

## Clinical guidelines on ultrasound viewing

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### The purpose of this guide

The purpose of this guide is two-fold. First, it creates a space where the reader can examine assumptions about patients' experiences of ultrasound viewing in abortion care, and how these assumptions compare with findings from current research. Exercises provide an opportunity for the reader to self-reflect on values and beliefs around the impact of ultrasound viewing on the patient's experience and her abortion decision. These can be done individually or in a group setting. Second, this guide provides the reader with tools to structure conversations around ultrasound viewing in terms of framing questions, initiating conversations with patients around ultrasound images, and responding to challenging patient statements.

Whether you are a provider working in an environment of mandated offering, viewing, and/or describing; in a clinic with a policy on offering to view; or in a clinic without any policy; this guide provides tools to facilitate patient-provider conversations. Through these conversations, we can create a context where women's choices are normalized, where concerns are validated, and where their feelings are addressed.

### Current legislation about ultrasound viewing

State laws vary on the provision of ultrasound and on viewing requirements. The trend to require that patients be offered the opportunity to view the ultrasound is growing and may become increasingly more common. As of June 2014, the Guttmacher Institute reports that nine states require abortion providers to perform an ultrasound and offer the opportunity to view the image.<sup>1</sup> Eight additional states require offering the patient the opportunity to view the image if an ultrasound is routinely performed as a part of pre-abortion care. In three states, the provider must display and describe the image; the woman is allowed to look away and in certain circumstances may decline to listen.

### What is the motivation that grounds this legislation?

Americans United for Life, a pro-life public interest law firm and advocacy group, hopes that by viewing an ultrasound image, women will be persuaded to continue their pregnancies and, overall, this will reduce the number of women who decide to have an abortion. Mandated viewing may also be a tactic to bog down clinic flow by placing additional burdens on staff. Certain provisions of current legislation are geared towards complicating the delivery of care by dictating the practice of medicine via protocols that would not be employed in other medical settings, e.g. by mandating that the same physician perform the pre-abortion ultrasound and the abortion, and requiring the pre-abortion ultrasound to take place 24 hours before the patient's appointment.

#### Exercise A:

Below are two scenarios that could arise in environments with or without legislation or policy around ultrasound viewing. Compare and contrast your responses to the two scenarios.

- As part of a patient's abortion visit, you perform an ultrasound and confirm that her pregnancy is 7 weeks gestation. The patient asks to see the image. You show the image to the patient and describe what you see. How do you imagine that this patient will respond?
- As part of a patient's abortion visit, you perform an ultrasound and confirm that her pregnancy is 20 weeks gestation. The patient asks to see the image. You show the image to the patient and describe what you see. How do you imagine that this patient will respond?

## What we know about women's preferences around ultrasound viewing when viewing is voluntary

When viewing is voluntary, simply being offered the opportunity to see the ultrasound increases the likelihood that a patient will decide to see it; as many as 43% of women will accept the offer to view the image.<sup>2</sup>

Research on voluntary viewing showed that women had a wide range of emotional responses to seeing the ultrasound image. In a study that looked at patients reports of their emotional response to viewing, in order of most frequent to least frequent, the responses were: a) no response; b) negative emotions such as feeling bad, sad or guilty; c) positive emotions such as feeling happy, excited, comforted and relieved.<sup>3</sup> Interestingly, the likelihood of having any particular response was not associated with gestational duration of the pregnancy. For example, women who viewed the ultrasound image later in gestation were not more likely to experience negative emotions and women who viewed images earlier in gestation were not more likely to feel positive emotions. Other research has shown that how certain women felt about their abortion decision matters in terms of whether viewing causes them to change their mind. Low to medium certainty about having an abortion—and this was a small minority of women (7%)—was significantly associated with continuing the pregnancy. For women with high decision certainty, viewing the ultrasound did not affect their decision.<sup>4</sup>

## What kinds of feelings could viewing bring up for women?

The most obvious concern for abortion care providers is that viewing the ultrasound image will complicate a pregnancy decision that initially was not complicated. This is a valid concern and originates in our desire to provide safe, compassionate medical care and to avoid harm. When viewing or describing the image is mandated, we once again find ourselves in the difficult position of being on the defensive—meeting the requirements of an additional legislative burden while simultaneously protecting patients from the consequences of laws that are incongruent with patient-centered medical practice. In the times prior to legislation, we had already recognized

that conversations about viewing the ultrasound arose organically and were addressed in a patient-centered manner. That is part of what can make the mandates feel offensive.

Some research suggests that there may be an unmet need for viewing the ultrasound image in women presenting for abortion.<sup>5</sup> Most staff working in abortion care environments without legislative mandates can attest to women's spontaneous requests to view the image on the screen and/or take home a copy of the image as a memento. It is interesting to wonder how many other women in our practices would have liked a chance to view but were afraid to ask, fearing a negative reaction from staff, being labeled as ambivalent, or being denied an abortion. It behooves us to be curious about whether we have made decisions for patients that did not necessarily benefit them but instead served to ameliorate our own anxiety.

Another issue that may arise from requirements to offer viewing is that it introduces an additional decision-moment within the process of obtaining an abortion. This decision-moment may be unexpected; it may catch patients off guard. Some patients may feel that they had adequate time to come to a pregnancy decision but that they were not presented with adequate time to decide whether or not to view the ultrasound. After making a decision, patients may begin evaluating their choice. What do other women decide to do? Am I a bad person if I (don't want to) view my ultrasound? What does my decision say about me as a person? A woman? A mother?

For some patients, viewing the ultrasound and/or keeping a copy of the image as a memento is a positive event and may also aid in post-abortion coping. Women who are certain in their decision to have an abortion may also be relieved to know that they are fertile. They may find themselves in awe of the event of pregnancy and want to satisfy curiosity about the developing embryo or fetus. When a provider is concerned about how viewing the ultrasound may have affected a patient, the simplest solution is to ask:

**PROVIDER:** How was that for you to view the ultrasound?

**PATIENT:** Definitely a little strange, but I'm okay.

**PROVIDER:** Do you have any questions that I could help answer?

**PATIENT:** No, I'm good.

**PROVIDER:** If anything comes up for you during your visit, don't hesitate to ask. It's important to us that you have your questions answered.

**PATIENT:** Thanks.

### What motivates women to view the image?

In environments lacking legislation or policy around mandated offering, viewing or describing the image, there always have been patients who requested to see the image. Most providers have had the experience where patients—while fully resolved around their abortion decision—have asked to see the image, asked questions about fetal anatomy and even requested a copy of the ultrasound picture to take home. These scenarios are often unremarkable, mostly because we have come to appreciate that pregnancy decisions can be clear and straightforward and that women are capable of holding complex and seemingly contradictory feelings about their pregnancies. In short, we have come to learn that women having abortions may also have feelings of attachment toward the pregnancy, are sometimes relieved to know that they are fertile even if they cannot continue this pregnancy, and/or feel that a memento of the pregnancy will help them through their grieving process.

The complex yet common feelings that arise during pregnancy decisions remind us that it is critical that we do not make assumptions about a patient's appraisals of her pregnancy—instead we seek to understand her particular experience and tailor our language to validate her experience.<sup>6</sup>

**PATIENT:** Can I see?

**ULTRASONOGRAPHER:** [shows the image] Absolutely....Do you have any questions?

**PATIENT:** Is this the head?

**ULTRASONOGRAPHER:** This part is called the calvarium—the head. You are seeing the image as if you are looking down on the head this way [gestures with her hand]. This gives us the most accurate measurement of gestational duration, meaning, how many weeks pregnant you are.

**PATIENT:** Thanks for showing me.

Sometimes patients ask to see the image during counseling—they ask if they can see the pictures that are in their

chart. They may also ask to have a copy of the image, which in most scenarios simply requires that you follow your protocol for the authorization to release medical information. It can be helpful to check in with the patient to see whether viewing the image had any impact.

**PATIENT:** Can I see the ultrasound?

**COUNSELOR:** Sure....Here's the image that the provider printed out and attached to your chart. What questions do you have?

**PATIENT:** None really. Can I have a copy?

**COUNSELOR:** Sure, I can make you a copy. How is it for you to see the image?

**PATIENT:** It makes me happy. Even though I can't have this baby I think of it as my first baby. Also, I was convinced that I couldn't get pregnant. I guess I'm relieved to know that I can. I'd like to keep the picture as something to remember the baby by.

**COUNSELOR:** I've met other people who feel the same way. I'm glad you've found something that will help you in a positive way.

### Offering to view the image

Research has shown that the majority of women who present for abortion care are certain of their decision to have an abortion.<sup>7</sup> We also know that in the context of voluntary viewing, seeing the image does not erode decision certainty in those women who are certain. Even so, it will be important to build confidence around checking in with patients about the impact of viewing and increasing your lexicon for how to respond to challenging questions.

Interestingly, the tools that we will use to transform a potentially negative experience for both staff and patients into an empowering one are the same tools that are useful in conversing around other challenging statements that patients may make during the course of their visit.

Providers can initiate the conversation around viewing using the same tools that they use to frame the purpose and limits of the ultrasound in abortion care. Thinking back to your practice before legislative regulation of viewing was introduced, a typical way of presenting the purpose of the ultrasound during the patient's visit might have been something like this:

**CLINICIAN:** I'm the clinician who will be doing your ultrasound today. The purpose of this ultrasound is to date the pregnancy—that's all that I'll be able to do.

Similarly, clinics have had different ways of how to deal with multiple gestations once they are discovered. Some clinics introduce the concept at the beginning of the ultrasound in order to normalize the discovery of multiple gestations. Again, in the days before regulation of viewing, your practice might have been something like this:

**CLINICIAN:** I'm the clinician who will be doing your ultrasound today. The purpose of this ultrasound is to date the pregnancy—that's all I'll be able to do. If I were to see that the pregnancy was a twin gestation—or greater if I were able to determine that—would you want me to tell you or would you want me to not tell you?

What is important about these two scripts is that the provider is creating a framework that sets expectations about the nature and purpose of the ultrasound. They promote transparency and communicate goals and limits. In the second example, the clinician introduces a decision-moment for the patient. Some providers only introduce this decision-moment when multiple gestations in fact are discovered. Proponents of this approach believe that it protects the patient from the idea of multiple gestations unless it arises. Critics of this approach say that when the question is presented after the ultrasound is in progress, the question itself reveals that a multiple gestation has been discovered thus precluding a neutral decision-moment.

In our current environment of regulation, our first decision is how to frame the introduction of this new decision-moment. One way would be to place a question on the patient intake form. When patients indicate in the affirmative, the ultrasonographer confirms the patient's preference at the time of the ultrasound. Patients who decline on the intake form are allowed to change their minds, but that change originates in the patient—they are not asked again. Some clinics may decide to or be required to ask the question in person. How should we frame the context of offering to view the image? Our ability to create and maintain rapport with our patients rests on a foundation of trust. That trust depends on honest and transparency between providers and patients. Being honest with patients without being inflammatory or communicating resentment and hostility toward mandates

may strengthen the bond of trust between patient and provider even in the context of mandates that feel oppressive and patronizing. In contexts where there are constraints being placed on our behavior, we must communicate with patients and one another in ways that work to transcend those constraints and empower patients to make decisions. Let's consider how providers might offer to view the image in contexts free of legislation:

**CLINICIAN:** I want to ask you a question that I ask everyone. Sometimes people want to view the image and sometimes they don't. I don't have a preference; I want to accommodate your request. Do you have a sense of whether or not you'd like to see it?

Sometimes clinics might decide to offer patients the opportunity to view as a matter of policy, apart from any legislation. An assessment of viewing preference is an easy addition to a patient intake form. Some may be concerned that asking everyone increases the likelihood that a patient could have a negative response simply from being asked. Here, transparency and honesty are your best tools. When a patient becomes upset as a result of the question, let the patient know the reasons behind the protocol at the same time as validating her personal experience.

**CLINICIAN:** I'm sorry about that. Our intention is not to make this harder for you. I'll tell you about why this became our policy. We've learned through research that many more patients want to see the ultrasound than we ever expected. And a lot of those patients were afraid to ask to see it. So we decided to offer it to everyone. We didn't want to feel like we were hiding things from patients.

In contexts where offering, viewing or describing is mandatory, we can still employ our goal of transparency. Above all, the way we present ourselves as responding to this legislative mandate should validate the experience of the patient. If the patient is angry or upset about the law, validate that response as legitimate—it isn't right that politicians are dictating medical practice. If a patient is grateful for the opportunity to view, express satisfaction that she is getting the care that is beneficial for her. No matter what the response, it often feels more honest to tell all patients the origin of the change in protocol:

**CLINICIAN:** I want to ask you a question that I ask everyone. Last year, our state legislature voted to require clinics

to offer all patients the opportunity to view the ultrasound. Sometimes people want to view the image and sometimes they don't. I don't have a preference; I want to accommodate your request. Do you have a sense of whether or not you'd like to see it?

Sometimes patients ask us our opinion about these laws. Again, keep pace with the patient. The truth is that her opinion is valid, no matter what it is. It's her opinion! We can always hear and witness her truth. Striving for a neutral response to a patient's inquiry about our opinion about politicians' motivations honors the possibility of good outcomes with honest skepticism about their origins.

**CLINICIAN:** Honestly, I feel conflicted about this new law. I want you to be able to access your medical information—we don't want to hide things from you that you want to participate in. But it also doesn't feel right to put patients in this position if it's not helpful to them.

## Normalizing and validating

Let's turn to some skills that are useful when patients are considering whether to view the image. No matter how we decide to frame the requirement of offering to view, the first tool that we will use to transform the decision-moment is to normalize the alternatives. The second tool that we will use is to validate the feelings that we see and hear. Let's start with an example of normalizing:

**CLINICIAN:** There's no right or wrong decision. We—the staff at the clinic—don't have a preference for how you decide; we want you to do what makes you comfortable. Some people decide to view and some people decline to view. We're still going to give you the same high-quality care, no matter which way you go.

Here's another example:

**CLINICIAN:** There's no right or wrong decision. Here in our state we are required to offer to show the image. It's not required that you view it. Everyone is allowed to make that decision based on what feels right for them.

At this point, some patients will evidence a choice and you may act on that decision.

Other patients may ask questions or make statements that reveal conflicting feelings about viewing or even

conflict with their decision to have an abortion. This is an opportunity to normalize and also to validate the feelings and concerns that you see and hear. Normalizing helps the patient to feel less strange and less different. Validating communicates to the patient that you have heard her, that her feelings and beliefs matter, and that her feelings don't scare you. Let's look at some sample dialogue of normalizing and validating.

### Dialogue A.1

**PATIENT:** You mean other people have these concerns?

**ULTRASONOGRAPHER:** Yes. Other people have said the very same thing.

### Dialogue A.2

**PATIENT:** I'm sorry that I'm crying. I didn't want to!

**ULTRASONOGRAPHER:** It's okay to cry here. This is a place where it's okay to show your feelings.

### Dialogue A.3

**PATIENT:** What do most people do?

**ULTRASONOGRAPHER:** About half of our patients ask to see the image and about half decline. Either way you go there are a lot of other people to keep you company. Remember, there's no right or wrong way to go.

### Dialogue A.4

**PATIENT:** What do you think I should do?

**ULTRASONOGRAPHER:** I actually don't know which way you should go; only you know. One thing that we have learned is that it is best to decide based on what you want—not based on what other people think you should do or what you think other people expect you to do.

In the context of mandatory viewing/describing, we can still normalize and validate the patient's responses, even if she has less freedom to decide:

**ULTRASONOGRAPHER:** In our state, abortion clinics are required to show you the image of the pregnancy from this ultrasound and to describe the image. In my description, I'll be honest about what I can see but I'll use gentle language. You are free to ask me any questions and I'll let you know about the limits of what I can see and know from this ultrasound picture.

**PATIENT:** I don't want to see anything! I don't want to hear

anything!

**ULTRASONOGRAPHER:** [gently, with compassion] I hear you, and I agree that it should be your right to decide what you see and hear. Other patients feel the same way about it as you do. This law did not come from people who work in abortion clinics. This law came from the state legislature and that's been difficult for us. I hope it makes more people stand up for the rights of women. For now, I have to turn the screen toward you and describe what I see. But you still have free will—whether you look or listen is still your personal right.

When patients are conflicted about whether to view, it can be helpful to assess expectations. Asking what a patient expects to see gives the ultrasonographer an opportunity to correct any medical misinformation that might be inhibiting a patient's ability to decide. Patients who are seven weeks pregnant and are expecting to see a fully formed fetus might benefit from hearing the estimated size of the embryo before viewing the screen. This could also help counteract patients' frequently expressed sense that regardless of gestational duration or actual size, the ultrasound image "looks so big." Patients struggling about whether to view a pregnancy in the second-trimester may feel conflicted because they already know what they will see. It can be helpful to discuss with a patient what she anticipates it will be like to view the image and what impact viewing might have on her pregnancy decision.

**PATIENT:** Part of me wants to see it but the other part is worried.

**ULTRASONOGRAPHER:** Can you say more about the worry?

**PATIENT:** I have a daughter, so I've seen ultrasounds before. I'm worried that if I look, it will make it harder to make a decision.

**ULTRASONOGRAPHER:** That's normal; I've talked to other women who felt the same way. It's interesting that in a way, you already know what you'd see on the screen. But at the same time, you think it might make things more complicated. I wonder if making this pregnancy decision has been hard for you all along, and the ultrasound question is simply bringing that out. Whether or not I'd asked you about the ultrasound, you'd still be somewhat uncertain about which way to go.

**PATIENT:** That's exactly it.

In sum, the key to a neutral presentation of the ultrasound decision-moment is to normalize all decisional outcomes—the patient is in good company no matter which way she goes—and to validate her decision. She is making the decision that is right for her. In addition, it is important for patients to hear that you and the clinic don't have a preference for which way she decides to go. In effect, you are communicating that her decision about the ultrasound won't affect her care at the clinic. Finally, validate the patient's response to viewing the image. Share your compassion for her sadness and grief; validate her frustration at government intrusion; express your satisfaction that she is pleased with her care.

### Exercise B:

The following are two different scenarios that come up in environments with legislation around mandated ultrasound viewing and description of the image. Compare and contrast your responses to the two scenarios. How do your responses differ from Exercise A where there may not have been legislated requirements?

- As part of a patient's abortion visit, you perform an ultrasound and confirm that her pregnancy is 7 weeks gestation. You are required to show the image to the patient and describe what you see. How do you imagine that this patient will respond?
- As part of a patient's abortion visit, you perform an ultrasound and confirm that her pregnancy is 20 weeks gestation. You are required to show the image to the patient and describe what you see. How do you imagine that this patient will respond?

### Describing the image

The most important factor in describing the image to the patient is combining truthfulness with gentle language. If there were to be anything about viewing the image or a truthful description of its contents that would help clarify a patient's decision to continue or end the pregnancy, we would not want to stand in the way of that

realization. In recognizing that patients have the right to a truthful representation of what is contained within their ultrasound image, we liberate ourselves from taking responsibility for her decision. That responsibility is hers and hers alone.

In that way we recognize the autonomy and agency of women. We do not possess knowledge about her decision that she does not. This allows us to be vigilant for any moment where our own biases and anxieties might interfere with our ability to be present for the patient. This is eased by the recognition that the patient is capable of finding out for herself everything she wants to know about her pregnancy—the anatomy, the size, its capacity to survive outside the uterus—by consulting any reputable medical publication. The availability of this information has become ubiquitous, along with erroneous information meant to confuse and shame.

We build trust in our patients by differentiating ourselves from those who would wish to influence decisions through medical misinformation, myth and negative judgment. We must maintain a stance of care and compassion throughout the process, while recognizing and honoring resilience and strength in the other.

One of the most important factors in describing the image is a consideration of the language that we use to describe what we see. In a patient-centered practice, we build rapport through using the patient's words, while at the same time providing correct medical information.

#### Dialogue B.1

**PATIENT:** Is that the baby?

**ULTRASONOGRAPHER:** That's the baby, right here [points]. At this gestation—you are in the seventh week of pregnancy—the baby is called the embryo. That term means that it is in an early stage of development.

#### Dialogue B.2

**PATIENT:** Does the baby have a heartbeat?

**ULTRASONOGRAPHER:** The baby has a heartbeat. I think it helps to realize that a heartbeat becomes present very early in the pregnancy—we can detect it on the screen here at about five or six weeks' gestation. That's because the heart is so important and is one of the first organs to develop.

#### Dialogue B.3

**PATIENT:** Is it a baby?

**ULTRASONOGRAPHER:** That's a good question; I'm glad you asked. I have two answers that I would give you. The first is that each person gets to decide how she defines her pregnancy and the words that she uses to describe it. You have the right to do that for yourself and base that decision on your own beliefs. The second answer I would give is to put things in a medical context. Medically speaking, the term that we use to describe your pregnancy is a fetus. That term is used to describe all pregnancies 10 weeks gestation or greater—all the way until the moment of birth. At birth, the fetus becomes a baby. You're 16 weeks pregnant. What is important is for you to decide is what you need to know about your pregnancy to help you make a decision. I will do my best to answer your questions.

In this example, the ultrasonographer must provide a lot of information in her answer because she isn't sure of the true motivation surrounding the patient's question. The question itself—is it a baby?—is arguably ambiguous and hints at the possibility of a more specific question that remains unasked. With the response above, the ultrasonographer covers a great deal of ground and provides important answers, but does so without a full understanding of what is driving the patient's question. An alternative method is simply to start with an open-ended question. While it may seem counterintuitive, this technique can reduce anxiety by giving you your “bearings.” Here's an example of a way to start with an open-ended question so that you can tailor your answer to the patient's (unstated) question:

#### Dialogue B.4

**PATIENT:** Is it a baby?

**ULTRASONOGRAPHER:** That's a good question; I'm glad you asked. I'll try to answer the best I can. Can you say more about what led you to ask me that question?

**PATIENT:** Well, I'm wondering if it can feel pain.

**ULTRASONOGRAPHER:** I'll share with you what I've learned about that.

Now the ultrasonographer has a much more nuanced understanding of what is driving the question and can tailor her answer accordingly. It's always important to

check in with the patient to see how she is doing after hearing the information:

**ULTRASONOGRAPHER:** How was it for you to hear that information?

The next aspect to consider is how to describe the image on the screen. Providers may have the ability to decide whether to freeze the image during the description or whether they are required to keep the transducer running during their description.

A good way to start is to freeze and show the image that you will use to calculate gestational duration. For earlier gestation, this will include a crown-rump measurement. For later gestations, the biparietal diameter serves as the most accurate measurement with the femur length providing a secondary estimate.

#### Dialogue B.5

**ULTRASONOGRAPHER:** I'm going to bring the picture into view so we can see it more clearly. First, I want to check with you about the word that you prefer to use to describe this pregnancy because I want to use the words that you use. Do you say "the baby," "the fetus" or "the pregnancy"?

**PATIENT:** I guess I've been saying "baby."

**ULTRASONOGRAPHER:** Okay. This dark part here is your uterus, where the baby grows. Here is the head, this section here is the body, and the arms and legs are right here. You are about 16 weeks pregnant and the baby is about 4 inches in length.

**PATIENT:** [silent]

**ULTRASONOGRAPHER:** How is it for you to hear this description?

It's also important to recognize that these conversations may arise during counseling, after the ultrasound has taken place. The counselor uses the same techniques as described here, validating and normalizing feelings, and seeking understanding of more complex statements, feelings, and beliefs.

### Seeking understanding

Sometimes the act of viewing brings up complicated feelings. The patient may or may not express these feelings during the ultrasound itself. Sometimes it feels

appropriate to talk about feelings during the ultrasound. Other times it may be more appropriate to have those conversations during a subsequent part of her visit. However, it is always important to normalize and validate the feelings that you see or hear. If your clinic uses an assessment tool to triage counseling, keep in mind that women with low to medium certainty may benefit from a conversation after viewing the ultrasound where they have the opportunity to explore how viewing the image affected their decision.

#### Dialogue C.1

**PATIENT:** I'm starting to have second thoughts about the abortion.

**ULTRASONOGRAPHER:** For some people, viewing the ultrasound can bring up second thoughts. It's okay to have second thoughts. At this clinic, we believe in creating a space for you to talk about your decision and you'll have that opportunity to do that during your visit. If at any time you feel that you've changed your mind and want to leave, you can do so.

Seeking understanding is a technique used in decision counseling when patients express conflict with their decision and wish to discuss that conflict.<sup>8</sup> Seeking understanding is difficult for many of us because often we are afraid to find out the deeper, more complex feelings that people are having about their pregnancy decision. Sometimes talking about feelings is uncomfortable. Other times, we simply need more tools for responding to complex patient statements. Fortunately, the technique for seeking understanding is simple. It involves using open-ended questions to allow the patient to describe her feelings and their origins. The goal of the listener is straightforward—to witness the feelings and create a safe space where they are heard and recognized. The goal of the listener is not to fix or eliminate the feelings—simply to witness. There is healing in listening and modeling an absence of fear and judgment. This normalizes the patient's experience and communicates that she is entitled to her feelings.

#### Dialogue C.2

**PATIENT:** I think I regret seeing that.

**ULTRASONOGRAPHER:** I've met other people who said the same thing after viewing. [Gently, with interest] Say more about what you are feeling.



**PATIENT:** It made it more real for me.

**ULTRASONOGRAPHER:** [silent]

**PATIENT:** This was a really hard decision. I almost didn't come to my appointment today. Seeing the baby is making me re-think my decision; I feel like it's moving me toward keeping it.

**ULTRASONOGRAPHER:** Thank you for sharing that. Just so you know it's okay to be unsure. And, it's important to listen to the different feelings that you're having. You used the word "regret" earlier and said that you regretted seeing the image. Can you say more about that?

**PATIENT:** Well, when I came today I finally felt relief that I had made a decision. Now that's gone.

**ULTRASONOGRAPHER:** It sounds like you found a bit of relief, yet you also almost didn't come to the appointment today.

**PATIENT:** That's so true.

**ULTRASONOGRAPHER:** Just so you know, a lot of people who are having a hard time coming to a decision say that they feel the same way.

**PATIENT:** Thank you.

### Dialogue C.3

**PATIENT:** It's a real baby!

**ULTRASONOGRAPHER:** [gently] How so?

**PATIENT:** I can see arms and legs; I can see that it's the shape of a baby.

**ULTRASONOGRAPHER:** How is that for you?

**PATIENT:** I guess it's starting to make me question my decision.

**ULTRASONOGRAPHER:** Say more about that.

**PATIENT:** It makes me think that it's a baby and I shouldn't get rid of it.

**ULTRASONOGRAPHER:** Before coming today, what made abortion the decision that seemed best for you?

**PATIENT:** I'm still in school; I don't have a job or my own place to live. My boyfriend is also finishing college and we don't really have our lives set up for parenting yet. We want to be parents, but felt like this wasn't the right time.

**ULTRASONOGRAPHER:** Are there things that would make continuing the pregnancy possible?

**PATIENT:** I know that my mom would accept either decision.

She would let me live at home and raise the child there. But it would really make things difficult for me in terms of moving forward with my life.

**ULTRASONOGRAPHER:** It seems like what you're saying is that you're trying to create something in your life that will allow you to be the best parent that you can be.

**PATIENT:** I'm trying to.

**ULTRASONOGRAPHER:** One thing that I've learned from my patients is that having an abortion is something that people decide to do because they want to put some things in place before they bring a child into the world. Having an abortion doesn't mean that you don't care about this pregnancy; in fact it's the opposite. You want to make sure that when you have a baby you're the most ready that you can be, and that is about caring for a baby in the way you feel is best.

### Exercise C:

Conduct this exercise with a small group of your co-workers. Compare and contrast responses to the two scenarios. Notice whether there were reasons that you previously had not considered.

- A woman comes in for a routine ultrasound as a part of her prenatal care. This is a pregnancy that she plans to continue; she and her partner are happy to be expecting a child. What are some reasons that this patient might not want to view the ultrasound image?
- A woman comes in for abortion care and is having her routine pre-procedure ultrasound for gestational dating. The woman has decided that she cannot continue this pregnancy and is seeking termination. What are some reasons that this patient might want to view her ultrasound image?

Let's return to the important finding from current research that reminds us that many patients will have either no reaction or a positive reaction to viewing the ultrasound. While these conversations may feel less complex, it's important to respond non-judgmentally to positive reactions and to normalize no reaction.

**PATIENT:** Wow! That's really neat. Can I have a copy of the picture there?

**PROVIDER:** Yes, you can. How is it for you to see the ultrasound image?

**PATIENT:** I'm so happy to know that I can get pregnant. All this time I thought I wasn't fertile. We've only ever used condoms and sometimes we don't even use them. I've never gotten pregnant until now. I just thought there was no way it would ever happen. Even though I'm not ready to be a parent now I'm just so happy to know that everything is okay inside.

**PROVIDER:** You know, I've met other people who felt the same way. The thing to keep in mind about our fertility is that sometimes it comes and goes in ways that we can't always predict. That's what makes it important to assume that you're fertile and use the method of birth control that fits best with your life and your plans for the future. The counselor will help you think about what's right for you.

Patients with no reaction to viewing present challenges that are similar to patients who, during counseling, exhibit no emotions, make little or no eye contact or have minimal interaction with staff. Establishing rapport in these contacts can be challenging, but is best initiated by recognizing the patient's right to maintain her privacy. Nevertheless, staff are required to ensure that the components of informed consent are satisfied and that the patient is safe. It's okay to communicate to the patient that you respect her need for privacy but that you need her to work with you to satisfy requirements.

**PROVIDER:** How was it for you to view the image?

**PATIENT:** [silent]

**PROVIDER:** Has it changed your decision?

**PATIENT:** [no eye contact]

**PROVIDER:** [gently] Much of the reason that I ask is because I want to make sure that you're okay and that you feel that you can ask questions here. I also want you to know that I respect a person's desire to have privacy and if that's important to you then I won't pry. But there's one deal that we have to make with each other—there's a few questions that I have to ask you and I'll need a truthful answer from you. I need to know your answers in order to provide care for you. Apart from that, I'll try not to bug you. Are we together on this?

**PATIENT:** [nods]

**PROVIDER:** Okay, good. I really appreciate it.

## Reframing

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Most of the time, seeking understanding can be accomplished with a few key open-ended questions. The purpose of the open-ended questions is to gather an understanding of the context of the patient's decision and to assemble the ingredients for a reframing of her decision in light of her stated values and beliefs.<sup>9</sup> What we know from surveys of women seeking abortion is that women have abortions in order to be able to care for the children that they already have and to be able to put things in place to parent in the future.<sup>10</sup> Within those main reasons are women for whom their family is complete and women who never want children. Overall, the most transformative reframe is to offer thinking about abortion not as something done out of malice or bad feelings toward a particular pregnancy but instead out of the women's stated moral values: care, compassion, mercy, justice, fairness and love. You learn about a woman's moral values through asking open-ended questions. Once you have this understanding and the role that it played in her pregnancy decision, you can offer a reframe as the ultrasonographer did in dialogue C.3.

## Conclusion

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We have the ability to use ultrasound viewing, whether voluntary or mandated, as a tool to empower patients and increase rapport and trust in the clinic. A key element to achieving honest, gentle communication is to skillfully employ tools for asking questions and responding to patient statements. A substantial portion of communication is our tone of voice and bodily posture. Readers are encouraged to spend time practicing the techniques presented in this guide with co-workers and to analyze tone of voice, word choice, and presentation. Mastery comes with practice. As we strive toward a more transparent and validating healthcare environment, cultivating professionalism in the face of uncertainty, our patients will respect us for standing up for their right to be at the center of care.

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