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Shift/Change

By Aya Sato

I'm an abortion doula at a clinic in a large city. I volunteer to provide non-medical, emotional and physical support for patients undergoing first trimester abortions.
These are short and safe outpatient procedures. This is a description of my shift/s.

To get in the building I show my ID, stuffed with my scrubs inside a cloth bag. My backpack is inspected and I walk through the clinic waiting room, down a long corridor to the recovery room. Here I change behind the curtain in the storage area.

Now, usually with another doula, I'll set up bags. Inside them are a sterilized blue gown and a pair of disposable blue booties. The pleather chairs recline (blue). These are the chucks (blue, blue) that we place over them.

This is the fridge with ginger ale and apple juice; these are the heat packs and cool packs and saltines next to the sink. This is the recovery nurse's desk and pink mug of dum-dums. I know the pillow on her chair says "Do Nothing" on one side and "Work" on the other.

Here are the two procedure rooms with a little adjoining room. The doctor moves between the two rooms from patient to patient, while the other room gets turned, or cleaned.

The charge nurse, who has spoken with each patient, will put their blue folder on the door and that will be our cue to call them. I take the folder over to the waiting room and call the patient by their first name. We walk together to the procedure room and I'll hand them their gown and booties. I explain my role—"I'm your doula. Not a doctor, not a nurse—I'm here to hang out with you and provide non-medical support through your procedure."

We talk in the cold room while we wait for the team, who is the doctor, the nurse and the medical assistant. We'll talk about jobs, the weather, food, TV, what is normal to feel during and after the abortion, kids, nails, god, tattoos, the city. Or sometimes we don't talk**.** We could look at each other and smile. We could go over questions the patient wants to ask the doctor.

"Will this feel worse than a period?" The patient is fourteen and has never had a pelvic exam. The patient is a forty-three-year-old schoolteacher whose son has special needs. She looks at me laughing, "Yeah, there's no way in hell I could do this." The patient is a twenty-five-year-old Dominican law student whose boyfriend is outside thinking she has a check up. The patient is a Bangladeshi woman who has four children and who tells me her husband is extremely angry with her for doing this. The patient is a pastry chef at a fancy restaurant. The patient manages a funeral home. They have travelled for hours, up at 4 a.m. The patient is panicked, guilty, the patient is giggly, the patient is extremely nervous. They have done this

twice before and just want it over with. They want me to talk about dumb shit, "Please, keep talking." I'll find myself complaining about my penchant for losing socks or forgetting online passwords during someone's abortion.

At this clinic, patients elect to get either what is called local anesthesia, which is administered directly into the cervix, or moderate anesthesia, which means that as well as the local shot they receive two other drugs through IV; one to calm nerves and one to lessen pain. Now I'll help the nurse juggle the blood pressure cuff or rip off medical tape for them to secure the IV tube.

After meds are administered the doctor asks, "Any questions before we start?" and if there are none, begins the procedure. There's the speculum, the duckbill-shaped tool that props open the vaginal canal and allows access to the cervix. This is the same tool used for general pelvic exams for people with female assigned reproductive systems. A local anesthetic is injected into the cervix before the provider begins to dilate the cervix with a succession of tools. The pregnancy is then removed from the uterus, commonly with an aspirator, which is a tube and suction device attached to either a vacuum or a hand-held syringe. The whole procedure will take just several minutes.

This isn't long, but time always tricks and bends us. I'll offer my hand, and it's often taken and held tightly. Some experience only mild discomfort, others experience such sharp pain, mental or physical, that they scream. My job is to be completely present and provide unconditional love. My role is to be witness to the story of the patient and to advocate for patients' needs when they feel too vulnerable or scared to do it themselves. In these minutes I will play the curious student, the stern maternal figure, the chill peer, the babbling idiot, based on their needs—explicit or intuited. This is complicated. I fail often.

I ask them their opinion on Beyoncé's "Lemonade," I stroke their hair, I breathe with them and talk them through keeping their pelvis very still and pointed towards the ground while they wince and growl. It is difficult to describe the intimacy of these moments but I do fall in love every time. Falling through this elastic, porous, delirious and scary stretch of six minutes—in love with people I don't know. Sometimes it's simple.

When the procedure is finished the patient gets up off the table, we swiftly fold the paper she was lying on back on itself when it's streaked with blood. After this intense experience, hurrying to cover a spot of red seems silly, but it's like saying "you don't have to deal with anything that isn't totally necessary right now." A tiny formal action of care I learn tacitly from the medical assistant.

The patient is wheeled to the recovery room in her gown and booties with a pad between her legs. The recovery room smells lightly powdery and sort of like alcohol. The TV above the nurse's desk is playing "The View." The doctor moves on to the next procedure and I sit with the patient.

The patient cries uncontrollably. We call the social worker. The patient beams while talking about her one-year-old daughter who is waiting in the lobby with her grandma. The patient projectile vomits from the sedative so the nurse sticks her with the anti-nausea meds. The

patient muses on the pregnancy being the size of a chickpea. The patient takes a nap. I disinfect the wheelchair and take it out for its next journey.

The recovery nurse here has been working at this same clinic for 45 years, pre-Roe v. Wade. She's quietly shaped mine (and, I'm sure, countless other's) experience working and learning at the clinic with her knowledge and presence. She is firmly rooted in the task at hand. Her responses to questions about the past are clipped and vague: "A very different time." I feel surges of affection, adoration, fan-girling in the empty recovery chair, and I want to say "Thank you thank you thank you." But I don't. I say good-bye. She winks up from a file, barely.

After the shift I log my hours, change/d and walk out through the clinic waiting room.

Aya Sato is a final-year nursing student, public healthcare worker and writer currently based in Naarm/Melbourne, Australia. After studying contemporary dance, a new love of science and education is challenging her to see healing and the human body through fresh intersections/lenses. Aya is looking for: ways to undermine the structural colonialism present in healthcare systems, time to write more poems, tools to connect people to their bodies and communities.