

A Day in the Life

Michelle M. Howe, MPAS, PA-C



The author performs preoperative ultrasonography.

I have been a full-time physician assistant for 6 years at Family Planning Associates Medical Group (FPAMG), the leading abortion provider in the state of Illinois. Located in Chicago, we provide medical and surgical abortions up to 23.5 weeks' gestation, the maximum gestational limit in Illinois. We serve women of all ages from the Chicagoland area and beyond. Because of restrictive laws in neighboring states, women often travel great distances to see us. I reap daily rewards by working with a health care team that is dedicated to providing the best care available and by knowing that I truly help many women on a daily basis, both medically and emotionally.

Michelle Howe is a PA with Family Planning Associates Medical Group, in Chicago, Illinois. She has indicated no relationships to disclose relating to the content of this article.

■ 8:00 AM

I arrive at the clinic. Abortion protesters loiter beyond our property line all day, verbally abusing our staff and patients. What an unwelcome surprise for first-time employees and visitors! I have become accustomed to the taunts, but other staff members, even longtime employees, are emotionally affected every day. Before the Freedom of Access to Clinic Entrances Act in 1994, protesters were legally allowed to be on our property, physically harass patients, and form barriers around our entrances. Volunteer patient escorts ushered women through the shouting, abusive crowds.

Second-trimester dilation and evacuation (D&E) surgery has already begun for the day. I greet our staff and check on the status of all of our surgical patients.

■ 8:30 AM

I see my first patient, a high school junior in the early second trimester of her pregnancy. I administer sublingual and buccal misoprostol, a cervical-ripening agent that she will hold in her mouth for 1 hour before surgery. She starts to have mild contractions and light bleeding just before her scheduled surgery time. She is scared and nervous but sure she has made the right decision.

■ 8:45 AM

A patient presents requesting a medical abortion, also known as the abortion pill or RU-486. Embarrassed, she has difficulty making eye contact with me and tries to hide tears. I reassure her that the abortion pill is widely used and has high acceptability and efficacy rates. She is very well-informed but frustrated with herself for being in this position. A 45-year-old mother, she raised her college-age daughter to be safe, talked with her about boyfriends and sex, and explained how to protect herself from pregnancy and STDs. My patient never thought that she would be the one to face an unplanned pregnancy. After her exam and ultrasound with me, a counselor will review the details of the procedure with her. Her symptoms at home will be similar to those of a miscarriage: heavy bleeding, blood clots, and cramping. In 1 week we will do an ultrasound to confirm that the abortion is complete. Since medical abortion with mifepristone is only about 99% effective, she may need additional misoprostol or dilation and curettage to complete the abortion.

■ 9:00 AM

First-trimester surgical abortion patients start arriving. I perform a targeted history and physical on each patient, do an ultrasound to determine gestational age, and discuss future contraceptive use. We encourage all our patients to start using birth control immediately after their abortion; a few companies provide us with free samples. Unplanned pregnancy occurs across all spectrums, and women of all races, ages, and economic classes come for the same reason. In the waiting room, they strike up conversations, talking with each other about how the pregnancy happened, the response from their partners and family, and their plans for the future. I think they are comforted to realize that they are not alone.

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■ 11:00 AM

I am called to the OR to do a quick ultrasound. The surgeon is unable to grossly identify products of conception in the aspirate of a patient who was only 5 to 6 weeks pregnant, so he needs to be sure the abortion is complete. The ultrasound is negative, but we are going to request a stat pathology report and ask the patient to return for a second serum hCG. The day of surgery is often the last time we see a patient, so we need to feel confident that she is no longer pregnant before we send her on her way.

■ 11:15 AM

I continue seeing what seems to be a never-ending stream of first-trimester patients. According to the Guttmacher Institute, approximately one-third of women in the United States have had at least one abortion by the time they are age 45. Medical professionals in other specialties may be unaware how many of their patients have a history of abortion or will need an abortion in the future. PAs who do routine contraception counseling in the OB/GYN setting have a great opportunity to discuss possible options for contraception failure.

■ 1:00 PM

The flow of patients has slowed enough for me to take a lunch break and catch up on research paperwork and correspondence. As the research coordinator at FPAMG, I organize and implement projects at our clinics. We have a large patient volume, so we are frequently approached to participate in academic research. I never expected to be involved in research, but I am grateful for the opportunity to contribute and hopefully influence advances in family planning practice. Currently, we are working on a project with Gynuity Health Projects, a research and technical assistance organization that works to make reproductive health technologies safer and more convenient, acceptable, and accessible. The project involves a new semiquantitative urine pregnancy test. We want to see if patients can use and interpret the test at home and if the test results are truly representative of serum hCG levels. Some locations, including rural areas of the United States and Third World countries, do not have easy access to ultrasound and serum hCG measurements. A test like this could help women and their providers more easily assess the suc-

cess of medical or surgical abortion within a relatively short time after the procedure.

■ 2:30 PM

I spend the rest of the afternoon doing laminaria insertions. Depending on the fetus's gestational age, 1 or 2 days before our physicians do a D&E for second-trimester termination, the PA performs the preop cervical dilation. We mechanically dilate the cervix and insert laminaria, and then the cervix gradually dilates further overnight. It is quite an uncomfortable procedure for the patient, but our staff does an excellent job of supporting her and helping her get through it as easily as possible. Patients who require 2 days of dilation before surgery return the following day to have the first set of laminaria removed and more placed.

Reasons for terminating pregnancies in the second trimester vary: Some patients do so because of fetal anomalies that have just been diagnosed on amniocentesis, some have experienced recent life alterations that change their decision to have a child, and some simply waited to decide or tried to deny the pregnancy existed at all. Performing late second-trimester abortions is what sets us apart from many other abortion clinics. It takes a special kind of surgeon, PA, and support staff to dedicate themselves to helping women get the medical care they need at this later stage.

■ 6:00 PM

After my last procedure for the day, I take a few minutes to finish my charting and follow up on patient phone calls.

■ 6:30 PM

As I am headed home in the car, my pager goes off. The answering service tells me that a patient who left the clinic after surgery earlier today has some questions about her medication instructions. I call her back to review the instructions and ask how she is feeling. She is nervous about her recovery and wants to make sure everything goes as planned. I remind her that she can call the clinic anytime with questions and that I am on call for the next week for overnight problems as well.

I alternate weeks on call with another PA in the office. We provide emergency overnight care in the clinic if need be. Rarely do we need to bring a patient into the office overnight, but this is always a possibility. Abortion is a very safe procedure, but no medical procedure is without risk. We feel that the team who performed the procedure is the team best equipped to provide postoperative care. Most overnight calls are from patients who simply need reassurance that their symptoms are normal. They can always come in the following day for a peace-of-mind checkup. Home care, such as ibuprofen and rest, works wonders!

Each day at my job can be both physically and emotionally demanding, but the rewards far outweigh the disadvantages, and I look forward to what the next day brings. [JAAPA](#)