prevention, the recommended dose is 2 mg / 50 ml.
REFERENCES


EXERCISES: MEDICATIONS AND PAIN CONTROL

EXERCISE 4.1

Purpose: To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios?

1. You are administering cervical anesthesia in preparation for vacuum aspiration on a 16-year-old patient who is 7 weeks pregnant. You have already injected 4 cc of lidocaine at the 4 o’clock position on the cervico-vaginal reflection. When you begin the injection at the 8 o’clock position, the patient complains of numbness around her mouth and ringing in her ears.

2. A patient comes to your office requesting abortion at 11 weeks gestation. She states that last year she had an allergic reaction to the local anesthetic that her dentist used.

3. You are about to start a vacuum aspiration procedure on a 15-year-old patient who is 9 weeks pregnant and weighs 123 pounds. The patient chooses to have IV pain management due to extreme anxiety. You administer midazolam 1.5 mg followed 2 minutes later by fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not easily arousable. Her oxygen saturation falls from 99% to 88%.

4. A patient who is 5 weeks LMP requests abortion. She has a history of alcohol and heroin abuse, and she states that she “shot up” the day before the abortion visit. She wants “all the pain medication she can get” for the abortion procedure. Venous access is limited, but you finally succeed in inserting a hep lock. You administer midazolam 1 mg followed 2 minutes later by fentanyl 75 mcg. You insert the speculum, and the patient complains that she “can feel everything” and “needs more meds.”
EXERCISE 4.2

Purpose: To become familiar with other medications used in abortion care.
Please answer the following questions.

1. At what gestational age range is it acceptable to administer mini-dose Rhogam (50 mcg) rather than full dose Rhogam (300 mcg) to the Rh-negative patient?

2. In which of the following abortion care situations is administration of Rh(D) immunoglobulin suggested?
   a. Patient is Rh-negative, Du-negative
   b. Patient is Rh-negative, Du-positive
   c. Patient has positive anti-D antibody titre
   d. Rh-negative patient received RhoGam 4 weeks ago during evaluation for threatened spontaneous abortion
   e. Rh-negative patient is 4 days post-abortion and did not receive RhoGam at the abortion visit

3. You offer one-day abortions in your office. You obtain urine for chlamydia and gonorrhea screening on all patients, but the results take several days to return. Under this circumstance, would you give antibiotics to all patients? To select patients? What antibiotic regimen would you use and why?

4. You have just completed an early vacuum aspiration procedure using local cervical anesthesia only. Suddenly the patient complains of nausea and “feeling faint.” She is pale and sweating. Her blood pressure is 90/50 and her pulse is 48. How would you manage this patient?

5. After completing an uncomplicated vacuum aspiration abortion, the patient states that she forgot to mention that she is allergic to latex. In the recovery room, the patient develops urticaria, pruritis, and becomes acutely short of breath. What is your diagnosis? In addition to supplemental measures such as oxygen administration, what medications might you administer?
EXERCISE 4.1

**Purpose:** To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios?

1. You are administering cervical anesthesia in preparation for vacuum aspiration on a 16-year-old patient who is 7 weeks pregnant. You have already injected 4 cc of lidocaine at the 4 o’clock position on the cervico-vaginal reflection. When you begin the injection at the 8 o’clock position, the patient complains of numbness around her mouth and ringing in her ears.

   Systemic symptoms of lidocaine toxicity can result from intravascular injection, which can be minimized by:

   a. A superficial to deep injection, constantly moving the needle (which may make block more effective (Wiebe 1992, decreased pain scores 25%; I/B evidence)
   b. OR aspirating before injection
   c. Using multiple sites of injection
   d. Minimizing the concentration of anesthetic (using 0.5% or replacing with saline)
   e. Using a vasoconstrictor mixed with the anesthetic (such as vasopressin) to slow systemic absorption

   A maximum recommended dose for lidocaine in paracervical blocks for pregnant women is 200 mg (20 cc 1% (10 mg/cc) or 40cc 0.5%).

   Adverse effects have been reported with lidocaine used in paracervical blocks. At low doses, common symptoms include those noted above. At higher concentrations, they can have muscular twitching, seizure, cardiovascular effects, unconsciousness or death.

2. A patient comes to your office requesting abortion at 11 weeks gestation. She states that last year she had an allergic reaction to the local anesthetic that her dentist used.

   **Key Point:**
   a. It is important to distinguish between allergic reaction, side effect, and toxicity.
   b. In this case, the safest alternative may be to avoid lidocaine.

   Instead of lidocaine, one can use:

   a. Bacteriostatic saline which contains the anesthetic benzyl alcohol for a comparable block (Miller 1996; 1/A evidence)
   b. Plain saline for a slightly less effective block (Chanrachakul 2001; 1/A evidence).
c. Chloroprocaine (nesacaine) which is an amino amide, unlike lidocaine which is an amino ester.

Allergic reactions to lidocaine are extremely rare, and mostly occur from the preservative or epinephrine. Allergic reactions include itching, hives, bronchospasm, and progression to shock.

3. You are about to start a vacuum aspiration procedure on a 15-year-old patient who is 9 weeks pregnant and weighs 123 pounds. The patient chooses to have IV pain management due to extreme anxiety. You administer midazolam 1.5 mg followed 2 minutes later by fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not easily arousable. Her oxygen saturation falls from 99% to 88%.

Both fentanyl and midazolam (versed) can cause sedation and respiratory depression. Although these doses are low, individuals react differently to the same doses due to interaction with other agents (eg alcohol) or genetic differences in metabolism. Physicians who administer “conscious sedation” must be prepared to handle those who become deeply sedated.

Prevention can be aided by using a stepwise approach to pain management.
   a. a substance abuse and medication history
   b. smaller doses for low weight patients
   c. serial doses until adequate pain control is achieved

Both narcotics and benzodiazapines can be reversed using antagonists, also in a stepwise fashion. The following guidelines can be followed.

<table>
<thead>
<tr>
<th>$O_2$ Saturation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 – 100%</td>
<td>Continue monitoring</td>
</tr>
<tr>
<td>90 - 94%</td>
<td>Check monitor lead placement</td>
</tr>
<tr>
<td></td>
<td>Advise deep breathing</td>
</tr>
<tr>
<td>89% or less</td>
<td>Initiate oxygen therapy</td>
</tr>
<tr>
<td></td>
<td>Consider appropriate stepwise use of reversal drugs</td>
</tr>
<tr>
<td></td>
<td>Transfer if persistent</td>
</tr>
</tbody>
</table>

Antagonist / Reversal Drugs

<table>
<thead>
<tr>
<th>Narcotic Reversal</th>
<th>Narcan</th>
<th>0.1 – 0.2 mg (0.25 - 0.5 ml) IV /IM; each min (max 0.4 mg = 1 ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazapine Reversal</td>
<td>Romazicon (Flumazenil)</td>
<td>0.2 mg (2cc) IV; repeat each 1 min to max 1 mg (10 cc)</td>
</tr>
</tbody>
</table>

Monitoring is recommended for a minimum of 2 hours after use of reversal agents, because the sedative may last longer than the antagonist (Kost 1998).
4. A patient who is 5 weeks LMP requests abortion. She has a history of alcohol and heroin abuse, and she states that she “shot up” the day before the abortion visit. She wants “all the pain medication she can get” for the abortion procedure. Venous access is limited, but you finally succeed in inserting a hep lock. You administer midazolam 1 mg followed 2 minutes later by fentanyl 75 mcg. You insert the speculum, and the patient complains that she “can feel everything” and “needs more meds.”

Narcotic tolerance among substance users often require higher doses. Many providers feel abortion is a brief procedure using short-acting medications, and may give a patient the benefit of the doubt. Ultimately you are the one to determine safety under the circumstances.

Keep in mind that intoxication can interfere with informed consent, warranting a delay in the decision. Rapid reversal of narcotics in chronic narcotic users can also provoke withdrawal or seizures.

Remember non-narcotic forms of pain control and relaxation, which include NSAIDS, breathing and relaxation techniques, visualization methods, so-called “vocal local” or “verbicaine”, and / or having a support person in the room. Studies of Naproxyn and Ibuprofen show statistically significant pain control compared to placebo (Suprapto 1984, I/A evidence; and Wiebe, I/B evidence, respectively).

**EXERCISE 4.2**

**Purpose:** To become familiar with other medications used in abortion care.

**Please answer the following questions.**

1. At what gestational age range is it acceptable to administer mini-dose RhoGam (50 mcg) rather than full dose RhoGam (300 mcg) to the Rh-negative patient?

   RhoGam is recommended to prevent the isoimmunization of Rho-D negative women at the time of therapeutic or spontaneous, and ectopic pregnancy (ACOG). A 50-mcg dose is standard practice for abortions less than 12 completed weeks of gestation. Beyond that point, full dose RhoGam (300 mcg) is recommended to provide adequate protection.

   The risk of sensitization is negligible prior to the production of fetal blood, but the minimal gestational age at which sensitization can occur is uncertain. Since the introduction of RhoGam in late pregnancy and postpartum, the incidence of isoimmunization has fallen over 8-fold (ACOG). Given the medical success of its use in term pregnancies, it is not surprising that RhoGam has been extended to women with miscarriages, ectopic pregnancies, and abortions, even though the evidence to support its use in early first trimester is sparse.
2. In which of the following abortion care situations is administration of Rh(D) immunoglobulin suggested?

   a. Patient is Rh-negative, Du-negative

   Du is a minor antigen in the D system, sometimes called “weak D”. While Rh determination is recommended, Du testing is not necessary (and only done in some labs when they test broadly). Only a small number of patients test positive for it.

   A Du-positive woman does not need anti-D, as she is functionally Rh-positive, although no harm results from giving it. (III / D evidence) ACOG recommends RhoGam “be given in any case where the D type is in question.” In this case, give RhoGam for Rh-negative status and because “weak D” (or Du) is not there to be protective in the body.

   b. Patient is Rh-negative, Du-positive

   *It is unnecessary, but it would not be harmful. Du protects against isoimmunization in an Rh-negative woman; “Du work in the body like D, but doesn't show up in the test-tube unless specifically looked for”.*

   c. Patient has positive anti-D antibody titre

   *This means either the woman is already sensitized (in which case RhoGam will not help), or the patient recently received RhoGam and still has those anti-D antibodies in her blood (t ½ is 24 days). In either case, don’t give RhoGam.*

   d. Rh-negative patient received RhoGam 4 weeks ago during evaluation for threatened spontaneous abortion

   While some studies suggest RhoGam may be present for up to 9-12 weeks after full-dose administration (Bichler 2003), the manufacturer advises that it be given if three or more weeks have elapsed since the initial injection in term pregnancies. Until further data delineates therapeutic levels after mini-dose RhoGam, re-dosing after 3 elapsed weeks may be prudent.

   e. Rh-negative patient is 4 days post-abortion and did not receive RhoGam at the abortion visit

   RhoGam should ideally be administered within 72 hours. Beyond 72 hours, some recommend anti-D should still be given as soon as possible, for up to 28 days (Fung Kee Fung 2003) (III/B evidence). For medication abortion, RhoGam is ideally given prior to insertion of misoprostol, but many give it up to 72 hours after.
3. You offer one-day abortions in your office. You obtain urine for chlamydia and gonorrhea screening on all patients, but the results take several days to return. Under this circumstance, would you give antibiotics to all patients? To select patients? What antibiotic regimen would you use and why?

Key Point: Antibiotics reduce the risk of post-abortal infection, and should routinely be used. It is less clear which antibiotic and what duration of treatment is ideal.

A substantial protective effect of antibiotics in all subgroups of women undergoing abortion was shown in a meta-analysis of placebo controlled trials. This protective effect was evident not only in women with risk factors (history of PID, positive pre-operative CT, or pre-operative BV), but also in low risk groups. In the 12 studies comparing antibiotics with placebo, there was a 42% overall reduction in postabortal infection rates (Sawaya 1996) (Evidence I / A).

Many providers give prophylaxis with Doxycycline on the day of abortion, but extend to treatment doses if CT screen returns positive (Doxycycline 100 mg twice daily for a week, or Azithromycin 1 gm single dose). Most studies in the meta-analysis used various doses of tetracyclines (used more commonly in the US) or metronidazole (used more commonly in Europe). These two classes were similarly effective in preventing infection.

Advantages of universal treatment (without screening) might include lower cost and reduced post-abortal infection rates. The disadvantages of universal treatment include no contact tracing, and the possibility that re-infection may result in long-term sequelae. In one clinical trial, women were randomized to universal antibiotics vs. screen and treat regimens. Post-abortal infection occurred in 5% of the universal antibiotic group vs. 7% of the screen & treat group (p = 0.08), but-universal antibiotics cost half as much as screen & treat (Penney 1998).

4. You have just completed an early vacuum aspiration procedure using local cervical anesthesia only. Suddenly the patient complains of nausea and "feeling faint." She is pale and sweating. Her blood pressure is 90/50 and her pulse is 48. How would you manage this patient?

This appears to be a classic vaso-vagal reaction, with low pulse, hypotension, and sweating. Vaso-vagal reflex is caused by stimulation of the parasympathic nervous system, and may occur with cervical dilation, fear and other emotions. Hemorrhage, over-medication, and not eating may also predispose to syncope.

Differential Diagnosis

<table>
<thead>
<tr>
<th>Vaso-Vagal Reflex</th>
<th>Hemorrhage</th>
<th>Low Blood Sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow pulse (&lt; 50)</td>
<td>Rapid Pulse</td>
<td>Normal / late rapid</td>
</tr>
<tr>
<td>Low BP</td>
<td>Late low BP</td>
<td>Late low BP</td>
</tr>
<tr>
<td>Pallor, Cool clammy skin</td>
<td>Pallor, Cool clammy skin</td>
<td>Pallor, Cool clammy skin</td>
</tr>
<tr>
<td>+/- N/V</td>
<td>+/- N/V</td>
<td>+/- N/V</td>
</tr>
<tr>
<td>+/- Abdominal Cramps</td>
<td>+/- Uterine cramps</td>
<td>+/- Abdominal Cramps</td>
</tr>
<tr>
<td>Rare: Syncope, Seizures</td>
<td>Rare: Syncope</td>
<td>Rare: Syncope, Seizures</td>
</tr>
<tr>
<td>Not orthostatic</td>
<td>Become orthostatic</td>
<td>Not orthostatic</td>
</tr>
</tbody>
</table>

Early Abortion Training Workbook
Vaso-Vagal Management
a. Airway / Positioning: supine or trendelenberg, head to side if vomiting
b. Cool cloth on head or neck; blanket
c. Monitoring Vital Signs and $O_2$ saturation
d. Prolonged vasovagal, consider:
   - Atropine
   - Oxygen
   - IV Fluids
   - Record events, copy record, and transfer as needed
e. Evaluation for other potential causes (hemorrhage, hypoglycemia, etc.)

5. After completing an uncomplicated vacuum aspiration abortion, the patient states that she forgot to mention that she is allergic to latex. In the recovery room, the patient develops urticaria, pruritis, and becomes acutely short of breath. What is your diagnosis? In addition to supplemental measures such as oxygen administration, what medications might you administer?

The combination of symptoms suggests acute allergic reaction. In addition, throat swelling and shock would suggest progression to anaphylaxis.

Other things can cause shortness of breath in our clinic settings including hyperventilation, asthma, and sedative medications. If the patient were showing significant sedation with respiratory depression, consider reversal agents in addition to the medications below. Otherwise, it is appropriate to use Benadryl, and if necessary Epinephrine for allergic reactions.

<table>
<thead>
<tr>
<th>Benadryl</th>
<th>Allergic Reaction / Anaphylaxis</th>
<th>50 mg (1 ml) IM/IV/PO (PO if rash only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine 1:1000</td>
<td>Severe Allergic Reaction</td>
<td>0.3 – 0.5 mg (1 mg/ cc) SQ/IM/ IV (each 10 min)</td>
</tr>
</tbody>
</table>

Other steps could include:
- monitoring (vitals and $O_2$ saturation)
- Start $O_2$ therapy
- Positioning
- Start IV with 2nd IV Line if needed for impending shock
- Record Events, Copy Record
- Transfer as needed, Alert designated emergency contact
5. ASPIRATION ABORTION PROCEDURE

MANUAL VACUUM ASPIRATION (MVA)
ELECTRIC VACUUM ASPIRATION (EVA)

This section contains information on early manual and electric vacuum aspiration, sometimes referred to as surgical abortion (see discussion below). You will receive training in the use of vacuum equipment, specific steps in the uterine aspiration procedure, tissue evaluation, and care in the immediate recovery period. Although most uterine aspiration procedures are technically straightforward, some present challenges. Management of the more complex cases will also be discussed.

CHAPTER LEARNING OBJECTIVES
Following completion of this chapter, you should be better able to:

- List the steps of the uterine aspiration procedure
- Identify and correctly use equipment for manual vacuum aspiration
- Demonstrate and consistently use the 'no touch technique' while providing aspiration abortion, and describe its importance
- Evaluate products of conception for presence of appropriate gestational tissue
- Assess and manage challenging situations that may arise at the time of the uterine aspiration procedure

READINGS:

- Early Abortion Training Workbook: Chapter 5
- Supplemental Readings:
    - Chapter 9: Surgical Abortion in the First Trimester
    - Chapter 13: The Challenging Abortion

“Aspiration abortion” is the term we use instead of “surgical abortion”, as suggested in Weitz et al. 2004. First-trimester abortion interventions are most often completed through either electric or manual aspiration – typically simple procedures that can be safely undertaken in a regular exam room, with local or oral analgesics and with little recovery time. The procedure can also be called “suction abortion”. Use of the term “surgical” connotes cutting of tissue, in a process likely to take place in a hospital operating room. In addition, it distances abortion from other common and routine gynecological procedures like IUD insertion or endometrial biopsy.
TIPS FOR SUCCESS

SKILL
Pay very close attention to tissue identification. Knowing what you are seeing and what should be present for a given gestational age are invaluable skills and important safety measures for your patient.

SAFETY
Being gentle is essential. Place the tenaculum with maximal purchase of the cervix, closing it slowly. Then exert firm traction applied gently and gradually to straighten out the canal. Use the first (smallest) dilator to find the cervical canal. It should advance without any force at all. If you encounter resistance, change the angle or path (still without force) until you identify the path of the canal.

If you are having trouble dilating the cervical canal, just stop. Some providers like to use an os finder (or less expensive version which is a flexible plastic uterine sound) to help avoid creating a false passage in these circumstances. Consider taking the instruments out and repeat your pelvic exam. Replace the instruments and try again. The slight change in position of the patient or instruments may help.

Try a speculum with a shorter blade (such as a Moore-Graves or Collins); this allows you more room to straighten out the cervical angle by applying gentle traction to the cervix with the tenaculum. Try a slightly different location on the cervix for the tenaculum, or the opposite lip (posterior rather than anterior, or vice versa). Posterior lip application may be especially helpful when the uterus is retroflexed. Opening the speculum blades wider may also help you attain the appropriate angle for dilation when the uterus is acutely retroflexed or anteflexed.

Other alternatives include waiting a few days or a week, then trying again; giving misoprostol and waiting a few hours; or asking a colleague to help.

Begin the vacuum when the cannula is in mid-uterus; as the uterus contracts, the uterine walls will feel firmer and you will feel more confident exploring all the way to the fundus.

If you are not absolutely sure that you see sac/membranes and villi when you evaluate the tissue, then assume none are present. Many providers do a post-abortion sonogram at this time, to determine if there is significant remaining tissue in the uterus. If so, they re-aspirate the patient. If not (and they see an endometrial stripe without remaining tissue), they follow serial βhCG levels and give ectopic precautions.
NO-TOUCH TECHNIQUE

Preventing infection after aspiration abortion is an important goal in abortion care. Measures to accomplish this goal include using sterilized instruments, paying meticulous attention to procedure technique, administering prophylactic antibiotics, and using the “no touch” technique when performing abortions.

The “no touch” technique was pioneered by abortion providers working in freestanding clinics in the 1970s. It requires that the provider not touch parts of instruments that will enter the uterine cavity. Thus, during aspiration abortion, the clinician:

- Grasps only the midportion of dilators, not the tips
- Attaches the cannula to the vacuum source without touching the tip of the cannula
- Keeps instruments that have been used away from sterile instruments remaining on the tray.

Underlying the “no touch” technique is the recognition that, even with antiseptic cleansing, it is impossible to “sterilize” the vagina. In fact, a randomized study showed that preoperative antiseptic cleansing of the vagina had no effect on post-abortal infection rates (Lundh 1983). Thus, even if a provider dons sterile gloves, sterility is compromised as soon as s/he touches the client’s perineum and vagina to insert the speculum. By using the “no touch” technique, the clinician assures that the parts of instruments that will enter the uterine cavity remain sterile.

In outpatient abortion, the safest approach is a strict no-touch technique.

At the same time, infection after aspiration abortion can and does occur, albeit infrequently. Some contamination of the uterine cavity may occur during the procedure, and pathogens residing in the vagina may ascend through the dilated cervix. Following a meta-analysis of randomized trials showing that antibiotic prophylaxis decreased the risk of post-abortal infection, even in women without risk factors, universal antibiotic prophylaxis has become common practice in abortion care (Sawaya 1996).

Photo on right displays a typical tray set-up. From left:
- speculum
- gauze
- metal cup containing anesthetic
- tenaculum
- ring forceps with gauze
- 2 sizes of dilators
- syringe with needle
- metal dish containing betadine
- cannula and manual vacuum aspirator
  - MVA Plus pictured
STEPS FOR VACUUM ASPIRATION

1. Review patient history, and use patient’s name to confirm identity.
2. Confirm patient consent.
3. Introduce yourself.
4. Ask how the patient feels about the procedure and what questions she has.
5. Perform pelvic examination to confirm uterine size and position. (If patient had ultrasound, pelvic exam can be done after administering IV medications)
6. Give IV medications if needed.
7. Put on sterile gloves and check equipment tray.
8. Insert the speculum.
9. Perform infection screening tests as needed.
10. Clean cervix.
11. Administer cervical anesthesia.
12. Dilate the cervix.
13. Vacuum the uterus (manual or electric).
14. Check cervix for bleeding.
15. Remove the speculum.
16. Check in with patient.
17. Check the tissue.
18. Arrange special follow-up care, such as post-procedure ultrasound and / or serial βhCG determinations if your tissue evaluation does not confirm villi, a gestational sac, and fetal parts appropriate for gestation.
19. Inform patient and staff that tissue evaluation indicates a complete procedure or explain special follow-up care needed – including ectopic symptoms to watch for.
USING MVA EQUIPMENT
Adapted from Manual Vacuum Aspiration, a presentation by Physicians for Reproductive Choice and Health (PRCH) and the Association for Reproductive Health Professionals (ARHP), 2000.

Instruments and Supplies
MVA instruments and cannulae from several manufacturers. The MVA technique described here uses a double valve aspirator, shown in the upper right of the picture on the left. Refer to directions for use with each manufacturer’s product. Necessary equipment includes:
- Manual Vacuum Aspirator
- Cannulae
- Speculum
- Tenaculum
- Dilators or misoprostol

Prepare the aspirator
- Begin with the valve buttons open and the plunger pushed all the way into the barrel.
- Close the valve by pushing the buttons down and forward until they lock into place.

Create the vacuum
- Pull the plunger back until its arms snap outward over the end of the barrel.
- Make sure the plunger arms are positioned over the wide edges of the barrel.
Dilate the cervix

- Necessary when the cervical canal will not allow passage of appropriate cannula
- Gently dilate with dilators or cannula of increasing size.
- Or, give misoprostol several hours before the procedure.

Insert the cannula

- Holding cannula with fingertips, gently insert through the cervix with a rotating motion.
- Attach cannula to the aspirator, using adaptors as needed.

Release the pinch valve

- When the pinch valve is released, the vacuum is transferred through the cannula to the uterus.
- Blood, tissue, and bubbles will flow through the cannula into the aspirator.

Evacuate the uterus

- Move the cannula gently back and forth, rotating the aspirator.
- Do not withdraw cannula aperture(s) beyond cervical os.
- Do not grasp aspirator by the plunger arms.
<table>
<thead>
<tr>
<th>Inspect the tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strain and rinse the tissue.</td>
</tr>
<tr>
<td>• Place tissue in a clear container.</td>
</tr>
<tr>
<td>• Recommended: backlight to inspect tissue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tissue at 7 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Dime-sized marker for comparison)</td>
</tr>
</tbody>
</table>
EVALUATION OF PRODUCTS OF CONCEPTION (POC)

When inspecting POC, you will see blood clots, uterine support tissue (called decidua), gestational sac (membranes and villi), and fetal parts if gestational age is 9 weeks or greater. You must identify both membranes and villi to confirm completion of abortion. Many clinicians check for fetal parts above 10 weeks gestational age, but at 12 weeks or greater, all fetal parts must be identified.

Decidua can look similar to the gestational sac. The following table outlines the differences between them. If you are unsure if sac and villi are present, proceed as if they are not in order to avoid missing ectopic pregnancies and incomplete abortions.

Don’t confuse sac with decidua capsularis, which is the matted appearing capsule that is often seen in the uterine aspirate. This capsule covers the growing gestational sac, and therefore grows proportionally to it in early pregnancy, and thus can be used as a another size check for adequate membrane and villi.

<table>
<thead>
<tr>
<th>Membranes and Villi</th>
<th>Decidua</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frond-like villi (floating or attached)</td>
<td>No fronds</td>
</tr>
<tr>
<td>Clumped villi held together by membrane</td>
<td>No villi or thin membrane</td>
</tr>
<tr>
<td>More transparent—like plastic wrap</td>
<td>More opaque—like wax paper</td>
</tr>
<tr>
<td>Luminescent, light refractory</td>
<td>Less light refractory</td>
</tr>
<tr>
<td>Turns white if vinegar added</td>
<td>Minimal color change with vinegar</td>
</tr>
<tr>
<td>Size guidelines:</td>
<td>Variable quantity. Caution: Don’t confuse sac with decidua capsularis (see above)</td>
</tr>
<tr>
<td>6 wk – dime size</td>
<td></td>
</tr>
<tr>
<td>7 wk – nickel size</td>
<td></td>
</tr>
<tr>
<td>8 wk – quarter size</td>
<td></td>
</tr>
<tr>
<td>Must confirm fetal parts at 12 weeks or greater</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


EXERCISES: ASPIRATION ABORTION PROCEDURE

EXERCISE 5.1

Purpose: To practice management of challenging situations that can arise at the time of aspiration abortion procedures. Please consider how you would manage the following case scenarios.

1. You are performing an abortion for an anxious and tense 20-year-old G₁P₀ patient at six weeks gestation. You have completed the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels gritty and tight, and does not have the "normal" feel of the dilator tip advancing against the internal os.

Questions: What is the differential diagnosis?

What would you do next?

2. You have just completed an aspiration abortion for a 19-year-old woman at six weeks gestation. She had reported intermittent episodes of scant spotting on three occasions during the past week, but did not have any severe cramping or clotting. Her pre-procedure ultrasound was performed one week ago, with a gestational sac identified, but no embryonic pole or cardiac motion noted. Her pregnancy test was positive. Dilation was not difficult and you were able to use a 6-mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see villi.

Question: What is the differential diagnosis?

What would you do next?

3. You are performing an abortion on a nulliparous 16-year-old at seven weeks gestation. You notice that her cervix is very small and it is hard to pick a site for the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reinsert the tenaculum at a slightly different site, although it is difficult because the cervix is so small. This time the cervix tears after inserting the third dilator, and this time there is substantial bleeding. (Adapted from Surgical Abortion Education Curriculum, PPNYC 1996)

Question: What do you do?
4. You are inserting the cannula for a procedure on a woman at 9 weeks gestation with a retroflexed uterus. Although the dilation was easy, you are having some problems inserting the cannula, and then suddenly you feel a popping sensation and the cannula slides in quickly, without hitting any fundal walls. (Adapted from Surgical Abortion Education Curriculum, PPNYC 1996)

What happened?

What should you do now?

How might you have anticipated and prevented this problem?
TRAINING SUGGESTIONS FOR ASPIRATION ABORTION PROCEDURE EXERCISES

EXERCISE 5.1

Purpose: To practice management of challenging situations that can arise at the time of aspiration abortion procedures. Please consider how you would manage the following case scenarios.

1. You are performing an abortion for an anxious and tense 20-year old G₁P₀ patient at six weeks gestation. You have completed the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels gritty and tight, and does not have the "normal" feel of the dilator tip advancing against the internal os.

What is the differential diagnosis?

Difficulty dilating the internal os is often caused by acute flexion of the uterus. It can also be due to congenital or acquired cervical or uterine abnormalities (eg, stenosis from prior cone biopsy, fibroid in the lower uterine segment).

What would you do next?

When you encounter this situation, consider trying the following:

- Ask the patient if she has a history of fibroids or cervical/uterine surgery.
- Remove the speculum and repeat the bimanual examination to confirm the size, shape, position and flexion of the uterus. If ultrasound is an option, scan the uterus for fibroids or other abnormalities.
- If the uterus is acutely flexed, loosen the screw and widen the speculum blades to better maneuver the cervico-uterine angle.
- Use traction on the tenaculum to help straighten the flexion of the uterus. If the uterus is retroflexed, consider tenaculum placement on the posterior cervical lip. A shorter Moore-Graves speculum also increases the effect of traction.
- Consider using an os finder or flexible uterine sound. This may help you find the path with less risk of perforation.
- If none of these measures succeed, cervical ripening with misoprostol for 1-3 hours may be helpful. Alternatively, allowing another week to pass may soften the cervix considerably.

2. You have just completed an aspiration abortion for a 19-year old woman at six weeks gestation. She had reported intermittent episodes of scant spotting on three occasions during the past week, but did not have any severe cramping or clotting. Her pre-procedure ultrasound was performed one week ago, with a gestational sac identified, but no embryonic pole or cardiac motion noted. Her pregnancy test was positive. Dilation was not difficult and you were able to use a 6-mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see villi.
Questions: What is the differential diagnosis?

- Spontaneous abortion
- Failed abortion
- Completed early abortion with “hidden” POC
- Ectopic pregnancy

What do you do next?

- Some providers routinely give patients with very early pregnancies the caveat that they may require a follow-up US or serial βhCGs to confirm completion of abortion.
- Repeat US prior to aspiration might have ruled out a spontaneous abortion, in which case aspiration could have been avoided.
- Extra steps in POC Evaluation: Check to see if the sac is stuck in the manual vacuum aspirator, electric vacuum bottle, cannula, or strainer. Re-wash and re-float the POCs, examining closely to see that the sac is not hidden in clot or decidua. Look with a magnifying glass. Try adding vinegar, which turns villi more bone-white compared to decidua. Weighing POC is unreliable in determining completion, as the amount of decidua is so variable.

Key point: If POC seems inadequate for gestational age, assume you are not finished.

- Check US, and reaspirate as indicated. Consider US guidance during re-aspiration.
- Draw serial βhCGs, and give ectopic precautions. Appropriately falling βhCGs are the most definitive finding of a complete abortion, and should be relied upon over US or pathology. A fall in the βhCG of around 50% within 24-48 hours suggests complete abortion.
- If free-floating villi are seen without any membranes present, the abortion is likely incomplete. You could have aspirated villi without disrupting the pregnancy (analogous to chorionic villus sampling).
- If you send the specimen to pathology, request a STAT evaluation (and phone report if available). A report identifying only “villi” still requires further confirmation of complete abortion. One study shows that provider examination of POC helps reduce the risk of failed abortion, and while pathology evaluation can be helpful, routine pathology confers no incremental clinical benefit, and adds extra cost. (Paul 2002)

3. You are performing an abortion on a nulliparous 16-year old at seven weeks gestation. You notice that her cervix is very small and it is hard to pick a site for the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reapply the tenaculum at a slightly different site, although it is difficult because the cervix is so small. This time the cervix tears after inserting the third dilator, and this time there is substantial bleeding. (Adapted from Surgical Abortion Education Curriculum, Planned Parenthood of New York City, Inc., September 1996)
What do you do?

These tears are fairly common, especially in small cervixes often seen in nulliparous women. They rarely require sutures. You can try the following:

- In a small cervix, inject anesthetic or saline into the cervix to make it larger before applying (or reapplying the tenaculum).
- Some providers argue that applying the tenaculum vertically may provide a better bite with greater purchase, but that may vary with the cervix.
- Try an atraumatic (Beier) or a second tenaculum on the other lip of the cervix to give you a broader base of support, and then re-attempt dilation.
- To stop the bleeding, apply pressure to the cervix. Options for hemostasis include clamping the cervix with ring forceps for a couple of minutes, injecting dilute vasopressin into the cervix (usually 4-6 units in 5-10 cc saline), applying Monsel’s solution or silver nitrate, or as a last resort, using absorbable sutures.
- If you are unable to complete the dilation, you can consider cervical ripening with misoprostol for 1-3 hours, Lamicel (fast-acting synthetic osmotic dilator), or standard overnight laminaria before re-attempting the procedure.
- You can also delay the procedure for a week or two to allow for more cervical ripening or offer the patient medication abortion.

4. You are inserting the cannula for a procedure on a woman at 9 weeks gestation with a retroflexed uterus. Although the dilation was easy, you are having some problems inserting the cannula, and then suddenly you feel a popping sensation and the cannula slides in quickly, without hitting any fundal walls. (Adapted from Surgical Abortion Education Curriculum, PPNYC 1996)

What happened?

A probable uterine perforation.

What should you do now?

1. Remove the cannula. Evaluate her for pain, vital signs, bleeding.
2. If she is stable, check an ultrasound to see if any part of the pregnancy is outside the uterus, or abdominal contents are in the uterus.
3. If the uterine cavity can be re-identified, it is permissible to finish the procedure under ultrasound guidance.
4. Look at the aspirate for any evidence of intra-abdominal contents such as omental fat. If seen, send the aspirate to pathology and refer the patient for immediate evaluation and possible surgery.
5. If the patient remains asymptomatic for pain or bleeding, consider observation for at least two hours, give her 7 days of antibiotics (with broad spectrum anaerobic coverage like Flagyl or Augmentin), and give her precautions before discharge.
6. Consider uterotonic if bleeding is significant: Choices include methergine IM or intracervically, dilute vasopressin intracervically, misoprostol rectally, buccally, or sublingually, or oxytocin IM or IV.
7. If the patient becomes hemodynamically unstable, place one or two IVs (large bore if available) to be used for IVF or medications.
8. Hospitalization overnight may also be appropriate management, but is definitely indicated if the patient is hemodynamically unstable, in significant pain, or if there is...
evidence of a large perforation, laceration, expanding hematoma, fetal parts in the abdomen, or viscera in the uterus or aspirate.

How might you have anticipated, and prevented this problem?

- Generally use gentle steady pressure during dilation, which you are ready to relinquish as you move beyond resistance of the cervix.
- Don’t ever hesitate to re-check your pelvic exam or use ultrasound guidance, if available.
- Use more traction on the tenaculum to help straighten the flexion of the uterus. Consider placing the tenaculum on the posterior lip of the cervix for a retro-flexed uterus to help straighten the angle.
- Consider using an os finder or flexible uterine sound if you encounter unusual resistance during dilation, a dry or tearing sensation, or a tortuous cervical path. This may help you find the path with less risk of perforation.
- Also consider a curved cannula to maneuver the angle better.
- Cervical ripening with misoprostol might also be helpful.
6. FOLLOW-UP CARE & MANAGING PROBLEMS

Knowing how to provide routine follow up care and manage complications or problems following abortion is essential. The trainee must become competent in managing such situations as reaction to medications, hyperventilation, no tissue or insufficient tissue obtained, ruling out an ectopic pregnancy, uterine perforations or cervical lacerations, post-op infection, prolonged bleeding and continuing pregnancy.

CHAPTER LEARNING OBJECTIVES
Following completion of this chapter, you should be better able to:

- Describe contraceptive options and contraindications to specific methods
- Know strategies to prevent abortion complications, as well as how to identify and appropriately manage them
- Provide post-procedure counseling and patient education
- Appropriately prescribe post-procedure medications

READINGS

- Early Abortion Training Workbook: Chapter 6
- Supplemental Readings:
    - Chapter 14: Routine Aftercare and Contraception
    - Chapter 15: Abortion Complications: Prevention and Management
TIPS FOR SUCCESS

SKILL
There are many ways to keep abreast of new information and technologies in abortion and contraception care. Look for abortion-related articles in ob-gyn and family practice journals. Attend conferences sponsored by the National Abortion Federation (NAF) or the Association of Reproductive Health Professionals (ARHP) to meet colleagues and obtain up-to-date information. NAF’s websites www.prochoice.org and www.earlyoptions.org have current information and CME on medication abortion, and the Access Project website www.reproductiveaccess.org has useful information on office practice issues affecting abortion provision.

SAFETY
Pay close attention whenever a patient calls or comes in for a possible problem. Patients so rarely call or visit that when they do, you should assume that something really is wrong even if the symptoms the patient describes are minimal.

Arguably the two most important problems to avoid are continuing pregnancy and ectopic pregnancy. Doing a good evaluation of the products of conception (POC), not fooling yourself if uncertain of adequacy, paying attention to ongoing symptoms of pregnancy, and considering a low sensitivity urine pregnancy test at the follow-up visit (which should be negative at 2 weeks) are important steps you can take to avoid these complications.

ROLE
You can play an important role in empowering a patient to find a contraceptive method that really works for her, getting questions answered, and dispelling contraceptive myths. In addition, consider prescribing emergency contraception to your patients undergoing abortion. Evidence suggests patients are more likely to use emergency contraception if they already have it at home, and most payers will cover it along with a primary method at an abortion visit. Preliminary studies also suggest that quick start of hormonal contraception on the day of abortion increases adherence to the method.
SURVIVAL GUIDE FOR AVOIDING EARLY ABORTION COMPLICATIONS

- Do a careful pelvic exam for position. If you really can’t feel uterine features, use extra caution with dilation.

- Dilate gently, slowly, cautiously (allowing dilator to follow the path of the canal). Traction can help.

- Consider using a flexible plastic uterine os-finder or sound (not metal sound) in difficult dilations. Low threshold to stop and re-check position.

- Carefully review past medical history and allergies for contraindications and precautions.

- To avoid underestimating gestational age – review LMP, uterine size on exam, ultrasound as needed, and later - expected POC.

- No-Touch Technique and Prophylactic Antibiotics help prevent infection.

- Don’t hesitate to use intra- or post-operative ultrasound for challenging cases.

- No negative self-talk during challenging cases.

- **Avoiding ectopic and continued pregnancy:**
  - Thorough tissue exam is one of the most important steps affecting patient management. If any doubt of adequate tissue for EGA:
    - Consider ultrasound
    - Serial βhCGs (Should see a 50% drop in 24-72 hrs)
    - Give ectopic warnings as needed

- While a high sensitivity pregnancy test may be positive for 4-6 wks after abortion, a low sensitivity urine pregnancy test (threshold level around 2000) should be negative after 2 weeks. A positive low sensitivity test raises concerns about ongoing pregnancy, ectopic, retained products, and mole. Also watch for ongoing symptoms of pregnancy.

- Warning signs for your patient to call or return include heavy bleeding, excess pain, persistent fever, foul discharge, or ongoing symptoms of pregnancy.

- Have a low threshold to consult!

- Help your patients avoid another unplanned pregnancy by giving EC along with any contraceptive methods (better compliance if it’s already at home!).
CURRENT EVIDENCE BASED DEVELOPMENTS IN CONTRACEPTION

Simplified requirements prior to prescribing hormonal contraception
(Stewart 2001)
- Medical History to screen for contraindications to estrogen or progestin
- Blood pressure if prescribing estrogen
- Not required:
  - Pap test, pelvic, lung, heart, and breast exam
  - Hemoglobin and routine lab tests
  - STI risk assessment and testing; consider in women ≤ 25

Pap screening guidelines (2002 ACS, ACOG, USPSTF)
- Current pap not required prior to hormonal contraceptive or IUD initiation
- No pap needed until age 21 or 3 years after initiation of vaginal sex
- Everyone else: annually until 30, then if no abnormal in 5 years, every 2-3 years
- Women >65 (USPSTF) or 70 (ACS) with 3 normal and no abnormal pap tests within 10 years can stop having pap tests
- Women without a cervix, removed for benign reasons don’t need a pap test

Evidence for prescribing or dispensing a full year of hormonal contraception
- Office protocols should minimize barriers for initial appointments and refills
- Dispensing a year’s supply of contraception is associated with higher method continuation and lower costs than dispensing fewer cycles per visit.

Quick Start
- Rationale: 25% don’t start prescribed method with 1st Sunday start due to confusion about how to start, change in motivation, and difficulty obtaining.
- Initiating Quick Start:
  - Confirm pregnancy test is negative
  - Start hormonal method on day of appointment at any time of the month
  - If unprotected sex within 5 days, give EC; start hormonal method within 24 hours
  - Back-up method for 7 days if Quick Start after cycle day 5
  - Repeat pregnancy test if no withdrawal bleed
- Impact:
  - Improved compliance over conventional start
  - No increase in abnormal bleeding
  - No teratogenic effect of hormonal contraceptives

Evidence based expansion of IUD patient profile and new FDA Paragard labeling
- Nulliparous women and women <25—WHO Category 2
- No association of IUD with increased risk of infertility
- No restriction for past history of PID, STIs, or ectopic pregnancy
- No restriction for women with HIV or AIDS (stable on ARVs)—WHO Category 2
- Consider LNG-IUS for non-contraceptive uses to treat dysmenorrhea and menorrhagia from:
  - Dysfunctional uterine bleeding, endometriosis, fibroids
Evidence supports the increasing use of extended contraception

- Extended contraception is safe, acceptable, and as efficacious as monthly cyclic regimens (Edelman 2006, Nelson 2007)
- Most regimens result in fewer scheduled bleeding episodes and fewer menstrual symptoms, particularly headache (Edelman 2006)
- Seasonale, Seasonique, Lybrel, Mono-phasic COCs, Nuvaring, may be used. The Patch is not yet recommended due to concern over increased levels of estrogen (see chart for further detail).

Emergency contraception now available over-the-counter for anyone ≥18

- Evidence shows advanced prescription increases use
- Comprehensive resource available at http://ec.princeton.edu

Use the WHO Medical Eligibility Criteria for Initiating Contraceptive Methods

- To determine appropriate method for women based on medical history
### WHO MEDICAL ELIGIBILITY FOR INITIATING CONTRACEPTIVE METHODS
Adapted from: Reproductive Health Access Project.
http://www.reproductiveaccess.org/contraception/WHO_chart.htm

<table>
<thead>
<tr>
<th>Condition</th>
<th>Qualifier for condition</th>
<th>Estrogen/ progestin: pill, patch, ring</th>
<th>Progestin-only: pill</th>
<th>Progestin-only: injection</th>
<th>Progestin-only: implant</th>
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*These contraceptive methods do not protect against sexually transmitted infections (STIs). Condoms should be used to protect against STIs.

For more information, see www.who.int/reproductive-health/publications/mec/mec.pdf

[www.reproductiveaccess.org](http://www.reproductiveaccess.org)
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<td>4 3 3 3 3</td>
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<tr>
<td>Tumors–malignant</td>
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<td>4 3 3 3 3</td>
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<tr>
<td>Viral hepatitis–carrier</td>
<td></td>
<td>1 1 1 1 1</td>
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<tr>
<td>Viral hepatitis–active</td>
<td></td>
<td>4 3 3 3 3</td>
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<tr>
<td>Obesity</td>
<td>BMI &gt; 30 kg/meter squared</td>
<td>2 1 1 1 1</td>
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<tr>
<td>Ovarian cancer</td>
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<tr>
<td>Ovarian cysts &amp; benign tumors</td>
<td></td>
<td>1 1 1 1 1</td>
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<tr>
<td>Pelvic inflammatory disease</td>
<td>Past, with subsequent pregnancy</td>
<td>1 1 1 1 1</td>
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<tr>
<td></td>
<td>Past, without subsequent pregnancy</td>
<td>1 1 1 1 2 2</td>
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<tr>
<td></td>
<td>Current</td>
<td>1 1 1 1 4 4</td>
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<tr>
<td>Postpartum, not breastfeeding</td>
<td></td>
<td>3 1 1 1 3 2</td>
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<tr>
<td></td>
<td>&lt; 48 hours</td>
<td>3 1 1 1 3 2</td>
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<tr>
<td></td>
<td>2–21 days</td>
<td>3 1 1 1 3 2</td>
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<td>3–4 weeks</td>
<td>1 1 1 1 3 3</td>
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<tr>
<td></td>
<td>&gt; 4 weeks</td>
<td>1 1 1 1 1 1</td>
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<tr>
<td>Postpartum, breastfeeding</td>
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<td>4 3 3 3 3</td>
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<tr>
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<td>&lt; 6 weeks postpartum</td>
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<td></td>
<td>6 weeks – 6 months postpartum</td>
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<td>&gt; 6 months postpartum</td>
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<tr>
<td>Post-abortion</td>
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<tr>
<td></td>
<td>First trimester</td>
<td>1 1 1 1 1</td>
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<tr>
<td></td>
<td>Second trimester</td>
<td>1 1 1 1 2 2</td>
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<tr>
<td></td>
<td>Immediately after septic abortion</td>
<td>1 1 1 1 4 4</td>
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<tr>
<td>Sexually Transmitted Infections</td>
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<tr>
<td></td>
<td>Yaginitis</td>
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<tr>
<td></td>
<td>High risk</td>
<td>1 1 1 1 3 3</td>
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<tr>
<td></td>
<td>Current GC/Chlamydia/</td>
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<tr>
<td></td>
<td>Puntent cervicitis</td>
<td>1 1 1 1 4 4</td>
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<tr>
<td>Smoking</td>
<td>Age &lt; 35</td>
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<tr>
<td></td>
<td>Age &gt; 35, &lt; 15 cigarettes/day</td>
<td>3 1 1 1 1</td>
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<tr>
<td></td>
<td>Age &gt; 35, &gt; 15 cigarettes/day</td>
<td>3 1 1 1 1</td>
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<tr>
<td>Seizure disorder</td>
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<tr>
<td>Stroke</td>
<td></td>
<td>1 1 1 1 1</td>
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<tr>
<td>Surgery</td>
<td>Minor, without prolonged immobilization</td>
<td>1 1 1 1 1</td>
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<tr>
<td></td>
<td>Major, without prolonged immobilization</td>
<td>2 1 1 1 1</td>
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<td></td>
<td>Major, with prolonged immobilization</td>
<td>4 2 2 2 2</td>
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<tr>
<td>Thyroid disorders</td>
<td>Simple goiter, hyperthyroidism, hypothyroidism</td>
<td>1 1 1 1 1</td>
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<tr>
<td>Uterine fibroids</td>
<td>Without distortion of uterine cavity</td>
<td>1 1 1 1 1</td>
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<tr>
<td></td>
<td>With distortion of uterine cavity</td>
<td>1 1 1 1 4 4</td>
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<tr>
<td>Valvular heart disease</td>
<td>Uncomplicated</td>
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<tr>
<td></td>
<td>Complicated</td>
<td>4 1 1 1 2 2</td>
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<tr>
<td>Venous veins</td>
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<td>1 1 1 1 1</td>
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<tr>
<td>Venous thrombosis</td>
<td>Family history (sister-degree relatives)</td>
<td>2 1 1 1 1</td>
<td></td>
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<tr>
<td></td>
<td>Superficial thrombophlebitis</td>
<td>2 1 1 1 1</td>
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<tr>
<td></td>
<td>Post DVT</td>
<td>4 2 2 2 2</td>
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<tr>
<td></td>
<td>Current DVT</td>
<td>4 3 3 3 3</td>
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</table>

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## CONTRACEPTIVE OPTIONS


<table>
<thead>
<tr>
<th>Method</th>
<th>Failure Rate*</th>
<th>Advantages</th>
<th>Possible Disadvantages</th>
<th>Patient Counseling Tips and Times to Remember</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td></td>
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</tr>
</tbody>
</table>
| 1. Vasectomy (male) | 1. 0.15%  
2. 0.50% | - Permanent protection against pregnancy  
- No lasting side effects  
- No effect on sexual pleasure  
- Permits spontaneous sexual activity  
- Protects women whose health would be seriously threatened by pregnancy  
- Varying techniques:  
  1. Scalpel vs. no-scalpel vasectomy  
  2. Laparoscopic, abdominal, hysteroscopic trans-vaginal (Essure) | - Risks of minor surgery  
- Possible later regret, not easily reversible  
- Consider offering other non-surgical long term methods  
- Rarely, tubes reopen, allowing pregnancy to occur | - Sterilization may be performed at any time  
- Nothing to remember |
| 2. Tubal sterilization (female) |  | | | |
| | 0.05% | - Effective up to 3 years  
- Acceptable for use in breastfeeding women  
- Can be used by women unable to tolerate estrogens  
- May have light menses or amenorrhea  
- Decreased dysmenorrhea  
- Decreased risk of endometrial and ovarian cancer  
- Lessens mood variability, headaches, breast tenderness, and nausea  
- Cost effective  
- Rapid return to fertility after discontinuing method | - Irregular menstrual patterns that rarely become predictable  
- May have amenorrhea, weight gain, hair changes, depression, skin rash, change in sex drive | |
| Progestin-only single rod implant: (Implanon) | 0.2% | - Effective up to 5-7 years  
- Reduces menstrual bleeding 70-80% and less dysmenorrhea  
- Amenorrhea in 20% at 1 year; 60% at 5 years  
- Decreased ectopic risk  
- PID risk reduction  
- Cost-effective  
- Rapid return to fertility after discontinuing method | - Metrorrhagia increased in first few months  
- Amenorrhea  
- Increased risk of pelvic infection in first 20 days after insertion (then risk decreased from baseline in several studies)  
- May not be used for emergency contraception after unprotected sex (see ParaGard)  
- Rare perforation or expulsion | - Must be inserted by a clinician  
- May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting >5 days after cycle began)  
- Nothing to remember |
| IUD: LNG-IUS (Mirena) | 0.8% | - Effective up to 10-12 years  
- Non-hormonal  
- Decreased ectopic risk  
- May be used for emergency contraception 5-8 days after unprotected sex  
- Cost-effective  
- Rapid return to fertility after discontinuing method | - May cause metrorrhagia, dysmenorrhea, and amenorrhea in first few months  
- Increased risk of pelvic infection in first 20 days after insertion (then risk returns to baseline)  
- Rare perforation or expulsion | - Must be inserted by a clinician  
- Begin any day of cycle, day of abortion, or at follow-up visit  
- Remember string check monthly |
| IUD: Cu-T380a (ParaGard) | 3.0% | - Effective for 12 weeks  
- Acceptable for use in breastfeeding women or adolescents  
- May have light menses or amenorrhea  
- Decreased dysmenorrhea  
- May be used by women unable to tolerate estrogens  
- Decreased risk of endometrial and ovarian cancer  
- Lessens mood variability, headaches, breast tenderness, and nausea  
- Spotting or amenorrhea  
- May cause suppressed fertility as ovulation may be delayed for up to 9-10 months after last shot  
- May cause weight gain or loss, hair changes, depression, skin rash, change in sex drive  
- Side effects may extend for up to 6 months after discontinuing method | | - Must be administered by a clinician  
- May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting >5 days after cycle began)  
- Remember shot every three months |

*Percentage of women experiencing an unintended pregnancy within the first year of typical use
<table>
<thead>
<tr>
<th>Method</th>
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<th>Possible Disadvantages</th>
<th>Patient Counseling Tips and Times to Remember</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Vaginal Ring (NuvaRing)</td>
<td>8.0%</td>
<td>- Effective for 1 month &lt;br&gt; - No daily pill &lt;br&gt; - Acceptable for use in adolescents &lt;br&gt; - Non-contraceptive advantages similar to COC &lt;br&gt; - Acceptable for use in adolescents &lt;br&gt; - Decreased risk of endometrial and ovarian cancer &lt;br&gt; - Does not require a fitting by a clinician &lt;br&gt; - Does not require the use of spermicide &lt;br&gt; - Permits spontaneous sexual activity &lt;br&gt; - Decreased risk of endometrial and ovarian cancer &lt;br&gt; - Rapid return to fertility after discontinuing method</td>
<td>- May have increased vaginal discharge, irritation, or infection &lt;br&gt; - Cannot use with a diaphragm or cervical cap as a backup method (condoms advised) &lt;br&gt; - Temporary irregular menses &lt;br&gt; - May cause spotting, weight gain or loss, breast tenderness, headache, dizziness, nausea, or changes in mood &lt;br&gt; - Rare but adverse health risks, including blood clots, heart attack, or stroke—increased risk for smokers &gt;35</td>
<td>- A new ring is inserted into the vagina for 3 weeks, followed by a ring-free week &lt;br&gt; - May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting &gt;5 days after cycle began) &lt;br&gt; - Remember once monthly (some women may check ring after vaginal sex)</td>
</tr>
<tr>
<td>Patch (Ortho Evra)</td>
<td>8.0%</td>
<td>- Effective for 1 month if changed weekly as directed &lt;br&gt; - No daily pill &lt;br&gt; - Non-contraceptive advantages similar to COC &lt;br&gt; - Acceptable for use in adolescents &lt;br&gt; - Permits spontaneous sexual activity &lt;br&gt; - Non-contraceptive advantages similar to COC &lt;br&gt; - Decreased risk of endometrial and ovarian cancer &lt;br&gt; - Rapid return to fertility after discontinuing method</td>
<td>- New Warning: Wearers may be exposed to 60% more estrogen compared to a typical OCP containing 35 mcg of estrogen which may increase risk of serious side effects &lt;br&gt; - May not be as effective for women who weigh &gt;198 pounds &lt;br&gt; - Temporary irregular menses &lt;br&gt; - Skin reaction at the site of application &lt;br&gt; - May cause spotting, weight gain or loss, breast tenderness, headache, dizziness, nausea, or changes in mood &lt;br&gt; - Rare but adverse health risks, including blood clots, heart attack, or stroke—increased risk for smokers &gt;35</td>
<td>- A new patch is worn each week for three weeks, followed by a patch-free week &lt;br&gt; - May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting &gt;5 days after cycle began) &lt;br&gt; - Remember to change weekly</td>
</tr>
<tr>
<td>Combined Oral Contraception</td>
<td>8.0%</td>
<td>- Predictable shorter periods &lt;br&gt; - Decreased menstrual flow and dysmenorrhea &lt;br&gt; - Stable hemoglobin in iron deficiency anemia &lt;br&gt; - Lessens premenstrual symptoms, menstrual migraines, dysmenorrhea in endometriosis, and menopausal symptoms &lt;br&gt; - Reduces risk of ovarian and endometrial cancers, PID, non-cancerous growths of the breasts, ovarian cysts, osteoporosis &lt;br&gt; - Decreased ectopic risk &lt;br&gt; - Improves acne &lt;br&gt; - Minimal weight gain or loss &lt;br&gt; - Rapid return to fertility after discontinuing method</td>
<td>- Pill must be taken daily &lt;br&gt; - Temporary irregular menses &lt;br&gt; - Skin reaction at the site of application &lt;br&gt; - May cause spotting, weight gain or loss, breast tenderness, headache, dizziness, nausea, fatique or changes in mood &lt;br&gt; - Rare but adverse health risks, including blood clots, heart attack, or stroke—increased risk for smokers &gt;35</td>
<td>- May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting &gt;5 days after cycle began) &lt;br&gt; - Remember daily pill 28 to 31 times a month</td>
</tr>
<tr>
<td>Progestin Only Oral Contraception</td>
<td>8.0%</td>
<td>- Acceptable for use in breastfeeding women &lt;br&gt; - Can be used by women unable to tolerate estrogens &lt;br&gt; - Decreased menstrual flow and dysmenorrhea &lt;br&gt; - Decreased risk of endometrial and ovarian cancer &lt;br&gt; - Stable hemoglobin in iron deficiency anemia &lt;br&gt; - Lessens mood swings &lt;br&gt; - Minimal weight gain or loss &lt;br&gt; - Rapid return to fertility after discontinuing method</td>
<td>- Pill must be taken at same time each day to reduce risk of pregnancy and spotting &lt;br&gt; - Irregular menses or amenorrhea &lt;br&gt; - May cause spotting, weight gain or loss, breast tenderness, headache, dizziness, nausea, abdominal pain, or fatigue</td>
<td>- May begin day of abortion, at follow-up visit or any day of cycle (use backup for 7 days if starting &gt;5 days after cycle began) &lt;br&gt; - Remember daily pill 28 to 31 times a month</td>
</tr>
<tr>
<td>BARRIER METHODS: Less effective but help protect against STIs (degree of protection varies by method)</td>
<td></td>
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<tr>
<td>Male Condom</td>
<td>15.0%</td>
<td>- Easy to buy over the counter (non-prescription) &lt;br&gt; - Helps protect against many STIs, including HIV &lt;br&gt; - Can be put on as part of foreplay &lt;br&gt; - May help relieve early ejaculation</td>
<td>- Latex allergies: polyurethane available but may be less effective &lt;br&gt; - May irritate skin &lt;br&gt; - May diminish penile sensations &lt;br&gt; - Can break or slip off during sex</td>
<td>- Requires consistent use and partner cooperation &lt;br&gt; - Remember every time you have sex</td>
</tr>
</tbody>
</table>

*Percentage of women experiencing an unintended pregnancy within the first year of typical use
<table>
<thead>
<tr>
<th>Method</th>
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<th>Possible Disadvantages</th>
<th>Patient Counseling Tips and Times to Remember</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Condom (Reality)</td>
<td>21.0%</td>
<td>• Easy to buy over the counter (non-prescription)</td>
<td>• May be noisy</td>
<td>• Requires consistent use and partner cooperation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helps protect against many STIs, including HIV</td>
<td>• May be hard to insert</td>
<td>• Remember every time you have sex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be put in as part of sex play</td>
<td>• May irritate skin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May help relieve early ejaculation</td>
<td>• May slip out of place during sex</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>16.0%</td>
<td>• Can last several years</td>
<td>• Allergies to latex or spermicide</td>
<td>• Must be fitted by a clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Costs very little to use</td>
<td>• Should not be used during vaginal bleeding or infection</td>
<td>• Must be properly inserted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be left in place for 24 hours</td>
<td>• Increases risk of bladder infection</td>
<td>• Must be used with spermicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not effective protection against STIs/HIV, condoms recommended to reduce risk</td>
<td>• Remember every time you have sex</td>
</tr>
<tr>
<td>Cervical Cap (Leah’s shield &amp; Femcap)</td>
<td>1. 40.0% 2. 20.0%</td>
<td>• Can last several years</td>
<td>• Allergies to latex or spermicide</td>
<td>• Must be fitted by a clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Costs very little to use</td>
<td>• Should not be used during vaginal bleeding or infection</td>
<td>• Must be properly inserted</td>
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<tr>
<td></td>
<td></td>
<td>• Can be left in place for 48 hours</td>
<td>• Efficacy decreases significantly in parous users as compared to nulliparas</td>
<td>• Must be used with spermicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not effective protection against STIs/HIV, condoms recommended to reduce risk</td>
<td>• Remember every time you have sex</td>
</tr>
<tr>
<td>Emergency Contraception (Plan B)</td>
<td>At least 11% in 72 hrs to 25% in 120 hours</td>
<td>• Lowers risk of pregnancy if taken within 72 hours, more effective sooner taken (data supports up to 120 hours) after unprotected sex or contraceptive error: including missed pills, condom break, misplaced cervical cap or diaphragm</td>
<td>• May cause nausea, vomiting, change in next menstrual cycle, breast tenderness, headache, dizziness, abdominal pain, or fatigue</td>
<td>• Take 2 doses at same time (Plan B), or 12 hours apart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Available over the counter to anyone ≥18</td>
<td>• Expensive for some women</td>
<td>• Remember to take as soon as possible after unprotected sex (up to 120 hours)</td>
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<tr>
<td></td>
<td></td>
<td>• Fewer side effects than daily COC</td>
<td>• Requires prescription for women ≤17</td>
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<td></td>
<td>• Non-teratogenic if already pregnant</td>
<td>• Remember every time you have sex</td>
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<td></td>
<td>• May be purchased by males</td>
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<td></td>
<td>• Standard of care following sexual assault</td>
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<td>• State insurances may cover prescription cost</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Rapid return to fertility after discontinuing method</td>
<td></td>
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</tr>
<tr>
<td>Spermicides (Nonoxynol-9)</td>
<td>29.0%</td>
<td>• Easy to buy over the counter (non-prescription)</td>
<td>• May irritate vagina or penis</td>
<td>• Should begin immediately post-abortion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be put in as part of sex play</td>
<td>• Can be messy</td>
<td>• Nothing to remember until sex resumes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comes in many forms: cream, gel, foam and inserts</td>
<td>• Using Nonoxynol-9 many times a day may increase risk of HIV infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Should never be used for anal sex</td>
<td></td>
</tr>
<tr>
<td>Periodic Abstinence</td>
<td>25.0%</td>
<td>• Eliminates pregnancy risk</td>
<td>• Many people find it difficult to abstain from sex for long periods of time</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No medical or hormonal side effects</td>
<td>• Many people fail to use protection when abstinence ends</td>
<td></td>
</tr>
<tr>
<td>Continuous Breastfeeding</td>
<td>6.0%</td>
<td>• No medical or hormonal side effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactational Amenorrhea</td>
<td></td>
<td>• For infants: best nutrition, decreases the likelihood of infections, allergies, and possibly asthma</td>
<td>• May be difficult to exclusively breast-feed</td>
<td>• Remember backup or new contraception: 1) as soon as menstruation resumes resumes, 2) frequency of breastfeeds is reduced or discontinued, or 3) 6 months post delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increases mother and child bonding</td>
<td>• Not an effective post-abortion method</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires no supplies or medical supervision</td>
<td>• Only effective for six months post delivery</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>27.0%</td>
<td>• Can be used in conjunction with consistent condom use for nearly 100% effectiveness</td>
<td>• Requires a trusted male partner with significant self-control, previous withdrawal experience</td>
<td>• Remember every time you have sex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be used if no other method is available or desirable, but not recommended</td>
<td>• Not for men with premature ejaculation</td>
<td></td>
</tr>
</tbody>
</table>

*Percentage of women experiencing an unintended pregnancy within the first year of typical use
REFERENCES


EXERCISES: FOLLOW-UP CARE & MANAGING PROBLEMS

EXERCISE 6.1

Purpose: To review routine follow-up procedures after vacuum aspiration abortion. Please answer the following questions.

1. List key criteria that should be met before a patient is discharged home after early vacuum aspiration abortion.

2. Intermittent cramping is normal in the days following aspiration abortion. What advice would you give your patients for managing post-procedure pain?

3. A patient has had nausea and vomiting throughout her pregnancy. She wants to know how long it will take to feel better after the abortion. What would you tell her?

4. Providers typically advise patients to call the office if they have certain “warning signs” following aspiration abortion. What “warning signs” would you include and why?

5. After an early vacuum aspiration abortion, how long would you advise your patient to wait before resuming the following activities? What is the rationale for your recommendations?

   a. Taking tub baths or swimming
   b. Douching
   c. Resuming vaginal intercourse
   d. Returning to work at a manual job where heavy lifting is required
6. How soon would you initiate the following methods of contraception after first trimester vacuum aspiration?
   a. Combined oral contraceptives or patch
   b. Vaginal ring
   c. Depo Provera
   d. Insertion of IUD or IUS

7. What would you recommend to the following patients in regards to their desire for contraception.
   a. A 36-year old smoker with moderate obesity who wants the patch.
   b. A 19-year old who intends to use abstinence.
   c. A 29-year old with migraine headaches with aura who wants the pill.
   d. A 20-year old nulliparous woman with a history of Chlamydia at age 15, currently in a monogamous relationship who wants an IUD.
   e. A 31-year old who takes anti-seizure medications who wants the pill.

EXERCISE 6.2

Purpose: To understand recent evidence based contraceptive developments and use.

1. Your patient presents in your office with another complaint but is at risk for unintended pregnancy and desires hormonal contraception. Your schedule does not permit a well-woman exam. What components of the history, physical, and lab are required prior to initiating hormonal contraception today?

2. A 24 year old woman on combined oral contraceptives complains of PMS, menstrual migraines, and bloating during her withdrawal bleed. a. Please describe extended contraception, and how it is used. b. Who are candidates for extended contraception?

3. We used to tell woman to initiate their hormonal contraception on the Sunday after their period but up to 25% forget or never initiate contraception. When can woman initiate contraception now, and how many months should you prescribe at a time?
EXERCISE 6.3

**Purpose:** To practice managing problems and complications that may occur during or after early aspiration abortion. Please review the following case scenarios and answer the questions.

1. The nurse consults with you about a possible problem telephone call. The patient has told the nurse that she had an abortion at the clinic three weeks ago. Bleeding began on the day of the abortion, and has continued throughout the interval since. It is not heavy, totaling one pad or less daily, and she has not passed any large clots or tissue. Cramping has been mild to moderate; she has used ibuprofen once or twice daily. She is afebrile.

   Question: What would you advise for this patient?

2. Ashley, a 21-year-old female, arrives at your office. She had an abortion two weeks ago at another facility, and still has some symptoms of pregnancy. A home pregnancy test this morning was positive. She is concerned that she is still pregnant. (Adapted from: AMWA Reproductive Health Curriculum)

   Current symptoms are breast tenderness and bloating in her abdomen. Medications: birth control pill. She has had intercourse regularly for the past six days.

   Vital signs normal; afebrile. Pelvic exam normal except slight amount of bright red blood in vault, uterus 8 week size. High sensitivity pregnancy test is positive.

   What is the differential diagnosis?

   How can you rule in or out any of your diagnoses?

   If the patient is found not to be pregnant, how can you explain the following clinical findings?

   a. positive urine pregnancy test

   b. breast tenderness
EXERCISE 6.1

1. **List key criteria that should be met before a patient is discharged home after early vacuum aspiration abortion.**

   - You have reviewed the POC and determined that the **procedure is complete**.
   - If uncertain, you can check an ultrasound if available, in addition to serial serial βhCGs and give ectopic precautions.
   - Severe cramping has subsided and the client is **comfortable**. Her **vital signs** are stable, and she has no excessive **bleeding**.
   - If sedative medications were used, the client is now **alert and oriented**, able to protect her airway, maintains a room air O₂ saturation over 95% (after IV meds), and has plans to get home without driving.
   - **Self care instructions have been reviewed** (including contraceptive plans, EC and any other medications). Consider offering EC-to-go to each patient.
   - Patient knows how to call after hours if questions or concerns arise, and she has a follow-up appointment.
   - **She feels ready to go home.**

2. **Intermittent cramping is normal in the days following aspiration abortion.** What advice would you give your patient for managing post-procedure pain?

   - **Heating pads** are useful.
   - **Pain medications** may be helpful:
     - **NSAIDs** (such as Ibuprofen 600 mg QID or 800 mg TID);
     - Add acetaminophen if needed.
     - Narcotic pain medications may be appropriate for some women.
   - Most women are able to return to **normal activity by the next day**. She can rest as needed, and advance her activity as tolerated.
   - Have her **call you** if she develops excessive pain, heavy bleeding, or sustained fever.

3. **A patient has had nausea and vomiting throughout her pregnancy. She wants to know how long it will take to feel better after the abortion. What would you tell her?**

   **Key point:** Nausea generally subsides within 24 hours for most women. Women are relieved to hear that nausea is one of the earliest pregnancy symptoms to subside after an abortion. If the patient has persistent nausea and vomiting beyond a week, have her contact you to rule out retained products or ongoing pregnancy. Breast tenderness often lasts 1-2 weeks, and may also be influenced by combined hormonal contraceptives.

*Early Abortion Training Workbook*
4. *Providers typically advise patients to call the office if they have certain “warning signs” following aspiration abortion. What “warning signs” would you include, and why?*

- **Persistent severe pain** or cramping (may indicate hematometra, infection, uterine trauma, or ectopic). Peritoneal signs (pain with cough, palpation, or sudden movement) may suggest perforation or infection and warrant reevaluation. Severe pelvic/rectal pain with little or no bleeding suggests post-abortal syndrome or hematometra.
- **Moderate to heavy bleeding** (saturating > 2 pads per hour for > 2 hours) or orthostatic symptoms suggest the need for intervention.
- **Sustained fever** (greater than 100.4° F.) raises concern about pelvic infection.

5. *After an early vacuum aspiration abortion, how long would you advise your patient to wait before resuming the following activities? What is the rationale for your recommendations?*

a. **Taking tub baths or swimming**
   Tub baths and swimming are typically prohibited, but there is no data indicating associated problems. Minimal, if any, water flows into the vagina during a bath or even swimming.

b. **Douching**
   **Key Point**: A variety of adverse reproductive outcomes have been associated with douching, including bacterial vaginosis, PID, preterm birth, low-birth-weight, ectopic pregnancy, and decreased fertility (Cottrell 2003, Martino 2002, Ness 2001). There is no study specifically looking at women post-abortion.

   Bacterial vaginosis is associated with douching (Holtzman 2001, Ness 2002, Royce 2001). Many types of antiseptic douches decrease the presence of normal vaginal flora, like protective lactobacilli, thus theoretically increasing the risk of bacterial vaginosis which is associated with preterm labor, premature rupture of membranes, and low birth weight infants. Some meta-analyses have found a strong association between PID and douching (Martino 2002), although some evidence is conflicting (Rothman, Ness). Since douching is a common practice among women and has been associated with harmful reproductive health outcomes with no clear benefit, it should be discouraged in all women.

c. **Resuming vaginal intercourse**
   Providers typically advise against vaginal intercourse for 1-2 weeks, or as long as the patient is bleeding. Many patients ignore this advice without a demonstrated ill effect. There are no data to suggest increased infection after intercourse. As another pregnancy can occur prior to the next menses, a plan for contraception should be initiated at the time of abortion.

d. **Heavy work or exercise**
   Women may return to their normal activity when they feel ready, typically within 1-2 days of an abortion. Providers empirically discourage strenuous exercise for the first week or two, to prevent exacerbation of bleeding or cramping, although there is little evidence to supporting specific recommendations. Probably the
best advice is for women to “listen to their bodies” and decrease any activity that exacerbates bleeding or cramping.

6. How soon would you initiate the following methods of contraception after first trimester vacuum aspiration?

a. Combined oral contraceptives or patch
A woman can start the day of the abortion, or within 5 days after. A Sunday start has historically been used to have menses fall during the week rather than the weekend.

Studies looking at “Quick Start” observed initiation of hormonal contraception in clinic show increased continuation rates, and no increased break-through bleeding or spotting (Westhoff 2002, 2003). In the non-abortion setting, a negative high-sensitivity pregnancy test and a back-up method for the first week are suggested.

b. Vaginal ring
A woman can start the day of the abortion or within 5 days after. There is no evidence of increased post-abortal infection.

c. Depo Provera (DMPA)
Depo Provera can be given at the time of procedure or within 7 days after. It may be helpful to remind clients of the increased irregular bleeding and spotting that often occurs in the first few months after initiation, as this may decrease calls from concerned patients who confuse this with post-abortal bleeding. As menstrual changes associated with Depo-Provera are still the primary reasons given for discontinuation, it is useful to counsel women proactively about early irregular bleeding and common later amenorrhea, asking at each visit if they find menstrual changes to be acceptable (Hatcher 2004)

d. Insertion of IUD or IUS:
Either can be placed at the time of a first trimester abortion procedure. A recent meta-analysis showed that IUD insertion at the time of first trimester abortion was not associated with a statistically significant increase in rates of expulsion, perforation, PID or discontinuation (Grimes 2003).

7. What would you recommend to the following patients in regards to their desire for contraception?

WHO Classification of Categories for Medical Eligibility

1. A condition for which there is no restriction for the use of the contraceptive method.
2. A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
3. A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
4. A condition which represents an unacceptable health risk if the contraceptive is used.
a. A 36 year old smoker with moderate obesity who want the patch.

There are 2 issues to consider:
- Smokers who are ≥35 years old should not be prescribed estrogen-containing contraceptives because of an increased risk of stroke and M.I. (WHO category 3-4; see classification of categories below).
- The patch does not work as well in heavier women. In 3 studies looking at patch efficacy, 5 of 15 pregnancies occurred in women 198+ lbs (30% of failures in 3% of women).

This woman could safely use an IUD / IUS, progestin-only, or barrier method.

b. A 19 year old who intends to use abstinence.

It is common for women to feel they will never have sex again after an abortion. Help your patient consider if this is an ideal or reality for her, and offer contraception as appropriate. Consider reviewing some obstacles that may exist when women do decide to become sexually active again, such as delays to get an appointment, the need to use a back-up method for the first 7 days of most hormonal methods, and the possibility contraception may already be packaged in her charges for the abortion. If she is receptive to these ideas, you can advocate for her to have an available method at home that she can initiate at a later date. If she declines, offer condoms and emergency contraception. Readdress the issue at her follow-up appointment.

c. A 29 year old with migraine headaches with aura who wants the pill.

Women with the following conditions should not use estrogen-containing contraceptives because of an increased stroke risk:
- any age and migraine with aura or focal neurological symptoms (WHO category 4)
- ≥35 years old and migraine without aura (WHO category 3)

These women are best served with an IUD/IUS, progestin-only or barrier method.

Estrogen-containing contraceptives can be used for the following women, although consideration should be given if additional pro-thrombotic risks exist (e.g. smoking).
- any age and non-migraine headaches (WHO category 1).
- <35 years old and migraine WITHOUT aura (WHO category 2)

Women who have migraine with focal neurological symptoms have a higher risk of stroke than those without focal neurological symptoms. Among women with migraines, those who use COCs have a 2 to 4-fold increased risk of stroke compared with women who do not use COCs. Migraine with “focal neurological symptoms” is equivalent to migraine syndrome with aura (also known as classic migraine). The most common migraine syndrome with aura consists of one or more of the following:
- visual disturbances,
• scintillating scotoma,
• paresthesias (numbness and tingling),
• hemiparesis (weakness or partial paralysis in an extremity),
• dysphasia (slurred speech or inability to speak).

d. A 20 year old nulliparous woman with a history of Chlamydia at age 15, currently in a monogamous relationship who wants an IUD.

IUDs have been found to be safe for use in nulliparous women, and this has been incorporated into the new ParaGard package label consistent with evidence-based data. The WHO Medical Eligibility Criteria lists its use in this group of women as category 2, benefits likely outweigh risks. A systematic review found no significant effect of IUD use on infertility (Grimes 2000). Tubal infertility is linked to presence of antibodies to Chlamydia but not to a history of IUD use (Hubacher 2001). Although nulliparous women have a slightly increased risk of difficult insertion or IUD expulsion compared with gravid women, those desiring highly effective longer term contraception are excellent candidates for an IUD.

e. A 31 year old who takes anti-seizure medications who wants the pill.

Select anti-seizure medications, antibiotics, and anti-fungals activate the p450 enzyme system in the liver, resulting in faster metabolism of hormones. This can affect the efficacy of combination and progestin-only pills and levonorgestrel/etonogestrel implants, which are all WHO category 3 while taking these select medications (see table below). Keep in mind that some of these medications may also be used to treat certain psychiatric illnesses, headaches, chronic pain and other conditions.

IUD/IUS or DMPA are the best options for these women (categories 1 and 2 respectively).

<table>
<thead>
<tr>
<th>Drugs known to ↑ liver enzyme metabolism/↓ contraceptive effectiveness</th>
<th>Drugs with questionable effects</th>
<th>Drugs known not to effect liver enzyme metabolism or contraceptive effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine (Tegretol, Equetro, Carbetrol)</td>
<td>Troglitazone (Rezulin)</td>
<td>Lamotrigine (Lamictal)</td>
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<tr>
<td>Oxcarbazepine (Trileptal)</td>
<td>Felbamate (Felbatol)</td>
<td>Gabapentin (Neurontin)</td>
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<td>Phenobarbital</td>
<td>Lamotrigine</td>
<td>Tiagabine (Gabitril)</td>
</tr>
<tr>
<td>Phenytoin (Dilantin)</td>
<td>(Lamictal)</td>
<td>Levetiracetam (Keppra)</td>
</tr>
<tr>
<td>Primidone (Mysoline)</td>
<td></td>
<td>Valproic Acid (Depakote)</td>
</tr>
<tr>
<td>Topiramate (Topamax) mild ↓</td>
<td>Zonisamide (Zonegran)</td>
<td>Ethosuximide (Zarontin)</td>
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<td>Rifampin</td>
<td>Vigabatrin (Sabril)</td>
<td>Benzodiazepines</td>
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<td>Rifampicin</td>
<td>Fluconazole (anti-fungal)</td>
<td>INH (not in combination with Rifampin)</td>
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<td></td>
<td>Ketoconazole (anti-fungal)</td>
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<tr>
<td>Griseofulvin</td>
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</table>
EXERCISE 6.2

**Purpose:** To understand recent evidence based contraceptive developments and use.

4. Your patient presents in your office with another complaint but is at risk for unintended pregnancy and desires hormonal contraception. Your schedule does not permit a well-woman exam. What components of the history, physical, and lab are required prior to initiating hormonal contraception today?

   - A thorough history to screen for contraindications to estrogen or progestin is critical, and a blood pressure is helpful but not required.
   - Other exams such as breast, pelvic, pap test, and lab tests are not needed.

5. A 24 year old woman on combined oral contraceptives complains of PMS, menstrual migraines, and bloating during her withdrawal bleed. a) Please describe extended contraception, and how it is used. b) Who are candidates for extended contraception?

   - Extended contraception is safe, acceptable, and as efficacious as cyclic regimens. (Edelman 2006)
   - In addition to fewer scheduled bleeding episodes, extended contraception is associated fewer menstrual symptoms such as headache, tiredness, bloating and menstrual pain. (Edelman 2006)
   - It is important to point out that women usually experience more unscheduled spotting and bleeding in the initial cycles, but those problems decrease with longer use (Nelson 2007)
   - Various COCs (Seasonale, Seasonique, Librel, mono-phasic COCs) and Nuvaring may be also provided for extended use. Frequency of withdrawal bleeds can be determined by client and clinician and extra cycles may be needed to complete a given time period.
   - The patch (Ortho Evra) lacks evidence for continuous use, but with its increased estrogen absorption, it is not recommended at this time.

6. We used to tell woman to initiate their hormonal contraception on the Sunday after their period but up to 25% forget or never initiate contraception. When can woman initiate contraception now, and how many months should you prescribe at a time?

   - “Quick start” (Westhoff 2002, 2003)
     - Confirm pregnancy test is negative
     - Start hormonal method on day of appointment any time of the month
     - If unprotected sex within 5 days, give EC; start hormonal method within 24 hours
     - Back-up method for 7 days if Quick Start after cycle day 5
     - Repeat pregnancy test if no withdrawal bleed
Women who were allocated to “quick start” vaginal ring use, were more likely to be highly satisfied with this method and to continue its use compared to OC (Shafer 2007)

- Dispensing a year's supply of contraception is associated with higher method continuation and lower costs than dispensing fewer cycles per visit. (Foster 2006) If insurance plans limit the amount that can be dispensed, refills can minimize additional office visits.

**EXERCISE 6.3**

**Purpose:** To practice managing problems and complications that may occur during or after early aspiration abortion. Please review the following case scenarios and answer the questions.

1. The nurse consults with you about a possible problem telephone call. The patient has told the nurse that she had an abortion at the clinic three weeks ago. Bleeding began on the day of the abortion, and has continued throughout the interval since. It is not heavy, totaling one pad or less daily, and she has not passed any large clots or tissue. Cramping has been mild to moderate; she has used ibuprofen once or twice daily. She is afebrile.

**Question:** What would you advise for this patient?

- This is not an unusual amount of vaginal bleeding, although it may be continuing a bit longer than usual.
- Consider whether hormonal contraception is playing any role in the patient’s bleeding.
- Consider increasing Motrin to QID.
- Consider using Methergine to help pass any clots or debris.
- Uterine massage and a heating pad may help.
- If the bleeding becomes worse (with orthostatic symptoms, worsening pain, sustained fever or ongoing symptoms of pregnancy), have her return for evaluation for possible retained clot or products.

2. Ashley, a 21-year-old female, arrives at your office. She had an abortion two weeks ago at another facility, and still has some symptoms of pregnancy. A home pregnancy test this morning was positive. She is concerned that she is still pregnant. It has now been 10 weeks since her LMP.

**Information from clinic nurse:** Current symptoms are breast tenderness and bloating in her abdomen. Medications: birth control pill. She has had intercourse regularly for the past six days.

**Vital signs normal; afebrile. Pelvic exam normal except slight amount of bright red blood in vault, uterus 8 week size.**

**High sensitivity pregnancy test is positive.**

**What is the differential diagnosis?**
a. A completed abortion in a patient with hormonal contraceptive side effects
b. A failed abortion with an ongoing pregnancy
c. Retained POC
d. Ectopic pregnancy or heterotopic pregnancy with continuing ectopic
e. Mole or partial mole

How can you rule in or out any of your diagnoses?

a. Key point: If you are using low sensitivity pregnancy test (LSPT), it should be negative by 2 weeks post-abortion. If it is still positive, it should raise suspicion for b – e above. Home pregnancy tests are high sensitivity pregnancy tests (HSPT), which generally remain positive for 4 – 8 weeks after an abortion,
b. Serial quantitative βhCGs will tell you if the hormone is rising or falling, and at what rate. See the detailed discussion of βhCG patterns in Chapter 3.
c. Ultrasound may be helpful to identify an ongoing pregnancy, significant remaining debris, or an ectopic pregnancy. A negative US may not be conclusive if the quantitative βhCG is rising.
d. Exam may be helpful to evaluate uterine size, bogginess, or adnexal masses.
e. Re-aspiration may be helpful to determine uterine contents, POC, or pathologic changes.

- Key point: a positive HSPT is often positive for 4-8 weeks, as βhCG drops back to zero. The cut off for positive HSPT is 25 –50 IU.
- Breast tenderness could be from hormonal contraceptives.
- 8 week uterine size could be due to fibroids, retained products or debris, or inter-examiner variability.

What clinical findings would prove or disprove each of your diagnoses?

a. A patient with a completed abortion should have a negative LSPT or falling low βhCG (already below 2000 by two weeks post-abortion).
b. A failed abortion with an ongoing pregnancy would likely have a positive LSPT, with a rapidly increasing βhCG (doubling approximately every 2 days), and evidence of an IUP on ultrasound.
c. In this setting, an ultrasound showing intrauterine heterogeneous debris is suggestive of retained POC. Uterine re-aspiration may show evidence of chorionic villi, membranes, or fetal parts.
d. Ectopic pregnancy or heterotopic pregnancy with continuing ectopic is likely to still have a positive LSPT, a rising βhCG (though rise may be less than a normal pregnancy). Ultrasound may show an ectopic, depending on its size and location.
e. Mole or partial mole may be suggested by an ongoing positive LSPT beyond 2 weeks or an increasing serial βhCG. Ultrasound may show or a typical “snowstorm” pattern, although this sign is often not evident until the late first trimester. The diagnosis can only be confirmed by a uterine aspirate showing hydropic villi or trophoblastic hyperplasia.
7. MEDICATION ABORTION

Medication abortion (or medical abortion*) provides a safe, efficacious alternative to aspiration abortion. It can be offered in diverse settings with less special equipment or staff. Since the process allows for significant patient autonomy, appropriate counseling and follow-up are essential.

LEARNING OBJECTIVES
At the end of this chapter you should be better able to:

□ Evaluate patients prior to medication abortion, including:
  - Pertinent history and physical exam
  - Laboratory evaluation and sonogram as needed
□ Counsel patients effectively throughout the process, including:
  - Important differences between medication and aspiration abortion
  - The range of what to expect during the medication abortion
  - Warning signs of any complications
  - The indications for intervention with a uterine aspiration
□ Describe differences in safety and efficacy between the FDA approved and the evidence based alternative mifepristone/misoprostol regimens
□ Assess completion of medication abortion
□ Assess and manage common complications

READING

□ Required: Early Abortion Training Workbook: Chapter 7
□ Supplemental Readings:
  - NAF website http://www.prochoice.org/education
    ▪ Module 2, Expected Side Effects and Management of Complications
      http://www.prochoice.org/education/cme/online_cme/default.asp
  - The Reproductive Health Access Project website
    http://www.reproductiveaccess.org/med_ab/menu.htm

* Note: We have adopted the term “Medication abortion” instead of the formerly common term “Medical Abortion”. It has been suggested that this adjusted modifier may more accurately represent use of the family of effective drug-based methods that can terminate an unwanted pregnancy. The former modifier was easily confused with “medical” necessity, or physician-only based practices, for example. For a complete discussion, see Weitz et al. “Medical” and “surgical” abortion: rethinking the modifiers. Contraception 2004 Jan;69(1):77-8.
TIPS FOR SUCCESS

SKILL
Medication abortion is a technically simple procedure, but it requires thorough counseling and follow-up. Your comfort in monitoring bleeding and side effects and assessing the patient for complete abortion will increase quickly with time and experience. Be patient with your learning curve and that of your staff.

SAFETY
Because the medication abortion process occurs outside of the office, it’s important to give patients a list of “warning signs” to look for and how to contact your practice if they have questions or concerns. If you have any concerns when a patient calls, don’t hesitate to have her come in for evaluation.

Keep in mind that mifepristone regimens for medication abortion are not efficacious for treating ectopic pregnancy. If a patient does not bleed or show findings consistent with complete abortion after the mifepristone regimen, it will be important to rule out this possibility.

While most heavy bleeding occurs in the few hours after using misoprostol, a small proportion of women will have delayed bleeding that may require treatment or aspiration several weeks after the abortion.

Helpful resources are available. The manufacturer of mifepristone has a helpful website (www.earlyoptionpill.com) and an on-call network of experienced providers to answer your questions. You can access the network by calling the toll-free Mifeprex Hotline (1-877-432-7596).

ROLE
Like other providers, you may feel a little uncomfortable when you first start offering medication abortion, because you have less control over the process than you do with aspiration abortion. Talk to more experienced colleagues about your concerns or questions. Your comfort will grow as you listen to your patients’ success stories and experience their appreciation and satisfaction with the procedure.

By offering early medication abortion to your patients, you are playing an important role in expanding access for women. Congratulate yourself and your staff for your commitment to women’s health!
MEDICATION ABORTION COUNSELING: KEY POINTS

- Discuss pregnancy options and ensure that the decision to have an abortion is informed, voluntary and uncoerced.

- Ask what the patient already knows about medication abortion.

- Ask about any previous abortion experience(s) and fears or anxieties.

- Compare the advantages and disadvantages of medication versus aspiration abortion. Explain the differences, timing of the visits, known side effects of the medications, what to expect during the process and at home.

- Discuss the potential teratogenicity of misoprostol and emphasize that, once the drugs have been administered, the abortion should be completed either medically or by aspiration.

- Clarify the time commitment and the minimum of two office visits.

- Discuss the amount of pain and bleeding associated with the abortion process, including possible heavy bleeding with clots, passage of the pregnancy, and pain, which may be significantly stronger than normal menstrual cramps.

- Plan with the patient the best time for her to use the medications at home, by discussing and taking into consideration the need for time off from responsibilities (work, childcare, etc.) during the abortion process.

- Discuss issues of confidentiality, as well as social and physical support.

- Instruct the patient on the use of all medications including pain medication.

- Advise the patient regarding substances to avoid (e.g. aspirin and alcohol).

- Discuss sexual abstinence until abortion is confirmed and bleeding has subsided.

- Be sensitive to patients who learn they are not eligible for a medication abortion.

- Offer contraceptive counseling.

- Review aftercare instructions, including emergency contact information and what symptoms warrant a call to the on-call provider.
COMPARISON OF MIFEPRISTONE REGIMENS
Adapted from The Reproductive Health Access Project, NYC (http://www.reproductiveaccess.org) and National Abortion Federation Protocol for Mifepristone/Misoprostol in Early Abortion Updated March 2006

The FDA approved mifepristone with misoprostol for medication abortion in 2000, using a specific regimen based on evidence collected through 1996. Since then, ongoing studies have delineated regimens with optimized convenience, efficacy, and side effects, thereby creating revised and improved evidence-based regimens.

Day 1 = Day of Mifepristone Administration

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>FDA-APPROVED REGIMEN Based on evidence up to 1998</th>
<th>EVIDENCE-BASED REGIMEN Based on evidence up to 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal Miso</td>
<td>Buccal Miso</td>
</tr>
<tr>
<td>Gestational Age Limit</td>
<td>49 days</td>
<td>Up to 63 days</td>
</tr>
<tr>
<td>Mifepristone Dose</td>
<td>600 mg orally</td>
<td>200 mg orally</td>
</tr>
<tr>
<td>Misoprostol Dose and Route of Administration</td>
<td>400 mcg orally</td>
<td>800 mcg per vagina</td>
</tr>
<tr>
<td></td>
<td>Any time from ingestion of mifepristone to Day 3 (Day 4 for &lt;56 days gestation)</td>
<td>Day 2 to 3</td>
</tr>
<tr>
<td>Place of Misoprostol Administration</td>
<td>Office</td>
<td>Home</td>
</tr>
<tr>
<td>Follow-Up Visit</td>
<td>Day 10-15</td>
<td>Day 2-14</td>
</tr>
<tr>
<td>Success Rate</td>
<td>92%</td>
<td>93-98%</td>
</tr>
<tr>
<td>Minimum Number of Office Visits</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

* Efficacy for regimen may fall off > 56 days; consult studies for further information.

Internationally, particularly in countries with restrictive abortion laws, there are many reports of women terminating pregnancies with misoprostol alone (Blanchard 1999). Although less common, this practice has been reported in the United States as well (Ballou 2007). Efficacy of misoprostol as a sole abortifacient varies with gestational age, dosing, and route of administration. Most of the studies occur at different gestational ages, test small samples, test different variations and show a range of results between 65% and 93% with multiple doses in pregnancies up to 63 days gestation (Gynuity 2003). At this point the most commonly advocated clinical regimen consists of 800 mcg of misoprostol administered vaginally, repeated every 24 hours to a maximum of three doses. Using misoprostol alone without mifepristone for abortion, however, is not FDA approved. More information about regimens is available in multiple languages at www.gynuity.org and www.ibisreproductivehealth.org.
FIRST OFFICE VISIT - DAY 1

Counseling and Informed Consent

Options counseling: If a patient chooses abortion:
- Discuss benefits and risks of aspiration and medication abortion.
  - Medication abortion is non-invasive, avoids risk associated with instrumentation and anesthesia, and may be available earlier than vacuum aspiration abortion.
  - Many patients perceive medication abortion to be more natural, and to allow for more privacy and control.
  - Medication abortion is associated with a longer bleeding duration and usually more abdominal cramping than aspiration abortion.
  - Uterine aspiration may be needed in 2-5% of cases following medication abortion, including a drug failure rate (i.e. continuing pregnancy) of about 0.4% (1 in 250 cases) using the evidence-based regimens.

Review adverse effects:
- Bleeding and cramping (usually heavier than with menses) are expected.
- Diarrhea and other gastrointestinal side effects are common, although these side effects are usually self-limited and seldom require treatment.
- There is a small risk (about 1-2/100) of heavy or prolonged bleeding which may require a vacuum aspiration.
- There is a small risk of endometritis, and smaller risk of atypical infection (see note below).
- Instruct patients on how to contact the provider-on-call with questions, and procedures to follow in case of an emergency. Recommend that if the patient goes to the ER for any reason, she should bring the written information you give her, since many hospitals are less familiar with medication abortion regimens.

Note: Since 2001, there have been a small number of reported deaths in the United States due to *Clostridium sordellii* mediated toxic shock syndrome (TSS) following medication abortion.
- These infections were characterized by nonspecific complaints of nausea, diarrhea, pelvic pain, lack of fever, and dramatic leukocytosis 2-7 days following medication abortion, and progressed rapidly to fulminant sepsis.
- To date, affected women received the regimen of 800 mcg of vaginal misoprostol, although there is no evidence that the vaginal route or self-administration contributed to the infections (Beal 2007). Some groups have revised guidelines to include only buccal and oral administration of misoprostol, while others continue vaginal administration. Others have added CDC recommended STI testing and/or antibiotic prophylaxis.
- Because the incidence of severe infection following medication abortion is rare (less than 1 per 100,000 women treated (Green 2005)), there are currently no standard recommendations for antibiotic prophylaxis.
- These infections have not been isolated to medication abortion. *C. sordellii* sepsis has been seen in diverse clinical contexts including birth, spontaneous
abortion, neonatal umbilical infection, prostate infection, trauma, and drug injection (Aldape 2006).

Adherence to protocol:
- Explain to the patient that medication abortion with mifepristone and misoprostol is FDA approved, however the method that you are asking the patient to use is evidence-based, which is not the same as experimental, but each step has been well supported in the scientific literature.
- Explain to the patient the minimum two-visit requirement and the importance of finishing the medication abortion protocol.
- If the abortion is unsuccessful, uterine aspiration must be performed due to the possible teratogenicity of the drugs used for medication abortion.

Review the required provider/patient agreement:
- This includes information about the FDA approved regimen and risks of a mifepristone medication abortion. Have the patient also sign and date an amended consent form that takes into account evidence-based improvements and how they differ from the FDA approved regimen.

Medical Screening

Confirm pregnancy with a urine pregnancy test or ultrasound. Some providers use ultrasound routinely, while others use it only as needed. See below for specific indications.

Rule out contraindications:
- IUD in place (must be removed prior to administration of the medications)
- Allergy to prostaglandins or mifepristone
- Chronic adrenal failure
- Long-term systemic corticosteroid therapy
- Known or suspected ectopic pregnancy
- Hemorrhagic disorders
- Concurrent anticoagulant therapy
- Inherited porphyria

Ensure that the patient has access to a telephone and transportation, and that she agrees to return for follow-up appointments as needed.

Obtain a medical history and menstrual history. Perform pelvic examination or sonogram to estimate gestational age. Obtain other tests as indicated (e.g., gonorrhea and chlamydia screen).

Laboratory Tests

Rh status may be determined from a blood donor card, from the patient’s chart, or by obtaining a new test. When ultrasonography is not used, draw a baseline quantitative βhCG level for comparison with a subsequent level. A baseline hemoglobin or hematocrit level can be ordered as well, especially if the patient has a history of anemia.
Give medication and directions for misoprostol administration

For buccal administration of misoprostol, the patient will place four 200 mcg tablets between the gum and cheek (2 on each side) at a convenient time 24 to 48 hours after taking mifepristone. Advise the patient to swallow the remaining pill fragments after 30 minutes.

For vaginal misoprostol, the patient should empty her bladder and wash her hands before placing four 200 mcg tablets as high as possible in the vagina. It may help to lie down for 30 minutes to avoid tablets falling out during absorption.

Administer Rh (D)-IG if indicated

MicRhoGam (50 mcg dose) suffices for prevention of sensitization from early medication abortion. It may be administered on the same day as, or within 72 hours of mifepristone administration, prior to using misoprostol. If an Rh-negative patient refuses the injection, include a signed statement to that effect in the chart.

Advise patient on use of pain medications and sanitary pads

Advise the patient she may take ibuprofen 600-800 mg just before taking the misoprostol, and to repeat the dose every 6-8 hours as needed. Also offer the patient a prescription for acetaminophen with a narcotic in case ibuprofen alone provides inadequate pain relief. Encourage the patient to fill the prescription/s so the medications will be on hand if needed.

Sanitary pads should be used to assess bleeding. Bleeding is difficult to assess with tampons. More than 95% of women are correct when they think they have completed the termination process, and some providers allow tampons to be used after a woman thinks she passed the pregnancy. Other providers prefer that the woman use pads until her follow-up visit and the pregnancy termination is complete as assessed by the clinician.

Make sure patient knows how to reach provider on-call

Give the patient an information sheet with instructions about how to call or page the provider. The patient should be advised to call if she:
- Has no bleeding in the 24 hours after taking misoprostol (a second dose of misoprostol may be indicated).
- Soaks 2 or more maxi-pads for 2 or more consecutive hours
- Has intolerable pain despite taking the analgesics prescribed
- Has a sustained fever or onset of fever in the days after misoprostol
- Has abdominal pain or discomfort, or “feeling sick,” including weakness, nausea, vomiting or diarrhea more than 24 hours after taking misoprostol
- Has questions or concerns

Review the information to be sure she understands.

Administer mifepristone: One 200 mg tablet by mouth.

Review plans for post-abortion contraception

Patients who choose oral contraceptives, the patch, or the ring should initiate the method within 5 days of administering the misoprostol – even if they are still bleeding.
DepoProvera can be given or an IUD inserted at the follow-up visit. Barrier methods may be used anytime after the abortion (although intercourse before 1-2 weeks is discouraged). Patients who choose sterilization should be referred as appropriate to avoid delays. All patients should be offered emergency contraception in case it is needed in the future.

SECOND OFFICE VISIT – DAY 2-14 (at least 24 hours after misoprostol administration)

To assess the completeness of the abortion, providers can use the following criteria:

- Combination of history (patient’s description of bleeding and cramping), pelvic examination, and falling βhCG levels (at least 50% drop from baseline by 48-72 hours after misoprostol or 80% after one week) OR

- Repeat ultrasound examination (key finding is absence of gestational sac; some residual tissue is normally present in the days following medication abortion and does not require intervention)

If pregnancy is ongoing several weeks after taking mifepristone (growing pregnancy, rising βhCG levels, or embryonic cardiac activity on ultrasound), vacuum aspiration abortion is recommended due to the teratogenic risk of the medications. If the abortion is incomplete (retained sac or tissue, but pregnancy no longer developing), the patient can choose to wait for the tissue to pass, administer a repeat dose of vaginal misoprostol, or have an aspiration procedure.

All test results (Pap, GC, Chlamydia) should be reviewed with the patient and managed appropriately. The contraception plan should be reviewed, confirmed, and in most cases initiated.

Further Follow-Up
Patients should be reminded how to contact the clinic if problems develop. A small proportion of women may have delayed heavy bleeding or persistent bleeding warranting treatment.
Although the original mifepristone trials in the United States always used sonography to confirm gestational age and to document completion of the abortion, many clinical guidelines do not recommend routine ultrasound. There are alternatives to in-office ultrasound including a combination of the following:

- Estimating gestational age by a reliable LMP and consistent uterine sizing on pelvic exam;
- Using declining serum \( \beta \text{hCG} \) levels as evidence of complete abortion;
- Patient history of cramping and bleeding after misoprostol administration, as well as the disappearance of pregnancy-related symptoms.

Further studies are underway, but the suggested absolute indications for sonography before and after medication abortion include:

**Pre-Abortion**
1. LMP consistent with gestational age >8 wk
2. Size / date discrepancy
3. Provider uncertainty with exam
4. Uncertain LMP (or no menses after delivery, abortion, depo, etc)
5. Adnexal mass or pain
6. History of previous ectopic pregnancy or current symptoms or signs consistent with possible ectopic pregnancy

**Post-Abortion**
1. History not consistent with successful medication abortion (no bleeding or cramping)
2. Woman still feels pregnant
3. Serum \( \beta \text{hCG} \) not declining appropriately (at least 50% drop from baseline by 48-72 hours after misoprostol or 80% after one week)
4. Provider uncertainty with history

**Complete abortion**

The absence of the gestational sac and the presence of intrauterine debris are typical after successful medication abortion.
Persistent gestational sac after mifepristone/misoprostol use

Transvaginal sonogram showing the presence of an empty gestational sac. A persistent gestational sac indicates an incomplete abortion. Management options include waiting for completion, administering a repeat dose of misoprostol, or performing an aspiration procedure.

For more information see www.reproductiveaccess.org/med_ab/indic_sono.htm
SAMPLE PATIENT INFORMATION FORM
From The Reproductive Health Access Project
(http://www.reproductiveaccess.org/med_ab/patient_aftercare.htm)

*Mifepristone Medication Abortion*

Today, _________________, you took a pill called mifepristone (also called RU-486 or Mifeprex) to end your pregnancy. You took 200 milligrams of mifepristone at ____am/pm. You will probably not feel different after taking this pill. You may have some vaginal bleeding.

Any time between 24 and 48 hours from now, at _____am/pm, you will put 4 pills of another medicine, misoprostol (also called Cytotec) between your cheeks and gum (2 on each side). You must use the misoprostol even if you have already started to bleed. Each misoprostol pill is 200 micrograms. Choose a time when you have had a good meal and plenty of rest. Take ibuprofen just before you use the misoprostol – this will help decrease your cramps. After putting these pills between your gum and cheek for 30 minutes swallow the remaining pill fragments.

**Symptoms to Expect:**
Misoprostol (the second medicine) causes cramping and bleeding, often with clots. The cramps and bleeding may be much more than you get with a period. The cramps usually start 2 to 4 hours after you insert the pills, and may last for 3 to 5 hours. Although you may have a lot of bleeding, it is not dangerous; this means that the treatment is working. You should call me if you soak through more than 2 maxi-pads per hour for 2 hours. Light bleeding usually lasts 9 to 16 days, and it may stop and start several times.

You may have a lot of pain or cramps – if so, take pain medicine. You can take ibuprofen (Motrin or Advil) up to 800 milligrams every 6-8 hours and/or Vicodin up to 2 pills every 4-6 hours. You can also use a heating pad to relieve the pain.

Some women get nausea, diarrhea or chills after taking the second medicine. This is uncomfortable, but is not dangerous, and does not mean anything is wrong. These symptoms are common 4 to 24 hours after taking the medicine. If they last longer than 24 hours or start after 24 hours, call the number listed below.

You should call me if:
- Your bleeding soaks through more than 2 maxi-pads per hour for 2 hours
- You do not bleed within 24 hours after using the misoprostol
- You start to feel very ill after the heavy cramping and bleeding is over

**To Contact Me:**
Call my 24-hour beeper: ____________. If you have any questions, think something is going wrong, or think you have an emergency, call this number and I will call you back. It may take me 10 to 15 minutes to return your call. Please feel free to call me.

**Follow-Up:**
You have an appointment to come back to the health center on ______at ______am/pm. At this visit I will make sure that the abortion is complete.

**Birth Control:**
If you want to use birth control pills, patch, or ring, I have given you a prescription. You should start these on ______, even if you are still bleeding. Other methods (DepoProvera, IUD) are available at your follow-up visit.
Mifepristone (Mifeprex®) Ordering Information

- Mifeprex® is sold only to medical providers directly, not to pharmacies.
- Sale of Mifeprex® is through authorized distributor.
- Prescriber’s Agreement must be read.
- Complete order form, sign and fax to distributor.
- Must also fax copy of MD state license and DEA #.
- Minimum order is 3-pill pack.
- Price: $270 for three 200 mg pills ($90/pill).
  - Discount price available for pills if National Abortion Federation (NAF) member ($235 for three pills or $79/pill). To join NAF, call (202) 667-5881.
  - Pills must be purchased through NAF Group Purchasing to get discount rate.
- Payment is by credit card or established line of credit.
- Shelf life of Mifeprex® is 18 months.
- Any unused, unopened Mifeprex® pills can be returned to distributor for refund or exchange up to one year after expiration date.
- Also included when pills are shipped are: Medication Guides, Patient Agreements, Patient Brochures (Q&A), and CDC Fact Sheet on state abortion reporting guidelines. Patient materials are also available in Spanish.
- There is a toll free on-call provider network of experienced mifepristone providers available to answer emergency and non-emergency questions: Mifeprex® Hotline 1-877-432-7596
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Aldape MJ, AE Bryant, and DL Stevens. Clostridium sordellii infection: Epidemiology, clinical findings, and current perspectives on diagnosis and treatment. Clinical Infectious Diseases 2006;43:1436-1446


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Fjerstad M. Medical Abortion Update: Service Delivery Issues: Mifepristone Medical Abortion at Planned Parenthood. Association of Reproductive Health Professionals Annual Conference 2006 (Publication Pending)


NAF Protocol for Mifepristone/Misoprostol in Early Abortion. 2006

NAF. Early Options: A Provider’s Guide to Medical Abortion. 2005


National Abortion Federation Clinical Policy Guidelines 2004


EXERCISES: MEDICATION ABORTION

EXERCISE 7.1

Purpose: To practice responses to questions that may arise during medication abortion counseling. What would you tell patients who ask the following questions?

1. I live 4 hours away. Can I still get the abortion pill?

2. How do the medications work?

3. My boyfriend and I are going on vacation next week. Will I still be bleeding? Can we have sex while we’re there?

4. What are my chances of needing an aspiration abortion? OR What are my chances of the medications not working?

5. How will I know if I’m bleeding too much?

6. Will I see “the baby” when it comes out?

7. When can I go swimming?

EXERCISE 7.2

Purpose: To practice responses to follow-up questions or concerns that may arise by telephone. How would you respond to the following questions?

1. I took the misoprostol 4 hours ago. Now my temperature is 100.5° and I feel like I have the flu. Should I be concerned?

2. After swallowing the pills I vomited (if using buccal or oral misoprostol). I think one of those pills just fell into the toilet (if using vaginal misoprostol). What should I do?

3. I have a big exam coming up, and I’m really behind in my studying. I know I passed the pregnancy, because I had a lot of cramps and bleeding. Do I really need to come for my follow-up visit?
EXERCISE 7.3

Purpose: To practice follow-up and management of complications after medication abortion. How would you manage the following situations?

1. A 24-year-old nulliparous patient is 6 weeks gestation by LMP. She takes mifepristone 200 mg on Day 1 and takes misoprostol 800 mcg buccally 24 hours later. When she returns on Day 6, she is still bleeding moderately. Her examination is normal, and her βhCG levels have dropped by 80% from baseline. She starts oral contraceptive pills. She calls on Day 35 to complain that “she has not stopped bleeding since her abortion.”

2. A 40-year-old multiparous patient uses mifepristone and buccal misoprostol at 8 weeks gestation. She returns to your office on Day 10. Ultrasound reveals a retained gestational sac and no embryonic cardiac activity.

3. An 18-year-old G2P0010 patient comes to your office at 35 days based on LMP to request medication abortion. She reports intermittent spotting over the past 3 weeks. You draw a βhCG level which returns at 1860 mIU/ml. Two days later the level is 2094 mIU/ml.

4. A 29-year-old G3P1011 patient requests medication abortion. She has irregular periods and does not recall her LMP. Her exam reveals a barely enlarged uterus, and her βhCG level is 782 mIU/ml. She takes mifepristone 200 mg followed 6 hours later by buccal or vaginal misoprostol 800 mcg. She has moderate bleeding and cramping during the next several hours. She returns on Day 4. Her exam is essentially unchanged, and her βhCG level is 5530 mIU/ml.

5. A 17-year-old patient at 7 weeks gestation (confirmed by ultrasound) takes mifepristone 200 mg on Day 1 and takes buccal or vaginal misoprostol 800 mcg on Day 2. She returns to clinic on Day 7 complaining of continued cramping and light bleeding. Ultrasound shows some heterogeneous echoes in the uterus but no gestational sac. She is afebrile with stable vital signs. Speculum examination reveals a closed os and a small amount of dark blood in the vault. Bimanual examination reveals moderate tenderness over the uterus and in right lower quadrant with mild guarding and no palpable masses.
TRAINING SUGGESTIONS FOR MEDICATION ABORTION EXERCISES

EXERCISE 7.1

1. I live 4 hours away. Can I still get the abortion pill?
   - Patients can undergo medication abortion if they live within a reasonable
distance of emergency medical care, they can return for follow-up, and they have
access to a phone and transportation.

   - Counsel her that this option may be more difficult than aspiration abortion, since
   a minimum of two office visits is required. Some clients from remote areas elect
to stay near the clinic until confirmation of complete abortion.

   - Same day use of misoprostol may be considered in this situation, as it has been
   shown to be quite effective, and shorten the process. Recent randomized control
   studies reveals comparable efficacy when vaginal misoprostol is administered
   simultaneously or 6 hours after mifepristone compared to 24 hours later (Creinin

   - Some clients choose aspiration abortion instead, which can be completed in one
day. Complications in the first few days are much less common than delayed
   bleeding, which may occur 2 to 5 weeks after medications are administered. If a
   client does require urgent or emergent care, the referral provider should be
   contacted to discuss management and follow-up care.

2. How do the medications work?

   Key points:
   - Mifepristone works by blocking progesterone, the hormone required to sustain
   pregnancy in the first trimester.
   - Misoprostol, a prostaglandin analogue, works by stimulating the uterus to
   contract and empty.

   Mifepristone 200 mg orally has similar efficacy rates to 600 mg orally (Ashok 1998;
Schaff 1999; Schaff 2000). Studies have shown that about 2-5% of women will have
a complete abortion after mifepristone administration but before misoprostol
administration (Creinin 2000). Mifepristone alone, however, has a much higher
failure rate compared with the combination of mifepristone and misoprostol.

   Buccal misoprostol 800 mcg has been shown to be as effective as vaginal
   misoprostol up to 56 days gestation (Middleton 2005). Vaginal misoprostol 800 mcg
has been shown to be more effective than oral misoprostol (Schaff 2002). Evidence
confirms that misoprostol can be administered safely and effectively at home,
thereby decreasing the number of office visits (Schaff 1997). In gestations up to 63
days, misoprostol can be vaginally administered simultaneously with mifepristone
through day 3 with high rates of success (Schaff 2002, Creinin 2004, Creinin 2007). Earlier misoprostol administration is noted to have fewer side effects (Creinin 2004).

3. My boyfriend and I are going on vacation next week. Will I still be bleeding? Can we have sex while we’re there?

Key Points:
• Although you can expedite the process and confirmation of complete abortion, she may have to delay her trip if any complications occur.
• Bleeding usually diminishes dramatically with expulsion of the pregnancy, but light to moderate bleeding may last for 1-2 weeks.

Median bleeding was 13 days in a large U.S. trial of the FDA-approved dosing regimen for gestations up to 49 days (Spitz1998). Bleeding was heaviest on the day of misoprostol administration; by day 15, 77% of women described their bleeding as spotting. In a study of 212 women offered abortion with 200 mg oral mifepristone and 800 micrograms oral misoprostol or MVA, mean days of bleeding was higher in the medical group (14 days) than the MVA group (9 days), but days of spotting (about 10) was similar in both groups. In this study, oral contraceptive use did not decrease bleeding after early medical or aspiration abortion (Davis 2000).

Usually patients are advised to await confirmation of complete abortion prior to resuming intercourse. However, there is no evidence to support or refute this recommendation.

4. What are my chances of needing an aspiration abortion?

Key Point: Although true drug failure rate is 0.4%, aspiration may be needed in 2 to 5% of patients.

With continuing viable pregnancy (true drug failure), aspiration is recommended because it is unlikely that repeat dosing of the medications will be helpful and misoprostol has a teratogenic risk (Kruse 2000).

If at 2 weeks the patient has persistent gestational sac with no evidence of development, she can be followed for several more weeks if she remains stable. Many clinicians will give a repeat dose of misoprostol although there is little evidence to indicate it improves efficacy.

Key Point: In an asymptomatic patient who has echogenic material in the uterus without a sac, no further treatment is necessary.

Overall aspiration rate after medication abortion includes continuing pregnancy (true drug failure), excessive bleeding, and patient request (Allen 2001). Symptoms that warrant aspiration include excessive ongoing bleeding and cramping.

<table>
<thead>
<tr>
<th>Proposed Criteria for Aspiration Include:</th>
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<tbody>
<tr>
<td>Continuing pregnancy</td>
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<tr>
<td>Symptomatic Incomplete abortion unresponsive to treatment</td>
</tr>
<tr>
<td>Excessive bleeding with orthostatic hypotension or drop in</td>
</tr>
</tbody>
</table>
5. **How will I know if I’m bleeding too much?**

- **Bleeding** can be heavier than a normal period, accompanied by cramps and/or clots. Bleeding usually slows substantially after passing the pregnancy. After misoprostol, bleeding usually starts within 1 to 10 hours (average 4 hours).
- **Heavy bleeding** (filling 2 maxi-pads per hour for 2 hours) should prompt a call to the provider. If she is otherwise clinically stable, it may be appropriate to monitor her by phone. But if the bleeding does not subside after another couple of hours, evaluation is warranted.
- **Hypovolemia symptoms** warrant immediate evaluation.
- **Uterine aspiration** is the recommended treatment for severe hemorrhage or persistent very heavy bleeding.
- **Blood transfusion** is rarely needed (0.1-0.2% of cases). (Spitz 1998; Hausknecht 2003). Preliminary data from a Planned Parenthood review of 80,000 medication abortions using mifepristone followed by vaginal misoprostol show 0.16% of patients had bleeding requiring ER visits, and 0.06% requiring blood transfusion (Fjerstad, unpublished).
- The treatment of mild to moderate problematic bleeding is an area where we have experience but scant data. It is unknown if a 2nd dose of misoprostol, methergine, or a tapered regimen of high-dose OC’s is effective, or if any of these treatments is better than the “tincture of time.”

6. **Will I see “the baby” when it comes out?**

Let the patient know that she may see tissue, blood, and clots. It is unlikely she will see a fetus, since at less than 9 weeks, the embryo or fetus is rarely visible to the naked eye. If the patient is uncomfortable seeing the pregnancy tissue, she may want to consider an aspiration abortion instead.

7. **When can I go swimming?**

There is no evidence that tub baths or swimming are dangerous, although both are commonly discouraged for the first two weeks. Douching, however, increases the risk of PID and should be avoided.
EXERCISE 7.2

1. I took the misoprostol 4 hours ago. Now my temperature is 100.5° F and I feel like I have the flu. Should I be concerned?

   Common side effects of medication abortion are temperature elevation, and flu-like symptoms (Kruse 2000). These are usually self-limited, and the body temperature should return to normal within a few hours. Have her check her temperature again in 2-3 hours.

   Persistent elevated temperature (>100.4° F) for several hours or more than 12 hours after misoprostol insertion warrants evaluation for infection. The work-up should include:
   - Questions about pelvic pain, bleeding pattern, odorous discharge
   - Review of systems to rule out other sources of fever
   - Pelvic Exam
   - Consider CBC to evaluate for leukocytosis.

   Significant pelvic or cervical motion tenderness with fever suggests PID, and antibiotics should be initiated. In this circumstance, significant debris in the uterus on US indicates aspiration is needed. The incidence of post-medication abortion endometritis requiring IV antibiotics is estimated at 0.023% (Fjerstad, ARHP).

2. After swallowing the pills, I vomited (if using buccal or oral misoprosol) or I think one of those pills just fell into the toilet (if using vaginal misoprostol). What should I do?

   If the misoprostol pills were placed between the cheek and gum for 30 minutes there is usually sufficient absorption and another dose of misoprostol is not necessary.
   If the misoprostol was taken orally, the same applies. If the misoprostol pills were placed vaginally, and a tablet falls out more than 30 minutes after insertion, the medicine will have had adequate time to be absorbed into the bloodstream, even if the pill appears undissolved. If this occurs before 30 minutes after insertion, advise the patient that she may need to return to your office for a second misoprostol dose if appropriate bleeding has not occurred.

3. I have a big exam coming up, and I’m really behind in my studying. I know I passed the pregnancy, because I had a lot of cramps and bleeding. Do I really need to come for my follow-up visit?

   Completion of abortion must be confirmed. This can be accomplished via ultrasound at a follow-up visit or with an appropriate fall in serial βhCGs (Clark 2007). Women can have bleeding and cramping and therefore believe they have passed the pregnancy when in fact they have not. If the abortion is not complete, the patient should be managed as described in exercise 7.1.4.
EXERCISE 7.3

1. A 24 year old nulliparous patient is 6 weeks gestation by LMP. She takes mifepristone 200 mg on day 1 and takes misoprostol 800 mcg buccally 24 hours later. When she returns on day 7, she is still bleeding moderately. Her examination is normal, and her $\beta$hCGs levels have dropped by 80% from baseline. She starts oral contraceptive pills. She calls on day 35 to complain that “she has not stopped bleeding since her abortion.”

With this drop in $\beta$hCG, we assume the abortion is complete. This patient appears to be having post medication abortion bleeding, although irregular spotting could be merely a side effect of oral contraceptive pills. Studies demonstrate that heavy bleeding requiring aspiration has a bimodal distribution, with about 38% occurring in the first week after medications and another 37% during weeks three to five (Allen 2001).

**History:** Has bleeding been daily? Saturated pads per day? Pain or fever? Symptoms of hypovolemia?

**Exam and Labs:** Orthostatic vital signs, a pelvic exam, and hemoglobin or hematocrit should be checked. If ultrasound is accessible, check for a persistent gestational sac. Remember that a thickened endometrial lining without symptoms is not an indication for aspiration. If ultrasound is not readily available, check $\beta$hCG.

**Management:**
- If history and exam findings are reassuring, no action is required. Schedule phone follow-up in one week, and remind the patient to call at any time should warning signs occur.
- If bleeding is concerning but not imminently dangerous, consider serial methergine dosing, a 2nd dose of misoprostol, or a high-dose taper of combined oral contraceptives as used with dysfunctional uterine bleeding. There is no definitive evidence to show which of these options are more efficacious.
- If a persistent gestational sac is present at day 35, this can be monitored as long as the patient remains stable.
- Persistent heavy bleeding or symptoms suggesting hypovolemia or infection should trigger urgent evaluation. For significant blood loss, aspiration is indicated.

2. A 40 year old multiparous patient uses mifepristone and buccal misoprostol at 8 weeks gestation. She returns to your office on day 10. Ultrasound reveals a retained gestational sac and no embryonic cardiac activity.

The patient has a non-viable persistent gestational sac. If she is clinically stable, her options include receiving a 2nd dose of misoprostol, waiting for the tissue to pass on its own, or having an aspiration procedure. See exercise 7.1 (4) for additional discussion.
3. An 18 year old G2P0010 patient comes to your office at 35 days based on LMP to request medication abortion. She reports intermittent spotting over the past 3 weeks. You draw a βhCG level which returns at 1860 mIU/ml. Two days later the level is 2094 mIU/ml.

Although it is likely that this patient is experiencing a spontaneous early pregnancy loss, it is necessary to rule out ectopic in this situation. Normally, βhCG levels approximately double in 48 hours. A βhCG that plateaus (+/-15% of the initial value) is highly suspicious for ectopic (Paul 1999).

The patient should be asked about
- risk factors for ectopic pregnancy, including history of prior ectopic, PID, tubal surgery, current use of an IUD, and assisted reproductive technology.
- symptoms including abnormal bleeding and unilateral pelvic pain.
- Remember patients with early ectopic can be asymptomatic.

On exam, check for
- POC at the cervical os (suggesting SAB in progress),
- uterus smaller than expected for dates, and
- adnexal tenderness or mass.

A formal ultrasound by an experienced ultrasonographer is warranted to evaluate for ectopic pregnancy. Since the patient’s 2nd βhCG exceeds the discriminatory threshold for transvaginal ultrasound, the absence of an IUP should lead to the presumptive diagnosis of an ectopic.

If at any point the patient develops pelvic pain, shoulder pain, or dizziness, she should go immediately to the ER.

A study of women seeking surgical abortion at < 6 weeks gestation reported that 6.7 out of 1,000 women had ectopic pregnancies (Edwards 1997). A very low frequency of ectopic pregnancies was diagnosed after medication abortion in only 10 of 44,789 women (0.02%) (Shannon 2004). This demonstrates that the various pretreatment screening methods used to exclude ectopic pregnancies are fairly successful.

4. 29 year old G3P1011 patient requests medication abortion. She has irregular periods and does not recall her LMP. Her exam reveals a barely enlarged uterus, and her βhCG level is 782 mIU/ml. She takes mifepristone 200mg followed 6 hours later by buccal or vaginal misoprostol 800 mcg. She has moderate bleeding and cramping during the next several hours. She returns on day 6. Her exam is essentially unchanged, and her βhCG level is 7530 mIU/ml.

Following abortion, βhCG levels decline rapidly at first, at a rate of about 50% every 2 days (NAF 2001). This patient’s rapidly rising βhCG level suggests continuing viable pregnancy, despite her history of bleeding after misoprostol. A continuing, growing pregnancy, in contrast to a non-viable retained gestational sac, is not generally considered an indication for repeat misoprostol dosing. Due to the potential teratogenicity of misoprostol, aspiration is indicated if there is embryonic cardiac activity on day 14 or later. Assuming that she is clinically stable, this patient can
return up to day 14 for reevaluation or choose to undergo an aspiration abortion today.

5. 17 year old patient at 7 weeks gestation (confirmed by ultrasound) takes mifepristone 200 mg on day 1 and takes buccal or vaginal misoprostol 800 mcg on day 2. She returns to clinic on day 7 complaining of continued cramping and light bleeding. Ultrasound shows some heterogeneous echoes in the uterus but no gestational sac. She is afebrile with stable vital signs. Speculum examination reveals a closed os and a small amount of dark blood in the vault. Bimanual exam reveals moderate tenderness over the uterus and in the right lower quadrant with mild guarding and no palpable masses.

**Differential diagnosis**
- Residual clot in the uterus (hematometra)
- Retained POC
- Infection
- Ectopic/heterotopic pregnancy
- Non-gynecologic related illnesses, like appendicitis.

Hematometra or retained POCs is most likely in this patient. Hematometra may result in rectal pressure/cramping and little to no bleeding. Retained POC is likely to present with cramping and bleeding. There may be uterine tenderness on exam and the ultrasound shows heterogenous material in the uterus. The patient’s symptoms typically improve after aspiration, and clot or pregnancy tissue seen on tissue examination confirms the diagnosis.

Post-abortal endometritis is suggested by significant tenderness on exam with fever and odorous vaginal discharge. The patient should be treated with antibiotics and aspiration.

Ectopic pregnancy suspicion should prompt you to order a formal ultrasound, check serial βhCGs, or send the patient to the ER for more urgent evaluation if she is symptomatic.

If a non-gynecologic illness is suspected, the appropriate work-up should be initiated.
8. MANAGEMENT OF EARLY PREGNANCY LOSS

Authored by Christine Dehlendorf MD; Tanya Panton MD, MPH; Michelle Wolfe MD; Louisa Hann MD, MPH; and Suzan Goodman MD, MPH

This chapter will assist you in learning skills to support your patients through a common and often emotionally and physically difficult experience - the spontaneous loss of a pregnancy (miscarriage). Early pregnancy loss is one of the most common reasons for women to seek urgent or emergency services. In the past, curettage was the recommended treatment. This procedure was performed primarily in the operating room, and in one review was found to be responsible for up to three quarters of all night-time emergency gynecologic interventions (McKee 1992). Outpatient management of early pregnancy loss now commonly occurs in the primary care setting, and is recognized as being both safe and effective, while also providing increased choices for women.

TRAINING OBJECTIVES
Following completion of this chapter, you should be able to:

☐ Evaluate, diagnose, and counsel patients presenting with signs or symptoms of early pregnancy loss.
☐ Evaluate for ectopic pregnancy vs. early pregnancy loss, including changes in βhCGs.
☐ Answer questions about short and long term implications of early pregnancy loss, including emotional effects and implications for fertility.
☐ Present expectant, medication and aspiration management options.
☐ Provide appropriate follow-up, including contraceptive counseling.

READING

☐ Early Abortion Training Workbook: Chapter 8
☐ Supplemental:
TIPS FOR SUCCESS

SKILL
When counseling a patient about a possible miscarriage, use open-ended questions and listen actively to help her best cope with the uncertainties inherent in the process.

For a woman who is comfortable waiting, her body can often safely complete the miscarriage process on its own. Resolution of the miscarriage may take longer than with management using medication or uterine aspiration.

Medication management is safe, effective, and avoids those risks associated with anesthesia and aspiration. However, there can be medication side effects and the process takes longer than uterine aspiration.

Uterine aspiration can be completed in an office setting by either manual or electric vacuum aspiration – typically simple procedures that can safely be undertaken with local anesthesia and oral analgesics and little recovery time.

Regardless of management choice, a spectrum of pain control options is available. Expectant, medication, and aspiration management are consistent with the scope of practice of most primary care providers who care for women of reproductive age.

SAFETY
It is unlikely that you will experience all potential challenges or complications during this training, so never hesitate to ask for assistance from a more experienced colleague or to refer outside your practice when appropriate. Miscarriage management has safety similar to aspiration abortion, with risks much lower than term pregnancy.

ROLE
A woman experiencing early pregnancy loss relies on you for support, information, and possible intervention. Important tasks are to listen to her story and concerns, normalize her physical and emotional experience, provide information about the implications of the diagnosis, offer a range of choices for management, and provide appropriate follow-up.
INTRODUCTION

Miscarriage is common, with approximately 15% of clinically recognized pregnancies resulting in spontaneous abortion (McBride 1991). The loss rate is estimated to be 2-3 times higher with very early pregnancies, many of which are clinically unrecognized. Women with early pregnancy loss often present with vaginal bleeding and/or abdominal cramping. Alternatively, a non-viable pregnancy can be detected by ultrasound or by failure to detect fetal heart tones. Evidence suggests that nearly one half of all miscarriages are the result of major genetic anomalies, while other factors such as environment, maternal age, maternal exposures and immunologic factors are also implicated (Gabbe 2001).

Early pregnancy loss refers to the constellation of abnormalities of first trimester intrauterine pregnancy that ultimately leads to miscarriage or spontaneous abortion. The clinical presentations of EPL are defined in the following table.

<table>
<thead>
<tr>
<th>Missed Abortion</th>
<th>A non-viable pregnancy that has not yet been passed and most often is discovered on ultrasound. The woman may be asymptomatic or have a history of bleeding. The cervix is closed. Based on ultrasound findings, missed abortion may be subdivided as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anembryonic Pregnancy</td>
<td>A gestational sac develops without an associated embryo or yolk sac. Formerly called “blighted ovum”.</td>
</tr>
<tr>
<td>• Embryonic or Fetal Demise</td>
<td>Loss of viability of a developing embryo or fetus.</td>
</tr>
<tr>
<td>Threatened Abortion</td>
<td>The cervix is closed with uterine bleeding but without passage of gestational tissue. The pregnancy may or may not be viable and may abort or continue.</td>
</tr>
<tr>
<td>Inevitable Abortion</td>
<td>The cervix is dilated with bleeding and uterine contractions. Passage of tissue is expected.</td>
</tr>
<tr>
<td>Incomplete Abortion</td>
<td>The cervix is dilated and some, but not all, of the gestation is expelled.</td>
</tr>
<tr>
<td>Complete Abortion</td>
<td>The gestation has expelled completely</td>
</tr>
</tbody>
</table>
COUNSELING

As primary care providers, we are often the first to evaluate women with threatened abortion and early pregnancy loss. Because the diagnosis is often unclear at the outset, counseling in this setting is a unique challenge. Evaluation of the presenting complaint – i.e. vaginal bleeding, abdominal pain, or inability to confirm viability - should occur with sensitivity to the emotional needs of your patient, so she can best manage the uncertainty inherent in the process.

Counseling Tips for Early Pregnancy Loss

- Consider remaining silent after providing initial results or information, allowing the woman to process and experience her emotions. Follow-up with open-ended questions.
- Determine if the pregnancy is desired, as this will be important in helping her arrive at emotional resolution and a plan.
- Validate feelings rather than trying to change them.
- Normalize emotions by making reference to the way others might feel in a similar situation.
- Whenever possible, encourage the woman to seek emotional support from others.

SPECIFIC COUNSELING EXERCISES

Counseling while awaiting results of evaluation

Pregnant women who present with possible pregnancy failure must undergo an evaluation. While in over 50% of cases the work-up reveals a viable pregnancy, a woman can experience a range of emotions during the process. There are various communication approaches that may be useful.

- Provide reassurance that not all vaginal bleeding or cramping signifies a miscarriage, while avoiding guarantees that “everything will be all right.”
- Assure that you will be available to her through the process, and answer questions as they arise.

Counseling for Threatened Abortion

A woman presenting in early pregnancy with uterine bleeding, a closed cervix, and no passage of tissue, is suspected to have a threatened abortion. The ongoing pregnancy rate is estimated to be 50%. If evaluation reveals a viable pregnancy on ultrasound, the rate of ongoing pregnancy is approximately 85% (Schauberger 2005). Vaginal bleeding occurs in as many as 30% of normal pregnancies. If the pregnancy is desired, you can generally be reassuring, and recommend follow-up as appropriate for routine prenatal care, or for evaluation of increased or ongoing bleeding.
Any feelings of guilt should be explicitly addressed, including reassurance that the bleeding is not her fault. This is very important for most women to hear. Some providers like to explicitly address what she thinks may have caused the miscarriage, which may help you address her specific concerns.

If the pregnancy is newly diagnosed, it is essential to determine the patient’s feelings about pregnancy options in a non-judgmental fashion, and refer or assist as appropriate. If the pregnancy is desired, no specific treatment is indicated. No evidence supports commonly prescribed interventions such as progesterone or bed rest. However, some women may experience emotional benefit from decreased activity for a few days, and prenatal care can be initiated. If the pregnancy is undesired, provide or refer for services as appropriate. Rh-negative women with a threatened abortion in the first trimester are recommended to receive 50 mcg of Rh immune globulin.

Counseling when Early Pregnancy Loss is Diagnosed

In instances where miscarriage is inevitable because either the cervical os is dilated or embryonic demise is clear, carefully assess the emotional needs of your patient. Take time to discuss the diagnosis with her, preferably when she is fully clothed and seated. The presence of a support person can be helpful.

Studies have found that some women experience depressive symptoms following the loss of a pregnancy, while other women do not. There is some increase in anxiety disorders, acute stress disorders and PTSD following miscarriage. Occasionally these symptoms may recur during subsequent pregnancies. Your role in this situation is not to change these emotions but to allow the woman opportunity to explore them. As providers, we can assist patients by listening and validating their emotions and by suggesting that patients develop individualized practices to facilitate their process. Some women have been helped by special activities to acknowledge the loss, like a personal memorial service.

It may be helpful to counsel or role-play with a woman how she might discuss the loss with family and friends, or how to prepare for future events such as the birth of a friend’s baby.

Common questions from patients experiencing a pregnancy loss are listed below, with background information that can help frame a response.

- How will this affect my ability to carry subsequent pregnancies to term?

Miscarriage is common, and in the majority of cases one or two previous miscarriages does not predict problems with subsequent pregnancies. Studies of women with 3 miscarriages found that over half were later able to carry a pregnancy to term. In order to minimize the likelihood of problems with subsequent pregnancies, patients can be advised in pre-conceptional counseling to minimize smoking, NSAIDs, and alcohol intake. Following two to three consecutive miscarriages, it is appropriate to initiate evaluation for conditions such as chromosomal abnormalities, anatomic problems, luteal phase defects, or immunologic disorders such as anti-phospholipid syndrome. Evaluate patients over 35 after two consecutive losses.
• When can I attempt to conceive following the loss of a pregnancy?

In most cases the woman can attempt to conceive when she feels emotionally and physically ready. While data is limited, many clinicians recommend waiting for one or two menstrual cycles.

• Was the miscarriage my fault?

It is important to emphasize that nothing she did caused the miscarriage. Most women benefit from learning that miscarriage is common and not due to problems with her behavior or body. Emphasize that we don’t know why women miscarry, but it is often because of problems that are unlikely to occur in subsequent pregnancies.
CLINICAL AND DIAGNOSTIC CONSIDERATIONS FOR SPONTANEOUS ABORTION

Accurate clinical assessment and diagnosis of an early miscarriage is essential prior to considering management options. There is no one classical presentation of a miscarriage. Common signs and symptoms can include:

- vaginal bleeding (the most common sign)
- abdominal cramping, back or pelvic pain
- passing of tissue or mucus from the vagina
- constitutional symptoms like fever, malaise
- loss of pregnancy related symptoms, such as breast tenderness or nausea.

In addition, it is not uncommon for pregnancy failure to occur with no symptoms, or to become apparent as an incidental finding with ultrasound.

Clinicians should consider asking women about medications they have taken. Some women may present after using medications, such as misoprostol, to induce abortion. These medications may have been obtained from the Internet, from unlicensed sources in the US, or from other countries where they are more widely used and available over-the-counter. For further information about these regimens, please see http://www.gynuity.org or http://www.misoprostol.org/File/guidelines.php.

There are also various herbal remedies that women may have used to induce abortion. Little information exists about potency and composition. While there are no reports that such treatments contain toxic substances, clinicians should be alert to that possibility when evaluating clients presenting with bleeding in early pregnancy.

In evaluating a woman with signs or symptoms of early pregnancy loss, it is essential to remember two critical aspects of the evaluation:

- Ensure hemodynamic stability, and refer to a higher level of care as appropriate
- Evaluate for an ectopic pregnancy, and refer or treat as appropriate

Your evaluation should include a physical examination and consideration of obtaining quantitative serum βhCGs and/or an ultrasound.

Your exam will help to assess the woman’s status and offer diagnostic clues.

- Vital signs and appearance assist in determining hemo-dynamic stability
- Abdominal examination may help rule out other causes for the patient’s symptoms.
- Vaginal examination allows assessment for bleeding, cervical dilatation, tenderness, and presence of products of conception.
- Tissue examination may assist in diagnosis, if a woman happens to be passing or has brought in pregnancy tissue. Review Chapter 5 for tissue examination technique.

In all patients presenting with first trimester bleeding, ectopic pregnancy should be ruled out. Ectopic pregnancies often present with vaginal spotting, frequently occurring at 6-8 weeks gestation. Due to the inappropriate implantation of an ectopic pregnancy, levels of βhCG can be insufficient to support the corpus luteum, causing declining levels of pregnancy hormones.
and sloughing of the endometrial lining. In addition to vaginal bleeding, other signs and symptoms of ectopic pregnancy include abdominal pain, shoulder pain, and syncope.

In some cases, when clinical diagnosis is consistent with threatened abortion or intrauterine pregnancy failure, exclusion of an ectopic pregnancy can be accomplished without further work-up. These circumstances include:

1. Gestational tissue documented by examination (at os or in vaginal vault or brought in by patient)
2. Known significant drop in βhCG:
   • Low sensitivity pregnancy test (LSPT) was known to be positive and is now negative
   • Serial serum βhCGs decrease by more than 50% in 48-72 hours in patients with bleeding who are followed expectantly (ie without treatment) (Barnhart K 2004)
   • Serial serum βhCGs decrease by at least 50% 48-72 hours after treatment with medication, such as misoprostol (Barnhart K 2004)
3. Previously documented intrauterine pregnancy

If the above criteria are not met, there are two ways in which you can rule out an ectopic pregnancy and establish whether a pregnancy is viable; serial βhCGs or ultrasound. Which is obtained first is often a question of resources, availability, and time.

If an ultrasound is obtained first:
- The presence of a viable or non-viable intrauterine pregnancy essentially rules out an ectopic pregnancy (with rare heterotopic exception).
- In the case of a non-diagnostic ultrasound three diagnoses are possible: ectopic pregnancy, spontaneous abortion, or early intrauterine pregnancy.
  o If there is a history of bleeding suggesting spontaneous abortion, obtain serial βhCGs. If the βhCG falls approximately 50 percent by day 3, spontaneous abortion is most likely (see Table 1 for more detailed values). If uncertainty remains, one or more additional βhCG(s) can be measured, or a repeat ultrasound can be obtained. If the βhCG does not fall as expected, consider diagnostic uterine aspiration. Refer or treat for ectopic pregnancy as appropriate.
  o If there is no history of bleeding, obtain a βhCG level to determine if it is below the discriminatory zone of 2,000 (the βhCG level at which an intrauterine pregnancy must be identified with transvaginal ultrasound),
    - If βhCG is <2,000, obtain a repeat βhCG in 2-3 days. Alternatively, an ultrasound can be obtained if the βhCG is predicted to be above the discriminatory zone within that time frame. If an intrauterine pregnancy is seen, a second βhCG is not necessary.
      - While traditional guidelines have stated a normal pregnancy would have a doubling of the βhCG in 2 days, new data suggests that less stringent guidelines of 50% rise in βhCG in 2 days and a 100% rise in 3 days are appropriate. The updated guidelines seek to minimize referral or aspiration of normal pregnancies for ectopic evaluation while minimizing the likelihood of missing an ectopic pregnancy (Barnhart 2004).
      - In the case of declining βhCGs, Table 1 can be used to determine whether the change is within normal limits for a spontaneous abortion. With ectopic pregnancies, the rate of decline is often
slower than with a spontaneous abortion.

- If βhCG is >2,000, treat or refer as appropriate for ectopic pregnancy.

If a quantitative serum βhCG is promptly available this can be the first step.
- If the βhCG is below the discriminatory zone of 2,000 an ultrasound in a patient without signs or symptoms of ectopic pregnancy is not necessary.
  - Obtain a repeat βhCG in 2-3 days. Alternatively, an ultrasound can be obtained if the βhCG is predicted to be above the discriminatory zone within that time frame. Follow the guidelines described above for evaluating the change in βhCG levels.
- If the initial βhCG is above the discriminatory zone, obtain an ultrasound to assess for a viable or non-viable intrauterine pregnancy (in select low risk patients, serial βhCGs can be used to rule out ectopic pregnancy when an ultrasound is not easily available).
  - If the ultrasound is non-diagnostic, refer to the Ultrasound section above.
  - If the ultrasound is diagnostic of an intrauterine pregnancy an ectopic pregnancy is essentially ruled out, as described above.

In all cases, if the βhCG rises or falls inappropriately, evaluate as appropriate for ectopic pregnancy if an intrauterine pregnancy has not previously been documented. When determining whether a decline in βhCG is within normal limits, note that the rate of decrease changes over the course of a spontaneous abortion, so that use of the above charts should take into account the timing of the women’s first βhCG relative to onset of symptoms. Evaluation for ectopic can include aspiration to evaluate for products of conception, formal ultrasound, and appropriate referral. Review Chapter 3 for greater detail about clinical and sonographic assessment of gestational age, dating, and viability.

Table 1: Minimum Expected Decline in βhCG in Spontaneous Abortions

<table>
<thead>
<tr>
<th>If initial βhCG is</th>
<th>Repeat βhCG on indicated day should be less than</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day 2</td>
</tr>
<tr>
<td>250</td>
<td>198</td>
</tr>
<tr>
<td>500</td>
<td>379</td>
</tr>
<tr>
<td>750</td>
<td>555</td>
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<tr>
<td>1000</td>
<td>723</td>
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<tr>
<td>1500</td>
<td>1056</td>
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<tr>
<td>2000</td>
<td>1381</td>
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<tr>
<td>2500</td>
<td>1701</td>
</tr>
<tr>
<td>3000</td>
<td>2016</td>
</tr>
<tr>
<td>4000</td>
<td>2638</td>
</tr>
<tr>
<td>5000</td>
<td>3249</td>
</tr>
</tbody>
</table>

MANAGEMENT OPTIONS FOR EARLY SPONTANEOUS ABORTION

If the diagnosis of miscarriage is made, most clinically stable women can choose among various management options. A small proportion will need urgent intervention — including those who develop hemorrhage with hemodynamic instability or infection. Medically stable patients have the following options:

- expectant management
- management with medications
- aspiration in an outpatient or inpatient setting

It is not uncommon for a woman to have completed a miscarriage prior to seeking out medical care. Identifying patients with complete miscarriages can sometimes be difficult, however, as clinical history, βhCG, and ultrasound images can not always distinguish between an incomplete and complete abortion. Therefore, the determination of whether a patient needs one of the management options requires an individual assessment of the patient’s clinical picture. Also assess the patient’s ability to follow up with you in determining which option is most appropriate.

EXPECTANT MANAGEMENT

Clinically stable patients may choose to proceed by waiting for the natural process of miscarriage. Patients may prefer this “watchful waiting” as it may minimize visits, avoid medical management or uterine aspiration and their associated potential side effects or complications. Expectant management has been shown to be safe and effective, with studies showing varied rates of successful uterine evacuation from 16 - 75% for missed abortions (Ankum 2001, Luise 2002, Wood 2005, Bagratee 2004) and 82 – 96 % for incomplete abortions (Gronland 2002; Blohm 2003, Bagratee 2004).

Many providers reassess their patients every 2 weeks. All patients should have access to their providers between appointments by phone. Some women may become tired of waiting and choose another option. A miscarriage allowed to proceed on its own can take days to weeks to complete.

- Monitoring may consist of continued symptom evaluation, physical exam, serial βhCG and/or ultrasound. See the step by step guide below for details on follow-up instructions and how to confirm completion of the miscarriage.

- Up to 10% of women will still require aspiration or medical management after 4 weeks of observation (Hurd 1997). Among women who were counseled appropriately, acceptability is no different than for medical or aspiration management (Bagratee 2004; Blohm 1997).

MANAGEMENT WITH MEDICATIONS

Miscarriage management using medications offers patients an alternative to expectant management with a more predictable time to completion. It also offers women who prefer to avoid uterine aspiration another alternative. Primary care providers can provide medical management of early pregnancy loss as an outpatient treatment.
Management with Misoprostol Alone

Misoprostol acts both to stimulate uterine contractions and soften the cervix, and has been shown to be effective and safe in treating spontaneous abortions (Nielsen 1995 and 1997). Misoprostol is inexpensive and does not require special conditions for storage, making it potentially useful in ambulatory settings and in places with limited resources. One study showed higher levels of bleeding and necessary follow-up with misoprostol compared to uterine aspiration (Zhang 2005). Studies have, however, found that patients find misoprostol to be acceptable, tolerable and would recommend it to a friend. With respect to efficacy rates, studies have evaluated success in missed abortion, incomplete abortion, and early spontaneous abortion as a whole, and we will review success rates from the best existing evidence. For additional information, see the Consensus Statement for the use of Misoprostol for Treatment of Incomplete Abortion and Miscarriage, available at www.gynuity.org.

Missed Abortion

- The treatment regimen which has been most studied is misoprostol 800 mcg vaginally. Buccal administration has been studied for elective abortion up to 8 weeks, and has been found to produce similar uterine effects as vaginal misoprostol.
- A recent large randomized trial showed success rates for primarily missed abortions (94% missed, 6% incomplete/inevitable) of 71% at day 3 and 84% at day 8 after vaginal misoprostol (Zhang 2005).
- Other studies have found success rates with misoprostol between 77% and 89% (Herbutya 1997, Demetroulis 2001, Bagratee 2004, Ngoc 2004), but there were differences in dose, route, and timing of follow-up.
- Bleeding is heavier with misoprostol than with aspiration, with 12.8% of women in one study having a drop in hemoglobin of 2g/dL or more. (Davis 2007)

Incomplete Abortion

- Studied treatment regimens include 800 mcg vaginally, 600 mcg orally, and 400 mcg sublingually.
- A recent large randomized trial showed a success rate for incomplete abortions of 96% at 2 weeks after oral misoprostol (Weeks 2005).
- Other studies have found success rates with misoprostol between 61% and 93% (Pang 2001, Moodliar 2005, Demetroulis 2001), but there were differences in dose, route, and timing of follow-up.

Mifepristone and Misoprostol Management

Thus far the evidence for combined use of mifepristone and misoprostol to treat spontaneous abortion is limited but quite promising. The few supporting trials for management of early pregnancy loss either had small sample sizes or were not randomized. (El-Rafeay 1992; Wagaarachchi 2001) Some small randomized control trials showed either an increase (Schreiber 2005) or minimal increase (Nielsen 2000; Gronlund 2002) in success rate with the addition of mifepristone to misoprostol. Initial studies have begun to support management of missed abortion specifically with this combined treatment (Schreiber 2006). We await further large scale trials to evaluate the effectiveness and economic feasibility of combined mifepristone and misoprostol for treating spontaneous abortions. The dosing and timing suggested for treating missed abortions is similar to evidence-based regimens for medication abortion. See Chapter 7 for instructions using these regimens.
STEP BY STEP APPROACH TO EXPECTANT MANAGEMENT OR MANAGEMENT WITH MISOPROSTOL

PATIENT PRESENTS TO OFFICE (Day 1)

1. Rule out contraindications
   - Suspected ectopic pregnancy
   - Hemodynamic instability or infection
   - Significant bleeding disorder or taking anticoagulants
   - An IUD in place (must be removed)
   - Uterine size greater than 12 weeks GA
   - Signs or symptoms of infection
   - Allergy to misoprostol or other prostaglandins (for medication management)

2. Laboratory testing
   - Urine or blood test for pregnancy
   - Rh (administer Rh immune globulin if negative)
   - Hemoglobin / hematocrit (if vaginal bleeding or hemodynamic instability)
   - STD risk assessment and testing per CDC Guidelines

3. Sonography as indicated

4. Counseling and Informed Consent
   - Discuss the risks, benefits and alternatives.
   - Assure telephone access to discuss clinical or emergency care.
   - For gestational ages greater than 9 weeks, women should be warned of the possibility of viewing fetal parts with expelled tissue.
   - Review and contrast expected side effects with warning signs for adverse events.
   - BLEEDING: For those using misoprostol, usually heavy within a few hours after using medication, followed by menstrual-like bleeding for 7-14 days. Women choosing expectant management may have a longer wait before onset of heavy bleeding. Intermittent spotting may last until the next menstrual period. Counsel patient to contact you if she:
     o Saturates 2 or more maxi-pads an hour for 2 or more consecutive hours.
     o Experiences lightheadness, dizziness, or fainting after days of heavy bleeding, or weeks of continuous bleeding.
   - FEVER AND/OR CHILLS: Patients using misoprostol can have a low grade fever of up to 100.5 or transient chills for up to 24 hours. Recommend antipyretic for fever during this time period. Counsel patient to contact you if:
     o Fever or chills persist beyond 24 hours after misoprostol administration, as this may indicate infection.
     o There is any fever in those choosing expectant management.
   - ABDOMINAL CRAMPING: Pain may be stronger than a typical period. Offer patients a prescription for NSAIDs plus a mild narcotic for pain relief at the time of their initial visit. Some clinicians recommend taking pain medications along with the misoprostol.
   - SIDE EFFECTS SPECIFIC TO MISOPROSTOL:
     o DIARRHEA – Patients may have diarrhea that can last up to 24 hours.
     o NAUSEA/VOMITING – Uncommon but can occur a few hours after misoprostol administration. Some providers provide anti-emetics expectantly
or information about over-the-counter medications.

5. Establish follow up and instructions
   • Answer all patient questions, and reiterate how the patient can contact you.
   • Review plans for the follow up visit at 2-14 days.
   • Many clinicians discourage vaginal intercourse, tampons or douching 1-2 weeks or until bleeding has stopped, although there is little data to support this.
   • Assess the patient’s social support, coping strategies and emotional state, and offer support as appropriate.
   • Make a contraceptive plan if appropriate. If prevention of pregnancy is desired, contraception should be initiated promptly because fertilization can occur before return of menses.

FOLLOW UP OFFICE VISIT (Day 2-14) Use the following combination of criteria to assess successful treatment of the miscarriage:

   • Assess History:
     o History of cramping, bleeding and the passage of clots
     o Diminishing bleeding
     o Passing tissue or products of conception
     o Patient no longer feels pregnant
   • Physical exam if diagnosis remains unclear
     o Uterus firm and smaller than pregnancy size (can be difficult to determine, in which cases further evaluation as below is appropriate).
   • Consider βhCG levels or ultrasound, neither is necessary in cases where an intrauterine pregnancy was previously documented and the history is consistent with a completed miscarriage
     o Serial βhCG levels should be obtained in all women who did not have a confirmed intrauterine pregnancy.
     o βhCG levels or ultrasound are also indicated in cases where the history and physical are not consistent with a completed miscarriage.
       ▪ See Table 1 for expected declines in βhCG levels with completed spontaneous abortion.
       ▪ On ultrasound, assess for the presence or absence of the gestational sac. The finding of a thickened endometrial stripe is typical after successful management, and without ongoing bleeding should not itself indicate the need for aspiration.

If initial management is unsuccessful:
   • Clinically stable patients may consider a dose of misoprostol and a second follow-up visit, or opt for uterine aspiration. For patients initially choosing misoprostol, some providers prefer dispensing an additional misoprostol dose, to be taken after phone follow-up if no bleeding has occurred.
   • Higher success rates are achieved with follow-up of at least 7 – 14 days to allow completion of expulsion (Consensus Statement 2004).
   • Uterine aspiration is recommended if there are signs of clinical instability or infection.

If initial management of the miscarriage was successful:
   • Confirm contraceptive plans and offer emergency contraception if pregnancy is not desired
   • Offer support and referral for additional counseling if needed
UTERINE ASPIRATION AND ADVANTAGES OF OUTPATIENT MANAGEMENT

For many decades, dilatation and curettage in an operating room setting was the standard management for spontaneous abortion (Edwards 1999) but this has largely been replaced with uterine aspiration techniques. Uterine aspiration offers the quickest management for the resolution of a missed or incomplete miscarriage, and there is no evidence that sharp curettage confers additional benefit. Patients may choose aspiration because it is quick, because the clinician will be with them for the entire process, or to avoid side effects of medications for management.

MVA is a technique of uterine aspiration where the suction to empty the uterus is generated mechanically with a handheld syringe. MVA has been shown to be a safe, effective, outpatient method for the management of both spontaneous abortions and early terminations in the US and internationally (Greenslade 1993; Blumenthal 1994). Studies have found no difference in reported pain levels, anxiety, bleeding, or patient acceptability with manual vs. electric vacuum aspiration (Goldberg 2004). Moving spontaneous abortion management out of the operating room saves both time and money and offers advantages to women, clinicians, and the health care system.

Patient advantages of management outside of the OR and / or use of MVA include:
- more privacy and continuity of care with a woman’s own provider
- fewer pelvic exams due to re-evaluation of the patient by different MDs or in OR
- less waiting time
- no need to be NPO
- a broader array of treatment and pain management options than are usually used in the OR (Lee 1996)
- less reported disturbance by noise with manual compared to electric vacuum aspiration (Dean 2003)

Provider advantages include:
- improved continuity of care
- the ability to offer broader spectrum of early pregnancy care and services in the office

Health care system advantages include:
- decreased patient waiting time
- decreased OR and hospital time
- decreased cost without compromising efficacy and patient safety

The choice of aspiration does include some risks of an intrauterine procedure, though serious risks occur very rarely (Goldberg 2004). Please review Chapter 5 for the steps for vacuum aspiration and use of the MVA equipment.
**SUMMARY COMPARISON BETWEEN EXPECTANT, MISOPROSTOL AND ASPIRATION MANAGEMENT FOR EARLY SPONTANEOUS ABORTION**

<table>
<thead>
<tr>
<th></th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Reported EFFICACY RANGE using best available data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPECTANT MANAGEMENT</strong></td>
<td>• Body naturally expels the non-viable pregnancy.</td>
<td>• Process can last days to weeks with bleeding and some abdominal cramping.</td>
<td>• Missed abortion: 16-75% (Ankum 2001; Luise 2002; Wood 2005)</td>
</tr>
<tr>
<td></td>
<td>• Non-invasive</td>
<td>• Despite waiting, may still need uterine aspiration.</td>
<td>• Incomplete abortion: 82-96% (Gronland 2002; Blohm 2003)</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>MEDICATION MANAGEMENT</strong></td>
<td>• Is safe</td>
<td>• May need additional doses of misoprostol or aspiration.</td>
<td>• Missed abortion: 77-89% with misoprostol (Herbutya 1997; Demetroulis 2001; Bagratee 2004; Ngoc 2004; Zhang 2005)</td>
</tr>
<tr>
<td></td>
<td>• Can be highly effective</td>
<td>• May cause more bleeding and need for follow-up than aspiration.</td>
<td>• Incomplete abortion: 61-100% with misoprostol (Pang 2001; Moodliar 2005; Weeks 2005; Bagratee 2004)</td>
</tr>
<tr>
<td></td>
<td>• Non-invasive</td>
<td>• May cause short-term side effects.</td>
<td></td>
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<tr>
<td><strong>ASPIRATION MANAGEMENT</strong></td>
<td>• Can offer the fastest resolution for a miscarriage.</td>
<td>• Uncommon risks associated with invasive procedure and use of local or general anesthesia.</td>
<td>96%-100% (Demetroulis 2001; Gronlund 2002)</td>
</tr>
</tbody>
</table>

**PAIN CONTROL IN MISCARRIAGE MANAGEMENT**

There are both physiologic and psychological components to the pain for miscarriage. Be prepared to consider differences in pain perception and to counsel each patient regarding her options for pain control. Pain management ranges from counseling and breathing techniques, to use of oral medications alone, to oral or IV analgesics with local anesthesia in the outpatient setting. See Chapter 4 for an in depth discussion of options and management issues.
IN CONCLUSION

Miscarriage can be an emotionally trying process for patients and their families. As providers it is important that we be compassionate, knowledgeable and proficient in the management of miscarriage so that we can offer women increased options and choices.

Acceptability studies indicate that most women who opted for expectant management, uterine aspiration or misoprostol would choose the same method again. Additionally, studies demonstrate the acceptability of outpatient management of early spontaneous abortions. This may be attributed to the extent and quality of patient counseling, continuity of care, and provider support received. Our key role as providers is to offer patient centered options counseling and our clinical guidance so that each patient can decide what she is most comfortable with.
REFERENCES


EXERCISES: MANAGEMENT OF EARLY PREGNANCY LOSS

EXERCISE 8.1

A 25 year old woman you have been seeing for 5 years presents for an urgent visit. Her only past history includes irregular periods, which you have managed with OCPs. She reports not having had a period for 7 weeks, and now is having abdominal cramping and heavy bleeding, up to a pad every hour. Her urine βhCG is positive.

a. How would you proceed with evaluation?

b. How would you counsel her while waiting for results?

c. If an ultrasound reveals an intrauterine pregnancy with the presence of fetal cardiac activity, how would you discuss the result with her?

EXERCISE 8.2

The same woman comes in one year later. She had a termination following the previous threatened abortion, and never restarted her OCPs. She recently began a new relationship, and has intermittently been using condoms. She began having vaginal bleeding about 5 days ago, and it is now decreasing. Her last menstrual period was 8 weeks ago. Her urine pregnancy test is positive. She brings in tissue and you see chorionic villi.

a. How would you proceed with evaluation?

b. How would you approach her initially with these results?

c. What information would you provide about what to expect in the future?

d. What other evaluation or management would you initiate?
EXERCISE 8.3

The same patient presents to you three years later, at 29 years of age. She is in a long term relationship with one partner, and has been attempting to get pregnant. It has now been 10 weeks since her last menstrual period, and she has been bleeding for 10 days. She is tearful and distraught. Her urine βhCG is positive, her cervical os is closed, and no gestational tissue is evident.

a. Does the patient need an ultrasound in this case?

b. You do obtain an ultrasound, and it reveals a 8 week fetus without cardiac activity. How would you approach her with this news?

c. What kind of support may be of use to her?

d. How would you manage her medical issues?
EXERCISE 8.1

A 25 year old woman you have been seeing for 5 years presents for an urgent visit. Her only past history includes irregular periods, which you have managed with OCPs. She reports not having had a period for 7 weeks, and now is having abdominal cramping and heavy bleeding, up to a pad every hour. Her urine βhCG is positive.

a. How would you proceed with evaluation?

The goal of this question is to encourage the learner to think through the steps in evaluating first trimester vaginal bleeding. The following points should be considered:

• Differential diagnosis: Threatened abortion, incomplete abortion, completed abortion, and ectopic pregnancy.
• The first step in the evaluation should always be to check for and ensure hemodynamic stability.
• Subsequently is it important to assess how the woman feels about the pregnancy.
• The evaluation can proceed with a speculum exam, pelvic exam, βhCG or ultrasound, and blood type. It is essential to keep in mind the priority of ruling out ectopic pregnancy when performing this evaluation.
• If the βhCG is above the discriminatory zone, an ultrasound is important to determine the location of the pregnancy unless the woman has a previously diagnosed intrauterine pregnancy or a known significant drop in βhCGs. An ultrasound can still be obtained if these criteria are met to assess for viability. Alternatively, serial βhCGs can be obtained if the patient is low risk for ectopic.
• If the initial value is less than the discriminatory zone, serial βhCGs can be obtained if the patient is not presenting with symptoms suggestive of an ectopic pregnancy.
• An ultrasound is another option for initial evaluation. If non-diagnostic, serial βhCGs can be obtained given that she has a history consistent with spontaneous abortion,
• If the woman has cervical or adnexal tenderness or a mass on pelvic exam, she should have an ultrasound and evaluation for an ectopic pregnancy.
• If the pregnancy is not desired, the woman can choose to proceed directly to uterine aspiration (without waiting for βhCG results). This enables the woman to receive treatment without delay, and also enables immediate confirmation that the pregnancy was intrauterine as opposed to ectopic (once products of conception are confirmed).
b. How would you counsel her while waiting for results?

The uncertainty of waiting for results of the evaluation can be stressful. Women should be fully informed of the evaluation process. Being honest and up-front about these possibilities will help you build trust.

“It is important that I perform a speculum exam (or ultrasound) to evaluate where the bleeding is coming from.”

“An ultrasound using a vaginal probe will provide us with information about the health of this pregnancy.”

If the pregnancy is desired, inform your patient that in over 50% of cases of bleeding in the first trimester, the pregnancy continues. Ask her if she has someone who can support and be with her in this potentially difficult time. You can also ask if she would like you to talk with that person.

c. If an ultrasound reveals an intrauterine pregnancy with the presence of fetal cardiac activity, how would you discuss the result with her?

When an ultrasound confirming viability is obtained, guarded reassurance is appropriate (assuming the pregnancy is desired). Over two-thirds of women in this situation go on to have full term pregnancies, and can be referred for routine prenatal care. For women who feel anxious about returning to daily activities you can mention a lack of evidence to support limiting activities, while exhibiting sensitivity to their concerns. You may offer her a note for a couple days of decreased activity or absence from work, if she prefers. If bleeding or cramping continues or begins again, a repeat evaluation is appropriate. Determine Rh status, and administer Rh Immune globulin as appropriate. If a termination is desired, appropriate referrals should be made.

EXERCISE 8.2

The same woman comes in one year later. She had a termination following the previous threatened abortion, and never restarted her OCPs. She recently began a new relationship, and has intermittently been using condoms. She began having vaginal bleeding about 5 days ago, and it is now decreasing. Her last menstrual period was 8 weeks ago. Her urine pregnancy test is positive. She brings in tissue and you see chorionic villi.

a. How would you proceed with evaluation?

This woman is presenting with a history consistent with a complete spontaneous abortion. The foremost question of whether she could have had an ectopic pregnancy is answered by the finding of chorionic villi. Her history of decreasing bleeding is consistent with a completed miscarriage. As with all cases, it is essential to assess for hemodynamic stability, and to determine if the amount of bleeding should prompt an evaluation for anemia. She should be asked about any fever over the last several days, and a physical exam should be performed for pelvic pain or the
presence of tissue in the cervical os. Her blood should be drawn to determine her Rh status.

b. How would you approach her initially with these results?

Await her response and consider open ended questions about her expectations. Approach this situation without preconceived notions about her previous experience. While this woman had a termination previously, it is important not to assume that she will feel similarly about this pregnancy.

“How are you feeling about what is happening?”

“How do you feel about what I have told you?”

c. What information would you provide her about what to expect in the future?

Address both the physical and emotional implications of this situation. To address the psychological aspects of this experience, encourage the use of social supports and grieving practices as necessary. With respect to the physical experience, inform her that the results of your history and physical suggest she has likely completed the process, and will only have light bleeding for several days to weeks but that if heavy bleeding or increased cramping occur, re-evaluation is recommended.

If her bleeding and cramping are ongoing, an ultrasound is optional to evaluate the contents of the uterus. If the overall picture is consistent with an incomplete abortion, she should be offered expectant, medication, or aspiration management.

d. What other evaluation or management would you initiate?

Administer Rh immune globulin as appropriate. In a woman using condoms infrequently, it is important to address contraceptive goals, methods and use. Advance provision of emergency contraception is appropriate. Testing for STIs may be appropriate. Offer a follow-up visit for continuity and support.

EXERCISE 8.3

The same patient presents to you three years later, at 29 years of age. She is now in a long term relationship with one partner, and has been attempting to get pregnant. It has now been 10 weeks since her last menstrual period, and she has been bleeding for 10 days. She is tearful and distraught. Her urine βhCG is positive, her cervical os is closed, and no gestational tissue is evident.

a. Does the patient need an ultrasound in this case?

In this case, you do not have any documentation of an intrauterine pregnancy, and also do not know whether or not the pregnancy is viable. Therefore, you can either obtain an ultrasound or serial βhCG levels. In this case, given her distress, an ultrasound (if available) as the first step may be beneficial in that it will provide answers more quickly.
b. You do obtain an ultrasound, and it reveals an 8 week fetus without cardiac activity. How would you approach her with this news?

As above, the importance of open ended questions and allowing space to grieve is crucial. Reminding the patient that the situation is not her fault, and is not related to her previous abortion, can be useful in addressing her, sometimes unspoken fears. While she has now had 2 spontaneous abortions, she has a greater than 70% chance of successful pregnancy in the future, and no further work-up is recommended at this time. As mentioned earlier, it is appropriate to initiate evaluation after two to three consecutive miscarriages and could include evaluation for chromosomal abnormalities, anatomic problems, or immunologic disorders such as anti-phospholipid syndrome.

c. What kind of support may be of use to her?

Useful resources include her family and community, as well as resources from the clinical setting. You can encourage her to acknowledge her grief with special time or a grieving practice. You can set up additional follow-up appointments with her as needed. Occasionally a referral to counseling or a miscarriage support group may be appropriate.

d. How would you manage her medical issues?

Management options include expectant, medication, and aspiration management. In addition, given that the patient desires a pregnancy, let her know that you will discuss the timing of subsequent attempts to become pregnant at her follow-up visit.
INTRODUCTION

This chapter is designed to aid primary care clinicians in integrating abortion services into their own practice. In recognizing the range of our audience - different states, training backgrounds, and political environments - we have aimed to provide a breadth of tools that may be useful to you as you proceed.

The majority of the information provided here will probably be familiar to you. Although the chapter seeks to address some unique concerns of an abortion service, many of the tips and suggestions it contains will refer to things you already do in your practice. Not all of the information provided is necessary for a successful abortion service; rather, the chapter is designed to cover a broad range of topics so that if you encounter a particular challenge, you can refer to the appropriate section for details. Additional tools and/or handouts for this chapter are available online at http://teachtraining.org. These downloadable resources are underlined throughout the chapter.

This chapter offers an overview of the following topics:

- Finding practice opportunities
- Getting started
- Medical documentation
- Ensuring quality
- Legal and reporting considerations
- Malpractice
- Security
- Financial issues
- Finding support

Throughout, we seek to emphasize a patient-centered approach to service. Patients are best served when they are "attended to by…caregivers who provide support throughout the abortion process and who encourage the patient to participate actively in her care. Patient-centered care can be beneficial to the patient's overall emotional and physical outcome…In addition, clinicians report greater satisfaction in providing abortion care when they are able to develop a deeper understanding of patients' feelings" (Paul 1999) The continuity of relationships common in family medicine and other areas of primary care may offer additional benefits to patients.

Abortion services can be integrated into general practice in a variety of ways. Many clinicians find it reasonable to incorporate medication abortion as an initial step to getting the practice accustomed to the issues involved in abortion care. Some may decide to only offer medication abortion, and others incorporate the full range of early abortion options. Some clinicians build abortion appointments into their primary care clinic schedule, thereby interspersing appointments throughout the week. Others prefer to establish a “procedure day” during which they offer abortions and perhaps other procedures. Whether you work in a small office or a large group practice and regardless
of the type(s) of reproductive health services you ultimately choose to provide, the information in this chapter will be useful to you.

Below are two examples (one urban and one rural) of primary care providers who have successfully integrated abortion care into their practice:

**Urban Provider**

“I work at a private family practice office in an urban suburb. It's a small office, with only 2 providers working at any time, and we see a culturally-diverse mix of insured, under-insured and non-insured patients. When I started there, the owner was already providing medication abortions (MABs). He says he was always interested in providing full-spectrum women's health care (and until recently when he had difficulties finding obstetric back-up, he was also doing deliveries). And so he called Danco, the maker of Mifeprex, who made it very easy -- they sent him all the information one would need to get set up. The main things he had to do were decide to follow the evidence-based protocol then find a physician who would perform the aspiration procedure if necessary. The process is simple: patients are counseled about options during the visit and, if they choose a MAB, we do a pelvic exam and confirm dates (if there is any doubt about dates or ectopic by history or exam we send the patient for a formal ultrasound) and do the rest of the usual evaluation. We check a serum ßhCG before and after the procedure to confirm--no ultrasounds. I have given patients my cell phone number to call over the next few days if there are any questions, but we also have a formal call system. It is a great part of the practice. The first time I did a MAB there it was with a teenage woman whose father, also a patient in the practice, had recently and unexpectedly died. It felt great to be able to help her through this time in an office where she and her family were known and comfortable.

We are now interested in also providing aspiration procedures. Two of us are completing training with manual vacuum aspiration so that hopefully we can help his office to set this up for this. While there will be challenges, I also know there will be invaluable rewards to being able to provide this procedure in a known, comfortable primary care setting.”

**Rural Provider**

“I am a family nurse practitioner sharing a primary medical care practice with a physician, also my husband. We integrate abortions into our everyday schedule by making what we call walk-in appointments, meaning that a woman calls and we say "what day would you like to come?" then offer: OK, come between 1:00 and 4:00 pm on that day, or sometimes give other times. We find this a more relaxing way to schedule and it sets a better tone from the start. Every day has walk-in appointments unless we are just too slammed. The receptionist takes money, gives the woman literature to read on her abortion choices (we offer medication method up to 9 weeks, and two different suction procedures, the MVA or electrical suction, and IV vs. PO pain meds. Our nurse takes the woman back and Dr. G or I can quickly and easily do an ultrasound even while seeing our other patients and then the nurse proceeds with the intake. We go back in at the end of the appointment to review the information and have the consent signed. If
the suction procedure is wanted, then we do schedule that usually for another
day as we like to prep with vaginal misoprostol and often the woman needs a
driver (if she chooses the IV meds). For the medication method, we give the
meds and will do a walk-in follow-up in 7-14 days at which time we do a
contraceptive visit as well.

We are the primary site of abortion care in the [southern half of our state] and we
find it fits into our primary care setting perfectly. Most of our patients do not know
we even do abortions. The local Planned Parenthood's get picketed by anti-
abortionists and they don't do abortions. About 8 years ago in our little town, a
doc who did only abortions had his office bombed and totally destroyed. We are
therefore somewhat secretive and thus our abortion patients can blend into our
primary care setting and this is good."

The best abortion services take time to build. Incorporating abortion services into your
practice is a process during which you may need to explore core values and attitudes of
your staff, while simultaneously attending to the more concrete tasks of ordering new
medications and implementing new protocols. Approaching this process with a
commitment to open dialogue is fundamental to a successful outcome.
TIPS FOR SUCCESS

SKILL
Continue your learning as much as you can about all aspects of abortion care—from advocacy to ordering—and the possible barriers to its provision, in order to be on the forefront of normalizing abortion as a part of your patients’ regular health care. Be patient and ask for assistance often.

SAFETY
Build relationships with other abortion providers; consult with them on difficult cases. Be sure you have the back up you will occasionally need—specifically, gynecologic and hospital back-up. Know when to refer a patient to another facility or physician (e.g. advanced gestational age or contraindications to outpatient setting). Train staff to handle medical emergencies or security-related situations.

ROLE
While you may find yourself the most knowledgeable person regarding abortion care at your new practice, don’t assume you have to know everything. Use the local and national networks to build a sense of collaborative community, find answers to questions (medical and administrative), and challenge yourself to learning best practices.
FINDING PRACTICE OPPORTUNITIES

While you are considering where to go after residency, here are a few tips to use while interviewing in order to evaluate whether you can offer abortion services in the future.

You will have many practice setting options and combinations including:

- group practice
- multi-practice group
- solo practice
- community clinic
- public health setting
- family practice clinic associated with a hospital
- hospital
- university health centers
- urgent care centers
- emergency rooms
- prisons

In most of these settings, you could be offering abortions to your patients if the practice is amenable to having you do so. When you network or interview in different practice settings, you may want to ask the following questions:

- Ask about the scope of practice (specifically reproductive health care) and patient demographics. For example, do they already provide prenatal and obstetric services? What is the mix of reproductive-aged women?

- Inquire about how they manage prenatal care and genetically indicated abortion referrals. (This will help you to know their feelings about abortion in general, and their referral systems and relationships in particular). Follow-up with asking how they respond to patients who ask for abortion services.

- Consider letting them know that you have special training in abortion care, advocacy, counseling, and administrative set-up; and that you would be willing to spearhead the effort to bring a broader array of these services to the practice. If they seem interested you may want to follow up with these questions:
  - Do you build in time and encourage staff training?
  - What arrangements do they have for hospital or OB / GYN back up?
  - Do they already provide 24-hour call?

- Talk about the importance of continuity of care to your patients and practice. Share a success story from your training—a patient who was able to be seen by her own doctor or provider and how comfortable she felt having this abortion in a familiar setting.

We know that the decision to provide abortions may not be the only issue you discuss in the interview, but it may give you additional insight into the practice setting. You can use this technique to identify how the practice may respond towards women’s reproductive health needs generally and women with unwanted pregnancies specifically.
Dealing with Challenging Questions from Key Players

Once you have started in your new setting and are beginning to embark on integrating abortion services, take the time to identify who are the key stakeholders in the new practice. Depending on type of practice they may be:

- Patients & community members
- The partners in a practice
- Clinic Owner or Medical Director
- Students, Residents, or Colleagues in a nearby training program
- ER / hospital
- CEO or CFO
- Board of Directors

You may want to be prepared to address some misperceptions or questions that could come from the key stakeholders

- This will bring picketers
- Our patients don’t need abortions
- What will it cost?
- There are other providers in this county, why would we take this on?
- Abortion is out of our scope of practice
- What about all the complications from abortion?

Consider ahead of time the multiple reasons to offer abortion care—to broaden the services you offer to women, to offer additional training and skills to the staff (which positively affects retention), and perhaps to provide a cost savings by getting abortions out of the OR. You may want to do some research or ask some of the numerous organizations listed in the “finding support” section of this chapter to help prepare you to spearhead this very important service. Be patient, as this may be a long process. The rest of this chapter should help provide the tools you will need. In addition, this training program also provides technical assistance to help you start offering this service in your new setting.
GETTING STARTED

This section addresses fundamental questions about training your staff, setting up your facilities, and ordering supplies for abortion care.

Be realistic and patient about the amount of work time this process will take. It will take time to integrate abortion and may require various staff meetings and trainings. It will help to clearly articulate the reasons you decided to include abortions in your practice. You may be asked to defend your decisions if, for example, you are faced with an unhappy staff person or realize you have spent more than you made your first month. Returning to your core beliefs about the importance of caring for your patients will be valuable.

GETTING STAFF INTERESTED

Everyone on staff should be considered in the ground work for expanding reproductive health and abortion care, including preparing, training, and offering abortion services. Specifically, they should be exposed to the principles of values clarification and non-judgmental language. Experience has shown that even those staff who may not believe in abortion are more likely to be involved if their feelings and beliefs are acknowledged early on and respected.

How to begin:

1. Conduct a Values Clarification Workshop (available at http://www.reproductiveaccess.org/getting_started/values_clar.htm). This is an invaluable process that can be used in many settings to:
   - Address anxiety around change
   - Identify and dispel myths
   - Separate personal beliefs from professional roles

2. Offer lunchtime trainings or discussions to:
   - Introduce advances in contraception and early abortion including medication and aspiration, as well as the public health impact of limited access to abortion services. Some helpful slide presentations on abortion can be found on the Guttmacher Institute website at www.guttmacher.org or Physicians for Reproductive Choice and Health (PRCH) website at www.prch.org. Some have used the papaya lab for MVA training (see Chapter 10) as an orientation and icebreaker.
   - Role-play options counseling and information sessions (refer to Chapter 2 in this Workbook)
   - Answer questions over the phone (see our Phone Script in the CD/website)
   - Explore what is entailed in informed consent for abortion (see Chapter 2 in your Workbook and the Medical Documentation section in this chapter)
   - Learn valuable verbal and non-verbal tips to build rapport with patients (Chapter 2 in this Workbook)
   - Assist during and after procedure (see Quality Management section of this chapter)
• Prepare for potential negative reactions from friends and family about being involved in abortion care (see excerpts from “Abortion and Options Counseling,” Anne Baker from the Hope Clinic).

You will need to have a plan for integrating staff that do not wish to be involved in all aspects of abortion care. For instance, they could answer phones, make appointments, or offer contraceptive counseling, instead of assisting in the procedure room.

3. Identify and include key staff to participate in conversations and decisions around the following:

- How are you going to integrate/schedule abortion services into the practice?
- What will your fees will be? (see Financial Issues in this chapter)
- How much information will you give over the phone?
- Will you have childcare available?
- Can support persons be present throughout the entire process?
- Will you require your patient to have a ride home (important if you are going to offer IV sedation)
- Will you accept abortion patients who are not already in your practice?
- Will you advertise?
- How will you let your patients know you will offer abortion services?
- Does your malpractice insurance cover abortion?

**APPOINTMENT MAKING AND SCHEDULING ISSUES**

Consider making “every effort to minimize the time between the patient’s request for an appointment and her procedure, as well as the number of visits required to complete the process.” (Henshaw, 1995) We know from patient satisfaction data, that women prefer a one-day abortion procedure and want an immediate appointment (within 3 days of calling). Based on patient forecast consider setting aside procedure-specific time slots to accommodate patients quickly.

“Patients often measure the clinic’s diligence in pursuing their best interest based simply on their perception of the clinic’s efforts in explaining and scheduling their appointment,” page 9, Striving for Excellence in Abortion Care: A Self-Assessment Tool. The CAPS Project.

As you know, medication abortion requires a shorter visit than aspiration abortion. Both require lab work, counseling, and an informed consent process. Aspiration abortion will also require procedure and recovery time. The visit may also include an ultrasound. Most clinicians can facilitate a medication abortion within a routine visit, whereas many clinicians will require a double appointment slot to accommodate patients wanting an aspiration abortion. Remember that your time spent going over information and handling forms will improve with familiarity.

Refer to the Phone Script to help your receptionist handle various abortion inquiries.
Importance of Confirmation Calls

While confirmation calls may be a regular part of your existing practice, it has a particular importance with abortion patients. Beyond the reminder of their appointment, you are calling to:

- Show concern, answer questions, and demystify fears
- Address concerns about transportation or payment
- Give important reminders (e.g. wear 2-piece clothing, underwear for a pad, be sure to have a ride home)

Some argue that there is a risk of breaking confidentiality; however the confirmation call can be done using a code name, calling your self the doctor’s office, or not being made if the client refuses to be contacted.

Where services are more available, patients shop around for abortion care. They may have an appointment with you and still plan to go elsewhere. Contacting them may ensure that you are the preferred provider or alert you to a cancellation.

No Shows

There are many factors that may feed into a “no show” patient: uncertainty, fear of the procedure, lack of funds, transportation, pressure from friends/family, or ambivalence.

You may want to call your patients who fail to show that day. Ask them if they would like to reschedule their appointment to a more convenient time, or if there is any other service that they need. This continues to show concern during what may be a difficult time for them.

Your no show rate is not an immediate measure of success or failure, but rather a reality in even the most successful dedicated abortion clinics. Do use the information gathered from patient comments during your confirmation and follow-up calls to tailor your service to better meet patient needs.

Referrals

Occasionally, you may have a patient you cannot help. She may be too far into the pregnancy, request or need general anesthesia, or require counseling beyond your scope. Have referral numbers for the nearest:

- Abortion providers (be familiar with their fees, anesthesia options, gestational limits)
- Adoption services: open and closed
- Counseling
- Domestic Violence
- Sexual Abuse
- Child Protective Services
- Translator services
- Crisis lines (suicide, overdose, etc)
- After abortion counseling referrals

Tip: The National Abortion Federation Hotline will help patients find a local, qualified provider. 1-800-772-9100.
After Hours Calls

It is critical to provide your abortion patients with an after-hours contact number. Counseling patients on what to expect will help decrease the number of calls, but in the majority of cases, a phone call can save your patients a trip to the emergency room. According to the National Abortion Federation (NAF), abortion providers “must provide an emergency contact service on a 24-hour basis where calls are triaged in accordance with appropriate law. The facility must assure physician referral if indicated,” NAF Clinical Policy Guidelines 2004, page 47.

It will help to have your after hours number printed on your written aftercare instructions. Let your on-call service know you are now offering abortion services.

FACILITIES

Stocking your Clinic: Medications

Refer to Chapter 4 in this Workbook for a listing of basic medications. Here are a few medications you will need to stock, or write prescriptions for:

For aspiration abortion:
- Ibuprofen
- Doxycycline
- Lidocaine +/- bicarbonate +/- vasopressin
- Anti-emetic rectal suppositories
- Methergine/ergonovine (PO/IM)
- Misoprostol
- Atropine
- Benadryl
- Epinephrine
- Ammonium “smelling salts”
- Rhogam (50ug dose sufficient through 12 weeks’ gestation)
- Contraceptive methods including Emergency Contraception

For medication abortion:
- Mifepristone
- Misoprostol
- Ibuprofen
- Hydrocodone with acetaminophen
- Rhogam (50ug dose sufficient through 12 weeks’ gestation)
- Contraceptive methods including Emergency Contraception

Refer to the Spreadsheet Tool in the Financial Issues section of this chapter for a comprehensive list of medications and equipment that you will need for your service.

Stocking your Clinic: Supplies

Below is a recommended list of supplies for your clinic, by room. You may already have many of these supplies.
**Front Desk**
- Pregnancy wheels
- Insurance and fee information
- Phone Scripts for abortion questions, as needed
- Referral numbers

**Exam Room**
- Ultrasound machine (not required)
- Vaginal probe (not required)
- Drape sheets
- BP cuff
- Kleenex
- Chux
- Flashlight
- Knee stirrups or soft padding on foot stirrups
- Emesis basins or bags for vomiting
- Extra sterile medical equipment (small and large spec, tenaculum, MVA parts, set of dilators)

<table>
<thead>
<tr>
<th>Front Desk</th>
<th>Exam Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy wheels</td>
<td>Cannulas</td>
</tr>
<tr>
<td>Insurance and fee information</td>
<td>Needle extenders (with 1.5 inch, 22 gauge needles) or 20 x 3 ½ Spinal needles, if applicable</td>
</tr>
<tr>
<td>Phone Scripts for abortion questions, as needed</td>
<td>Syringes (control top, preferable)</td>
</tr>
<tr>
<td>Referral numbers</td>
<td>Pillow for exam table</td>
</tr>
</tbody>
</table>

Tip: You can make your exam room more comfortable for patients during the procedure by considering the following:
- Indirect lighting will avoid overhead fluorescent lighting shining into the patient’s eyes. This is easy to do by turning an exam light against the wall.
- Hanging a calming mobile or poster over the exam table will help the patient focus.
- You may want to have music in the room.

**Recovery Room** (or place where patients will recover)
- Mirror
- Patient information handouts
- Patient referrals
- Brown bags for supplies/contraception
- Condom basket
- Emergency contraception (pack or prescription)
- Birth control samples
- Gingerale
- Crackers
- Patient journal (for comments/sharing experiences with other patients)

**Lab** (or where you will check products of conception)
- Red biohazard bags
- Strainer
- Shallow clear glass or plastic bowl (Pyrex dish)
- Light source, back light (a slide light box)
- Running water to rinse off blood and clots
- Tweezers or tissue forceps
- Handheld magnifying lens
- Rhogam in the lab refrigerator
- Containers with fixative for sending tissue to pathology
Tip: Find a pathology laboratory where you can send tissue and blood for βhCG. Not all pathology labs will accept fetal tissue specimens.

Emergency
The following is, according to the NAF Guidelines 2004, the minimum equipment and medications that must be available to handle medical emergencies:

- O2 delivery system
- Oral airways
- Uterotonics
- Epinephrine

Refer to Quality Management section for Medical Emergency Drills.

Stocking your Clinic: Medication and Supply Vendors

Below is a list of supply vendors to help you get started. We do not endorse one company over the other and suggest you call around for competitive prices and services.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Products and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Pharmaceutical Partners</td>
<td>Vasopressin, oxytocin, and cefoxitin.</td>
</tr>
<tr>
<td>1-888-386-1300</td>
<td></td>
</tr>
<tr>
<td>Berkeley Medevices</td>
<td>Cannulas, vacuum aspirators and accessories.</td>
</tr>
<tr>
<td>1-510-231-2474</td>
<td></td>
</tr>
<tr>
<td>Henry Schein</td>
<td>General medical supplies, including Rhogram and methergine.</td>
</tr>
<tr>
<td>1-800-772-4346</td>
<td></td>
</tr>
<tr>
<td>Ipas</td>
<td>Manufactures Ipas manual vacuum aspirator (contact HPS Rx, below, to order)</td>
</tr>
<tr>
<td>1-800-334-8446</td>
<td></td>
</tr>
<tr>
<td>HPS Rx Enterprises</td>
<td>A distributor for Ipas manual vacuum aspirator and general medical supplies.</td>
</tr>
<tr>
<td>1-800-850-1657</td>
<td></td>
</tr>
<tr>
<td>Pharmapax</td>
<td>Will re-package medications into patient-friendly dosage, with instructions.</td>
</tr>
<tr>
<td>1-800-547-6315</td>
<td></td>
</tr>
<tr>
<td>McKesson</td>
<td>General medical supplies, including Rhogram and methergine.</td>
</tr>
<tr>
<td>1-800-366-8990</td>
<td></td>
</tr>
<tr>
<td>MedGyn Products, Inc.</td>
<td>Forceps, curettes, specula, and tenacula.</td>
</tr>
<tr>
<td>1-800-451-9667</td>
<td></td>
</tr>
<tr>
<td>Medline</td>
<td>General medical supplies.</td>
</tr>
<tr>
<td>1-800-633-5463</td>
<td></td>
</tr>
<tr>
<td>Pie Medical</td>
<td>Ultrasound machines and equipment.</td>
</tr>
<tr>
<td>732-245-0091</td>
<td></td>
</tr>
<tr>
<td>Shimadzu Medical Systems</td>
<td>Ultrasound machines and equipment.</td>
</tr>
<tr>
<td>1-800-228-1429</td>
<td></td>
</tr>
<tr>
<td>Smith Medical</td>
<td>The only distributor in the United States for mifepristone. Only the physician (not pharmacy) can order mifepristone. For more information on ordering mifepristone from Smith Medical, go to <a href="http://www.reproductiveaccess.org/">http://www.reproductiveaccess.org/</a> or <a href="http://www.earlyoptions.org">www.earlyoptions.org</a>.</td>
</tr>
<tr>
<td>1-800-292-9653</td>
<td></td>
</tr>
</tbody>
</table>
Fetal Tissue Questions and Disposal

Patients often have questions about embryo-fetal development, want to see the tissue, or know what happens to the POC. Please refer to Chapter 2 of this Workbook for ideas on how to handle these questions.

One great resource for staff and patients on embryo-fetal development was developed by Center For Choice in Toledo, Ohio. These books provide detailed information about embryo-fetal development throughout pregnancy. Each week of development is described separately and includes a line drawing showing the actual size of the embryo/fetus. On the back of the fetal development page is a photograph of tissue removed during an abortion. Call for order information 419.255.7769.

According to the 2004 NAF Guidelines, page 51, “all surgically removed tissue must be considered biohazardous and be disposed of in accordance with applicable local, state, and federal regulations. A proper protocol for tissue disposal must be in place.” Contact your local Department of Health to find out current regulations.
MEDICAL DOCUMENTATION

Medical documentation is fundamental to patient care, follow up, and risk management. Customized forms that allow you to document quickly and thoroughly will help with the successful integration of abortion care into your practice.

The main forms that you will need include informed consent, operative or procedure note, discharge note, after care instructions, and follow up visit. Consider having fact sheets on comparison of medication versus aspiration abortion, ectopic precautions, Rh factor, contraceptive options and emergency contraception. Examples are available on the CD/website.

In this section, we will review important points to include in staff training.

INFORMED CONSENT

In Chapter 2 of this Workbook you will find information to help train your staff about the issues specific to abortion when obtaining informed consent. It is important for staff to understand the informed consent process – even if they are never formally obtaining it – because they have contact with patients that the provider does not. Staff should feel empowered to bring any concerns to the provider’s attention (e.g. staff witnesses an overbearing partner telling a patient that she has to “go through with this.”).

The goal of informed consent is to assure that the woman’s decision is voluntary and informed and to obtain legal permission for an abortion. Informed consent is a process, not a just signing a form. It is an opportunity to establish a relationship with your patient, ensure the decision is her own, and explore her understanding of the procedure.

Discussion should include:

- Information about pregnancy options (abortion, parenting and adoption), and potential risks and benefits of continuing or terminating the pregnancy;
- An opportunity to explore the patient’s feelings about her decision and confirm that it is voluntary;
- Information about the types of abortion available to the patient and the risks and benefits of each;
- Test that may be performed (e.g. pregnancy test, hemoglobin, ultrasound, Rh typing) prior to the abortion procedure;
- Permission to treat the patient in the event of a complication or emergency;

Tip: For Medication Abortion, most providers and patients prefer to use newer, evidence-based regimens rather than the FDA regimen (see Workbook Chapter 7). Due to FDA requirements, you will need to have each medication abortion patient sign Danco’s Patient Agreement, as well as your evidence-based alternative treatment informed consent. Plan to spend some time explaining why both have to be signed.
ABORTION PROCEDURE NOTES

For medication or aspiration abortion, document and verify:
- Pertinent medical history;
- Confirmation of pregnancy (by urine βhCG or US);
- Gestational age, ultrasound results (if performed);
- Completion of procedure (by POC exam, βhCG or US)
- Rh testing and immune globulin, if indicated. (NAF Clinical Guidelines 2004)

For aspiration abortion, you should also include:
- Pre and post procedure vital signs;
- Comments section – special findings or problems;
- Time (e.g. start and end of procedure, medication given);
- Tissue exam results;
- Allergies;
- Physical exam, as indicated;
- Medications given for pain control, bleeding, or antibiotic prophylaxis
- Birth control choice including offer of Emergency Contraception;
- Referrals given;
- A note on patient’s tolerance to procedure;
- Scheduled follow-up visit, if applicable.

DISCHARGE NOTES

For aspiration abortion, assure that you have documented that
- Patient is ambulatory with documented stable BP and pulse;
- Bleeding and pain are controlled;
- Patient understands instructions outlining signs and symptoms of post-abortion complications and after-hours contact number;
- Post op vitals immediately following procedure;
- Final discharge vital signs.

AFTERCARE INSTRUCTIONS

Include the following in your written aftercare instructions:
- Symptoms of possible complications (fever, severe cramps, heavy bleeding);
- What to expect (cramping, bleeding);
- Limitations (sex, exercise, bathing, swimming, heavy lifting);
- After hours phone number;
- When to return for follow-up.

WORKING WITH INTERPRETERS

If your patient does not speak English, and you do not have bilingual staff available, you must have someone who can interpret. A professional interpreter services is best. However, if you must rely on a friend or family member, be sensitive to the possible limitations.
SAMPLE FORMS, FACT SHEETS, and TOOLS

Samples to help you in developing forms for your practice are available on the accompanying CD/Website. These include:

- MVA Pre Procedure Note
- MVA Procedure Note
- MVA Consent
- Medication Abortion Consent
- Medication Abortion Log
- Medication Abortion Follow-Up Log
- Medication Abortion Visit (Screening Checklist)
- Post-Abortion Patient Instructions
- Aftercare Instructions – medication abortion
- Aftercare Instructions – aspiration abortion
- Interpreter Agreement
- Working With An Interpreter Training Tool
- Rh Information
- Comparison of Medical and Surgical Abortion
- Ectopic Precautions
ENSURING QUALITY

This section will highlight a few areas in quality management that will help you assess and monitor the integration of abortion into your practice, using a 4-Point Quality Management Approach:

A) Training of staff, documentation, and medical emergencies;
B) Data and audit processes;
C) Patient Satisfaction and Complaint processes;
D) Trend Analysis.

A. TRAINING OF STAFF, DOCUMENTATION, AND MEDICAL EMERGENCIES

Evaluate the training needs of your staff in the following four areas.

1. Sterilization and Disinfection

We have included easy-to-follow training posters on the following techniques from Consortium of Abortion Providers (CAPS):

- Wrapping Instruments and Trays for Sterilization
- Unwrapping Sterile Packages, Using Aseptic Technique
- Decontaminating IPAS Syringe
- Cleaning IPAS Syringe
- Drying, Disinfecting, and Storing the IPAS Syringe
- Reprocessing Vaginal Ultrasound Probe

2. Assisting in Procedure Room

Just as you went through your training to learn appropriate procedure room support techniques, you will train your support staff in many of the same techniques. You may want to review with your staff the information included in Chapter 2 of this Workbook.

We have included a checklist for staff when they are in the procedure room with a patient.

During the procedure:

- Address the patient by name and introduce yourself upon entering the room.
- Show empathy and warmth both verbally and non-verbally toward the patient. Look her in the eye and stand near her.
- Indicate that you understand her needs.
- Enlist patient input rather than taking a dominant role during the procedure (offer to hold her hand, if that would be comforting, but do not assume she wants a hand to hold).
- Talk to the patient during the procedure, specifically using relaxation and breathing techniques.
- Explain what is happening during the procedure in simple terms, and relay patient reactions to the provider.
After the procedure:
- A staff or support person should stay in the room with the patient while she is recovering (if recovery is in same room).
- Help her into a comfortable supine position.
- Document post procedure vitals while she is lying down.
- Clean up the immediate area before she sits up so that she does not see the instruments or any blood.
- Monitor until she is stable for discharge.
- Have her put on underwear with a pad before she gets off the table. Allow her some privacy with out leaving the room while she dresses.
- Document another set of vitals with her dressed and sitting. These will be the discharge vitals unless she is unstable.
- Check in with your patient about how she is feeling.

Having a support person in the room may allow your staff to have more flexibility with monitoring the patient. Staff may be able to leave the room if the patient has a support person present. The door should be left slightly ajar if staff has to leave. Another option may be to move the patient from the exam room to a semi-private recovery area allowing the patient to be monitored by staff as they continue routine tasks. Consider a recliner chair tucked into the end of a hallway.

Tip: After IV pain medications, patients may be groggier and have more nausea than with local anesthesia, therefore requiring more observation and longer recovery time. If you have a separate recovery area, you may want to consider having a wheel chair to transport patients.

3. Documentation

In addition to the standards you already follow for medical charting, here are some things that may be pertinent to abortion care.
- Document who assisted in the procedure
- Record initials by each set of vitals
- Use non-judgmental statements in records
- Abortion provider should sign off on ultrasounds, unless performed by a certified radiologist
- Document allergies, specifically latex, iodine, shellfish, and medications
- Document any changes in patient status during recovery (e.g. patient states, “I feel dizzy.”), and have provider sign the discharge note.

4. Preparing for Medical Emergencies

Preparedness is the key to managing any medical emergency effectively. You may already do emergency drills for your office, but we have included drills on two scenarios that may occur during an abortion. Scenarios work best when they are acted out.

Include all staff. If you are in a larger practice it is helpful to break staff into 2 teams. One observes and later critiques, while the other does the drill.
Role-playing: Have staff go to the places where they would normally be on a given day (e.g. lab, front desk, rooming patients). You will want to monitor:

- Communication
- Response (and time it took to respond)
- Preparedness
- Documentation
- Accessibility of medications and equipment

Medical emergencies will go more smoothly if the staff work well together as a team. Spend some time working on how to communicate with one another during an emergency. Remember to practice documenting in the chart what is happening to the patient.

Review where and what medications you will need (e.g. methergine in the refrigerator, ammonia inhaler in the drawer, and O2 tank is in the hall).

Drill 1: Patient “Feels Faint”

Scenario: Medical assistant is cleaning room just after an abortion. Patient sits up, states she feels woozy, and appears pale and sweaty.
Set Up: Pick one person to be the patient and another to be the medical assistant.
Action: Each drill should be conducted twice. The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:

- Immediate steps to take: have patient lie down, cool cloth on head or neck, feet up, record vitals
- Always ask for help
- Determine who is in charge
- Know where atropine is kept
- Know where your ammonia inhalants are kept
- Discuss how long you want to monitor the patient
- Review appropriate and timely documentation
- Discuss actions taken for follow-up

Perform the drill a second time

- Review staff performance and improvements

Follow-up

- Discuss preventive measures (e.g. avoid leaving patient unattended and recognize symptoms of a vasovagal reaction).
- Offer positive feedback on improvements.
Drill 2: Hemorrhage

Scenario: After presumed completion of the procedure the patient begins to bleed heavily.
Set Up: Assign one person to be the patient. A provider and a medical assistant are in the room with the patient.
Action: Each drill should be conducted twice: The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:
- Did provider communicate clearly to staff how she wants to manage the bleeding?
- If provider needs uterotonics, did the assistant leave briefly or not at all to retrieve it?
- Document vitals signs every few minutes until emergency is resolved

For purposes of the drill, practice managing a hospital transfer:
- Provider instructs someone to call to 911/ambulance service
- Designate a staff person to copy entire medical chart to accompany patient, including up-to-date notes and vital signs
- If necessary, designate someone to accompany patient to the hospital
- Designate staff to contact or speak to support person
- Consider if and what to tell other patients
- Provider calls ER or hospital ahead of time to discuss the case

Perform the drill a second time:
- Review staff performance and improvements

Follow-up:
- After the emergency is resolved, encourage the staff to debrief about what worked

B. USING DATA AND AUDIT PROCESSES

Gathering data and performing audits periodically will allow you to measure how well your newly integrated services are operating. It is important to measure from the patient perspective and to measure systems, not the performance of individuals. Having staff and patients involved in identifying necessary improvements will facilitate positive change.

1. Using Data to Evaluate New Services

To undertake an audit of abortion care in your practice, we suggest you gather data on the following indicators:
- Length of visit
- Patient wait time
- Length of time between first call and appointment date
- Patient perception of pain and pain management
- Ease of scheduling follow-up appointments
Here is a simple but useful methodology for measuring your service indicators:

- Identify criteria
- Set performance goals
- Collect data
- Analyze data
- Identify areas of improvement
- Implement improvement activities
- Evaluate both desired and undesired outcomes

**Example: Measuring the Total Time of a Visit**

1. Identify criteria: Time from check-in to discharge. It is helpful to note the significant or distinct parts of a visit (start and end times for: completing paperwork, ultrasound, time with provider for counseling and procedure, and recovery).
2. Set performance goals: No more than 1 ½ to 2 hours for visit.
3. Collect data: Create a small sheet where you can collect patient name, date, and above mentioned times. Decide to collect for 2 weeks or a month.
4. Analyze data: Find out where the bottlenecks are within the visit and why they are happening.
5. Identify areas of improvement: Is service taking longer than you thought? Are you taking too many ultrasound pictures? Could you create an FAQ Sheet to help with your patient’s most commonly asked questions? Are there ways to streamline counseling, consents or procedure? Are there necessary and ample instruments in room?
6. Implement improvement activities: Implement the solutions identified for the above problems.
7. Evaluate: Collect data again to see that you made the right improvements. Or, did you create different bottlenecks?

**2. Audits to Evaluate your Services**

An important part of managing the quality of your services is to review charts for completion and accuracy. This enables you to determine what sort of improvements and training is needed.

We suggest auditing approximately every 3 months after beginning your abortion service, and at least twice a year. National quality standards suggest reviewing 30 charts each time, or 10% of your total visits.

Refer to the sample chart review tools at [www.reproductiveaccess.org](http://www.reproductiveaccess.org) for auditing medication and aspiration abortion charts: [MVA Chart Review](http://www.reproductiveaccess.org), and [MAB Chart Review](http://www.reproductiveaccess.org).

We suggest you also conduct audits of the following:
- Medication Abortion follow-up rate
- Any abortion complication (see NAF textbook Chapter 15 for complication definitions)
- Number and type of after-hours calls
- Coding practices and actual reimbursement
C. PATIENT SURVEY PROCESSES

In a patient-centered practice having consistent and useful patient feedback is crucial to offering excellent care. This information creates opportunities for reflection, enriches learning, and ultimately helps to improve the patient’s experience.

1. Using Patient Satisfaction Surveys

In collecting patient feedback, it is important to create and maintain an environment where criticism and feedback (both positive and negative) are used for improvement of systems to benefit the patient, not as punishment of individuals.

The following questions come from the 1999 Picker Institute Abortion Study, which identified these as the 22 most important criteria for patients. Consider obtaining patient feedback through the use of surveys on an intermittent regular basis.

We are interested in your opinions about your visit today and about the care you received from your doctor and the staff. Please rate each of the following things about this visit. (Mark one answer for each item).

For the questions below, circle a number from 1 to 5 to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>1=Strongly Disagree</th>
<th>2=Disagree</th>
<th>3=Neutral</th>
<th>4=Agree</th>
<th>5=Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person on the phone put me at ease</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person on the phone was knowledgeable</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person on the phone was courteous</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount of time that I waited to see a staff person was acceptable</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the waiting areas of the clinic, staff was very sensitive regarding my confidentiality</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the procedure, clinic staff showed respect for my privacy</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The amount of time with the provider during the procedure was acceptable</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The medications I received for pain management were adequate</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The staff did enough to make me feel comfortable in the recovery room</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had enough privacy in the recovery room</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I received as much attention from the staff that I wanted in the recovery room</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would rate my overall experience as positive</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please circle “Yes” or “No” to answer the questions below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I received all of the information that I wanted about the procedure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I was given the opportunity to discuss all of my concerns and fears</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I received information about emotions or physical reactions I may have after my procedure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I received information on birth control methods</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I received information on sexually transmitted diseases</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I received as much information and counseling as I wanted</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The provider who performed the procedure made me feel comfortable</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>During the procedure, the pain was less than I expected</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When I left to go home, I felt physically ready</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I was told what problems to watch for after I left the clinic</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
2. Complaints

In a patient-centered environment, concerns and complaints are not a measure of failure, but an opportunity for improvement. There should be no punishment for surfacing and discussing problems.

A patient with a complaint is frequently satisfied to know that someone has listened to her issue and that action is being taken to resolve the situation. Concerns and complaints are not a measure of failure, but an opportunity for improvement. In addressing complaints, the following steps should take place:

- Acknowledge the problem being described and reflect it back, letting the patient know that you take her comments seriously.
- Take responsibility for the problem instead of shifting blame. Find out what you can do to resolve the situation for this patient. Ask her what she would like. Do not assume or make suggestions for her.
- Thank her for bringing the issue to your attention. Let her know that her willingness to voice her concerns helps improve services for everyone.
- Be committed to respond in a timely (usually 48 hours) manner.
- Document complaints, including date, time, and type of complaint.
- Consider reviewing complaints intermittently to identify improvement opportunities.

D. TRACKING TRENDS IN YOUR PRACTICE (TREND ANALYSIS)

You may already undertake a process of trending and analyzing risk management information. If so, you know that it can help identify problems, and potential problems, in a timely manner. Looking at trends can be more helpful than looking at statistics alone, by allowing you to look at data over time. You may experience a rash of complaints or complications all at once, and then none for many months. Looking at data quarterly and annually will give you a better overall picture of your service, rather than looking at data in shorter intervals.

We suggest you perform trend analysis on the following indicators:

- Utilization of services (how many patients did you see for a specific service)
- Completion rate (how many medication abortion patients come for follow-up)
- Complications
- Complaints
- Worker’s Comp claims
- Medication errors

Consider maintaining and reviewing logs for each indicator above. When creating logs, the simpler the better.
LEGAL AND REPORTING CONSIDERATIONS

This section will provide a brief overview of the laws and reporting requirements specific to abortion care in different states. We are only mentioning laws that pertain to first trimester aspiration and medication abortion. For the most up-to-date information go to www.naral.org, www.guttmacher.org, www.prochoice.org, or www.plannedparenthood.org. The states listed below are states with restrictions as of 2007.

Your practice will already have reporting procedures for statutory rape or abuse and sexually transmitted diseases. Be aware that certain states require reporting of abortion complications and hospitalization. Consult your Department of Health for more information and reporting procedures.

BIASED COUNSELING AND MANDATORY WAITING PERIODS

Biased counseling laws require clinic staff to give patients detailed, usually state prescribed information before being eligible for an abortion. Mandatory delays require women to wait usually 24 hours between a state mandated counseling session and an abortion. States that require one, or both of these are: AL, AK, AR, DE, GA, ID, IN, KS, KY, LA, MI, MN, MS, MO, NE, ND, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI.

Counseling Bans these “Gag Rules” prevent facilities that receive state funds from counseling about or referring to abortion under certain circumstances: AL, AZ, IL, IN, KS, KY, LA, MI, MN, MS, MO, ND, NE, OH, OK, PA, SC, VA, WI

TITLE X FUNDING

In 1993 President Clinton rescinded the domestic Title X gag rule. Section 1008 of Title X states, “women who request options counseling must be given information about carrying a pregnancy to term, adoption, and abortion, and a referral to an abortion provider if requested.”

The discussion for options of an unplanned pregnancy must be non-directive. Title X clinics may provide “as much factual, neutral information about any option including abortion, as they consider warranted by the circumstances, but may not steer or direct clients towards selecting any option including abortion in providing options counseling.” 65 Federal Register, Section 41270.

The Department of Health and Human Services has not prohibited “self-referral” for abortion services to date.

For more information go to www.prochoice.org to read their “Abortion and Title X: What Health Care Providers Need To Know” fact sheet.
INSURANCE COVERAGE PROHIBITION

4 states prohibit private insurance coverage for abortion except in cases of life endangerment or if the woman pays an extra premium for additional abortion coverage. They are ID, KY, MO, ND.

9 states prohibit state employee insurance for abortion except in cases of life endangerment, health endangerment, rape/incest, and/or fetal anomalies. These states are: IL, MA, MS, NE, ND, OH, PA, RI, VA. Colorado and Kentucky laws prohibit abortion coverage under any circumstance for state employees.

MANDATORY HOSPITALIZATION

25 states require the performance of abortions in hospitals or other specialized facilities even in the early stage of pregnancy: AK, AR, CT, GA, ID, IN, MA, MN, MS, MO, NV, NJ, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, UT, VA, WI.

PROTECTION AGAINST CLINIC VIOLENCE

The Freedom of Access to Clinic Entrances (FACE) Act is a federal law that was enacted in 1994 to protect medical personnel and women seeking reproductive health care against blockades and violence. The following states have passed similar laws in order to increase their options for enforcement: CA, CO, CT, DC, KS, ME, MD, MA, MI, MN, MT, NV, NY, NC, OR, WA, WI.

PUBLIC FUNDING AVAILABILITY & RESTRICTION

There are 17 states in which Medicaid will fund abortion in all or most circumstances: AK, AZ, CA, CT, HI, IL, MD, MA, MN, MT, NJ, NM, NY, OR, VT, WA, WV.

In 33 states and DC, Medicaid has restrictions on abortion coverage: AL, AR, CO, DE, DC, FL, GA, ID, IN, IA, KS, KY, LA, ME, MI, MS, MO, NE, NV, NH, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WI, WY. Most will only cover abortion in cases of life endangerment, rape, or incest. A few have physical health endangerment and fetal abnormality exceptions. South Dakota will only cover in cases of life endangerment.

REFUSAL CLAUSES

These laws protect the right of certain medical personnel, health facilities, or institutions to refuse to participate in abortion on the basis of moral or religious beliefs. 46 states and DC have such laws: AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WY.
PARENTAL CONSENT OR NOTIFICATION LAWS

There are 36 states that enforce the laws requiring a minor to obtain the consent, or notify an adult (usually a parent) before having an abortion: AL, AZ, AR, CO, DE, FL, GA, ID, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, NE, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI, WY.

Only Utah does not have a judicial or other bypass provision to secure a court order in lieu of notifying her parents.

Tip: Jane’s Due Process (www.janesdueprocess.org) is a Texas-based organization working to help minors seeking abortions. They are an excellent resource for forms and advocacy regardless of where you practice.

TARGETED REGULATION OF ABORTION PROVIDERS (TRAP)

33 states impose onerous restriction and regulations on abortion providers that are not imposed on other health care providers. As a general rule, TRAP laws require the licensing of facilities that provide abortions and then authorize the state health department to inspect those facilities and to ensure compliance with a range of statutory or regulatory requirements. AL, AK, AZ, AR, CT, FL, GA, ID, IL, IN, KY, LA, MA, MI, MN, MS, MO, NV, NJ, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WI.

Tip: Do not reinvent the wheel or think you are in this alone. There are many national, state, and local pro-choice advocacy groups who can share their expertise on how to provide abortion even with these restrictions.
Obtaining affordable malpractice coverage is currently a challenge for clinicians in every area of medicine, and abortion services in particular. Although the financial risk to the insurer for abortion services is approximately one third that of obstetric services, insurance companies often “bundle” abortion with general Ob-Gyn coverage, in spite of much lower complication rates. In addition, many insurance companies do not yet recognize abortion as a service that falls safely within the scope of practice of primary care providers, in spite of significant safety and efficacy data.

The good news about malpractice is that federal and state lawmakers are moving toward considering legislation to help resolve this issue within the next few years. There have been a series of recent physician-led community efforts to help insurance companies understand the safety of covering abortion services, and others have identified sources of law that may limit insurers’ ability to deny coverage or charge high premiums for medical abortion. However, for most providers in private or small group practice there remains no easy, affordable solution. We therefore provide a list of options, along with the potential advantages and disadvantages of each.

<table>
<thead>
<tr>
<th>Malpractice Option</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAF Group coverage in progress (contact NAF for update or to join plan)</td>
<td>• Large group of physicians ensures bargaining power.</td>
<td>• Cost is unknown at this time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinic coverage only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be NAF member.</td>
</tr>
<tr>
<td>Risk Retention Group</td>
<td>• Allows providers to decide what to charge the group for premiums, what policies to adhere to, and what level of risk is acceptable.</td>
<td>• Physicians within the group must be like-minded and share a similar level of risk.</td>
</tr>
<tr>
<td></td>
<td>• Profit can be put back into premiums.</td>
<td>• Still may need to attract a secondary (excess) carrier.</td>
</tr>
<tr>
<td>Commercially purchased insurance</td>
<td>• Risk is individually assessed, which may be helpful for some.</td>
<td>• Most likely to be high-cost.</td>
</tr>
<tr>
<td>(potential carriers include companies such as Chubb, Eevinston, and Admiral)</td>
<td>• Does not require organizing with other physicians.</td>
<td></td>
</tr>
<tr>
<td>Going without (going “bare”)</td>
<td>• No insurance premiums.</td>
<td>• May put personal assets at risk.</td>
</tr>
<tr>
<td></td>
<td>• Does not require organizing with other physicians.</td>
<td>• This option may not be legal in your state.</td>
</tr>
<tr>
<td>Gap coverage</td>
<td>• Covers services such as abortion that are not covered by Federal Tort Coverage (FTCA) – FQHC 330 sites</td>
<td>May be expensive</td>
</tr>
<tr>
<td>Part-time policy</td>
<td>• Less expensive in some cases than gap coverage, because it only covers the % time the physician is performing abortions.</td>
<td>• Safest to purchase alongside &quot;entity coverage&quot; that covers the clinic at all times.</td>
</tr>
<tr>
<td></td>
<td>• May be particularly helpful for Federally Qualified Health Centers</td>
<td></td>
</tr>
</tbody>
</table>
No matter which option you choose, it is important to check first with the insurance commissioner of your state to ensure the coverage is adequate for your services. There is currently no uniform code for insurance coverage. Not only do states differ in terms of whether they require you to have insurance coverage, but they also differ in which insurance companies they consider to be legitimate. Especially if you plan to purchase individual insurance, make sure to check that your carrier is on the approved list.

Tip: A targeted, short-term fundraising campaign may be an option for raising the fee required for a rider. See fundraising suggestions on www.grassrootsfundraising.org.

Tip: Contact Allen Labadorf of Sobel Associates to discuss Gap Coverage: (516) 745-1111
SECURITY

Many of you already have security plans in place in your practice setting. This section is intended to help coordinate some of those plans with some preparedness training for any new security concerns you may have to consider while providing abortion care. Security is an issue for any medical setting, and this is really no different, but if you do not have some sort of structured security training or preparedness training, than perhaps this section can help.

The very thought of this issue conjures visions of clinic blockades and invasions, or worse. Certainly there was a time when this was more the norm at abortion clinics. The main factors contributing to the decrease in clinic violence are: stronger federal and state laws protecting clinics, a move towards more “mainstream” action from those opposed to abortion, and changes in public tolerance towards violent behavior. In fact, well-executed TRAP (Targeted Regulations of Abortion Providers) laws and restrictive legislation are more of a threat to integrating abortion services today. For the most current information on incidence of violence and disruption, go to www.prochoice.org.

While the instances may be rare, as with any good risk management program, security preparedness and violence prevention are the best steps towards protecting your staff and patients. It is important to document any incident. A sample Incident Report Form (Disruption/Violence Report) sample is available on the CD/web.

When working with your staff it may be helpful to put security into a larger framework (e.g. all clinics need to be prepared to handle fires or disruptive patient behavior, not just those that offer abortion services)

DRILLS

We have included drills on four different scenarios. One drill is outlined here and the other three can be found on the CD/Website as Security Drills. These drills help prepare staff to handle critical situations. They also help staff express concerns, know their fears are taken seriously, and understand their role in keeping their workplace safe.

The best preparedness training is achieved when scenarios are acted out and staff has to actually respond.

Begin by telling staff you are going to run drills on a certain day. Include all staff. If you are in a larger practice it is helpful to break staff into 2 teams. One observes and later critiques, while the other does the drill.

Role-playing: Have staff go to the places where they would normally be on a given day (e.g. lab, front desk, rooming patients). You will want to monitor:

- Communication
- Response (and time it took to respond)
- Preparedness
Emergencies will go more smoothly if staff communicates well. Spend some time working on how to communicate with one another during an emergency. We recommend that the following drills be practiced every six months. They don’t all have to be done at the same time. With practice, a drill can take as little as ten minutes. Drills include:

- Manageable Fire
- Unmanageable Fire
- Bomb Threat
- Patient or visitor disruption (included here)

**Patient or Visitor Disruption or Violence**

Scenario: The patient is in an exam room with her boyfriend, waiting for the provider to return with some forms. Patient’s boyfriend begins screaming, threatening her.

Set Up: Choose to act as either boyfriend or patient. Designate a staff member to play other role. Begin yelling and making threatening gestures.

Action: Each drill should be conducted twice. The first drill is used to see what staff would normally do and the second to make improvements.

After the first drill review these key points:

- Ask the patient/visitor to change behavior immediately.
- Tell the patient/visitor to leave the clinic. Let them know the police have been called.
- Instruct someone to call 911 and inform them that you have disruptive or violent people in the clinic that need to be removed immediately.
- Do not get involved in their fight.
- Do not get in between this person and the exit. You do not want to be trapped and you want to encourage them to leave.
- Do not physically get in between the patient and boyfriend.
- Assign staff to move other patients away from incident.
- Document on an Incident Report Form (see sample Disruption/Violence Report).

Perform the drill a second time to:

- Review staff performance and improvements
- Debrief. These drills may bring up a lot of emotions for you and your staff.

Things to think about:

1) Understandably, staff feel that it is their job to make sure the patients are safe. However, emphasize that it is not their responsibility to intervene in these situations, and that doing so may make the situation worse.

2) Consider contacting local law enforcement to solicit their suggestions for this situation, and what their response time would be. This gives you an idea of how long you will need to manage the patient and contain the situation.
MAIL HANDLING

While mail handling is an important security measure to review, it really does not work as a role-play scenario. Instead, please review with your staff the important salient points about handling mail.

When handling mail, there are a few ways to identify a suspicious letter or package:

- Excessive or no postage
- Inaccurate or misspelled names and addresses
- Lack of return address or return address and postmark are from different areas
- Noticeable messiness or discoloration, unusual odors, or unprofessional wrapping
- Drawing, unusual statements, poor typing, or handwritten address
- Statements such as “Open Addressee Only,” “Special Delivery,” or “Personal and Confidential”

What to do:

- Trust your instincts. If package doesn’t “feel” right, do not handle it!
- Isolate the package
- Notify the in-charge person
- Notify the police and follow evacuation procedures if necessary

What not to do:

- Do not shake a suspicious package
- Do not open a suspicious article
- Do not place a suspicious article in a confined space such as a cabinet or a drawer
PHONE NUMBERS AND CONTACTS

Here is a security phone list for you and your staff to fill in:

<table>
<thead>
<tr>
<th>Phone Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Police</td>
<td></td>
</tr>
<tr>
<td>(contact name: ______________________)</td>
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<tr>
<td>Local FBI</td>
<td></td>
</tr>
<tr>
<td>Local ATF</td>
<td></td>
</tr>
<tr>
<td>(Bureau of Alcohol Tobacco and Firearms)</td>
<td></td>
</tr>
<tr>
<td>U.S. Marshals</td>
<td></td>
</tr>
<tr>
<td>Postal Inspector</td>
<td></td>
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<tr>
<td>Fire Department</td>
<td></td>
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<tr>
<td>Bomb squad</td>
<td></td>
</tr>
<tr>
<td>Hazardous materials team</td>
<td></td>
</tr>
<tr>
<td>Alarm company</td>
<td></td>
</tr>
<tr>
<td>Fire alarm company</td>
<td></td>
</tr>
<tr>
<td>Phone company</td>
<td></td>
</tr>
<tr>
<td>Electric/utilities company</td>
<td></td>
</tr>
<tr>
<td>Landlord/Management Office</td>
<td></td>
</tr>
<tr>
<td>EPA Chemical Emergency Response</td>
<td>1-800-424-8802</td>
</tr>
</tbody>
</table>
FINANCIAL ISSUES

If done well, adding abortion into your practice should not cost you money. In time, all costs should be recoverable through proper billing and appropriate setting of cash fees. But the information may help you make sure of this.

There are three main components of financial analysis for integration of abortion services, including cost, revenue, and profit or loss. As you know, there are also many intangible benefits of integrating these services, including improved continuity of care, patient retention, and enhanced relationships with your patients.

Because of many one-time expenses, you may not be able to show a profit in the first year of services, especially if you are seeing a low volume of patients. However, over time – maybe 2 to 3 years – the variable supply costs should be very low, especially if you take advantage of group purchasing programs.

COST

Like any service, the first thing you will do is cost out what it will take to provide an abortion, then identify your revenue sources (e.g. cash, state funds), and research what your competitive market will bear.

Please see Spreadsheet Tool on the CD/website. You can input your own variable and fixed costs and patient volume to determine your approximate cost per procedure.

REVENUE

Knowing who will pay for abortion services is another important step. In the following 15 states, Medicaid will reimburse for abortion services in most circumstances: AK, AZ, CA, CT, HI, MA, MN, MT, NJ, NM, NY, OR, VT, WA, WV

In other states patients most often have to pay cash. (See Fee Setting below).

Because many of your patients are already insured, it will be beneficial to research if any of those insurance plans will cover abortion services. If not, then consider negotiating contracts with those insurance companies with which you already have relationships. Be prepared to dedicate staff time to building these relationships and establishing new contracts. Although some of your patients may be insured, it is important to note that approximately 40% of women who have insurance decline to use it for abortion services.

Tool: See FP Insurance Letter to use as blueprint for contacting an insurance company.

When billing Medicaid or private insurance, using proper billing codes is very important to getting accurate reimbursement. Billing codes differ from state to state. The www.reproductiveaccess.org has a list of billing codes for aspiration and medication abortion. In the state of California, please see the ANSIRH CD/website for a listing of Abortion Reimbursement Rates.
There are three considerations when setting your fee:

1) What are your actual costs?

2) What are your competitors charging?

3) What is the value placed on it by patients?

In setting your fees, include:

• Rhogam
• Pain medication
• One month of birth control
• The follow-up exam
• Emergency contraception

The receptionist making the appointment should be able to articulate all the services included in this bundled fee.

According to the Guttmacher Institute, in 2003 the average fee for a first trimester abortion in the United States is $400.00. Medication abortion fees vary significantly. Fee differences may impact on a woman’s choice or make her preferred procedure inaccessible. Therefore consider setting the same fee for aspiration and medication abortion.

**PROFIT OR LOSS**

For the first year, due to capital purchases, and assuming a low volume of patients, there may not be much profit, and may even be some loss. We suggest a three year forecast to show a trend of breaking even, and eventual profitability. Be patient.

Often we hear that the controversy that comes with offering abortion services is not worth the minimal profits. A simple cost and expense analysis may not be enough to refute this argument. Be prepared to respond to these obstacles with your reasons for learning the procedure in the first place.
FINDING SUPPORT

DEVELOPING A NETWORK

Building a supportive community may be the key element to helping you sustain your abortion services. Building community support requires some advance planning, creativity, and courage.

Think of your support network in three key groups: your Core group, Usual Suspects, and Unusual Suspects. Your Core Group might be made up of those people working with you to implement the services (perhaps a supportive receptionist or nurse, a mentor, board members, the person who referred you to your training program). Think of these people as your key stakeholders.

The Usual Suspects might be the other local abortion providers, local Planned Parenthood, reproductive health care providers known to refer for abortion (this may be a list that other abortion providers can help generate), and political organizations (NOW, NARAL, PRCH League of Women Voters).

Identifying your Unusual Suspects requires creativity and is specific to your community. This might include faculty at a university women’s studies department, women-owned businesses, community health care providers, community educators, advocacy groups, high school nurses or guidance counselors.

Start with what is easy, and be encouraged whenever you make useful contacts. After identifying your Core Group, meet to decide what your goals or needs are in terms of support. If it seems that broader community support will be beneficial, identify and contact your Usual Suspects, inviting them to an informal discussion group. Consider inviting each person to talk about:

- The services or programs they offer
- The patients they see
- How abortion touches the lives of their patients or their day-to-day work
- What kind of support they have needed and what kind they can offer

This is an important networking opportunity. Be sure to gather everyone’s contact information. Discuss ways in which you can continue to support each other in the future.

The local Planned Parenthood or political group might host this, to reduce your workload and to limit your exposure.

You may want to go further in your search for community support. One suggestion would be to work with Planned Parenthood or another feminist group to set a panel discussion aimed at demystifying and normalizing abortion. Inviting you Core and Usual Suspects along with some identified Unusual Suspect would be appropriate.

When you are trying to start an abortion service, don’t be surprised that people within and outside your practice may throw you curveballs. For instance, if your head administrator or CEO is continuing to stall the initiation of abortion services, you may want to use some of the techniques in the Values Clarification Tool to discover her or his
underlying concerns. Integrating abortion is much more than adding a service, or learning a new technique. It will require patience and determination to overcome obstacles at various steps of the way. Such barriers will vary with the existing culture of the practice, the level of knowledge and skill, as well as the attitudes and feelings of the staff.

Integration of broader reproductive health and abortion services is a process. As you move through it, your health center staff will also begin to gain a more balanced understanding of pregnancy options and abortion access, as well as an enhanced ability to handle divisive issues in a positive, patient-centered manner. Your patients will also gain greater access to these services in a safe, more private and familiar environment.
ORGANIZATIONAL RESOURCES

Your job is to offer excellent care for your patients, not take on the world with endless legal and advocacy issues. If you want to find the best deals for supplies, troubleshoot complications, stay current on new technologies, vent frustration, or build a broader referral network, this list may be a good place to turn. The following organizations are available to provide the assistance, expertise, and support to allow you to get on with your work.

<table>
<thead>
<tr>
<th>Medical and Professional Organizations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Association of Reproductive Health Professionals</strong>&lt;br&gt;www.arhp.org</td>
<td>This site provides excellent information on reproductive health in an easy to understand and fun format.</td>
</tr>
<tr>
<td><strong>National Abortion Federation (NAF)</strong>&lt;br&gt;www.prochoice.org&lt;br&gt;202-667-5881</td>
<td>With membership you have access to:&lt;br&gt;• Group purchasing program&lt;br&gt;• Security consultants&lt;br&gt;• Referral services&lt;br&gt;• Abortion technical assistant&lt;br&gt;• Access to ultrasound training&lt;br&gt;• Educational conferences&lt;br&gt;• Archived tools and forms</td>
</tr>
<tr>
<td><strong>NAFbytes Listserv</strong>&lt;br&gt;<a href="mailto:robinred@hotrock.com">robinred@hotrock.com</a></td>
<td>Email listserv offering access to the shared experience, knowledge, support, and resources of hundreds of NAF members and abortion providers, immediate answers to real time problems, community to combat feelings of isolation or frustration, and archived tools/forms.</td>
</tr>
<tr>
<td><strong>STFM Access Listserv</strong>&lt;br&gt;<a href="mailto:techmanager@rhedi.org">techmanager@rhedi.org</a></td>
<td>Email listserv created to help family practice doctors integrate medication and early aspiration abortion in their practice. Enrollment requires nomination by current member for security purposes.</td>
</tr>
<tr>
<td><strong>Planned Parenthood Federation of America</strong>&lt;br&gt;www.plannedparenthood.org</td>
<td>A national umbrella organization for all local Planned Parenthood affiliates. The website has position papers and fact sheets, as well as numerous FAQs about abortion.</td>
</tr>
<tr>
<td><strong>Physicians for Reproductive Choice and Health (PRCH)</strong>&lt;br&gt;www.prch.org</td>
<td>Educational assistance and opportunities. Regional meetings to network with fellow abortion providers, as well as other non-abortion providing doctors who are supportive of choice.</td>
</tr>
<tr>
<td><strong>Clinicians for Choice</strong>&lt;br&gt;www.prochoice.org/cfc</td>
<td>Membership organization representing CNMs, NPs, and Pas working to increase access to comprehensive reproductive care.</td>
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</tbody>
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<table>
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<tr>
<th>Hotlines</th>
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<tbody>
<tr>
<td><strong>Emergency Contraception Hotline</strong>&lt;br&gt;800-584-9911</td>
<td>Provides information emergency contraception and referrals</td>
</tr>
<tr>
<td><strong>Exhale</strong>&lt;br&gt;www.4exhale.org&lt;br&gt;866-4-EXHALE</td>
<td>Toll-free after-abortion talkline to provide support for women and their support people after an abortion</td>
</tr>
<tr>
<td><strong>NAF Hotline</strong>&lt;br&gt;800-772-9100</td>
<td>Abortion referrals</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Legal</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>ACLU Reproductive Freedom Project</strong>&lt;br&gt;www.aclu.org</td>
<td>Local chapters can provide referrals to pro-choice lawyers</td>
</tr>
<tr>
<td><strong>Center for Reproductive Rights</strong>&lt;br&gt;www.reproductiverights.org</td>
<td>Clearinghouse for information on federal and state laws and policy regarding abortion and reproductive health care issues. Legal advocacy organization dedicated to promoting reproductive rights in the US and abroad.</td>
</tr>
<tr>
<td><strong>Jane’s Due Process</strong>&lt;br&gt;www.janesdueprocess.org</td>
<td>Texas-based organization working to help minors seeking abortions. Excellent source for forms and advocacy wherever you practice.</td>
</tr>
</tbody>
</table>
### Research

<table>
<thead>
<tr>
<th>Institution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guttmacher Institute <a href="http://www.guttmacher.org">www.guttmacher.org</a></td>
<td>Conducts research and publishes extensively on abortion and reproductive health issues.</td>
</tr>
<tr>
<td>Centers For Disease Control and Prevention (CDC) <a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>The CDC works to promote health and quality of life by preventing and controlling disease, injury, and disability. Great source for fact sheets.</td>
</tr>
<tr>
<td>Picker Institute <a href="http://www.pickerinstitute.org/">http://www.pickerinstitute.org/</a></td>
<td>Quality assessment surveys and analysis on health care models</td>
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### Advocacy

<table>
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<tr>
<th>Organization</th>
<th>Description</th>
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<tbody>
<tr>
<td>Abortion Access Project <a href="http://www.abortionaccess.org">www.abortionaccess.org</a></td>
<td>Seeks to ensure access to abortion for all women by increasing abortion services, training new providers, and raising awareness about the critical importance of abortion access to women's lives.</td>
</tr>
<tr>
<td>Catholics For A Free Choice <a href="http://www.cath4choice.org">www.cath4choice.org</a></td>
<td>Information and advocacy for patients, providers, and activists on abortion and reproductive health care issues within a catholic framework.</td>
</tr>
<tr>
<td>Center for Reproductive Health Education in Family Medicine at Montefiore Medical Center <a href="http://www.rhedi.org">www.rhedi.org</a></td>
<td>Tools and forms for family practice physicians starting or continuing abortion services, including sample charts, billing codes, and audits.</td>
</tr>
<tr>
<td>Choice USA <a href="http://www.choiceusa.org">www.choiceusa.org</a></td>
<td>Mobilizes and supports the diverse upcoming generation of leaders in reproductive justice.</td>
</tr>
<tr>
<td>Feminist Majority Foundation <a href="http://www.feminist.org">www.feminist.org</a></td>
<td>National organization working to advance women’s equality and empower women and girls in all sectors of society.</td>
</tr>
<tr>
<td>Indigenous Women’s Reproductive Rights and Pro-Choice Page <a href="http://www.nativeshop.org/pro-choice.html">www.nativeshop.org/pro-choice.html</a></td>
<td>The purpose of this page is to provide information concerning Indigenous women's reproductive health and their perspectives on pro-choice issues.</td>
</tr>
<tr>
<td>NARAL-ProChoice America <a href="http://www.naral.org">www.naral.org</a></td>
<td>Provides information and political action around issues of abortion and reproductive health care issues.</td>
</tr>
<tr>
<td>National Asian Women’s Health Organization <a href="http://www.nawho.org">http://www.nawho.org</a></td>
<td>NAWHO was founded in 1993 to improve the health status of Asian American women and families.</td>
</tr>
<tr>
<td>National Latina Institute for Reproductive Health <a href="http://www.latinainstitute.org">http://www.latinainstitute.org</a></td>
<td>The mission of NLIRH is to ensure the fundamental human right to reproductive health for Latinas, their families and their communities through education, advocacy and coalition building.</td>
</tr>
<tr>
<td>National Network of Abortion Funds 413-582-5645</td>
<td>Network of independent organizations that provide financial assistance to women to pay for abortions.</td>
</tr>
<tr>
<td>Religious Coalition For Reproductive Choice <a href="http://www.rcrc.org">www.rcrc.org</a></td>
<td>National organization of pro-choice clergy and churches. Can provide spiritual counseling</td>
</tr>
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</table>

### Sexuality Education

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<tr>
<th>Organization</th>
<th>Description</th>
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<tbody>
<tr>
<td>Advocates for Youth <a href="http://www.advocatesforyouth.org">http://www.advocatesforyouth.org</a></td>
<td>Champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health.</td>
</tr>
<tr>
<td>Coalition for Positive Sexuality <a href="http://www.positive.org">www.positive.org</a></td>
<td>Information about all aspects of sexuality along with information about parental involvement laws.</td>
</tr>
<tr>
<td>Go Ask Alice! <a href="http://www.goaskalice.columbia.edu">www.goaskalice.columbia.edu</a></td>
<td>This site is run by Columbia University’s Health Education Program and provides accurate and non-judgmental information.</td>
</tr>
<tr>
<td>My Sistahs <a href="http://www.mysistahs.org">www.mysistahs.org</a></td>
<td>Information about sexual health run by and for young women of color.</td>
</tr>
<tr>
<td>Scarleteen <a href="http://www.scarleteen.com">http://www.scarleteen.com</a></td>
<td>Sex education for the real world with a section for men as well.</td>
</tr>
<tr>
<td>Sexuality Information and Education Council of the US <a href="http://www.siecus.org">http://www.siecus.org</a></td>
<td>SIECUS develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates the right of individuals to make responsible sexual choices.</td>
</tr>
</tbody>
</table>
REFERENCES


**EXERCISES: OFFICE PRACTICE**

1. In which settings do you visualize your future participation in abortion services? Do you imagine joining a team that offers abortion services? Or do you picture starting services in a new site? Do you see yourself adding abortion services in a setting where access is currently limited?

2. How would you connect with other abortion providers in your region?

3. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?

4. If an employer thought Title X clinics couldn't provide abortions, what would you say to them?

5. List 3 barriers that you think you may encounter in trying to integrate abortion services in your practice. How would you address them?

6. In a future job site, who are the key stakeholders in starting an abortion service? How would you approach getting buy-in from your stakeholders or staff?

7. What might you do if you have a complication in your clinical site? How will you secure OB or hospital back up? How would you cover call?
EXERCISE 9.1

1. In which settings do you visualize your future participation in abortion services? Do you imagine joining a team that offers abortion services? Or do you picture starting services in a new site? Do you see yourself adding abortion services in a setting where access is currently limited?

   There are multiple settings in which abortions are performed: clinics (community, non-profit, for profit, privately owned, independent, chain), out-patient surgical centers, private doctor or clinicians office, and hospitals.

   There are many ways a trainee could be involved: integrate into current practice, join practice that already offers some abortion services, accept a rotation at a hospital, moon light at a local clinic, or get involved in teaching other providers.

2. How would you connect with other abortion providers in your region?

   Contact NAF, local Planned Parenthood, or local NARAL chapter. Look in the yellow pages for other abortion providers. Ask the Reproductive Health Access Project (RHAP) for contacts in your new area. Ask for contacts on the listserves (NAFbytes, ACCESS) or sign up to join one of the list-serves by having your current faculty recommend you. Get on mailing lists of state and local pro-choice groups so you know what is happening in your community.

   Keep in mind that due to security issues, these organizations may require a direct referral or some identification before allowing you to join their online community sharing contact information.

3. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?

   • Interview your potential employers about the scope of practice (specifically reproductive health care), patient demographics, and staff training.
   • Ask how they manage pre-natal care and genetically indicated abortion referrals. Follow-up by asking how they respond to patients who ask for abortion services.
   • Let them know that you have special training in abortion care, advocacy, counseling, and administrative set-up; and that you would be willing to spearhead the effort to bring these services to the practice or to teach these skills to residents if there is an affiliated program.
   • Talk about the importance of continuity of care to your patients and practice. Share a success story from your training – a patient who was able to be seen by her own doctor and how comfortable she felt having this abortion in a familiar setting.

   Early Abortion Training Workbook
4. If an employer thought that a Title X clinic couldn’t provide abortions, what would you say to them?

While options counseling must be non-directive, agencies who receive Title X funding may still perform and self-refer for abortion services. In some cases the cost of abortion services must be broken out from other services in order to prove that federal funding is not being used to provide abortions. This may require setting up a separate cost center, which is easy to do.

Title X clinics may provide “as much factual, neutral information about any option including abortion, as they consider warranted by the circumstances, but may not steer or direct clients towards selecting any option including abortion in providing options counseling.” 65 Federal Register, Section 41270.

5. List 3 barriers that you think you may encounter in trying to integrate abortion services in your practice. How would you address them?

Expense of malpractice/unable to obtain malpractice coverage.
(See Malpractice section for possible solutions and support)

Capital equipment cost
There are ways to bring abortion services on without investing too much early on. One way to do this is to start with medication abortion. If the ultrasound is the most daunting expense, you can find other alternatives: You can rely more on your expertise in pelvic sizing, refer out for ultrasound when necessary, and use serial beta hCGs instead of ultrasound to ensure the abortion is complete. Investing in a manual vacuum aspiration (MVA) system is only $28.00, and a tray or two of dilators and tenacula may cost around $500.

Reimbursement
Limited reimbursement may be more of an issue in states where there is no Medicaid funding of abortion.

Controversy
There will always be controversy where there is change. The most important step is to find the root cause of the controversy and try to directly address that issue.

• If the problem is that staff may object to the very idea of including abortion in your service, refer to the tools included here for working through values clarification.
• If the controversy is about "turning into an abortion clinic", the statistics in family practice settings suggest that most integrated clinics are likely to perform 1-2 abortions per week
• If the fear is security, there are many resources and people to help assess the actual risk, and determine if there are any areas that may need additional security re-enforcement. Also going through the security drills included here should help staff feel prepared.

The most compelling response to these issues is the experience of the patient. Being able to offer comprehensive care is the most important reason to start abortion services, and will benefit the practice in terms of client retention.

Early Abortion Training Workbook
“No one ever asks for an abortion here. It’s not a needed service”
Consider that by age 45 35% of women will have had an abortion (Guttmacher 2007). Half of pregnancies are unintended, and if you care for pregnant women in your practice, about 1 of every 4 pregnant patients will choose to have an abortion. Women will make different choices at different points in their lives. About 60% of women seeking an abortion have had at least one child. You can safely project that a certain percentage of the women in your practice will seek abortion services. Offering your patients balanced options counseling and abortion care may increase both comfort and access for your patients.

Fear of complications
According to the CDC from 2002, serious complications arising from surgical abortions performed before 13 weeks are quite unusual. About 88% of the women who obtain abortions are less than 13 weeks pregnant. Guttmacher Institute reports that of these women 97% report no complications; 2.5% have minor complications that can be handled at the medical office or abortion facility; and less than 0.5% have more serious complications that require some additional surgical procedure or hospitalization (1996).

Myths about abortion (only poor women need abortion services, none of our patients have unintended pregnancies)
Obviously, these types of arguments are stereotypes that have very little to do with the real information about which type of women seek abortion care. The answer is that women from every age group, every socio-economic background, and who use every type of contraception, seek out abortion services. When faced with these myths, the goal is to move the discussion away from punishing the woman who may need services to focus on the bias the speaker may have about abortion in general.

There are other providers in the area, why do we have to take this on?
There are many areas where there are multiple services being offered - management of hypertension, management of diabetes, dentistry…The reason to offer the services is to meet the needs of your patients, not to compete with other providers. The idea that abortion is just part of the spectrum of comprehensive care for women is the most compelling argument.

Abortion is out of our scope of practice.
Early pregnancy termination is within the scope of practice of Primary Care Physicians, and Advanced Practice Clinicians in some settings. In the Maternity and Gynecologic Care Guidelines for Family Physicians that were developed jointly by ACOG & AAFP, “voluntary interruption of pregnancy up to 10 weeks gestation” is specifically noted as an advance skill for Family Practice Physicians.

Appropriate training in abortion care and demonstrated competency are the key issues. Clinicians from many specialties have excelled at abortion provision and furthermore, have come to make significant advances in the reproductive health field.

Early Abortion Training Workbook
6. In a future job site, who are the key stakeholders in starting an abortion service? How would you approach getting buy-in from your stakeholders or staff?

Depending on type of practice stakeholders may include:
- CEO
- CFO
- Medical Director
- Board of Directors
- The partners in a practice
- Clinic or practice owner (and family)
- Students, Residents, or Colleagues in a nearby training program
- ER/hospital
- Patients

These parties may be swayed by the broadened services for women, increased patient retention, the cost-effectiveness of minimizing referrals or getting services out of the OR, or the training or faculty development options associated with training.

In incorporating staff, first, allow time for this process and room for initial negative and mixed reactions. You may never get everyone to be enthusiastic, or even okay with providing abortions. That does not mean you will not be able to offer abortion services. Try the following tactics to encourage their participation:

Model:
- Commitment to patient centered care
- Confidence in your technical skills and your ability to assist staff in transition to offering this service.

Train – offer formal and informal staff meetings on the following:
- Q&A about abortion (safety of, who has them, types of abortion services)
- Values Clarification exercises
- Shared experience from your TEACH training

Reassure:
- Offering abortion will not disrupt but rather enhance services
- Do not intend to become an “abortion clinic”, but rather help our patients who trust us already
- We will begin slowly and have all the training and support that we require

Personalize:
- “I would want my sister or friend to be cared for by a staff like this.”
- Share success stories from your TEACH training of specific patients.
7. **What might you do if you have a complication in your clinical site? How will you secure OB back up? How would you cover call?**

Despite careful planning, systems development, and staff training, complications will occur. Prescreening and sound medical practices will minimize their severity. Your first priority is to stabilize the patient and adhere to her needs.

Remain calm and clear. Let your other patients know there may be a delay. Document clearly and completely. Pay attention to the details. Allow time for staff to ask questions and debrief, particularly if the complication required a hospital transfer. Send complete notes, and communicate directly with your referral MD or clinician. Meet all state and local reporting requirements.

Keep in mind that most complications can be cared for by the primary care providers on either an outpatient or inpatient basis, as appropriate. Primary care providers can do aspirations for retained products or hematometra, treat most hemorrhages (as they would in OB patients), and treat pelvic infections (even if the patient needs hospital admission and IV antibiotics) (Prine 2003).

Talk with other providers in your practice to see if they know of providers for back-up referral. Ask the nearest abortion provider who provides their back up. Contact Access Project to see if they can help you identify an abortion-friendly hospital and then contact their OB Department.

Most early perforations are benign and can be managed conservatively. The rare occurrence that would require OB-Gyn backup is the major perforation requiring surgery or a ruptured ectopic.
10. EVALUATION

Evaluation and feedback are among the most important tools in effective learning. The ACGME and the American Board of Medical Specialties (ABMS) provide information about the validity and feasibility of a variety of evaluation methods that may be used to assess performance and skills (http://www.acgme.org/Outcome/assess/Toolbox.pdf).

The following instruments, developed for use with this Training Workbook, are based on ACGME-recommended methods (in parentheses). They are designed to assist in the evaluation of participants, faculty, staff, and the overall rotation. All forms may be used or adapted for the residency or high-volume training setting. These and various alternative evaluation forms can be downloaded separately at either http://teachtraining.org or www.rhedi.org.

- Abortion Performance Log (Procedure Log)
- Observed Performance Assessment (Checklist Evaluation)
- Clinic Services Satisfaction Survey (Patient Survey)

In addition, this section includes:

- Clinician Feedback Form for Clinic Staff: Designed to provide the staff of training sites with an opportunity to review the trainee’s performance, particularly with regards to patient care and professionalism.
- Abortion Training Program Evaluation Form: Designed to provide trainees with an opportunity to review the overall training program.
## PROCEDURE PERFORMANCE LOG

**Trainee:** ______________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Pt/Case #</th>
<th>Type</th>
<th>Weeks Gest.</th>
<th>Trainer Comments and Initials</th>
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</thead>
<tbody>
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<td>MVA / EVA / MED</td>
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OBSERVED PERFORMANCE ASSESSMENT

Trainee: ____________________ Evaluator: ____________________ Date: _______________

Indicate the rating that best describes the clinician’s performance:

**Beginner**: close observation/monitoring and supervision; Demonstrates limited fund of knowledge or significant gaps

**Developing Competence**: developing independent thinking and needs intermittent assistance/ supervision; knows limitations and seeks guidance when needed; Demonstrates improving fund of knowledge with some gaps

**Competent**: Independent; need for assistance and direct supervision is occasional; knows limitations and seeks guidance when needed; asks appropriate questions to attending; approaches task of supervision of peers; demonstrates solid fund of knowledge with rare gaps

<table>
<thead>
<tr>
<th>A: Patient Care</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
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</thead>
<tbody>
<tr>
<td>Reviews history thoroughly; asks additional questions as indicated</td>
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<td>Confirms patient consent</td>
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<td>Accurately estimates uterine size and position from pelvic examination</td>
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<tr>
<td>Able to interpret sonogram findings for dating and completion of abortion</td>
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<tr>
<td>Asks and answers questions in a patient-centered manner (one that is free of personal judgments and is focused on meeting the patient’s expressed needs)</td>
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<tr>
<td>Discusses post abortion contraceptive options and prescribes as necessary</td>
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<tr>
<td><strong>ASPIRATION for Abortion or EPL</strong></td>
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<tr>
<td>Administers analgesics/sedatives in appropriate doses</td>
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<tr>
<td>Provides effective paracervical block</td>
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<tr>
<td>Safely dilates cervix to correct size for gestational age</td>
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<tr>
<td>Consistently uses no-touch technique</td>
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<tr>
<td>Communicates with patient during the procedure with attention to her comfort and expectations</td>
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<tr>
<td>Accurately assesses when uterus is empty</td>
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<tr>
<td>Completes procedure in a timely manner</td>
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<tr>
<td>Examines POCs for appropriate elements and consistency with gestational age</td>
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<tr>
<td>Prescribes appropriate post-procedure medications as needed</td>
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<tr>
<td>Provides anticipatory guidance for post-procedure course</td>
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<tr>
<td>Effectively manages difficulties encountered during procedure (ex. dilation, cervical laceration, anatomical variations)</td>
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<tr>
<td><strong>MEDICATION for Abortion or EPL</strong></td>
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<tr>
<td>Prescribes and administers medications according to protocol</td>
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<tr>
<td>Appropriately counsels patient about procedure taking into account life circumstances</td>
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<tr>
<td>Provides patient centered counseling</td>
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<tr>
<td>Provides anticipatory guidance to distinguish expected side effects from complications</td>
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<tr>
<td>Appropriately assess for completion of abortion</td>
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<tr>
<td>Demonstrates appropriate management of complications of medication abortion</td>
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</table>

| B: Communication and Interpersonal Skills                                       |          |                       |           |
| Consistently introduces him/herself to patients                                |          |                       |           |
| Consistently uses open-ended questions when counseling patients                |          |                       |           |
| Establishes rapport with the patient                                           |          |                       |           |
| Provides patient-centered options-counseling                                  |          |                       |           |
### C. Professionalism

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
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<tbody>
<tr>
<td>Arrives at clinic on time</td>
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<td></td>
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<tr>
<td>Demonstrates respect for patients and staff</td>
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<tr>
<td>Maintains strict patient confidentiality</td>
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<tr>
<td>Is receptive to constructive feedback</td>
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<tr>
<td>Documents all relevant patient data</td>
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<tr>
<td>Is aware of his/her limitations</td>
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### D. Systems-Based Practice

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<th>Beginner</th>
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<tr>
<td>Is aware of his/her limitations</td>
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| Able to compare and contrast the delivery of reproductive services provided in family practice setting with that in family planning clinic system |
| Demonstrates knowledge of range of access issues related to abortion services including billing and insurance |

### E. Practice-Based Learning and Improvement

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<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
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<tr>
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<td></td>
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<tr>
<td>Maintains strict patient confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is receptive to constructive feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documents all relevant patient data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is aware of his/her limitations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Able to compare and contrast the delivery of reproductive services provided in family practice setting with that in family planning clinic system |
| Demonstrates knowledge of range of access issues related to abortion services including billing and insurance |

### F. Medical Knowledge

<table>
<thead>
<tr>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrives at clinic on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates respect for patients and staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains strict patient confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is receptive to constructive feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documents all relevant patient data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is aware of his/her limitations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Able to compare and contrast the delivery of reproductive services provided in family practice setting with that in family planning clinic system |
| Demonstrates knowledge of range of access issues related to abortion services including billing and insurance |

| Describes the differences between medication and aspiration abortion |
| Identifies factors pertinent to abortion care during patient history review |
| Describes the expected process of an uterine aspiration |
| Describes the expected process of a medication abortion |
| Identifies contraindications to medication abortion |
| Knows appropriate use of medications |
| Knows appropriate use and interpretation of laboratory tests |
| Identifies features of ectopic pregnancy |
| Knows contraceptive options and contraindications to specific methods |
| Knows indications for sonography |

### ADDITIONAL COMMENTS:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

SIGNATURE OF EVALUATOR: ___________________________ DATE: ______________
CLINIC SERVICES SATISFACTION SURVEY

We are interested in your opinions about your visit today and about the care you received from the health professionals (the doctors and nurses) and staff. Please rate each of the following things about this visit. (Mark one answer for each item).

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all satisfied</th>
<th>Somewhat satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>a The courtesy of the staff</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b The staff's flexibility in scheduling my appointment around my needs</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c Privacy when talking with staff or health professionals</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>d The amount of time I spent in the waiting room today</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>e The amount of time I had to talk with my abortion provider</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>f My abortion provider’s ability to answer questions in a sensitive and caring way</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>g My abortion provider’s ability to explain things clearly</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>h My abortion provider’s ability to help me feel comfortable talking about my concerns</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>i The chance to ask all of my questions</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>j My abortion provider’s willingness to explain different options for my care</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>k My abortion provider’s effort to make my medical services as comfortable as possible</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Do you have any suggestions for us?
TRAINEE FEEDBACK FORM FOR CLINIC STAFF

Clinic: _______________________________ Date: ______________
Name of Trainee: __________________________

1. Please rate the trainee on the following:

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Rarely</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. makes patients feel comfortable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. explains procedures in patient friendly manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. answers patient questions appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. maintains patient confidentiality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. treats me respectfully</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. manages time effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. charting is legible and complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What are this trainee’s strengths?

3. How might this trainee provide better abortion services to our patients?
**ABORTION TRAINING PROGRAM EVALUATION FORM**

For completion by training participants.

Be sure to complete any additional evaluation required by your residency or program.

Name: ___________________________     PGY: ___________     Date: __________

I. Please evaluate the following aspects of your rotation training experience by circling the appropriate response:

<table>
<thead>
<tr>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Excellent</th>
<th>Did not experience/cannot evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Didactic teaching</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>b Syllabus</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>c Clinic orientation</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>d Abortion counseling experience</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>e Medical screening and management</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>f Pelvic examination and sizing technique</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>g Pain management techniques.</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>h Vacuum aspiration technique</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>i Use of ultrasound</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>j Routine post-abortion care</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>k Opportunities to ask questions</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>l Opportunities to interact with clinic staff</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
<tr>
<td>m Initial Program Orientation (didactic session at residency program)</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
<td>1 2 3 N/A</td>
</tr>
</tbody>
</table>

2. What did you like most about the training?

3. What did you like least about the training?

4. In your opinion, the length of your training was:
   □ adequate
   □ too short
   □ too long

5. Did the abortion training rotation adequately prepare you to:

| a Counsel patients about pregnancy options | Yes | No, need more |
| b Counsel patients choosing abortion | Yes | No, need more |
| c Counsel patients about contraceptive options | Yes | No, need more |
| d Obtain informed consent for abortion | Yes | No, need more |
| e Perform accurate pelvic sizing | Yes | No, need more |
| f Perform aspiration procedures under local anesthesia | Yes | No, need more |
| g Perform 1st trimester aspiration abortions with confidence | Yes | No, need more |
| h Manage common abortion complications | Yes | No, need more |
| i Integrate abortion with other health services in your regular practice | Yes | No, need more |

6. What additional abortion training opportunities would you like your residency program to provide, if any?
7. Please evaluate the following training faculty by circling the appropriate responses:

<table>
<thead>
<tr>
<th>Name of Trainer</th>
<th>Poor</th>
<th>Good</th>
<th>Excellent</th>
<th>Did not experience/cannot evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>Other:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
</tbody>
</table>

8. What are your immediate career plans following graduation from this residency program?

9. What are your long-term career plans?

10. Where do you hope to practice after graduating from this residency program?

   □ In this state
   □ In another US state (specify: __________________)
   □ Outside the US (specify: _________________)
   □ Don’t know yet

11. Do you plan to pursue additional abortion training during or after your residency?

   If “Yes,” what additional training? ________________________
   _____________________________________________________

12. Do you anticipate providing aspiration abortions in your post-residency practice?

   Yes No Undecided

13. Do you anticipate providing early medication abortions (mifepristone or methotrexate) in your post-residency practice?

   Yes No Undecided

14. Since completing the abortion training rotation, has your interest in or commitment to providing abortion services:

   □ Increased
   □ Decreased
   □ Remained the same

15. Has the abortion training rotation influenced your attitudes or opinions about abortion in any positive or negative way? Please explain:

16. What suggestions do you have for improving the training program?

17. Other comments:
Feedback for Trainers and Clinic Staff

Please consider writing a message below to thank the clinicians and clinic staff at your training site for their assistance and to provide any feedback you would like them to review directly. This page will be detached and sent to the clinic with other trainee responses, so it will be anonymous unless you choose to sign your name.
11. TRANSITIONING FROM PROVIDER TO TRAINER

Authored by Suzan Goodman, MD, MPH

INTRODUCTION

The large decline in abortion providers in the last two decades has been, in large part, a direct result of the decrease in training opportunities for physicians and medical students. Regional and national initiatives are now working collaboratively to reverse that trend by integrating options counseling, new contraceptive technologies, and early abortion care into the routine training of primary care physicians and clinicians.

This chapter is designed to help you transition to training physicians or clinicians to integrate early abortion in primary health care settings. Some of you using this chapter will be recent trainees, some experienced abortion providers planning to train in a new setting, and others still will be seasoned faculty planning to incorporate early abortion into your teaching repertoire. We will present many techniques for training, hands-on guidance, maintenance of clinic flow while teaching, use of evidence, and the cultural and philosophical considerations that commonly arise. We also present a number of challenging training cases for your review and preparation. Additionally we have included many tools for the training and evaluation process.

TRAINING OBJECTIVES

Following completion of this chapter, you should be able to:

- Utilize observable competencies to assess trainees and trainers-in-training
- Ask for self-assessment and give effective feedback to trainee during and after each procedure and session
- Provide effective feedback for introductory skills in early pregnancy ultrasound
- Delineate practice based on existing evidence vs. provider preference
- Maintain balance between patient-centered care, safety, clinic flow, and training
- Respond appropriately to difficult training situations

READING

- Early Abortion Training Workbook: Chapter 10 (Transitioning from Provider to Trainer).
  - Additional tools and/or handouts for this chapter are available online at http://teachtraining.org. These downloadable resources are underlined throughout the chapter.
TIPS FOR SUCCESS

SKILL
In the early abortion training process, there is the need to ensure a patient’s comfort, emotional experience, and safety at the same time as respecting a learner’s need to be seen as a competent clinician. To maintain the patient’s confidence, it helps to present the teaching relationship as teamwork rather than training. Before initiating patient care, reinforce a method for communicating so a trainee can listen for your cues even if s/he is focused on the procedure. Review a plan for each case. Each skill can be broken into clear steps with observable competencies for both learners and for trainers-in-training. Make expectations clear from the outset. Give the trainee the first opportunity at feedback, and offer positive comments before constructive criticism in a specific and timely fashion. Try to make a distinction between your recommendations based on evidence versus those based on provider preference. As you transition to training, get exposure to as many styles of care and teaching as possible. In a busy clinic, there are multiple competing priorities, including clinic flow, patient support and safety, staff dynamics, and teaching.

SAFETY
To maximize safety, give a complete orientation to the patient’s experience and to the steps of the procedure before a trainee starts providing abortion care. Hands-on clinical skills can be achieved more quickly and safely when trainees are given the opportunity to practice prior to patient contact. Many trainers like to use a step-wise process to involve a new trainee as they gain confidence. Review a general plan for communication and specific plans for each case, as well as cautionary signs that should prompt a trainee to back off or allow you to take over. To prepare trainees for the challenges they may encounter, take every opportunity to discuss the management of potential complications.

ROLE
Encourage a culture of ongoing learning in your clinical site. Involve your staff in managing clinic flow and taking an active role in training. Mentor in ways that aspire to a high level of expertise, but also that prepare a trainee to integrate these services into their own future practice. Try to connect learners with logistical support, ongoing dialogues in abortion care, and the broad network of abortion providers in the country.
GETTING STARTED

Many providers describe this work as highly poignant in its impact on the trajectory of patients’ lives and the gratitude they express. Physicians and trainees who have more involvement with client counseling tend to feel more positively about their patients’ choices (Joffe 1995). Counseling exposure has been described as a strong predictor of future abortion provision (Joffe, personal communication), so do not hesitate to emphasize its value in training.

Pregnancy can raise various issues for each of us: from abortion, adoption, and fetal development to birth control, sexuality, and risk-taking. Helping trainees to evaluate and recognize their biases can help them balance their approach to reproductive care.

- Allow each trainee to shadow a patient all the way through the counseling and abortion process, to shed light on the experience from a patient’s perspective before getting into the specifics of clinical care.
- Build some training time for values work and options counseling for each learner.
- Continue to revisit your own values as you work with patients and trainees, as these interactions may shed new light on your experience.

Even when providers are confident in their clinical skills, it can be challenging to manage a trainee’s relative inexperience while providing patient-centered care in the context of a busy practice. Here are a few broad ideas for transitioning from being a provider to being a trainer.

- Witness the different styles and techniques of as many providers and trainers as possible.
- Use the opportunity to review literature on topics as they arise.
- Strive to maintain a relaxed environment for you, your trainee, and your patients.
- Some providers may benefit from building experience in a training setting before teaching independently.
- Develop your teaching style to highlight your own strengths.
TRAINING SKILLS

Modeling Care and Communication

Your own interactions with patients and staff will communicate your underlying philosophy.

- Consider sitting at your patient’s level during dialogue, and using open-ended questions.
- Approach contraceptive plans with the intent to empower.
- Demonstrate your respect for your patient’s perspective and background.
- Model a collaborative approach to clinical care and office flow with your staff.
- See Communication Skills Checklist for further ideas.

Promoting Inclusiveness and Cultural Competency

- Honor the cultural differences in your patient population.
- Promote linguistic access for your patients through interpreter services.
- Build awareness about quality and defined interpreter roles, especially for underrepresented language groups in your community.
- Promote development of health materials that incorporate community input and appropriate levels of medical terminology.
- Support synthesis of the critical elements of cultural competence training programs, and their use in your institution, especially on topics related to the needs of newcomer groups to your community.
- For more detailed information, the following resources are helpful. (Louden 1999) (Puebla Fortier 1999) (http://www.diversityrx.org/HTML/TOC.htm).

How do we learn best?

After one month we remember the following about what we have learned:

- 14% of what we hear
- 22% of what we see
- 30% of what we watch others do (demonstrations)
- 42% of what we repeat seeing, hearing, and doing
- 83% of what we experience as a first-time demanding action that applies new learning
- 92% of what we teach others.

(Phillips)

This emphasizes the value of interactive teaching methods for trainees and our growing community of faculty trainers. Studies of medical education have shown that didactic sessions alone are not effective in making significant change in practice (Davis 1999) In contrast, mixed and interactive sessions are more effective. The use of both printed and graphic materials has been shown to assist in making more effective practice changes (Cauffman 2003).

There are also different learning styles to be taken into account. It may be appropriate to use an inclusive approach by varying your techniques in clinical teaching. Consider asking learners which teaching methods they find to be most useful.
Learning style can be formally assessed using existing learning style inventories, such as the Kolb Learning Styles (http://www.haygroup.com/tl/Questionnaires_Workbooks/Default.aspx) or the Multiple Intelligences Model (Overview and Activities to Support Use of the Intelligences).

Kolb’s method for categorizing individual learning styles, for example, is as follows.

1) Accommodators (doing & feeling), who tend to prefer feedback, interaction and hands-on teaching
2) Assimilators (watching & thinking), who tend to prefer lectures and less interaction
3) Diversers (feeling & watching), who tend to prefer brainstorming and viewing situations from different perspectives
4) Convergers (doing & thinking), who prefer practical application of ideas

Learning involves more than just being exposed to new information. Adults learn best when:

- The learning experience is active and not passive
- The learning experience fits their immediate needs.
- They accept responsibility for their learning.
- They are treated as equals, in an atmosphere of mutual respect.
- Their learning is self-directed and meaningful to them.
- Their learning addresses feelings as well as ideas.
- New material is related to what they already know.
- The trainer values their contributions.

(Wegs 2003)

For exercises that help trainers define specific strategies to address each of these learning principles, see Adult Learning Principles (Learner & Trainer Versions), and the Ipas Training Manual at http://www.ipas.org/english/publications/training_materials.asp

Problem-based curriculum is also associated with deeper learning and retention, and serves as the fundamental methodology of this training workbook.

- Keep learning active, and tailor content to needs of the learner.
- Foster collaboration and interaction over solitary learning.
- Engage a learner by asking questions often.
- For further ideas, see Golden Rules of Training.

Competency-Based Teaching

It is very helpful to break down the material into clear steps for a learner. These observable “competencies” allow you and the learner to have clear achievable expectations, as well as a basis for evaluation and constructive feedback. Competency-based teaching emphasizes a set of basic learning steps instead of ad-hoc exposure. Before practice, the trainee reviews the skill, including the steps to be completed. During practice, you observe, coach and provide feedback to the trainee. After practice, the trainee can review a competency based checklist to discuss their strengths and weaknesses with you, and receive suggestions for improvement. The Observed Performance Assessment in the Chapter 8 was developed for trainees learning abortion provision, in keeping with ACGME standards of training.
Faculty members who are training-the-trainers also need to have a clear set of skill competencies for the those in training, in order to assess and provide appropriate feedback. A very useful Trainer's Self-Assessment Tool is available to be used optionally as you transition individually to training. The Trainer's Competencies Checklist at the end of this chapter was created specifically for trainers being signed off to teach early abortion care. Another helpful checklist for clinical training is Effective Clinical Coaching: Competency Checklist.
Providing Opportunities for Practice Prior to Patient Contact

The use of anatomic models and other training aids has been shown to significantly decrease training time as well as risk to patients. Consider using anatomic models and the manual vacuum aspirator to help trainees review the stepwise abortion procedure before they undertake it with patients.

In a study done in Thailand, the traditional IUD training method was compared with one that involved simulation. When trainees were allowed to learn and repeatedly practice with pelvic models, 70% of the trainees were judged to be competent after just two insertions in clients, and 100% by six insertions. By contrast, in an equal number taught without the use of pelvic models, half obtained competency only after over 6 insertions in clients, and 10% never achieved it even after 15 insertions. (JHPIEGO Clinical Skills Course Handbook).

• In residency settings, consider incorporating a simulation lab into one of the orientation sessions. Existing models include a low-cost papaya model (Paul year) which also enables trainees to practice cervical anesthesia, and a plastic-velcro pelvic model (UW, Ipas). These sessions have also been used to build interest and activism among medical students and other audiences.
• Before starting procedures with patients, have the trainee get accustomed to the manual vacuum aspirator (putting it together, setting and releasing the vacuum, and emptying it).
• Some trainers like to have trainee run through all the steps in front of an exam table prior to seeing a patient. For best results, have the trainee role play, as if addressing the patient throughout the practice
• See Simulations (ACGME).

Teaching During the Procedure

At the beginning of the training session, review plans for communicating with the trainee during procedures so it is not intrusive to patient care, unless your patient is receiving general anesthesia.

• Review the chart and decide on appropriate plans and equipment needed before starting the procedure, including which dilator and cannula size will be needed for the gestational age. This will minimize trips out of the procedure room.
• Review more challenging steps of the procedure, such as the pelvic exam for position, the first dilator pass, and the final check for completion.
• Tell trainees that part of your communication with them may be through speaking with the patient. “Next you may feel pressure or a pinch as [provider’s name] is giving you some medicine for your cervix”, which may remind a new learner to draw up the anesthetic.
• Consider having a signal for “trading places” such as a tap on the shoulder, should they get uncomfortable, or the situation become challenging. This allows transitions to occur smoothly, without causing undue alarm.
• Have learners avoid force against resistance with initial dilation, allowing you take over or guide their hands, if necessary.
• Encourage “a sixth sense”, so that if something doesn’t feel right (such as a tearing sensation or instrument passing further than usual) trainees should stop for assistance.
• It is very helpful to have an assistant present at the bedside to support, talk with, and help distract the patient a bit from the teaching process.

Many trainers like to use a step-wise process to involve a new trainee as they become comfortable. “Backing into the procedure” refers to adding steps progressively from the end of the abortion. For example, the trainee can observe you through the first client, feel the empty uterus with the second, place the cannula on the third, and administer the cervical anesthesia and aspiration on the fourth. With time they should also take command of most aspects of the communication with the patient.

• Keep explanatory teaching to a minimum while you are with your patient, staying focused on their safe and supportive care.
• Provide most feedback and teaching between cases.
• Reinforce and build on learning from previous experiences whenever possible.

Distinguishing between Evidence and Provider Preference

It is very helpful to differentiate evidence-based recommendations from those based on provider preference and style. It is additionally useful if you can describe the strength of existing evidence in terms of the studies used, and strengths and weaknesses in their design.

• Using a combination of evidence and style is common in teaching many skills. “There is a little science and a lot of art in the area (of paracervical anesthetic injection)”, for example (Paul1999). See Chapter 4 for a discussion of technique.
• Become familiar with the growing body of literature that pertains to advances in aspiration and medication abortion. See the Bibliography at http://reproductiveaccess.org/resources.htm
• See Levels of Evidence and Strength of Recommendations.
• Encourage trainees to be exposed to the styles of various providers.

Giving Effective Feedback

Feedback helps an individual keep her skills or behavior “on target”, and thus better achieve her goals. All learners need, and can benefit from, constructive feedback, so don’t shy away from giving it even to an experienced provider. Without it, good performance is not reinforced, mistakes go uncorrected, clinical competence comes about empirically, and learners may feel insecure. Providing this information can increase a learner’s rate of improvement, and inspire higher levels of performance.

• Make sure you have a private place to give feedback, away from the patient and staff.
• Invite a trainee to take the first shot at their evaluation. Ask “How do you think that case went?” or “What else might you try in this circumstance?”
• Offer praise before constructive criticism, which tends to soften the delivery, and avoid discouragement.
• Make feedback timely, brief, and specific after each case.
• Share observations about non-verbal body language, wording, tone, steps toward safety, judgment, questions asked, or aspects of clinical technique.
• Feedback should include an action plan for what to try next.

Feedback can be given on various levels.
• One level involves simply sharing your observation. “You used a number of open-ended questions with that client”.
• Another level of feedback involves personal reactions. “I liked your reassuring tone there. It really seemed to calm her down”.
• Another level of feedback predicts the outcome of a situation if the learner proceeds incorrectly, emphasizing the consequences of a practice. “A risk of continuing to push against resistance is creating a false tract or perforation. You avoided that by stopping to confirm her uterus was more retroverted.”
• For further information, see Giving and Receiving Feedback, and Guidelines for Constructive Feedback.

Gauging a Trainee’s Ability and Need for Assistance

To best support the growth of a trainee, stay aware of his skill and safety, backing off as he progresses. Your assessment of patient safety is crucial, and should drive your pace.

• At first, stand (or sit) next to a trainee, so you can assist with your hands, and see what they are seeing.
• Set the stage for a learner to ask for assistance if something feels wrong.
• As the learner gains competence, gradually move to the patient’s side so you can support the patient while observing.
• Trainees need to learn to support the patient too, so it is important not to do it yourself, but encourage them to develop their own style.
• If appropriate for your setting, consider having a trainee work independently for some procedures at the end of the rotation, staying within earshot if they need your assistance.

Training Within and Across Disciplines

Differences in training approaches are also necessary across fields. Examples include more anticipated time to procedural competency in non-surgically trained physicians and clinicians, and more comprehensive training required for clinicians offering services in primary care settings where the ancillary support will be limited.

While we should not be inhibited by our differences in training and experience, it is important to recognize the practical differences in our approaches, skills, liability, and referral practices – and to build alliances where ever it will support better provision of care for our patients.

There are many beneficial outcomes associated with collaborative reproductive health services, training and research. The provision of medication abortion has been significantly expanded by its inclusion in the scope of practice of a broad range of physicians and advanced practice clinicians. The possibility for referral and management options is vastly improved by cooperation between medical specialties. And even during an era when ideology has trumped scientific evidence, we have made substantial collaborative advances in abortion research, contraceptive technology, and public policy.
TEACHING POINTS FOR EARLY PREGNANCY ULTRASOUND

Although ultrasound is not necessary for the safe provision of abortion, either by aspiration or medication, it is important for providers to know specific indications (see Chapter 3 and 7). In many practices, ultrasound is not a routine component of abortion care. Where ultrasound is available onsite, it is a valuable tool in diagnosis and management of early pregnancy. It can be helpful for pre- or post-abortion assessment, or during procedures with difficult anatomy or advanced gestation. Ultrasound is not a required competency of this training, but an advanced skill for trainees. It should not be interpreted to imply that sonography is a standard that should be uniformly adapted in the provision of abortion care.

In most settings, it is ideal to have a trainee perform proctored ultrasounds until they have done approximately five each at various gestational ages. For the purpose of early pregnancy sonography, these should include early (4 – 6 weeks, (with small sac and no fetal pole), 7 – 12 weeks (with fetal pole), and late first trimester (≥ 12 weeks, with biparietal diameter measurements)). If you have other staff members proctoring, consider observing at least 1-2 sonograms yourself from start to finish to allow you to assess the skill level for each trainee.

To assure a systematic approach, consider giving feedback after each proctored ultrasound that includes the trainee’s ability in the following areas: (Adapted from the Ultrasound in Abortion Care Workbook, Deutchman et al. 2007)

- Patient counseled properly
- Patient asked about latex allergy
- Patient asked about desire to know about twin gestation or other findings
- Equipment set up properly
- Transducer(s) cleaned between exams
- Client ID put onto US
- Gain and zoom adjusted for image quality
- Essential structures examined for gestational age
- Measurements taken properly
- Appropriate images captured
- Systematically scanned through uterus (A-P, and side-to-side) to help rule out twins, uterine anomalies, fibroids, large adnexal masses, free fluid.
- Ultrasound and physical findings correlated.

Have trainee do basic calculations for sonograms that you observe.
- The yolk sac is the first structure that definitively confirms a gestational sac, and helps rule out pseudosac
- Routinely get transverse and longitudinal images, especially before a yolk sac appears
- Avoid limbs and yolk sac in CRL (crown rump length) measurement
- FEEDS mnemonic - Fundal, Elliptical (or round), Eccentric (to endometrial stripe), Decidual Reaction, Size (> 4 mm)

Identify and review each feature in early sonogram images. Point out that demonstrating these suggests - but does not guarantee - a gestational sac (vs. pseudosac).

Review elements of an appropriate biparietal diameter (BPD).
• Symmetry
• Continuity and shape of skull
• Avoidance of facial and nuchal structures
• Capturing appropriate plane with ventricles and thalamus; “butterfly view”

Review a summary evaluation with trainees to assure understanding of all areas (see sample evaluation at end of chapter). Re-visit any areas of poor understanding or performance in subsequent sessions, and suggest pending items required for your review.

Ideas for Teaching Faculty

Abortion training is sometimes passed from those recently residency-trained to more senior faculty. This can be a challenging prospect for learner and trainer alike. In some circumstances, faculty trainees have already had extensive abortion experience, and their challenge is to learn to provide the service in a new context (such as an integrated family practice clinic instead of an operating room hospital practice or women’s health clinic). We have found a few things to be helpful under these circumstances.

• Affirm experience and perspectives brought to the training situation.
• Review best teaching practices and useful teaching points. This allows a level of detail without implying a lack of knowledge on the topic.
• Tailor the curriculum to what is most relevant to that trainee.
• Use evidence-based teaching over opinion.
• Respect and share knowledge, but try to stick to the core content of the curriculum.

Alternative Curriculum Options

Our intent in this training is to broaden the perspective of trainees on unintended pregnancy, balanced counseling, and abortion services. The importance to women is illustrated by the idea that most women don’t feel comfortable talking to their own doctor about an unintended pregnancy. And yet abortion is one of the most common procedures among women, with over a third going through an abortion during their reproductive years.

Many studies have shown that significantly more residents receive abortion training when it is incorporated as a routine part of the curriculum with an opt-out alternative, compared to when it is elective only. One study showed that in Obstetric residencies programs that offer only elective training, 21% of residents were trained – compared to 72% when training was routine with the opportunity for residents to opt-out for personal or ethical reasons (MacKay 1995). Even if programs offer routine training, it can be a challenge for residents to have the opportunity to obtain competency (See Routine vs. Optional Abortion Training).

• Reinforce that even trainees ambivalent about abortion have important knowledge to gain from this rotational experience. It will improve the care they offer to their women patients.
• Be explicit about not forcing anyone to perform procedures. There is much else to learn.
• The program may be tailored to focus on values clarification, balanced options counseling, contraception, and handling of complications they may see in various practice settings.
• Your respect for varying opinions may go a long way to defuse the polarity common around abortion and other reproductive health issues.
• Use or modify the Alternative Teaching Curriculum defined in Chapter 1.
• Consider sharing part of your own experience, such as the first time you looked at fetal parts or used intra-operative ultrasound. A learner may realize that choices to provide abortion services are not black and white for providers, but should be focused on unbiased care for the patient.

Difficult Trainees

As clinical teachers, we often work with residents or trainees who provide significant challenges to our ability to instruct. This may present as a distressing behavior, a knowledge deficit, or a slow response to constructive feedback. Trainers can rely on strategies they use in other challenging situations. For practical exercises to respond to various challenging teaching circumstances, consider working with the Challenging Learners Cards. For a more in depth discussion of challenging learners, see Special Series: Working with Residents in Difficulty; Family Medicine, 1993.
INTEGRATING TRAINING INTO THE CLINIC SETTING

Building Staff Support

When considering the stake-holders are in establishing a training program in either a primary care or reproductive health clinic setting, it is invaluable to consider your staff and the various ways to get and maintain their support and involvement. The following strategies have been useful:

- Discuss the benefits to patients
- Consider bringing speakers perceived as peers who can attest to the value of training
- Cultivate interest in contraceptive advances and balanced options counseling
- Present the public health implications of poor access to services and providers
- Consider the use of appropriately timed staff surveys and values clarification workshops
- See potential Meeting Agenda for Staff Meeting to Build Buy-In.

Preparing For and Supporting Change

We all appreciate that change is not easy. Incorporation of new and controversial programs like abortion training is likely to require significant institutional change, regardless of the setting in which it is being introduced. Understanding the stages people go through when trying to adopt change helps to broaden and personalize the strategies we can use to support them.

Don’t reinvent the wheel. There are various models for change that include building the case for change, creating a plan and enrolling others to champion the change, identifying and preparing for resistance, supporting and recognizing the momentum, evaluating and openly addressing unanticipated problems, and redirecting to stay the course. See Stages of & Supporting Others with Change.

Presenting the Training Relationship to Staff

In most teaching hospitals in the country, a training hierarchy is a customary part of patient care. Patients usually receive care from a team, with direct resident participation and attending physician oversight. Although the training is ongoing, it is not usually made explicit to patients. The situation of abortion training is not appreciably different, and may be approached in a similar fashion. There are varying ways to present this arrangement to staff and patients, reminding them that this is part of the established process of resident education. They may be doing many of these things already, as they teach other procedures and treatments.

- Consider emphasizing the team approach to care, instead of who is training whom, or has more or less experience.
- Prior to training initiation, consider discussing and scripting ways for your staff to talk about the training with patients. They should feel comfortable presenting it.
- The training initiative can be described as a project to address patient access to abortion services, to extend the expertise to more providers.
• One way for staff to present the situation is to say “You will be seen by two doctors (or clinicians) today; one from our clinic and one from the university”.
• To maintain a patient’s confidence, allow the providers to describe the details of their training background as needed.

Presenting the Training Relationship to Patients

• Some trainers like to introduce themselves and say “We’ll be doing your procedure together today” or “You will have two of us doing your procedure today”. Depending on who is undertaking the hands-on role, the trainer could alternatively say “I’ll be assisting with your procedure today”.
• Utilize staff to help talk with the patient when you need to focus attention on the trainee.
• Consider posting information explaining the training partnership in waiting rooms.

Managing Clinic Flow While Teaching

In a busy clinic, there are multiple competing priorities, including clinic flow, patient support and safety, the training process, and dynamics with staff. Although it is ideal to teach when it is topical, this may not always be possible in a busy clinic. Use techniques that you find helpful in other teaching situations.

• Stay aware of the teaching time and patient wait times.
• Continue to refine clinic flow so that the next patient is ready when you are.
• Use down time to review questions with the trainee, or to help turn over rooms.
• ‘Bookmark’ topics to finish teaching at the end of the clinic day.
• If you are the only physician training, the following methods have been used to help maintain flow. Alternate training and demonstration, letting the trainee do every other case. Periodically have the trainee work with other staff (for example, to help with recovery or discharge teaching techniques) while you catch up the clinic.
• In high volume settings, some programs have used the model of having one flow doctor, and one training doctor who can go more slowly with the teaching. Reimbursement can be arranged to maintain a cost-neutral situation for the clinic.
• To cut down the time needed for room turnover, try having staff prepare the sterile set-up on an extra mayo stand outside the room, which can be brought in between patients.
• Try assigning one of your staff to keep tabs on the progress of the clinic. Whether or not you train existing staff to integrate this focus, or have someone designated to the role of Flow Facilitator, many clinic settings have found this to be cost-effective in the provision of patient care. See Flow Facilitator Tools and Research.
Encouraging a Culture of Ongoing Improvement in your Clinic

Embracing the concept on ongoing improvement sets a positive tone in a clinic, where trainers, trainees, and staff alike may be part of the learning process. Is there an outlet for staff concerns and suggestions regarding the training program or trainees? Is there an outlet for patient concerns?

- Especially while introducing the training program, encourage periodic discussion of clinic flow issues, strategies, and patient care with your staff to maximize involvement and integration of training into your clinic site.
- Models include short debriefing session at the end of the clinic day, a notebook for staff comments or a periodic staff survey which can be reviewed at a staff meeting. See Clinic Flow Debriefing Questions.
- Another method is to create a check-off sheet to track the number of times a patient had to wait more than a specified time (whatever you consider to be too long) in her care.
- Help reinforce the value of staff contribution in training new abortion providers. Encourage leadership by asking particular staff to be involved with demonstrating counseling, ultrasound, recovery or discharge teaching.
- Encourage staff to give feedback to particular trainees. See Feedback Form for Clinic Staff in Chapter 8.
- Improving the transfer of learning to trainees and staff through ongoing support within the work environment, can help protect investments in training. See Transfer of Learning Matrix.
- Offer periodical updates to staff to broaden their knowledge and buy-in around contraception, abortion, and counseling.
- Periodically share trainee feedback with staff, or cumulative results of the training.
CONTINUING AND CONTEXTUALIZING THE TRAINEE’S EXPERIENCE

Assisting with Transitions to Practice

Although the training received in residency programs or higher volume abortion clinic settings may not translate exactly to a primary care practice setting, it is likely that most of the skills gained are entirely transferable. Ask trainees to imagine how they would extrapolate to their own practice site, for any aspects of care that will vary.

- Most high-volume settings have significantly more ancillary staff to provide options counseling, lab work, ultrasound, or recovery support. They are also likely to have more staff supportive of reproductive rights. Trainees should be encouraged to consider how they will adapt to these differences.
- Many of Chapter 9 Questions will assist with this process.

Be creative about ways your training program could approximate a trainee’s future practice environment. Reinforce the expectation that the trainee be able to provide competent abortion care by the end of their rotation – including counseling, ultrasound interpretation, the abortion procedure, recovery, contraceptive education, and discharge.

- For the first patient of the last day, consider all these steps being carried out in one room, to simulate an office practice.
- Ask often how trainees would approach an issue in their own practice setting.
- Point out areas where different practice standards exist (such as selective vs. routine ultrasound for pre- and post-medication abortion)
- Whenever possible, reinforce the stories and special benefits of being able to offer services in your own family practice, integrated with the rest of the care provided to your patients.

Mentoring

If our goal is to improve access to providers and services, training is only the first step. As learners come to the completion of their training with you, assess how the experience has affected them, their approach to women’s health care, and their desire to utilize the skills and approaches they learned in their own practice. Take steps to welcome in a larger community of providers integrating reproductive health into primary care. See further Mentoring Strategies.

- Offer to help trainees sign up with of the national list serves of abortion providers for ongoing discussion. These include the Access Listserve, and NAFbytes Listserve, both of which require being recommended by a current participant for security reasons.
- Help put them in contact with providers in the geographic region they want to practice. There are various organizations that can link individuals to others providing abortion services in regions of the country. See Chapter 9 Networking Section for more details.
- Bring up frequently asked questions that arise in initiating new services, especially where services are lacking. Not all trainers will have experience here,
so it will be important to be comfortable posing questions, without knowing all the answers. Use Chapter 9 Questions to facilitate this discussion.

- Encourage trainees to come to national conferences such as ARHP, NAF or STFM to network with other providers.
- Have them consider sharing their experience by collaborating on presentations or articles to document the successes and obstacles that arise as we try to integrate these services into primary care environments.

**Beyond Training - Encourage Creative Networking**

There is a proud, egalitarian, and cooperative history of women's health care which arguably informs the training process around abortion. This movement has vastly changed the delivery of women's reproductive health care and had many other affects on the medical establishment in this country. As we proceed with efforts to improve training and access to abortion services, there are many inspiring examples of collaboration within and across disciplines, not only between different fields of medicine, but also between clinicians and activists. Effective training in reproductive health is an incredibly important goal to achieve, but is also just the beginning.
Early Pregnancy Ultrasound Skills Evaluation

Trainer: __________________________ Date: ____________
Number of Sonograms Observed: ___________________________________________

<table>
<thead>
<tr>
<th>TRAINING SKILLS</th>
<th>Beginner</th>
<th>Competent</th>
<th>Comments</th>
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<tbody>
<tr>
<td>INTERPERSONAL SKILLS</td>
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<tr>
<td>Introduces self to patient and</td>
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<td>establishes rapport</td>
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<td>Explains sonogram procedure to</td>
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<td>client, and routinely asks about</td>
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<td>LMP, latex allergy, etc.</td>
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<td>Pays attention to patient comfort</td>
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<td>Uses appropriate language to</td>
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<td>discuss ultrasound findings</td>
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<td>in presence of patient</td>
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<td>Solicits and answers patient</td>
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<td>questions appropriately</td>
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<tr>
<td>CLINICAL SKILLS</td>
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<tr>
<td>Selects and prepares ultrasound</td>
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<td>probe properly for use</td>
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<td>Uses keyboard and screen</td>
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<td>functions properly</td>
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<td>Keeps uterus in center of screen</td>
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<td>and zooming as needed</td>
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<td>Systematically identifies uterus</td>
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<td>in longitudinal and transverse</td>
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<td>views, taking appropriate images</td>
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<td>Systematically scans across</td>
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<td>pelvis (to assess for anomalies,</td>
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<td>masses, twins), requesting help</td>
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<td>as needed.</td>
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<td>Measures gestational sac in at</td>
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<td>least 2 planes</td>
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<td>Identifies yolk sac</td>
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<td>Identifies fetal pole and cardiac</td>
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<td>activity</td>
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<tr>
<td>Measures CRL in longest view</td>
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<td>(without limbs or yolk sac)</td>
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<td>Assures location of pregnancy</td>
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<td>is intrauterine</td>
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<td>Perform post procedural or post</td>
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<td>medical abortion US to</td>
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<td>establish no evidence of IUP</td>
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<td>Ensures transducer(s) cleaned</td>
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<td>between exams</td>
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<td>MEDICAL KNOWLEDGE</td>
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<td>Knows discriminatory levels</td>
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<tr>
<td>Able to name key US characteristics of pseudo vs. true gestational sac</td>
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<td>(identify if possible)</td>
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<td>Accurately calculates GA with</td>
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<td>gestational sac measurements</td>
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<tr>
<td>Accurately calculates GA with CRL measurement</td>
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<tr>
<td>Knows when to switch to BPD</td>
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<td>measurement, and elements of an</td>
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<tr>
<td>optimal BPD measurement</td>
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ADDITIONAL COMMENTS:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Evaluation by Trainer:
☐ Approved
☐ Further orientation and observation suggested/required

SIGNATURE OF EVALUATOR: __________________________ DATE: _________
New Trainer Skills Evaluation

New Trainer Being Evaluated: __________________________________________
Faculty Evaluator: __________________________________________
Number of Training Sessions Observed: ______________________________

In addition to meeting the criteria for competency as an abortion provider, a trainer must be able to:

<table>
<thead>
<tr>
<th>N/O=Not Observed</th>
<th>1=Poor</th>
<th>2=Average</th>
<th>3=Good</th>
<th>4=Excellent</th>
<th>Comments</th>
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<tbody>
<tr>
<td>TRAINING SKILLS</td>
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<tr>
<td>Assesses trainee’s skills and learning needs</td>
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<td>Engages trainee in learning experience</td>
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<td>States objectives for each training day</td>
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<td>Encourages trainee to ask questions</td>
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<td>Answers questions clearly and completely</td>
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<td>Demonstrates strong knowledge of subject matter</td>
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<td>Gives appropriate evidence and resources</td>
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<tr>
<td>Uses variety of teaching methods including cases, role plays, “what if” scenarios, and didactics</td>
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<td>Discusses various approaches to the procedure</td>
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<td>Demonstrates knowledge of site specific protocols</td>
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<tr>
<td>Reviews chart and informed consent</td>
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<tr>
<td>Reviews / interprets US, labs, and medical history with trainee</td>
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<td>Demonstrates establishing rapport with the patient</td>
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<td>Demonstrates non-judgmental attitude towards the patient</td>
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<tr>
<td>Demonstrates clear communication with the patient regarding procedure and management</td>
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<tr>
<td>Allows trainee to solicit and answers patient questions</td>
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<tr>
<td>Confirms physical exam findings</td>
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<td>Gives feedback about no touch technique</td>
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<td>Gives feedback about trainee’s attention to patient comfort during procedure</td>
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<tr>
<td>Can take over a case when appropriate without disturbing the patient or undermining the trainee</td>
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<tr>
<td>Provides feedback to the trainee after each procedure, and at the end of session</td>
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<tr>
<td>Reviews elements of tissue exam with trainee</td>
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<td>Reviews appropriate post operative orders with trainee</td>
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<td>Reviews patient’s contraceptive needs (including EC) and contraindications with trainee</td>
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<td>Models respectful attitude towards staff</td>
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<td>Is receptive to feedback from trainee / peers</td>
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<td>Models and teaches trainee attention to clinic flow</td>
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ADDITIONAL COMMENTS:
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REFERENCES


Deutchman M, Reeves MF, Fjerstad M, Andrews M. Ultrasound in Abortion Care Training Workbook. Affiliates Risk Management Services, Inc. 2007


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EXERCISES: TRANSITIONING TO TRAINING

EXERCISE 11.1: Challenging Training Situations

Purpose:
For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training. Strategies and suggestions can be found below.

1) A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions “I felt some obstruction and a tearing feeling.”

2) A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. She tends to sit back and doesn’t say much, making assessment of her skill difficult.

3) You conduct a session with a trainee who has attended several previous sessions with another trainer. The trainee is senior to you in terms of age and overall medical experience. As you work together, you notice that he avoids direct eye contact and does not ask questions. After he completes a procedure, you provide feedback on what went well, and also point out one area for improvement. He replies angrily that he has never heard of the technique you recommend.
4) You meet a trainee who is shy but friendly. You start off with the values clarification exercises. After your brief introduction, she tells you that she is struggling over whether or not to provide abortions. She feels that some women should have abortions, but it is hard to “help someone commit a sin”. She would feel better if only she could spend a lot of time with each woman to make sure that she thought abortion was the right decision for that patient. She especially wanted to avoid giving abortions to those women who use it as birth control. She states, “Clearly some women make bad decisions for themselves, so I can not trust that they are making the right decision about this.”

5) A physician trained outside the U.S. shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

6) The last couple days in your training clinic, you’ve noticed the clinic flow seems to be less than optimal, with longer patient waiting times, and your staff becoming mildly inpatient with training. How might you approach this problem?

7) After a brief tour of your training site with a new resident trainee, you sit down to discuss the values clarification exercises. The trainee shares that he feels okay about abortion in the case of rape, incest, or threat to a woman’s life, but not for any other reasons. After reviewing some of the principles of balanced pregnancy options, you ask him to consider how he would discuss abortion with this patient. In apparent sincerity, he says he would find someone in the church who had had a bad experience having an abortion, and he would have that person talk to his patient. How do you respond?

8) You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. What do you do? She also becomes more active on the table, withdrawing from each cervical dilation by the trainee. Then she starts crying loudly in the middle of the dilation. How do you proceed?
9) You are assisting a trainee, and at the end of an aspiration procedure the patient begins to bleed heavily. What do you do, and how do you co-manage this with the trainee? After the patient is stabilized (or transferred), how do you discuss this with the trainee?

10) A trainee approaches clients with a particularly flat affect that makes you somewhat uncomfortable in her lack of empathic skill.

11) After completing a 5 week aspiration with a trainee, you can not confirm adequate POC, even after checking all the instruments. The trainee is very upset about needing to communicate this with the patient and doesn’t know how to proceed with the situation. How might you communicate with the trainee and patient?
EXERCISES: TRANSITIONING TO TRAINING

EXERCISE 11.1: Challenging Training Situations

Purpose:
For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training. Strategies and suggestions can be found below.

1) A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions “I felt some obstruction and a tearing feeling.”

- Assure patient safety first and foremost. In this case you probably need to assess what the trainee has done, making the transition as smooth as possible so as not to alarm the patient.
- Use a pre-arranged system to communicate the need to switch places.
- Help reassure the patient if there is a change in her procedure.
- Have a low threshold to use ultrasound guidance if available.
- Consider the following preventative steps. Introduce the trainee gradually to the procedure. Practice with a simulation model like the papaya. Have the trainee observe first. Prepare them for “moments of particular caution” including the exam, the first dilation, and determination of complete evacuation. Explain how you will work together during these points until comfort is achieved, and that a cautious approach is expected. Work very closely next to a trainee, assisting with your hands, until you gradually gain confidence in their skill level.
- Give feedback after the case, starting with the opportunity for self-assessment. Offer any positive before constructive feedback. Give ideas for improvement, and ask steps to take to either prevent or manage this challenge if it arises again.
- Determine independent competency only when the trainee reaches what is appropriate for patient care.
2) A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. She tends to sit back and doesn’t say much, making assessment of her skill difficult.

- Engage the trainee with values clarification work and counseling exercises.
- Ask the trainee for specific contributions or actions.
- Ask for her assistance in making this a meaningful experience. “How can I make this training more useful for you?”
- If the behavior continues, ask the trainee about her apparent lack of enthusiasm, and focus on basic expectations of the rotation.
- Evaluate the trainee honestly.

3) You conduct a session with a trainee who has attended several previous sessions with another trainer. The trainee is senior to you in terms of age and overall medical experience. As you work together, you notice that he avoids direct eye contact and does not ask questions. After he completes a procedure, you provide feedback on what went well, and also point out one area for improvement. He replies angrily that he has never heard of the technique you recommend.

- Consider starting feedback with the opportunity for self-assessment. “How did that seem to go?”
- Attempt to teach actively by asking questions, and providing some evidence for alternative methods.
- Recognize his wealth of experience.
- Perhaps ask for assistance in a specific question in the time that follows, to emphasize your respect and collaboration.
- Keep some of the review pertinent to ideas for teaching (not just performing the methods at hand). This can help bypass the emphasis on the individual learning, instead making room for review, acknowledging what he already knows, and focusing on training techniques.
- If this continues, you might observe that he seems uncomfortable. Ask what learning style works best for him. It may have been some time since this trainee has been in the position of being considered a student rather than a teacher.
- Some trainees in this situation will respond well to discussions about relevant topics in the medical literature.
4) You meet a trainee who is shy but friendly. You start off with the values clarification exercises. After your brief introduction, she tells you that she is struggling over whether or not to provide abortions. She feels that some women should have abortions, but it is hard to “help someone commit a sin”. She would feel better if only she could spend a lot of time with each woman to make sure that she thought abortion was the right decision for that patient. She especially wanted to avoid giving abortions to those women who use it as birth control. She states, “Clearly some women make bad decisions for themselves, so I can not trust that they are making the right decision about this.”

- Consider asking more about how she perceives sin and forgiveness, and how she weighs the relative difficulty of decisions in this realm.
- Perhaps she believes in the concept of choice but under a broader definition than just the woman’s decision. Consider trying broader platform such as the right to privacy or the ability to make decisions without government interference.
- "Broaden" the approach to explore other scenarios that might evoke physician bias in relation to childbearing or not (e.g. alcoholism, HIV, a Christian Scientist refusing blood transfusion, or a woman who refuses C-section).
- Do quite a bit of values clarification and some counseling observations, then reassess.
- It’s important to give her the space to work it through in a way that doesn’t adversely affect the care of your patients, as it sounds like she is grappling with her own tolerance.
- As trainers, we must evaluate trainees on their ability to render non-judgmental care. When trainees are unable to do so, we need to give an honest evaluation and let the residency faculty know what areas still need work.

5) A physician trained outside the U.S. shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

- Do counseling exercises and role plays early. Ask the trainee to play the patient at times, and see how which tone she prefers being listened or talked to as a patient.
- Review ideas in the Counseling Survival Guide (Chapter 2) which presents alternative ways to say things.
- Give feedback after every case, offering positive before constructive feedback. Offer it in the first person, such as “I noticed,” or “I feel”, and give ideas for improvement.
- Reinforce the benefits gained by the things she tried.
- Reinforce his strong procedural skills, and potential to provide support.

6) The last couple days in your training clinic, you’ve noticed the clinic flow seems to be less than optimal, with longer patient waiting times, and your
staff becoming mildly inpatient with training. How might you approach this problem?

- Acknowledge that training can slow down the clinic, and enlist the support of your staff in its long term outcomes and success.
- Stay aware of how much time goes into teaching so the patients aren’t waiting long, and ‘bookmark’ topics to finish reviewing at the end of the clinic day.
- Ask the staff to help share observations about the clinic flow and to brainstorm strategies for improvement. This could take place in short few-minute planning or debriefing session at the beginning or end of the day, or in a staff meeting. See Clinic Flow Debriefing Questions.
- Create a check-off sheet to track the number of times a patient had to wait more than a specified time (whatever you consider to be too long) in her care.
- Consider other options that may work in your own practice setting.

7) After a brief tour of your training site with a new resident trainee, you sit down to discuss the values clarification exercises. The trainee shares that he feels okay about abortion in the case of rape, incest, or threat to a woman’s life, but not for any other reasons. After reviewing some of the principles of balanced pregnancy options, you ask him to consider how he would discuss abortion with this patient. In apparent sincerity, he says he would find someone in the church who had had a bad experience having an abortion, and he would have that person talk to his patient. How do you respond?

- Try to help this resident recognize and understand his opinions, and what factors play the strongest role in developing them.
- Assist to “separate” judgments or bias from the care rendered. Ask how this situation is different from any other one in which a balanced, evidence-based presentation of the options is the clinician’s role.
- Spend a good deal of time working through values clarification exercises.
- Consider "broadening" the approach to explore other scenarios that might evoke physician bias in relation to childbearing or not (e.g. alcoholism, HIV, a Christian Scientist refusing blood transfusion, or a woman who refuses C-section).
- Evaluate trainees on their ability to render non-judgmental care, which applies to all aspects of medicine.

8) You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. What do you do? She also becomes more active on the table, withdrawing from each cervical dilation by the trainee. Then she starts crying loudly in the middle of the dilation. How do you proceed?

- Consider the patient safety and comfort first and foremost.
- You can have the trainee pause during the procedure so you can assess the situation clinically and check in with the patient
- Consider taking over the procedure if the trainee’s technique is painful for the patient, unsafe, or uncomfortable for the trainee. Do this using a subtle signal so the patient doesn’t become alarmed.

*Early Abortion Training Workbook*
• If you feel the procedure is safe, help reinforce the techniques of relaxation including breath, stabilizing her hips into the table, visualization, and talking her through the procedure. Assess whether more local, oral or IV medication will be helpful.
• Discuss the case after you finish, giving the trainee the first opportunity for assessment and problem-solving, and explaining why it was important if you needed to take over the case. Offer positive before constructive feedback, and reinforce the different techniques that are helpful in this situation.

9) You are assisting a trainee, and at the end of an aspiration procedure the patient begins to bleed heavily. What do you do, and how do you co-manage this with the trainee? After the patient is stabilized (or transferred), how do you discuss this with the trainee?

• Consider the patient’s safety and comfort first and foremost, but try to proceed in a fashion that reinforces rather than undermining the involvement of the trainee.
• Recommend steps that may be necessary to stabilize the patient, saying something like “Perhaps we can try uterotonics. What would you like to use first” “Let’s do vitals and repeat her pelvic exam to assess where the bleeding is coming from”. “Do you think an IV may be helpful?”
• Update the patient as you proceed.
• After the patient is stabilized, debrief the case outside of the room. Give the trainee the first opportunity for assessment and problem-solving. Offering positive before constructive feedback
• Reinforce the different techniques that are helpful in this situation or if another scenario had played out.
• Give some context for the frequency, etiology, and management of complications such as hemorrhage.
• Try to involve the trainee in the follow-up of this patient.
• Be supportive and reinforce that complications happen even for the most experienced of providers.

10) A trainee approaches clients with a particularly flat affect that makes you somewhat uncomfortable in her lack of empathic skill.

• Do counseling and values exercises early. Use role plays with the opportunity to try different approaches. Encourage her to vary the tone of her voice. Try a role play where she is the patient, and gets to reflect on styles of care.
• Give feedback after every case, starting with an opportunity for self-assessment, then offering positive before constructive feedback. Offer it in the first person, such as “I noticed,” or “I felt”, and give ideas for improvement
• Model the empathy, but also give her the opportunity to develop her style.
• If you feel she continues to be somewhat apathetic, consider asking her what is going on. It may important to understand if there is a root cause for her approach, and whether it is related to her attitudes about abortion, or are just a part of her behavior.
• Evaluate trainees honestly on their ability to render non-judgmental and empathic care, which applies to all aspects of patient care.
11) After completing a 5 week aspiration with a trainee, you can not confirm adequate POC, even after checking all the instruments. The trainee is very upset about needing to communicate this with the patient and doesn’t know how to proceed with the situation. How might you communicate with the trainee and patient?

- Before you go back in the room, try breaking the situation down into steps. Ask the trainee about the differential diagnosis and illicit a management plan for each possibility.
- Consider ultrasound if available, re-aspiration, and serial βhCGs with the trainee.
- Explain the situation and options with the patient as a team. Try to normalize the situation in terms of how often this can happen in very early pregnancy. Many providers like to prepare a client who is very early in pregnancy for these possibilities before the procedure is started.
- After the case, give some context to the trainee for the frequency, etiology, and management of complications such as failed or incomplete abortion.
- Discuss the case after you finish it, giving the trainee the first opportunity for assessment and problem-solving. Offering positive before constructive feedback, and reinforce the different techniques that are helpful in this situation. Consider reinforcing the modicum of “avoiding negative self-talk when things become challenging”.
- Be supportive and reinforce that this happens even for the most experienced of providers.
- Create a format to regularly discuss challenging cases, so trainers learn from one another.