

AFTER TILLER

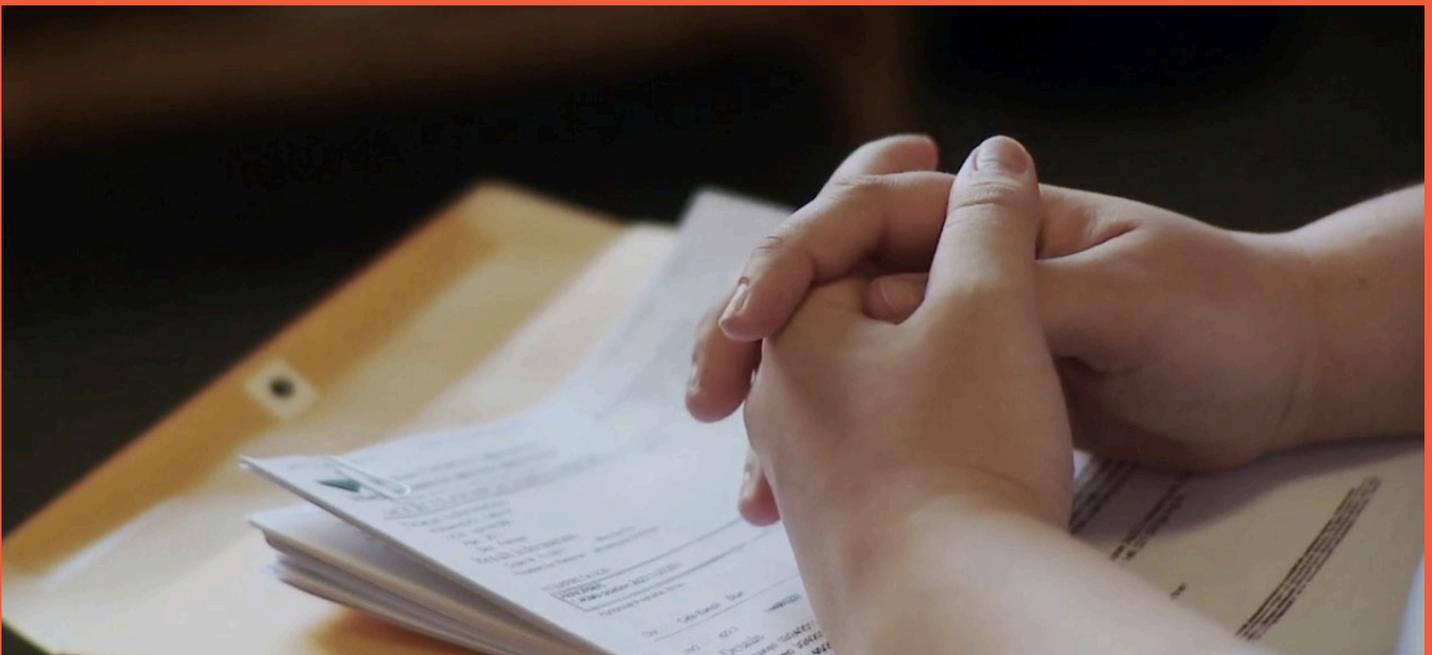
A film by Martha Shane & Lana Wilson



EDUCATIONAL GUIDE

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LETTER FROM THE FILMMAKERS

Reality is complicated. Yet when it comes to the abortion issue in America, we are often presented with two very different, black-and-white versions of what is right and what is wrong – no exceptions granted. As a result, the nation’s shouting match over abortion has become increasingly distanced from the real-life situations and decisions faced by those people most intimately involved – the health care providers and their patients. It was for this reason – and with a desire to shed more light, rather than more heat, on this issue – that we decided to go inside the lives of the only four openly known third-trimester abortion doctors in America with *After Tiller*.

We chose to explicitly frame our film as being from the point of view of these four doctors. Given the amount of violence directed towards abortion providers since the passing of *Roe v. Wade* in 1973, the murder of Dr. George Tiller in 2009 being only the most recent example, these doctors have frequently been forced to live in the shadows. As filmmakers, our goal was to show who these doctors are as people, and to give them a voice. One of the most interesting things we discovered through interviewing the doctors is that they recognized the moral and ethical complexity of doing this work better than anyone – in fact, they struggle with the issues at the heart of this debate every day.

News coverage related to abortion usually allots equal time to both sides of the issue, but as independent filmmakers, we were free from any such constraints. We chose to focus the scope of our film because it allowed us to tell much deeper and more intimate stories, and yet as the film evolved, we began to recognize that many of the doctors’ personal moral and ethical struggles were reflected in the larger national debate over abortion.

Likewise, the women who came to these doctors for late abortions did not typically think of themselves as pro-choice political activists. They were women from a huge variety of socio-economic and religious backgrounds, and they expressed a range of emotions, including guilt, sadness, anger, and even ambivalence about their decisions. The reason so many women agreed to participate in the film is because, like many women who seek abortions, they never thought they would end up in such a desperate situation, and saw sharing their stories as the only way anyone could possibly understand their experience and their



decision-making. This is a refrain echoed by the doctors in the film, and was also part of the reason they decided to participate. They thought that if more Americans could meet them, and hear where they were coming from – even if they still disagreed with the work that they did – they at least might not want to harass or kill them, perhaps instead standing up for them against such extremist actions.

We decided to represent the abortion opponents as they are experienced by the doctors themselves – as a constant presence in the background, standing outside their clinics in protest – but not as the main story. We were careful not to portray the protestors in any extreme or cartoonish way, but rather, to calmly hear some of the arguments that they have against late abortion.

The doctors in our film would be the first to acknowledge that people can disagree about this subject. But they are also absolutely dedicated to their work, and see it above all as something that helps women and alleviates suffering. In this way, their motivations are the same as those of any other doctors. What is different, of course, is that because of the nature of their jobs, these four doctors are more controversial and targeted than any others in the country. It is thanks to the courage and willingness

of the doctors to be open and candid with us, and to allow us such extraordinary access to their patients and lives, that we were able to make a film that pulls back the curtain on a profession that is so often kept out of sight.

Our agenda is not political, but humanist, and we hope that no matter where audiences stand

on the question of legal abortion, *After Tiller* will lead them to look at it in a new way. People with a range of opinions on abortion will have the opportunity to consider the perspectives and circumstances of women they may have never heard from or thought about. The film provokes audiences to think about whether or not they can accept other people who make decisions they may disagree with. How do we judge the life circumstances of others? How do we judge women who must make difficult decisions? As Dr. Tiller once said, we are all prisoners of our own experience, and we hope that our filmmaking will help people evaluate their positions in a more honest, thoughtful, and complicated way.

- Martha Shane and Lana Wilson

FILM SYNOPSIS

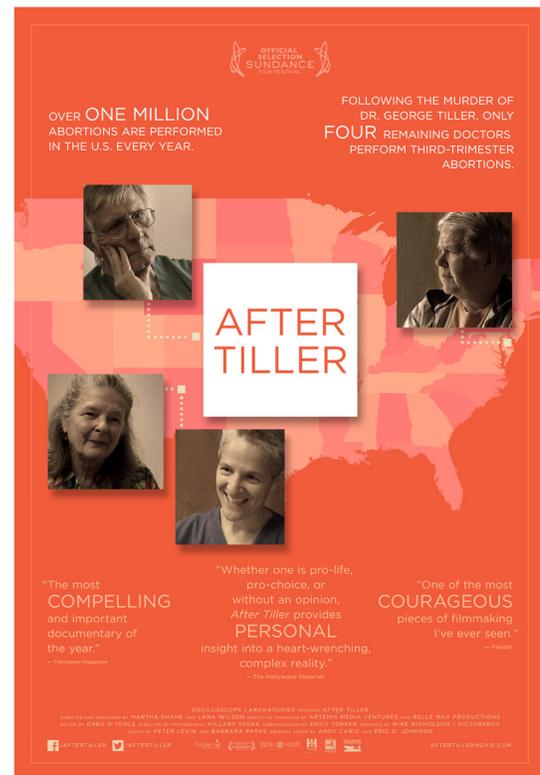
After Tiller is a feature-length documentary film that goes inside the lives of the four doctors who openly provide third-trimester abortions in the United States.

Dr. George Tiller of Wichita, Kansas, was a faithful churchgoer and a father of four. He was also one of the only doctors in the country who openly performed third-trimester abortions for women, and in 2009, he became the eighth North American abortion care worker to be assassinated since *Roe v. Wade*. With his death, there are now only four physicians in the country who openly provide late abortions in an outpatient setting. *After Tiller* moves between the stories of these four doctors – two men and two women – all of whom were close friends and colleagues of Dr. Tiller, and are fighting to keep this service available in the wake of his death.

One of these physicians is Dr. LeRoy Carhart, an Air Force veteran who decided to start providing third-trimester abortions at his practice in Bellevue, Nebraska, following Dr. Tiller's death and the closure of the Kansas site where he practiced with Dr. Tiller. In response, the Nebraska state legislature passed a new law that prohibits all abortions after twenty weeks into a pregnancy, forcing Dr. Carhart to look for another clinical space outside of the state. After protestors in Iowa blocked his efforts to open a new practice there, he finally found a location where he could practice in Germantown, Maryland – but anti-abortion protestors immediately converged, with the goal of shutting down Dr. Carhart's medical practice forever.

In the meantime, Dr. Warren Hern, a longtime late abortion provider in Boulder, Colorado, struggles to reconcile a family life he wants to fully embrace with a demanding career that endangers his life and the lives of those around him. After threats and harassment from protestors led to the unraveling of his first marriage, Dr. Hern was lonely and isolated until meeting his new wife, Odalys, herself a former abortion provider from Cuba, and adopting her nine-year-old son Fernando. Now that Dr. Hern finally has the family he always wanted, though, he recognizes the severe toll his work takes on his personal life, and must find out if it's even possible for these two things to peacefully co-exist.

Finally, we meet Drs. Susan Robinson and Shelley Sella, two physicians who, like Dr. Carhart, used to work with Dr. Tiller in Kansas, but were left without a location to offer third-trimester abortions when Dr. Tiller's practice closed following his death. After finding a practice in Albuquerque, New Mexico, that was willing to expand its services to include third-trimester care, these women soon realized that they had moved to a very different legal landscape. In Kansas, an outside physician had to approve every decision to give a woman a third-trimester abortion based on an articulated health need,



while in New Mexico, the final decision is left entirely up to the abortion provider. As a result, these two doctors are now facing complicated new moral terrain, and Dr. Robinson in particular grapples with this situation. As the sole decider of which patients may receive abortions while she is the doctor at the clinic, she must learn how to evaluate patients' stories and medical eligibility, and make her decisions accordingly. At the same time, Dr. Sella, a former midwife, struggles with the nature of the work itself, and with how to develop a moral calculus that takes both the situation of the patient and the potential life of the fetus into account.

After Tiller follows these four doctors as they confront a host of obstacles – from moral and personal dilemmas to restrictions placed on their practices by state legislation. Rather than trying to take a comprehensive look at the heated political debate surrounding abortion, the film weaves together revealing, in-depth interviews with the doctors with intimate verité scenes from their lives and inside their clinics, where they counsel and care for patients at profoundly important and challenging crossroads in their lives. For all of these doctors, the memory of Dr. Tiller remains a constant presence, serving both as an inspiration to persevere in helping women, and a warning of the risks they take by doing so.

ABOUT THIS GUIDE

This guide is intended as an informational and educational resource as well as a prompt for dialogue after viewing *After Tiller*. It is designed for individuals and organizations who want to use the film as a conversation-starter, and made with the belief that dialogue is critical in the context of the frequently heated debate over abortion and women's rights. In a world where differences of opinion and philosophy have led to not only political debate, but also violence and harassment directed toward abortion providers, we hope that this new dialogue will be built on compassion and empathy. It is our goal that this guide, like the film, takes a humanistic approach, asking us to critically examine our own judgments as we consider the circumstances and the experiences that others are facing.

In order to encourage greater understanding of the issues in the film, the guide provides some background information before moving into prompts and activities to generate discussion. We provide a number of ideas, but it is not our intention that you use all of them in one sitting. Please pick out the discussion prompts or activities that you believe will work best in your context and for the group with whom you are working.

Please note: There is much to be gained from both large and small group discussions, as well as individual reflection. Individual reflection and small-group discussions may be easier when dealing with very sensitive issues. If you are facilitating a workshop or lesson using this guide, we recommend moving back and forth between individual, small group, and whole group reflective activities for a dynamic experience. Please note, also, that large groups will require more time to respond to a question than small groups.



BACKGROUND INFORMATION: OVERVIEW

Late abortions, which are most commonly defined as any abortion performed after the 24th week of pregnancy, comprise less than 1% of all abortions that occur in the United States each year (according to the Centers for Disease Control and Prevention). (These abortions are also popularly known as “late-term” abortions, a phrase used by some in the anti-abortion movement to imply that the pregnancy is close to term or birth.) These abortions should not be confused with abortions called “partial birth abortions” which refer to a particular technique used in later pregnancy which was banned by the federal government in 2007.

According to a 2011 Gallup poll, only about 10% of Americans support the legality of abortions in the third trimester, meaning that many people who consider themselves to be pro-choice may not support the rights of women to have late abortions. There are rampant misconceptions about why women seek late abortions, and many Americans, both those who support and those who oppose abortion rights, believe that the decision to have a late abortion is made casually or cavalierly by women who simply didn’t find the time to have an abortion earlier in the pregnancy. In fact, the women who seek late abortions do so for many complicated personal and medical reasons, that are expanded upon in the next section of this guide.

On January 22, 1973, in *Roe v. Wade*, the Supreme Court divided pregnancy into three stages and created the construct of “trimesters,” each one-third (about 13 weeks) of a full-term pregnancy. **The Court ruled that the states were forbidden from outlawing or regulating any aspect of abortion performed during the first trimester of pregnancy, could only enact abortion regulations reasonably related to maternal health in the second and third trimesters, and could enact abortion laws protecting the life of the fetus only in the third trimester.** The Court ruled that with any restriction, including in the third trimester, an exception had to be made to protect the life and health of the pregnant woman. In a later ruling, the Supreme Court clarified *Roe v. Wade*, stating that a woman has a right to have an abortion up until the point when the fetus becomes viable. This decision defined “viable” as being “potentially able to live outside the mother’s womb, albeit with artificial aid,” adding that viability is “usually placed at about 28 weeks but may occur earlier, even at 24 weeks.”

The Court later rejected Roe’s trimester framework, while affirming Roe’s central holding that a person has a right to have an abortion up until the point when the fetus becomes viable. Current medical technology has moved the line of viability to approximately 24 weeks of pregnancy. Subsequent legal decisions have allowed states to regulate all abortions regardless of trimester as long as those regulations do not place an “undue burden” on women.

The issue of late abortion rights has become the focus of a wave of legislation that began in 2010 with Nebraska’s so-called “Pain Capable Unborn Child Protection” Act, which banned abortions after twenty weeks and included only an extremely limited exception for the physical health of the pregnant woman.

At present, nine states, including Alabama, Arkansas, Indiana, Louisiana, North Dakota, Oklahoma, Texas, Kansas, and North Carolina have passed similar or identical legislation. Three additional states (Arizona, Georgia, and Idaho) have passed comparable laws – some with even earlier restrictions (Arizona bans abortions after 18 weeks)—and are waiting to enact the bans pending the outcome of litigation. Since Roe, many states have significantly restricted abortions in the third trimester, which is why there are only four doctors in America who publicly acknowledge providing this care. Efforts to further restrict these abortions as well as efforts to limit abortions at earlier points in pregnancy mean the number of states where late abortion is available is decreasing sharply.



BACKGROUND INFORMATION: THE WOMEN WHO NEED LATER ABORTIONS

There are about 1.2 million abortions performed in the U.S. each year, and of these, 88% occur in the first trimester of pregnancy.ⁱ About 15,600, or 1.3% of these abortions, occur after 21 weeks.ⁱⁱ A far smaller number of abortions occur at 24 weeks or later, and it is these abortions that *After Tiller* focuses on. They are provided for a small, but important patient population.

Debates over women's reproductive rights and the current legislative landscape have led to a number of popular myths about late abortion and the women who seek them. Among those myths is that the women who seek late abortions are irresponsible, or make flippant or casual decisions about whether to have an abortion. On the contrary, research has found that women are very thoughtful as they weigh the multitude of factors, responsibilities, and realities of their lives in their decisions about abortion.ⁱⁱⁱ



Reasons for seeking late abortions fall into two major categories.

The Status of the Fetus

Some women decide to terminate a pregnancy because testing has identified that the fetus is not developing as expected. There can be several reasons for this occurring in the third trimester of pregnancy:

1. Some fetal abnormalities only develop as the pregnancy advances (e.g., fetal stroke), some can only be detected later in the pregnancy (e.g., dwarfism), and some can worsen with time (e.g., hydrocephalous, excess water in the brain).
2. Many women do not have access to early, comprehensive prenatal care, so an abnormality might not be detected until later in the pregnancy.
3. Often, a single abnormality will prompt other developmental problems in the fetus. While one abnormality might be manageable for a family, two or three might not be.
4. The decision to terminate a pregnancy because of the status of the fetus can take time, because these pregnancies are often very much wanted. Often patients seek multiple opinions, which also takes time, especially for those who have to travel for specialty care.



The Health Needs of the Pregnant Woman

Some women have severe medical conditions that develop late in the pregnancy, or the pregnancy develops in such a way that there would be a significant risk to the woman's health, and a third-trimester abortion may be needed to save the life of the woman.

Other women decide to terminate a pregnancy because they believe it threatens their physical, emotional, mental, or family health, safety, or well-being. For example:

Many women do not know that they're pregnant until late in their pregnancy.

1. Some women do not have symptoms of pregnancy so are never prompted to take a pregnancy test.
2. Some women may not experience body changes suggestive of pregnancy, sometimes because of weight, height, or body conditioning.
3. Some women continue to have intermittent bleeding during their pregnancy that they interpret as periods.
4. Some women may have been to a health care provider and been told they're not pregnant.
5. Some women may have experienced non-consensual sex and thus are disassociated from the pregnancy potential.
6. Some women have been using one or more forms of birth control, or taken the morning after pill, without realizing that it could have failed them. (No form of birth control is 100% effective, not even sterilization.)



Many women do know that they are pregnant and want an abortion, but are unable to react quickly. There are several possible reasons for this.

1. **Fear.** This is most common with teenagers, but is seen with all age groups. A teenager who has been told that she will be kicked out of the house, or that she will bring a huge amount of shame upon her family should she get pregnant, has a very hard time telling her parents that she is pregnant. (In addition, many states require parental involvement for a teenager to have an abortion.)
2. **Money.** Abortion is more expensive the further in pregnancy a woman is. Only 17 states allow low-income women to use their Medicaid to pay for an abortion, so most women have to raise the money. For every week after 12 weeks the cost increases, so it is not uncommon for women to get later and later in pregnancy as they try to raise the money they need.
3. **Access.** With the increasing restrictions states have placed on abortion, access has become an increasingly important issue. Not only are there fewer facilities where abortions are performed, but most facilities do not offer abortions after the first trimester. A common scenario is a woman seeking care at the facility nearest her home. She is beyond the gestational limit of that facility and is referred to another location. She now has to raise more money to pay for the procedure and for transportation, must arrange to take off more time from work, and may have to find child care as well. By the time she has organized all of that and arrives at the next facility, she has passed their gestational limit as well, and on and on it goes. If she's extremely persistent, resourceful, and lucky, she will eventually make it to one of the facilities seen in *After Tiller*.
4. **Change in circumstance.** A woman may have initially welcomed a pregnancy, but then something in her life changes drastically—her partner becomes abusive, or goes to jail, or leaves her, or a hurricane destroys her home—and she reassesses, realizing that she cannot do a good job of parenting this baby if she has it.
5. **Chaotic life situation.** Some third-trimester abortion patients live lives of chaos that most people cannot even imagine—lives of extreme poverty, physical and emotional abuse, and social isolation. These women ultimately come to realize that bringing a baby (or another baby) into their life would likely give that child a lifetime of hardship and suffering, and that is something they do not want to do.

What About Adoption?

One common question about third-trimester abortion is related to adoption. Many people can have difficulty understanding why patients choose to have an abortion, rather than carry the pregnancy fully to term and put the child up for adoption. Adoption, like abortion, is a complicated and difficult decision for many women. While we have not studied adoption extensively, what data exists finds that when it is voluntarily selected women and children do well, but when it is involuntarily imposed on women there can be significant long-term repercussions.

Here are some examples from Dr. Shelley Sella of why a woman might decide that adoption is not the right decision for her:

1. Women may believe that the child they are carrying would not be healthy given their own medical history or the behaviors they engaged in during pregnancy.
2. Women may be concerned that the child will be mistreated and they will not be able to manage those feelings.
3. Women do not want their child to feel that it was abandoned. The doctors in *After Tiller* say that they particularly hear this from women who were themselves adopted.
4. Women whose pregnancies were especially traumatic do not want to have to tell those experiences to the child. Some women worry that even if they put their child up for adoption, their child will look for them when they are older.
5. It is physically safer for a woman to have a third-trimester abortion than it is to have a full-term delivery. Protecting her health for a future pregnancy is a significant concern for some pregnant women.

Whatever the specific circumstance, the decision to have a third-trimester abortion is always complicated, serious, and deeply personal.



BACKGROUND INFORMATION: THE LEGISLATION

In 1973, the U.S. Supreme Court determined in *Roe v. Wade* that a woman's right to an abortion is not absolute and that states may restrict or ban abortions after fetal viability under certain conditions.

As of September 1, 2013: ^{iv}

- 19 states prohibit abortions starting at fetal viability (with exception for the life and health of the woman)
- 2 states prohibit abortions starting at fetal viability (with exception for only the life of the woman)
- 8 states prohibit abortions beginning at 20 weeks

While 9 states permit third-trimester abortions without restriction, there are only 3 states with known providers: Maryland, Colorado, and New Mexico.



BACKGROUND INFORMATION: THE PROVIDERS

Today in the U.S., only four doctors openly acknowledge that they perform abortions at 25 weeks or later. Why?

1. LEGISLATIVE RESTRICTIONS.

Most states limit abortions in the third-trimester to those necessary to save a woman's life. A few more states will allow abortions if the health of the fetus is so compromised that it is likely to die when it is born. However, only nine states allow third-trimester abortions for the many reasons women need them (see earlier discussion).

2. VIOLENCE.

Physical intimidation of abortion care facilities and providers is common. In 2000, 82% of large providers (facilities providing 400 or more abortions per year) experienced some type of harassment. Typically, harassment took the form of picketing and physical contact with or blocking of patients, but 15% of large providers reported that they had also received at least one bomb threat.

The death of Dr. George Tiller in 2009 is a tragic example of the profound threat to individuals who provide abortion care. In fact, eight abortion care workers have been murdered since 1977, with an additional 17 murders attempted. ^v The film gives us a glimpse into the issues of security and safety that these doctors are faced with in their lives. Dr. Robinson tells us about having a safety inspection of her home by a federal marshall. Dr. Hern had gunshots fired into his office, and his mother frequently receives threatening phone calls. And all of the doctors have received death threats and hate mail over the years that they have been doing this work.

3. LACK OF TRAINING IN ABORTION CARE AT MEDICAL SCHOOLS AND IN RESIDENCY PROGRAMS.

In the film Dr. Susan Robinson professes, "I just thought the other day, 'I can't retire. My God.' There aren't enough of us."

The reasons for the lack of new physicians to take their place are numerous. Many medical schools do not include abortion in their curriculum. While there is a requirement that ob-gyn residency programs include abortion training, the US Congress prohibits penalizing any program that chooses not to teach this procedure. Consequently, almost half of all ob-gyn residency programs do not offer any abortion training. Even when training is obtained, most graduating residents find institutional barriers to incorporating abortion care into their practice. To get a job, many doctors have to sign a contract that says they cannot perform abortions.

So why, then, do the doctors in the film offer this care? The doctors give us several reasons. Dr. Hern shares the tragedy he witnessed as a younger physician when he cared for babies that were abused, battered, and damaged "because their parents didn't want them," noting the stark contrast between the women he cared for who were prepared to have children and those who weren't. He also spoke about his experience working as a Peace Corps physician in Brazil, where he said many of the women who were recovering from illegal abortions died. Dr. Carhart fears the harm women will do to themselves or to their babies if they are unable to access services. Dr. Sella was drawn to abortion care because of the elements it shares with her previous work in midwifery, such as an emphasis on emotional support for the patients, and on treating the woman as the best judge of her own reproductive decision-making process. And Dr. Robinson, who initially decided to provide abortions because she thought that a wave of recent anti-abortion violence might dissuade many doctors from continuing to provide that care, finds the gratitude of her patients to be incredibly rewarding.

For all of the doctors, we see enormous compassion for patients as they listen to their stories. We also hear the resounding message from them, and from Dr. Tiller before them, that they are putting their trust in their patients and providing them the necessary and compassionate care that they need once they've made the decision to have an abortion.



PROFILES: THE DOCTORS



DR. LEROY CARHART served as Lieutenant Colonel in the US Air Force for 21 years, and now works full-time providing abortions. He founded the Abortion & Contraception Clinic of Nebraska (ACCON) in Bellevue, Nebraska, with his childhood sweetheart and wife of 50 years, Mary Lou Carhart, in 1992. Dr. Carhart was trained to do third-trimester abortions by Dr. George Tiller, and was an associate physician at Dr. Tiller's clinic in Wichita, Kansas, from 1998 until Tiller's assassination in 2009. After Dr. Tiller's death, Dr. Carhart decided to start providing late abortions at his own clinic in Nebraska. In 2010, when Nebraska enacted a 20-week abortion ban, Dr. Carhart opened a clinic in Maryland, where he currently offers this care.



DR. WARREN HERN is the Director of the Boulder Abortion Clinic in Boulder, Colorado. He has been performing abortions full-time in Colorado since 1973, and founded his own private practice in 1975. He began doing third-trimester abortions in 1982, and along with Dr. Tiller, was one of the experts in that field. A scholar as well as a physician, Dr. Hern received his Ph.D. in Epidemiology from the University of North Carolina School of Public Health in 1988, and has also studied fertility and the use of contraceptives in Peru's Shipibo Indian communities for the past forty years. He has written extensively about that research as well as about abortion practice and women's rights.



DR. SUSAN ROBINSON is board-certified in obstetrics/gynecology. She started doing abortion care after John Salvi murdered workers at two abortion clinics in Brookline, Massachusetts, in 1995, and has been doing abortion care exclusively since 2001. She has worked in private abortion clinics and for Planned Parenthood in several affiliates, and has taught abortion care to doctors, nurse practitioners, certified nurse midwives, and physician assistants. From 2005 to 2009 she worked with and learned from Dr. George Tiller at Women's Health Care Services in Wichita. She is now doing late abortion care with Dr. Shelley Sella, working at Southwestern Women's Options in Albuquerque, New Mexico, which is owned by Curtis Boyd, MD and Glenna Halverson Boyd.



DR. SHELLEY SELLA is an obstetrician/gynecologist who worked as a home birth midwife in Santa Cruz, CA, from 1987-1989 prior to being licensed as a physician. She performed her first abortion in 1990, and ten years later, she began providing abortions exclusively. From 2002 to May 31, 2009, she was mentored by, and worked with, Dr. George Tiller in Wichita, Kansas. Following his assassination, a friend of his, Dr. Curtis Boyd, invited her and her colleague from Wichita, Dr. Susan Robinson, to begin offering third-trimester abortions at his clinic in Albuquerque, New Mexico.

STARTING THE DISCUSSION

Start out with a question for individual reflection that can help individuals make sense of what they've seen and think about what feels most important to them in this moment. It may be useful to have individuals write their initial reflections to gather their thoughts in a safe and personal space before opening up for discussion with the group. Depending on the tone and the level of comfort in the room, you may ask people to share what they've written in a small or large group discussion. Reflective writing questions may include:



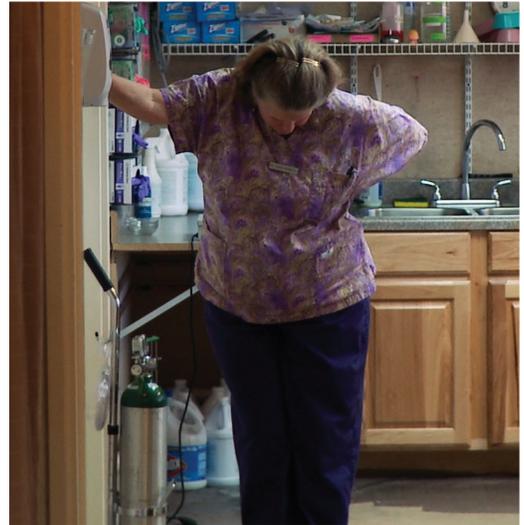
- **What feelings did you have as you listened to the women? As you listened to the doctors? What information was new to you about the women who needed abortions? What information was new to you about the doctors or their staff members? What information was new to you about the protestors?**
- **Write down four things about the film that you will tell someone close to you.**
- **Dr. George Tiller was quoted as saying that we are all “prisoners of our own experience.” What does this mean to you in the context of this film? What does it mean for patients? For doctors? For protestors? For legislators? For activists?**



ACTIVITIES TO BEGIN THE DISCUSSION

Perspective-Taking Part 1: THE WOMEN

- Step 1: Break into groups of 3-6 people, and assign each group to put themselves in the position of women who are pregnant at 25 weeks.
 - Group 1: Women who have a wanted pregnancy but have recently discovered a fetal anomaly.
 - Group 2: Women who have just discovered that their own health is at risk.
 - Group 3: Women who have been trying for 8 weeks to find an abortion provider.
- Step 2: You have all been told you can have an appointment with one of the doctors in the film in the next 3 days if that is what you want. Within each group, discuss the following:
 - What factors will you weigh in making the decision about whether to end this pregnancy?
 - What factors feel unique to you and which might be true of other women?
 - How would you feel about a woman in a similar situation who makes a different decision about their pregnancy than you are making about yours?
- Step 3: Large group share-out: Have each group share some highlights from their discussion, shedding some light on the perspective of the group they discussed. Provide the opportunity for questions and answers among groups.



Perspective-Taking Part 2: THE WOMEN AND THOSE WHO AFFECT THEIR CHOICES

- Step 1: Break into groups of 3-6 people, and assign each group to take on the identity of a population represented in the film.
 - Group 1: Women who are pregnant at 24 weeks
 - Group 2: Medical providers and counselors (this can also include medical students who are thinking about becoming abortion providers)
 - Group 3: Anti-abortion protestors
 - Group 4: Legislators and policy makers
 - Group 5: Abortion rights activists
- Step 2: Within each group, discuss the following: Dr. George Tiller was quoted as saying that we are all “prisoners of our own experience.”
 - What does it mean for the people represented in your group to be “prisoners of their own experience?”
 - Based on what we saw in the film and what we know from our lives, how does this group of people experience later abortion?
 - What do we know, or what can we speculate, about the earlier experiences in their lives that may have led them to the position they are in?
 - What do we know, or what can we speculate, about how they experience the perspectives of the other groups?
- Step 3: Large group share-out: Have each group share some highlights from their discussion, shedding some light on the perspective of the group they discussed. Provide the opportunity for questions and answers among groups.

What We Need:

- Step 1: Have individuals write the following sentences and fill in the blank. Then, as a group, have each individual share what they wrote in the blank and why.
 - “What I need After Tiller is _____”
 - “What women need After Tiller is _____”
 - “What medical professionals need After Tiller is _____”
 - “What medical students need After Tiller is _____”
 - “What anti-abortion protestors need After Tiller is _____”
 - “What legislators and policy makers need After Tiller is _____”
 - “What abortion rights activists need After Tiller is _____”
- Step 2: To continue the dialogue online: Direct individuals to the “What we Need” images [online](http://bit.ly/1e4d5yb) (<http://bit.ly/1e4d5yb>). Fill in the blank for yourself and post the image on social media.

Partner Dialogue:

- Step 1: Instruct individuals to think of one person from the film. Break into partners and discuss the following from the perspective of the person you chose:
 - What matters most to me about later abortion?
 - What is most important for me to pay attention to?
 - What am I afraid of or concerned about?
 - What am I feeling about my situation right now?
- Step 2: Time permitting, have a larger group discussion where partners can share what they learned from their dialogue.



DISCUSSION PROMPTS

(for small group or large group discussion):

The Patients

- The women in the film represented a variety of reasons why women get later abortions. What were some of them? Did any of the reasons surprise you? Did any of the women's stories seem more/less compelling to you?
- In the film, we hear a patient tell Dr. Sella, "...It's guilt no matter which way you go. Guilt if you go ahead and do what we're doing, or bring him into this world and then he doesn't have any quality of life." Oftentimes, the abortion debate is framed around "choice." But many of the women who seek abortions do not feel they have a choice. Think about the women you saw in this film. What feelings were they having other than guilt? What types of choices were they facing? What were the possible outcomes of their choices?



- According to the Guttmacher Institute, 1 in 3 women will have an abortion by age 45. Have you or someone you known had an abortion? If so, what was that experience like? How did you or that person make her decision? What considerations went into that decision?

- The pregnant women in the film faced very difficult situations. Yet, the women in these challenging circumstances are sometimes blamed and demonized by those opposed to abortion. What were your feelings as you heard each woman's story? Did seeing the difficulty and the pain in the women's experience make you think differently about abortion in general or later abortion in particular? What would you want if you found yourself in the same situation as these women? What would *you* say to a woman who found herself in this difficult situation? What might you tell someone who places blame and shame on women who seek abortion care?

- In the film, we met a patient who said that her baby, if she chooses not to terminate her pregnancy, is not "viable" because of his medical condition. She shared that the baby might die in utero, might be a stillborn, or might live in a vegetative state and have a very short life, "full of shunts, surgeries, and seizures." She makes the choice to terminate her pregnancy rather than letting the baby live this life, suffer, and pass away naturally. Why might some women choose to terminate a pregnancy in a case like

this one? Why might other women choose to give birth to a baby with this condition? Who should determine "the best decision" for a family?

- Today, because of medical costs, legislative restrictions, and other reasons, it is very difficult for some women to access abortion services. What impact do you think the lack of access to care has on individual women, their families, and their communities?
- While some of the stories that were told by the film were about women who planned their pregnancies and wanted to have children, there were also stories of women with unplanned or unwanted pregnancies. How might we help other people gain more empathy for these women?
- Sometimes, an abortion is delayed because young women do not feel safe to talk with adults about being pregnant. What can we do societally to make sex and pregnancy a safer conversation?
- Sometimes, a woman wants to have a baby, but during pregnancy, her situation changes - her partner becomes violent, her house is destroyed in a hurricane, or she loses her job and ability to support another child. What could be done to support women in these situations?

- A father in the film talks about praying in Dr. Sella's office, and asking for a sign to tell him if he and his wife are making the wrong decision about terminating their pregnancy. Dr. Robinson meets with a 16-year-old patient who is Catholic and has always been anti-abortion, but has decided to terminate her pregnancy. Women of all religious faith traditions have abortions. Dr. Tiller himself was a man of deep religious conviction. How might religion support women and families making abortion decisions?



The Providers

- After watching this film, do you have a greater understanding of the doctors who provide later abortions? What strikes you most about each of these four individuals? How do they compare to other physicians you have met?
- Dr. Robinson says, “After Dr. Tiller was assassinated, there was no question at all that we would keep on doing this work.” Dr. Hern shared that Tiller’s death was a “profoundly traumatic experience for me and my family.” Amidst the violence and threats directed at these doctors, and the toll this takes on their personal lives, why do you think they remain committed to continue performing later abortions?
- In addition to the doctors, the film gave us a window into the work of the other staff at the facilities. We met nurses and counselors, we saw intake interviews and counseling sessions, and we saw serious and difficult conversations take place between the counselors and the doctors. We saw these women counsel and care for patients in some of the most difficult moments of their lives. What do you think these staff members have in common? What do you think is most challenging for them?
- Dr. Robinson shares one of her challenges: “It’s a struggle for me to figure out – is it okay for me to say no, that’s not a good enough story? I’m not doing an abortion for you? You’re really on your own out here trying to figure out what’s the right thing to do. What’s really helping people?” If someone close to you needed a later abortion, do you think you could support them in that decision? What factors would you take into account?
- There are only four doctors who openly perform third-trimester abortions, but there are many other doctors and medical professionals who refer patients to these four doctors for their services. Other doctors may be restricted, either legally or by lack of training, from performing third-trimester abortions themselves, or they may simply choose not to perform these services. Consider how these four doctors are connected to the larger medical community. What support do you think these physicians need from their colleagues and others in the healthcare community? What role do you play in this support?



The Debate

- According to a 2011 Gallup poll, only about 10% of Americans support the legality of third-trimester abortion, meaning that many people who consider themselves to be pro-choice do not support late abortion rights. Where do you stand on support for these procedures after seeing the film?
- The movie depicted many different types of protest, from peaceful prayer to acts of violence. What impact do you think the protests have on the women who are considering abortion? What types of protest feel to you like a reasonable way to state a political viewpoint? What types of protest do you think go too far?
- When you think about the different voices in the conversation about abortion and the stories of the different people in this film, where do you situate yourself? What is the most challenging issue for you?



THE LEGISLATIVE LANDSCAPE: INFORMATION

9 states now ban abortions after 20 weeks (as dated from the last menstrual period) for any reason except to save the pregnant woman's life. The current legislative landscape can be viewed at:

- **Advancing New Standards in Reproductive Health (ANSIRH)** <http://ansirh.org/research/late-abortion/coverage.php>

For information about why women seek abortions later in pregnancy, research articles and fact sheets are available here:

- **ANSIRH** <http://ansirh.org/research/late-abortion/facts.php>

For more information about abortion providers, where you can get financial assistance, and how to pick a quality clinic please see:

- **National Abortion Federation Hotline**, 1-877-257-0012 (weekdays 9am-8pm EST, Saturday noon-5pm EST)
- **National Abortion Federation** <http://prochoice.org/pregnant/hotline>
- **Abortion Clinics Online (ACOL)** <http://gynpages.com/ACOL/category/late-abortion.html>
- **Planned Parenthood** <http://plannedparenthood.org/health-center/findCenter.asp>
- **Abortion Care Network** <http://abortioncarenetwork.org/considering-abortion/choosing-a-quality-clinic>
- **ANSIRH** <http://ansirh.org/research/late-abortion/referrals.php>



The recent legislation that is banning abortion after 20 weeks is based on the premise that at 20 weeks, a fetus can feel pain. This claim is unsubstantiated by science. For more information, see:

- **ANSIRH** <http://ansirh.org/research/late-abortion/fetal-pain.php>

There is also a lot of disagreement about when a fetus is “viable”. For more information see:

- **ANSIRH** <http://ansirh.org/research/late-abortion/countering-misinformation/viability.php>

Learn more about the legislative and legal fights over later abortions:

- **The Guttmacher Institute** tracks data about states laws and pending legislation (<http://guttmacher.org>)
- **NARAL Pro-Choice America** conducts advocacy about abortion rights (<http://nara.org>) as does **Planned Parenthood** (<http://plannedparenthood.org>)
- **The Center for Reproductive Rights** (<http://reproductiverights.org>) and the **ACLU Reproductive Freedom Project** (<https://www.aclu.org/reproductive-freedom>) work to protect abortion rights in the courts

If you want to help women directly, reach out to a talkline or an abortion fund:

- **Exhale** <http://exhaleprovoice.org>
- **Backline** <http://yourbackline.org>
- **National Network of Abortion Funds** <http://fundabortionnow.org>

If you want to help the providers:

- Participate in addressing the harassment at **Voices for Choice** (<http://vochoice.org>)
- Learn more about **Medical Students for Choice** (<http://msfc.org>), **Nursing Students for Choice** (<http://nursingstudentsforchoice.org>), and **Physicians for Reproductive Health** (<http://prch.org>)
- Visit **The Guttmacher Institute** (<http://guttmacher.org>)
- Visit **The National Abortion Federation** (<http://prochoice.org>)
- Visit **Advancing New Standards in Reproductive Health (ANSIRH)** (<http://ansirh.org>)



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