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# Abortion Waiting Rooms

**By Jacquelyn Leung**

The Planned Parenthood at 1055 Commonwealth Avenue in Boston is built like a fortress. It takes up most of the street, and shiny cement-like rocks line the gray walls like a castle. The corners of the building are lined with heavy metal about twelve feet high, and you cannot see into the one-way windows that begin a few floors up.

On December 30, 1994, years before this exact Planned Parenthood opened, John Salvi stormed into a Planned Parenthood on Beacon Street in Brookline, Massachusetts. He killed two employees, fired bullets in the waiting room, and injured five more. He then drove two miles to Preterm Health Services, another abortion center, where he killed a receptionist, and wounded two more people. Salvi was captured the next day in Virginia, opening fire in yet another clinic.

A few years later, Planned Parenthood on Beacon Street shut down and moved all abortion and gynecology services to Commonwealth Avenue. This steely building is imposing, impenetrable, and cold. It bleeds into the long New England winter months, delineated by the first frost of October through blustery May.

I am a physician in the final months of my medical residency training in Boston, and I'm coming to Planned Parenthood to do an elective rotation. An elective rotation is a voluntary clinical experience (which can last many weeks) for the purpose of filling any education gaps. This is something I desperately need to complete my training. When patients ask me about abortions, I can recite back quotes from books and journal articles, but my lack of experience is noticeable. Medical school—in the late 1990s— was no help because their curriculum never included information about surgical abortions despite the United States performing over one million legal surgical abortions every year. On my first day at Planned Parenthood, I am full of hope for a chance to be a better physician, unaware that I would not always be welcomed.

I get off the T and walk towards the building before I see a small group of elderly protestors standing near the corner carrying large signs. There is a pink fetus floating in an amniotic sac. Another is a picture of a pregnant woman holding her swollen belly. Protestors are praying to Our Father, and others are reciting a poem I can't make out. A small woman, eyes closed, dangles a rosary from her fingers. Loud chants come from the back of the group. Sound waves chase me towards the entrance. I don't want to see or hear, and I need to get inside fast. I want the main door to slam behind me, but it is so heavy that it only closes with a thick muffle.

The entrance corridor is drafty, dark, and quiet. A guard stands there, and he nods good morning while chewing gum. He's got a handgun on his belt, but he's the kind of guy you'd see at a Red Sox game enjoying nachos with his kids. I walk through the metal detector as he searches my backpack. I explain my elective rotation arrangement and he calls someone to

come and get me. "Did the protesters bother you outside?" he asks. Everything was fine, I say, as I pull my backpack closer. "They really are okay. Just smile at them and wave. They wave back at me because they know me," he laughs, tilting his chair back to lean against the wall. "You know why I do this job? I have a nine-year-old daughter. One day, if she needs an abortion or birth control, this kind of place needs to be open."

For a few moments, I forget about the protestors. My education started right there.

I'm assigned to work with Linda. She is one of the social workers who speak to patients after they check in at the reception desk. She tells me that she first interned at this Planned Parenthood while in graduate school and then accepted when they offered her a job. Her hands move quickly, and her feet never stop moving. She's very tall and I'm jogging to follow her from one place to another.

Linda's interview with a patient is the only time a patient is asked why they are seeking an abortion. Patients respond with faint whispers like they wish they weren't in the room. Others speak with exclamation marks or with a distant monotone. Some laugh too loud when they get nervous. I see wet eyes. I see sad faces and we pass around the box of tissues for a second time. They are unmarried. They are married to a jerk. They don't have enough money to support a child, they barely have enough savings to pay rent. They have enough money but already have too many kids at home. This is all private, right? they ask.

Linda only writes a few words in their chart. I notice her cursive handwriting is sparse, and there are columns of blank white space on the page. I point this out to Linda. "I only document that the patient is unable to be a parent," she states. That's it? In medical training, I was told that documenting the entire patient encounter is crucial to thoroughly communicate your assessment and plan. Anyone who reads a medical chart should get a good sense of the main problem, pertinent information and follow the logical flow of events that lead to a diagnosis and medical intervention. If you don't record, it didn't happen, or it wasn't discussed—a legal pitfall, warn the malpractice lawyers. Linda nods. "If someone else reads the patient's chart, that is all they need to know." She closes the chart, and I follow her down the hall, still jogging.

*The patient is unable to be a parent. That is all they need to know.* She just simplified the entire patient interview, stripping the color and emotion unwrapped in these meetings. It didn't seem fair to the patient. But I understood that if an outside party ever obtained these records, we were protecting the patient's privacy by omitting information that was nobody's business. This was the art and discipline of separating passion from reasoning, a skill that would take time and maturity to learn.

I remember one patient who is at the clinic alone and sits with me in a waiting room before her medical screening with a nurse. She is in her early thirties, eleven weeks pregnant, and older than any other patient that day. She has wavy hair tucked behind one ear and constantly taps her foot. She smells like shampoo and has dark shadows under her eyes.

"You know," she begins, "I was set up by a friend to meet this nice guy. We went on a great first date. I slept with him on that first date." She leans towards me, "I'm not the kind of person who has sex on the first date. But I did, and then *this* happened." She doesn't feel comfortable about ending her pregnancy, says having a baby would be impossible, unfathomable. "I can't believe I'd be the person who needs an abortion, but I have to do this." She stares at me, pausing. Foot taps the floor.

I want to tell her that what she did was okay, she made a mistake, please don't be so hard on herself, that life was not judged by a single event. But I don't say any of those things because I am afraid that my stammering would reveal that I have no real-life experience and no wisdom from other patients to pass on. I haven't had time to practice an answer, and I'm terrible at impromptu. I say *it's going to be okay* and then feel like a failure, a disappointment, a fraud of a doctor.

In every hospital, there are rooms next to the intensive care unit designated as family meeting rooms. Doctors call for a family discussion when a patient's health condition is dire, and there is almost no chance of meaningful recovery. A fellow resident calls it The Death Talk. I watch experienced physicians deliver gloomy messages to despondent families, building a case for why withdrawing care is the most compassionate decision for their loved one. Doctors go over what they want to say beforehand in their minds. They tell me to practice what I need to say, the points I must hit. So, when I become a senior resident in the intensive care unit and lead those family discussions, I borrow the phrasing, let the weight settle in the air, and pause in the right places for questions. I feel deft at handling intimate and complex grief. But this is different—the words I want to tell this woman, who is waiting for her abortion, are mixed up like alphabet soup. I look for the world to hand me a script even though what she needs from me cannot be rehearsed.

Another day, Linda and I meet a young woman still in high school. She lives in a neighboring state in a town filled with farms and one interstate highway running through it. Between the time it took her to tell her parents she was pregnant and the lack of access to abortion care near her home, she arrives at this appointment twenty-one weeks pregnant. Her father drove eight hours to get her here and he looks exhausted. This abortion is different: longer sedation, wider dilators, more suctioning, forceps. Nurses speak in low tones, lean in to give orders, double-check for medication accuracy, and triple-check that the correct instruments are on the sterile field. There is relief that the gynecologist assigned to this case has a lot of experience.

There are more. At the check-in desk, a college student, surprised at the up-front costs of an abortion, panics at the prospect of not having one. She uses her girlfriend's credit card to cover part of the fees. Other women approach their appointment with intense anxiety over the procedure and grief over the permanence of their choice. They pray for a miscarriage, so they won't have to tell their parents. They are afraid to drop out of college or quit their job and lose health insurance.

Another day that week, I sit in the waiting room with a woman in her twenties with long acrylic nails. *The patient is unable to be a parent* is written all over her medical records. She is

accompanied by her mom, who crosses her arms tightly while sitting in the room. She asks her daughter how many abortions she's already had. The daughter inspects her long nails individually at first, then spreads her hand out to view them collectively. "Six." The mom scolds her daughter's impending abortion. "This is wrong! You got to stop," she yells and yells. I want to melt into the carpet because I can't look at the mom or patient, who now stares straight ahead, yawns, and focuses on her fingers.

I'm trying to imagine how someone could have so many unwanted pregnancies. Abortion isn't a form of birth control, right? There must be a reason for this. I wonder if she has a mental illness or a personality disorder causing her to make poor decisions. I wonder which doctor let this patient leave their office without any good birth control. Or did they give her a prescription for birth control, but she forgot to fill it? I wonder if the patient is in a non-consensual or abusive relationship, making it hard for her to access or afford contraception. I wonder if she is disassociated from the cycle of pregnancy-abortion to the point that none of her mom's fury matters. Or maybe multiple abortions are simply the best alternative for her. Maybe for some people, having an abortion isn't really a big deal. I must be overthinking everything.

After an abortion is done, the patient is moved into a large recovery room; each woman sits in a semi-private recovery station equipped with beeping blood pressure and heart monitors. A pink color returns to their cheeks. They sip juice and nibble on crackers. The sun shines through the one-way windows high above the sidewalk, where fewer protestors now swing signs in the air. Nurses go over discharge instructions and the patient signs a form. *Goodbye, thank you* they say to the security guard as they walk out of Planned Parenthood and wait at the T stop until an old green train pulls into the station. They squeeze into a crowded train stuffed with puffy winter coats and standing room only. The train starts moving again and picks up speed; their faces blur, and you cannot see them anymore.

Over twenty years have passed since my rotation at Planned Parenthood. Since then, many have stripped away the human experience of the individual and value her pregnancy more than we value the woman. It's easier to criticize when we keep people at a distance, but I was lucky to get up close. I have since counseled many women looking for an abortion or undecided about a pregnancy and I remember how women at the abortion clinic tapped me into their private struggle, intentional or not. They taught me that behind every abortion is a profoundly personal and complicated story. Today, these truths enable me to handle my patients' challenging circumstances and I have these women at 1055 Commonwealth to thank for it.

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