

## Medication Abortion Role Play

Two people can do this informal role-play to illustrate abortion options counseling and the medication abortion counseling process. It's more a basis for improvisation and discussion than a script. We encourage you to invite questions from the participants, so that most of what you need to cover in the counseling session with the patient has been asked by the audience.

**Clinician/Narrator:** I'm here in my office with my patient, Emily, a cisgender woman. At a previous visit, she told me that she had never gotten around to filling her prescription for her contraceptives. For a few weeks, she had been feeling nauseated in the morning and wondered if she might be pregnant. She also realized that it's been around 7 weeks and she still didn't get her period. We did a pregnancy test, and it was positive. She was really surprised and upset and so we made an appointment for today to talk more about it.

*(Clinician/Narrator turns to mock patient.)* "So, Emily, you've had a bit of time to digest this information. What thoughts or feelings are coming up for you right now?"

**Emily:** "It's just not in my plans to have a child right now. I've decided that I just really need to be referred for an abortion."

**Clinician:** "Well I want you to know I appreciate the thought you put into this decision. And I'm here to support you. You actually don't have to go anywhere else for your abortion. Since your pregnancy is early, I can do early abortion care here in the office. There are two ways to have the abortion – using pills or an in-office procedure called a manual vacuum aspiration or MVA."

**Emily:** "You do? There's a pill for abortions? I didn't know that!"

**Clinician:** "Yes, the "abortion pill" is two different pills that can be used for pregnancies under 12 weeks, like yours. I would give you one pill called mifepristone, which you can take here in-office, or at home and a different set of pills called misoprostol to use later at home. Misoprostol are the pills that cause cramping and bleeding and help to pass the pregnancy. It's similar to an induced miscarriage. Misoprostol is inserted in the vagina or can be held and absorbed in your cheeks."

Another option is the abortion procedure, or MVA. Here is a factsheet with information on the two methods for you to consider. While you read this, I will go get the paperwork and give you some time to think over the options. Then, I'll come back and answer any questions you might have."

**Clinician – to audience:** In a busy office, people may need some time to talk and digest information. So, I often give them some of the information to read while I go see another patient, or prepare paperwork or the ultrasound machine. In most cases, we don't need to do an ultrasound because we can confirm how far along the pregnancy is by asking about the

patient's last period. So if they don't need an ultrasound, I'll go see another patient. Some patients bring a support person, like a partner, to talk to. If they don't have a support person with them, some patients may want to call someone, like a partner, family member, or friend.

**Clinician:** "So, Emily, what do you think about the abortion care options?"

**Emily:** "I'm interested in medication abortion. I just have a few questions –

Will I be able to have kids later if I want?"

**Clinician:** "Absolutely. In fact, you will be fertile again in your very next cycle, so we can also talk about contraception options if you're interested.

**Emily:** "Can we do this today?"

**Clinician:** "Yes, we can." (Confirm that your state doesn't have any mandatory waiting period laws or other restrictions that may delay the abortion.)

**Emily:** "What if the pills don't work?"

**Clinician:** "The pills are 98 to 99% effective in ending the pregnancy. If they don't work the first time, there is the option of repeating the second pills (misoprostol). That works 50 – 75% of the time. If we're still not successful, we will need to do aspiration abortion to prevent any health complications for you."

**Emily:** "Another question I have is how much time will I need to miss from work to do this? If I take the first medicine today, will I be able to go in for my night shift tomorrow?"

**Clinician:** "We have a lot of flexibility about when you use the medications. If you take the first pill, mifepristone, now you can use the second medication, misoprostol, as soon as 24 hours from now if inserted vaginally, which would be in the late afternoon. That means your cramping and bleeding would peak around 9PM. The bleeding would slow down after that, and by tomorrow you will feel more like you are just having your period. So, by tomorrow evening you could go to work. On the other hand, you can take the second medication as late as 72 hours from now, if inserted vaginally, which means you could wait until the weekend. If you'd rather take the second medication by holding it in your cheeks or under your tongue, you can take it within 24-48 hours after taking mifepristone."

**Emily:** "I'm so relieved. Even though the bleeding sounds scary, I'd much rather go through this at home where it's more private."

**Clinician:** "Do you want to do the medication abortion here today? We'll just need a few more minutes to talk through some more information and sign a few forms."

**Emily:** “Yes, please, my partner and I talked this over, and we are sure we’re not ready for more children now.”

**Clinician:** (turns to audience): If I don’t already have this information, I ask about last menstrual period (LMP) to confirm gestational age. If she’s unsure about when her last menstrual period was, I may ask a few more questions, like when she thinks she got pregnant, or do a bimanual exam. I only want to do an ultrasound to determine gestational age if the patient’s last menstrual period may be over 84 days, if the patient had no menses and it’s been more than 84 days since a delivery or abortion, if the pregnancy happened while the patient was having no periods from certain contraception, if I suspect ectopic pregnancy, or if I’m uncertain with the bimanual exam.

We’ll also talk about options for contraception, if the patient is interested.

Then, I go through the consent forms, explaining the protocol in terms of when and how the patient should take the misoprostol pills. I review the patient instruction form line by line with the patient, so they know where to find information if they forget and to ensure I covered everything. I solicit questions often as we go through the info sheet.

I give the patient the mifepristone and misoprostol pills, and discuss when and how will be a good time to insert them, thinking about who may be around at home, etc. They can choose to take the mifepristone right there and then, or take the mifepristone at home.

I also give a prescription for pain medicine and information on when to start the contraception option they chose or to a reminder to review contraception options if they want to talk about them at another time.

I tell the patient about situations when they need to contact me, like potential “warning signs” like too much bleeding or no bleeding. I give the patient our on-call phone number so they can reach me or another trusted clinician right away if they experience any problems. I find that this is hugely reassuring to people.

To review the reasons that people do call:

- 1) “I didn’t bleed and it’s been 24 hours since I inserted the pills.”

This happens most often with very early pregnancies. If an intrauterine pregnancy was seen on ultrasound, there is nothing to worry about and a little more time is often all that is needed. In this case, options include waiting another 24 hours and having the patient call back if they still haven’t bled or dispensing a second dose of misoprostol right away.

If an ultrasound wasn't performed prior to the medication abortion or an intrauterine pregnancy wasn't seen on the ultrasound, then ectopic pregnancy should be considered. Patients should be asked about symptoms of ectopic, given ectopic precautions, and be evaluated in the office as soon as possible.

2) "One of the pills came out in the toilet when I went to the bathroom"

If the patient took misoprostol vaginally, as long as the medication has been in the vagina for 30 minutes, it has had time to get absorbed. This is why we tell people to lie down for the 30 minutes after they insert their misoprostol. If they are using it buccally (or in the cheeks), you sometimes get calls about, "I swallowed it before the 30 minutes was up" which is also OK, they just might have more GI side effects. Only if they swallowed all of the pills right away, the efficacy be a little bit lower.

3) "I had my medication abortion two weeks ago and I'm still bleeding."

On average, people bleed for 9 -14 days following a medication abortion. Some people bleed or pass clots for as long as 4 weeks. After the first few days of heavy bleeding some people will have little or no bleeding, some will have bleeding that stops and starts, and others will have bleeding similar to a menstrual period for several weeks. Sometimes the first menses following a medication abortion is especially heavy. In the absence of other symptoms, the bleeding is not dangerous and it is safe to wait for it to stop on its own.

If a patient experiences heavy bleeding (not spotting) greater than 4 weeks after mifepristone, or if they have symptoms of anemia, hypovolemia, or infection, they should be evaluated in the office.

For more frequently asked questions, visit our [Medication Abortion FAQ](#) resource.

Routine follow-up is actually not needed for most medication abortion patients, but we can offer the opportunity to schedule a phone or in-person visit to check-in on how the process went and to assess the completeness of abortion.

So, if I have a phone call or in-person visit with the patient, I ask how it went. Most people will say it was pretty much as we described. When we hear that, we figure we've done good counseling, though the experience is different for every person. Through a phone call, we can confirm whether the abortion is complete with history (the patient's description of bleeding and resolution of any pregnancy symptoms) or with a negative home pregnancy test 4 weeks after taking the first pill, mifepristone.

If the patient decided to use contraception after their abortion, we make sure they are comfortable with their contraceptive choice or if they have any questions or concerns. If they want an IUD, implant, or progestin injection, we'll make sure they have an in-person

appointment to get those services. If interested, we can also use the time to talk about contraceptive options if they did not want to talk about them earlier.