An orientation checklist for new clinicians: What to be sure to ask about and understand starting day one

THE ABORTION CLINIC TOOLKIT

LEARNING OBJECTIVE

After reviewing this section of the curriculum (the checklist document and this video), you should be able to:

- Identify the key questions to ask to get a comprehensive orientation to an outpatient abortion care clinical environment

Introduction

Many clinicians who are considering working in a new abortion clinic setting wish they had asked more questions during the process of getting to know the clinic. But it can be difficult to know what are helpful questions to ask.

The goal of this video and the accompanying orientation checklist is to equip you to get the best orientation possible to the inner workings of a new clinical environment.

If you haven't already, go ahead and download the checklist document in either Microsoft word or PDF format from the Abortion Clinic Toolkit website. If you download it as a word document, you can customize it to your unique setting and role, and fill it in as you get your questions answered. If you download it as a PDF, you can print it and take handwritten notes in the notes section.

In this video, I am going to guide you to what the orientation checklist contains, and provide some advice on how to use it. A group of over thirty abortion clinic experts – physicians, advanced practice clinicians, and administrators – contributed to the development of this checklist. We hope you find it useful!

Part 1 of the checklist gives you a list of things to physically DO – for example, to walk around the clinic and make note of what is where.

Parts 2 through 5 are lists of questions to ask about:

The internal workings of the clinic
Emergency management in the clinic
Resources that are external to the clinic
And some questions that are important to ask, but may not necessarily need to be addressed immediately.

When you're asking these questions, remember to keep an open mind. A lot of us are trained one way in one institution or clinic, and discover that very reasonable and skilled clinicians do things differently in another clinic. Often there is little data to guide us on knowing if one way is definitively superior to another way.

Here is one **example of how some questions are clinic-dependent**:
In what circumstances do you refer patients for a "rule-out accreta" sonogram?
When this question was posed to the family planning fellowship listserv, the responses were varied:
One respondent said they refer any patient over 12 weeks with a history of 1 or more c-sections and an anterior placenta. Some people refer patients for placental assessment after 13 weeks or later. Some people assess placental location and appearance and perform doppler studies themselves.
There currently aren't studies that provide a definitive answer to this question for the abortion care setting.

Having said that, it's reasonable to talk to the providers and staff who are orienting you about how you're used to doing things – saying something like "I'm open to doing things an alternative way, and in line with what most providers here do, but in other settings, I've, for example, performed cervical prep using medication alone for up to 19 weeks. These conversations allow you to identify if there's a clinical protocol or instrumentation to which you might need to adapt. Conversely, the clinic may be willing to adapt to meet your needs. It is important, however, to demonstrate your openness to an alternative approach that might have been working well for a very experienced team in a specific clinical setting.

Important sections of this checklist

The section on page 11 of the PDF instructs a provider to get familiar with how state restrictions affect clinical management, counseling, and patient flow.

> State restrictions impose things such gestational limits, waiting periods, mandatory ultrasound viewing by the patient, state-mandated counseling, insurance coverage restrictions, and parental involvement laws.

To learn more about these restrictions in general and to look at a specific state, you can visit these websites on state abortion laws. The links to these websites are also available on the Resources page of "The Abortion Clinic Toolkit" website, at the very bottom.

Here is a real-world example of how these state-specific restrictions play out with patients.
In Texas, the state law dictates that the physician who provides the state-mandated consent information has to be the physician who performs the procedure, at a minimum of 24 hours after the state mandated information is reviewed and a sonogram is performed. This means that if the consenting physician is not present at the clinic on a day that the patient can return for the abortion, the patient will need to re-schedule with another physician, go through the state-mandated consent process once again, have another sonogram and wait another, at least, 24 hours. The 24-hour waiting period (or other waiting period depending upon the state) can also dictate clinical care, such as cervical prep. For example, if you consent the patient later in the day, a same-day cervical prep for a D&E may not be an option 24 hours later because the prep cannot begin until at minimum 24 hours after the consent process. Therefore the patient will have to have an alternative cervical prep plan which may involve an additional day, or a day that is not convenient for her.

Here is an example of how providers who work in politically hostile states navigate restrictive state laws.
The content of state-mandated counseling is, of course, state-dependent, and you should be very clear on these requirements as it relates to your care. The messaging required by a given state can be difficult to approach with a patient, because often this information is inaccurate or uses biased language.

Two suggestions:
First – you are allowed to make clear to the patients that this process, forced upon clinicians by state laws, **is often intentionally misleading or inaccurate.**
Second – you are allowed to discuss the *factual* data supporting the safety of abortion during the consent process. In other words, although you are required to recite the state-mandated information, you should also conduct the informed consent process as you normally would.

Remember also that unexpected clinical issues will arise. Many clinicians find it useful to have one or a few go-to "clinical experts" or colleagues that they can easily reach. For example, some people stay in touch with an attending from residency who has expertise in family planning – and they would feel comfortable texting or calling that person to get an opinion about a challenging or unusual situation. Make note of who these people are; It is often someone from your prior work or training, but it could also be someone who is a provider in your new clinical setting and who is therefore familiar with trouble shooting in that clinic.

While this checklist is by no means exhaustive, it should be useful as you transition to working in an abortion clinic as a new clinician there, as well as a guideline once you've started. It could possibly even serve as a tool for quality improvement once you are established at your site.

Thank you for viewing this presentation and best of luck!
For more information, please visit The Abortion Clinic Toolkit and Innovating Education in Reproductive Health.