

the abortion option



**A Values Clarification Guide
for Health Care Professionals**

The National Abortion Federation (NAF) is the professional association of abortion providers in the United States and Canada. We are grateful to Alix Hirabayashi and Lisa Butel who revised, expanded, and updated this publication. We acknowledge Lauren Tews, MPH who provided feedback and guidance, and who developed and wrote with Terry Beresford the 1998 publication on which this guide was based. We additionally acknowledge Annie Baker, Joan Garrity, and Pat Anderson who provided expert feedback on the original 1998 publication and Educational Foundation of America, The Richard and Rhoda Goldman Fund, The John Merck Fund, Open Society Institute, and The David and Lucile Packard Foundation whose generous support of NAF's Access Initiative Project and programs to educate health care professionals made this work possible.



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THE ABORTION OPTION: A VALUES CLARIFICATION GUIDE FOR HEALTH CARE PROFESSIONALS

Why this publication was developed

The exercises in this publication are designed to help you examine your beliefs about abortion so that you may be better able to care for women considering this option.

Because one's beliefs about abortion are linked to one's thoughts about sexuality, pregnancy prevention, parenting, and adoption among other issues, some exercises examine these topics as well. While some exercises are geared specifically toward providers who are making decisions about whether or not to obtain abortion training and ultimately to be involved in providing abortion services to their patients, the majority of exercises are appropriate for the wide range of health care professionals who provide care to women. As a health care provider, your responsibility to assess your feelings about abortion and providing abortion care is greater than that of people in other professions, because your decisions will ultimately determine whether or not women receive accurate information about their reproductive health care options, are empowered to make the health care decisions that are best for them, and are able to obtain high quality, supportive, respectful abortion services if they choose abortion. Further, because information about abortion is not included as a routine component of most medical school or nursing curricula, and

abortion training is not incorporated into many residency programs, most health care providers will need to decide for themselves how important it is to learn about abortion and/or to obtain abortion training.

The following exercises are designed to help you critically examine the factors that might influence your beliefs about parenting, adoption, and abortion and, for some, your choice to become trained and to provide abortion services. They are also intended to illustrate the possible consequences of your choice to provide or not provide service. It is for these reasons that the National Abortion Federation developed this publication.

How to use this publication

The legal and historical overviews in Part I provide background information about the context in which abortion services are currently provided and the personal and public health implications of restrictions on women's access to abortion. This baseline information can help set the stage for health care professionals as they proceed with the values clarification exercises.

Many exercises that follow in Part II and Part III can be used either individually (Part II) or in a group setting (Part III). Ideally, both formats will be used so that you will have an



opportunity for personal reflection, free of peer pressure, as well as the benefit of hearing other people's viewpoints and testing your beliefs against possible challenges from others in your group.

Further, each of the exercises is designed to stand on its own and, thus, instructors or others using this publication, particularly in a group setting, can choose to use only one or two exercises that suit their particular objectives. Certainly all the exercises have value, but given time constraints and other considerations, the publication is designed to give flexibility to those who use it.

We have arranged the exercises in sections to help guide users through the various sources of influence that affect one's values. We have also included graphics in the upper corners of the pages that can serve to orient users to the broad categories addressed by the exercises in this publication.

Why it is important for health care professionals to examine our values

In spite of our efforts at objectivity, we all hold personal values that can influence how we respond to our clients. Sometimes these values are very clear to us and are easily articulated. Others exist at a deeper level, so that we don't necessarily recognize the influence they have on our behavior and judgments as health care providers. Further, one's values may change in response to life experiences and your encounters with clients and colleagues may influence your beliefs without your having much of a chance to reflect on these changes.

The exercises presented here are intended to help you clarify for yourself your present personal values about pregnancy options, abortion, and abortion training, and to help you think about those values in the context of professional judgments you may be called upon to make.

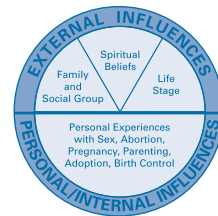


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PART I: PAST AND PRESENT – HISTORICAL OVERVIEW OF LAWS, REGULATIONS, AND CONSEQUENCES OF LIMITED ACCESS TO ABORTION SERVICES

Legal Issues in the United States and Canada

Given that your professional judgments, and perhaps your personal values as well, are influenced in part by legal limits and regulations that govern the medical profession, it is appropriate to give a brief overview of the regulations and laws that relate to abortion. These overviews are by no means meant to serve as a comprehensive review, but will provide a basis for understanding where the law sets limits on the provision of abortion as opposed to where individual practitioners or hospitals might set personal or institutional limits.

An Overview of Abortion Laws and Policies in the United States

Abortion laws differ, rather dramatically in some cases, from state to state. However, the Supreme Court has issued some key decisions, starting with *Roe v. Wade* in 1973, which today serve as the basic foundation for state abortion laws.

In the *Roe* decision, the Court established that:

(a) In the first third of a pregnancy (about the first 13 weeks), state laws and regulations may not interfere with a woman's right to end a pregnancy through abortion. This

means that the decision whether or not to have an abortion is left to a woman and her physician.

- (b) During the second third of pregnancy (about 14 to 24 weeks), state laws may regulate abortion procedures only in order to protect the woman's health.
- (c) During the later part of pregnancy (after about 24 weeks), and after the fetus is viable, state laws may prohibit abortion except when it is necessary to preserve the life or health of the woman. Most states (40 states and the District of Columbia) have passed laws to prohibit post-viability abortions under most circumstances and, in practice, there are only a small handful of doctors nationwide who offer this care to women who need it.

For some time, the framework of *Roe v. Wade* served as the basis by which the constitutionality of state laws related to abortion was determined. Subsequent Court decisions, however, particularly *Planned Parenthood v. Casey* in 1992, have established that states can restrict pre-viability abortions, even in the first trimester and in ways that are medically unnecessary, as long as such restrictions do not place an "undue burden" on women seeking abortion services. Thus, state



laws requiring waiting periods before a woman can have an abortion, mandatory counseling which promotes childbearing, reporting requirements, and parental consent or notification have been implemented in many states. (Note: Some state constitutions have stronger privacy protection than the federal constitution and thus in these states some of these restrictions would not be permitted.)

Additionally, in practice, individual hospitals and practices can and do impose other restrictions, such as gestational limits, anesthesia requirements, and so forth, on the abortion services they provide. Thus even though women in the U.S. have a constitutionally protected right to obtain pre-viability abortions, these medical services might not, in fact, be available or accessible.

A woman's access to abortion services in the U.S. is influenced in part by her ability to pay for that care, either out-of-pocket or through her private or public health insurance program. The Hyde Amendment forbids the U.S. Medicaid program from paying for abortions except in cases of rape or incest, as well as when a pregnant woman's life is endangered by a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself. States may use their own funds to pay for abortions not covered by Medicaid. However, only 23 states offer additional funding.

In addition, Congress permits health maintenance organizations (HMOs) serving

Medicaid recipients to refuse to cover counseling or referral for services, such as abortion, which the HMO objects to on moral or religious grounds. As a result, even in states with expanded funding, women seeking abortions may face obstacles to finding a Medicaid provider that will cover services.

Since 1996, anti-choice forces in Congress have maintained a statutory ban on even privately funded abortions at all Department of Defense facilities, including military bases. These facilities are restricted from performing most abortions, except in cases of rape, life endangerment, and incest. Further, medical insurance for military personnel and their dependents only covers abortion in cases of life endangerment. Although members of both the House and Senate have repeatedly attempted to remove these restrictions they have been unable to garner enough support to reverse it.

An Overview Abortion Laws and Policies in Canada

(Contributed By Joyce Arthur, Director & Spokesperson, Pro-Choice Action Network, Vancouver, British Columbia, Canada) (April 2004)

Canada first liberalized its strict law against abortion in 1969. The new law allowed abortions to be performed in hospitals with the approval of a "therapeutic abortion committee." A woman could get an abortion only if the committee decided her life or health was in danger. But the law resulted in arbitrary obstacles and unequal access for women. Dr. Henry Morgentaler, Canada's pioneer abortion provider and pro-choice activist, fought various



court battles culminating in a 1988 Supreme Court decision that threw out the entire abortion law as unconstitutional. This ruling became known as the Morgentaler decision.

The Supreme Court grounded the right to abortion in women's constitutional right to "security of the person." One judge also found that the abortion law violated women's rights to "freedom of conscience" and "liberty." Unlike in the U.S., women's equality rights are enshrined in Canada's constitution, so courts have been very reluctant to confer any rights on fetuses – to do so would interfere with women's established constitutional right to equality. Various court rulings since 1988 have denied fetuses any legal recognition in Canada and no abortion restrictions have ever been passed.

Although the Canadian legislature tried to re-criminalize abortion in 1990, the bill failed to pass. Today, Canada's governments, judicial system, and the mainstream media are largely pro-choice.

Abortion is fully funded by Medicare in Canada, except for four provinces that refuse to fully fund abortions in private clinics, even though they have been ordered to do so under a federal law, the Canada Health Act. This law says that provinces must provide all Canadians with equal access to fully funded healthcare according to five basic principles: portability, accessibility, comprehensiveness, universality, and public administration. Abortion is probably the only medically required treatment that doesn't fully measure up to any of these ideals. That is because

many provinces flout the law due to an anti-choice political bias that dismisses abortion as an "elective" and abortion clinics as private businesses operating outside of Canada's universal healthcare system.

Clinics became legal only in 1988, but there is not enough volume to support clinics except in the largest cities. About two-thirds of abortions in Canada are still performed in public hospitals. However, only about 20% of hospitals perform abortions, which forces many women to travel long distances from their communities. Hospitals often restrict access to abortion because of arbitrary or anti-choice policies. For example, many hospitals impose restrictions such as quotas, gestational limits, and general anesthesia requirements. Most hospitals require physician referrals and many have long waiting periods. A few hospitals require the approval of two doctors, or parental consent for any surgery on minors with no exception for abortion. Anti-choice doctors and hospital employees often act as gatekeepers, preventing women from accessing abortion services or even obtaining accurate information about them. Finally, the Canadian Medical Association maintains an old policy that essentially curtails abortions after 20 weeks, unless they're for compelling health or genetic reasons.

Anti-choice protest activity is low in Canada, especially in recent years, although clinic protests are still routine at some clinics, particularly in British Columbia, Ontario, and New Brunswick. However, three Canadian doctors were shot between 1994 and 1997, with American James Kopp as the leading



suspect. A bomb destroyed a Toronto clinic in 1992, and one of the shot doctors was also stabbed by an unknown assailant in 2000. A provincial bubble zone law in British Columbia, the Access to Abortion Services Act, protects two clinics and one hospital from protesters. Clinics in Alberta and Ontario use court injunctions to keep protesters at bay.

As stated above, this overview should provide enough general legal information for completing the exercises in this publication, because the exercises focus on personal values clarification. It is prudent, however, for all health care providers in practice to be as informed as possible about laws related to the medical care that they provide and thus we would recommend further study of abortion related regulations and legislation in your state or province.

Consequences of Limited Access to Abortion Services

The negative impact on public health when abortion is illegal or otherwise inaccessible is well documented. As a health care provider, your decision to provide women with unbiased information and appropriate referrals, or your decision to provide or not provide abortion services has a direct influence, positive or negative, on the accessibility of abortion. The following examples show possible consequences of limited access to legal abortion and may help you determine what role you might play in addressing decreasing access.

Examples in the United States during the 1950's and 1960's

We have excerpted passages from Carole Joffe's *Doctors of Conscience*¹ describing the experiences of physicians who practiced when abortion was illegal in most states.

A doctor who was a resident in a New York City hospital during the 1960's describing what he called the "Monday morning abortion line-up":

What would happen is that the women would get their paychecks on Friday, Friday night they would go to their abortionist and spend their money on the abortion. Saturday they would start being sick and they would drift in on Sunday or Sunday evening, either hemorrhaging or septic, and they would be lined up outside the operating room to be cleaned out Monday morning. There was a lineup of women on stretchers outside the operating room, so you knew if you were an intern or resident, when you came in on Monday morning, that was the first thing you were going to do. (Joffe, p.60)

Another doctor describing her residency experience with illegal abortion in a county hospital:

There were two gyn wards. They were supposed to have thirty-two beds each, but they had to have beds all up and down the hallways. They were always full [because of illegal abortions]. They must have had one hundred and forty beds in those wards... The residents would get duties of twenty-four hour periods, and in that period, you'd get ten to twelve admissions. They walked into the emergency room bleeding. The first thing the

¹Joffe C. *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*. Boston: Beacon Press, 1995



doctor down there did was send them for an X-ray to see what was in their belly—to see if there were knitting needles, hooks, catheters up their belly...Then when they got to the ward, the first thing you did besides examine them was to do a culture for gas gangrene. It was a standard we had, whether they had a fever or not, to take this culture, because if they had gas gangrene, you really had to take drastic measures, like surgery, heavy duty antibiotics, and all that kind of stuff. Until the suction curettage came through, the routine was that you accumulated all the women until two o'clock in the morning when all the major surgery was done, and the last gunshot wound had been cleared out of the emergency room – then the first-year residents dragged the patients down to the operating room and started doing the D. & C.'s at two o'clock in the morning. That's when the operating room was quiet... There would be two or three operating rooms going at the same time. Between 2:00 and 6:00 AM you could get a certain number of D. & C.'s done and clean up the women who weren't septic, scrape their uteruses and get them back upstairs so they could be discharged in a day or two. (Joffe, p. 61)

A chief obstetrical resident in a public hospital in the 1950's describing a twenty-two year old patient whom he treated for septic shock following an illegal abortion:

What happens there, the infection is so overwhelming, the bacteria produce toxins that lead to a collapse of the cardiovascular system. These patients have no blood pressure, no pulse—in some cases there is absolutely nothing you can do to reverse the situation. We gave the girl blood, cortisone, hydrocortisone – nothing was working,

she was not responsive. We finally figured the only chance we had was to do a hysterectomy. We took her to the O.R., but Anesthesia said, “We won't give her anesthesia, without getting blood pressure or a pulse. We can't monitor where we are, and so we might kill her with the anesthesia.” So I had to do something I don't recommend to anybody, which is a hysterectomy under local anesthesia. We got the uterus out – I still have a picture of it in my teaching files – it was basically a bag of pus. We found a coiled up catheter in there. When we were all done, I was walking along beside her in the corridor – they were taking her back to her bed. And one of the tragedies of this septic shock is that people remain lucid until the end, and she was holding my hand, and saying, “Doctor, help me, I'm dying.” And I knew she was, and I knew there was not a blessed other thing we could do for her, and before she got to her bed, around midnight, she died, and I have been haunted by that girl ever since. (Joffe, p. 58).

Examples in the United States after *Roe v. Wade*

While the scenarios described above occurred before *Roe v. Wade*, on a smaller scale, similar situations sometimes still arise because safe, legal abortion is still not accessible to many women. A 2003 study² found that 87% of counties in America do not have a single abortion provider. Some women, particular immigrant women, are unaware that abortion is legal in the U.S. and turn to alternative methods for self-abortion, for instance self-administered misoprostol which has been widely used by women in Latin American countries for self-abortion and is documented

²Finer LB, Henshaw SA. Abortion incidence and services in the United States in 2000. *Perspectives on Sexual and Reproductive Health* 2003; 34(1): 6-15.



to be quite widely available in some communities and urban areas in the U.S. Further, legislative restrictions, such as parental consent laws, mandatory biased counseling, and waiting periods, make it difficult for women, particularly young, low-income, and rural women, to obtain abortions. The following two stories are examples of the consequences of access limited by financial constraints.

A) Rosie Jiminez, a 27-year-old woman living in Texas, died on October 3, 1977 from complications from an illegal abortion she obtained in Mexico. Rosie was on Medicaid but, because the Hyde Amendment prohibits the use of federal Medicaid funds to pay for abortion except in cases of rape, incest, and life endangerment, she could not obtain a safe legal abortion using her health insurance. While some argued that Rosie went to Mexico for her abortion because she was ashamed and wanted to protect her privacy, the fact that she had twice before obtained a safe, legal abortion using her Medicaid coverage, before Medicaid stopped funding abortion services, clearly connects the cutoff of Medicaid funding with Rosie's decision to resort to a cheaper, although illegal, abortion in Mexico. Rosie was a single mother of a five-year-old daughter. She was a scholarship university student supporting herself and her child while in school with welfare payments and her income from a part-time job. She was six months away from obtaining her bachelor's degree.

B) On March 27, 1994, Kawana Ashley, a nineteen-year-old single mother with a three-year-old son, shot herself in the stomach during the 25th or 26th week of her pregnancy. She was hospitalized but ultimately survived her injuries. Doctors delivered a female infant by emergency caesarean who died 15 days later. Ms. Ashley was a Medicaid recipient, but since Florida's Medicaid program funds abortion only in cases of rape, incest, or life endangerment, she needed to find a way to pay for the surgery herself. Unfortunately, by the time she got enough money together, she was into her second trimester, and the cost was higher. When she had raised the extra money she needed, she was beyond 20 weeks, the cutoff point at which the clinic stopped providing abortions. Out of desperation to end her unwanted pregnancy, Ms. Ashley endangered her own life.

The World Health Organization has estimated that worldwide approximately 80,000 women each year die as a result of illegal or unsafe abortions.³ Additionally, hundreds of thousands suffer wide-ranging and serious health consequences. Clearly, limited or nonexistent access to safe abortion has monumental consequences for individual women and their families. These figures make clear, however, the impact on public health when access to safe, legal abortion is restricted.

³Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data. Third edition. Geneva, Switzerland: World Health Organization, 1997. Available at http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_abstract.en.html



PART II – TOOLS FOR CLARIFYING OUR VALUES

Individual Exercises for Values Clarification

Sometimes it is helpful in the course of narrowing down our focus to look at both the external and the personal influences on the development of our values. Life stage, social culture, and our early spiritual environment are examples of external influences on our values. Individual experiences with sexual intimacy, parenting, adoption, abortion, and birth control also have their places in the shaping of our views. The following exercises are designed to help you identify the experiences that may contribute to your present values about both the broad and specific aspects of abortion. Again, it is hoped that understanding our personal beliefs about abortion will help us provide better care for women facing an unplanned pregnancy and considering the option of abortion. The exercises are divided into four categories: *external influences, personal experience influences*, and, with those in mind, *a woman's life circumstances* around her abortion. Finally, we look at *professional roles and responsibilities*.

These exercises and questions can provide you with insights as you work through them alone. Discussing your reactions to and thoughts about them with others can also expand your insights through shared and different experiences.

Section A: The Role of External Influences in the Formation of Our Values

External influences on our thinking can encompass many areas. As we grow up we are introduced to values and ideas by everyone around us while we simultaneously compare them to our personal experiences and perceptions. We have chosen to focus on the influence of **our culture** (family/race/social groups), **our spiritual/religious beliefs**, and **life stage** to connect them to our ideas about family and parenting, and consequently pregnancy options and abortion.

Exercise A-1: Examining the Role of Family and Social Groups on Our Values

The family or social group (i.e. heritage, extended family, adoptive family, socio-economic group) that we grow up in provides us with our customary beliefs and early social values. We use these as a backdrop when we interact with others and form opinions as we mature. Depending upon our personal temperament we may integrate these values automatically or challenge them at different points in our lives.

The purpose of this exercise is to reflect on the source and influence these core beliefs have on your present ideas about parenting, abortion, and adoption.



1. a) Did the family you were brought up in discuss specific values around parenting, adoption, or abortion? ___ Yes ___ No
If yes, describe: _____

b) Were there any family events that changed these views while you were living with the family? ___ Yes ___ No
If yes, describe: _____

c) Describe any similarities or differences between the values you presently hold about parenting, adoption, or abortion and your family's values about parenting, adoption, or abortion. _____

2. Did your family's values reflect your race/heritage or nationality's values?
___ Yes ___ No
If no, how did they differ? _____

3. a) Did the socio-economic group you were brought up in have any influence on your values about parenting, adoption, or abortion? ___ Yes ___ No
If yes, describe its influence: _____

b) Does your present socio-economic group differ from that of the family you were brought up in? ___ Yes ___ No
If yes, has this affected your views about parenting, adoption, or abortion? _____

4. Which social group would you consider has been the predominant influence on your values on parenting, adoption, and abortion?
Heritage/race ___ Socio-economic ___
Family ___

5. a) Choose one of the options in each category that would be the most encouraged by your predominant social group.

Number of children	Family forms	Age of new parents
<input type="checkbox"/> 0 child	<input type="checkbox"/> single parent	<input type="checkbox"/> Teenage parents
<input type="checkbox"/> 1 child	<input type="checkbox"/> two-parent	<input type="checkbox"/> Parents age 20-30
<input type="checkbox"/> 2 children	<input type="checkbox"/> multigenerational in household	<input type="checkbox"/> Parents age 30-40
<input type="checkbox"/> 3-4 children	<input type="checkbox"/> same-sex parents	<input type="checkbox"/> Parents age 40-50
<input type="checkbox"/> 5+ children	<input type="checkbox"/> single gay parent	

b) Does this represent your present life experience? _____
In what ways, if any, has this caused conflicts with your family? _____



6. a) Do your current values differ from the values you were brought up with in any of the following areas? Check any that apply.

- large families small families family on welfare
- role of women role of men mothers working
- birth control adoption abortion
- daycare divorce blended families
- sex before marriage mixed race parents marrying outside of culture

b) If your values differ, what influenced the change? _____

7. What percentage of your current ideas about family is culturally (family/social group) influenced? ____ Influenced by personal experience? ____ Other? ____

Exercise A-2: Examining the Role of Spiritual Beliefs on the Formation of Our Values

Our spiritual or religious beliefs may be rooted in our family or arrived at independently during different points in our lives. Some people consider these private contemplations while others share these beliefs openly in their everyday interactions. The merging of political and spiritual ideals in society has historically been a difficult marriage. The purpose of these questions is for you to reflect on the role of your spiritual beliefs in your everyday life.

Take a moment to reflect on the following questions and take note if these raise any other issues for you.

1. Have you held the same spiritual beliefs since childhood? _____

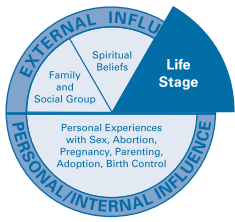
2. How often, on average, during a day, do you consciously refer to your spiritual beliefs before making a decision? After making a decision? _____

3. Have you been challenged by life circumstances that called on actions not supported by your religious or spiritual beliefs? Were you able to reconcile these actions with your beliefs at a later date? Did you do this on your own or with support? _____

4. Do your beliefs about any of the following topics that are influenced by your spiritual values conflict with anyone in your life at present?

- Beliefs about family? ___ Yes ___ No
- Beliefs about social roles? ___ Yes ___ No
- Beliefs about sex? ___ Yes ___ No
- Beliefs about birth control? ___ Yes ___ No
- Beliefs about abortion? ___ Yes ___ No

If yes, how have you reconciled these differences? _____



Exercise A-3: Examining the Role of Life Stage on the Formation of Our Current Views

Our age influences our reactions to life and change. Youth provides us with optimism, easy access to childhood memories, and endless possibilities but it can also limit our broader understanding of the impact of our decisions. Additional years bring us the perspective provided by an accumulation of experiences but the depth of this perspective is dependent upon their range and the personal insights we have about these experiences. The purpose of these questions is to remind us to pay attention to the influence of our age on our understanding of our clients' dilemmas and the fluid nature of our perspectives throughout our lives.

1. How did you feel about romantic relationships when you were 16? 25? 35? 45? Describe the differences: _____

2. What do you think would be the ideal age for a woman to have her first child? Have your views changed about this since you were 18? Since you were 30? 40? 50? What influenced these changes? _____

3. What did you think of teenage pregnancy, adoption, single parenting, and abortion

when you were 18? Describe how your views have changed since that time. _____

4. Have your views about the choice of not having or having children changed since you were 18? Describe: _____

5. How does your present age affect your perspectives when discussing pregnancy options with a patient? _____

Section B: The Role of Our Personal Experiences in the Formation of Our Values
 We have raised questions about the external influence of family and social culture, age, and spiritual values on the formation of our values. In the following exercises we explore how our own experiences (and those of our intimate others) with sexual intimacy, and our histories with pregnancy, fertility, infertility, adoption, abortion, and parenting can also influence our perspective.

Exercise B-1: Examining Our Own Experiences with Sexual Intimacy and Risk-Taking.

Because the need for an abortion always begins with the act of sex, it is important to be aware of our underlying attitudes about this topic. Depending upon our own personalities, our sexual identity and experiences are often deeply personal and not often



discussed with others. We gather information through our own experiences, what we read and see in the media and literature, and from stories gleaned from our social circle. Take a moment to reflect on the following questions and ask yourself if any of these experiences affect how you would consider a patient's sexual history and its role in her pregnancy.

1. Was your first sexual intimacy well planned or spontaneous? Was birth control an issue? Given your present perspective, is there anything you would change about that experience? If yes, describe. _____

2. How healthy is your own sex life at present? Is there anything you would like to be different? If you are unable to make any changes, how has this affected your life at present? Describe: _____

3. Have you always had a sexual partner during your adult years? If not, what was the longest period of time you went without sexual intimacy? Describe any effects it had on your life at the time. ____

4. Which of the following have had an impact on your sexual or intimate relationships:
- Sexual abuse or sexual assault _____
 - Coerced sex _____
 - Sexual infidelity (yours, partner's, parents') _____
 - Infertility or fear of infertility _____
 - Sexually transmitted disease _____
 - One night stand _____
 - Unplanned pregnancy _____
 - Abortion _____
 - Drugs or alcohol _____

5. Which of the topics listed in #4 above would you feel the most comfortable discussing with a client having a similar experience in her own life? _____ The least comfortable? _____

6. Describe how your experiences (or lack of) influence your discussions with clients in a positive way. _____

7. Describe how your experiences (or lack of) influence your discussions with clients in a negative way. _____

8. What strategies would you use to improve your comfort level with these topics if they impacted the life of one of your clients? ____



Exercise B-2: Examining Our Own Experiences with and Views about Parenting, Adoption, Abortion, and Pregnancy Prevention

Not all of us become parents, but many of us have had experiences and/or risks with pregnancy. Our experiences often affect how we see others in similar situations. Think about your responses to these questions and your present ideas about the challenges of parenting, adoption, abortion, and pregnancy prevention.

Parenting

Our experiences with parenting color the way we see it as an option for women. It is important to acknowledge our own experiences to help us be aware of our biases.

1. If you do not have children, which of the following statements would apply to you? (check all that apply)

- Do not want to have children _____
- Not ready to have children _____
- Infertility/difficulty conceiving _____
- Lack of opportunity _____
- Do not want to be a single parent _____
- Financial reasons _____
- Health reasons _____
- Career goals _____
- Placed a child for adoption _____
- Loss of a child _____
- Undecided _____
- Other _____

If any of the above reasons have created stress in your life, describe how you have coped.

Have any of these experiences complicated or assisted in your ability to understand your clients' choices? If yes, describe: _____

2. Which, if any, of the following have you had personal experience with in the role of child or family member? (check all that apply)

- Welfare _____
- Mental health problems _____
- Drugs and alcohol abuse _____
- Prenatal health risk by mother _____
- Single parenting _____
- Divorce/blended families _____

Was your experience as a parent or child compromised in any way by these issues?

Describe: _____

How have you coped with these experiences?

Have any of these experiences complicated or assisted in your ability to understand your clients' choices? If yes, describe: _____

3. Would you or others view your parents/family as the "perfect" family? _____

If yes, describe the impact on your present views on parenting and family. _____



4. If you are a parent, have you experienced any of the following with your child (children)? (check all that apply)

- Health challenges _____
- Mental health issues _____
- Drug addictions _____
- Financial challenges _____
- Single parenting _____
- Divorce _____
- Death of a child _____

How have you coped with these experiences?

Have any of these experiences complicated or assisted in your ability to understand your clients' choices? If yes, describe: _____

Adoption

Fewer of us have personal experience with adoption than we do with parenting. As with parenting, it is important to acknowledge how our experiences or lack thereof may influence our views of this option.

1. If you have a personal experience with adoption, which of the following apply? (check all that apply)

- I am adopted _____
- Family member/friend is adopted _____
- Placed a child for adoption _____
- Family/friend placed child for adoption _____
- Trying or tried to adopt _____
- Family member/friend adopted a child _____

Considered adoption when _____
 I or my partner became pregnant _____
 Work(ed) in the adoption field _____

How have these experiences affected your personal life? _____

Have any of these experiences challenged or assisted in your objectivity as a health professional when counseling a woman about pregnancy options? If yes, describe: _____

2. If you have no personal experience with adoption, has your objectivity been challenged as a health professional when counseling a woman about pregnancy options? If yes, describe: _____

Abortion

Our experiences with abortion vary. It is important to assess where our experiences are derived from and the influences they may have on our objective understanding of other women's choices.

1. If you have experience with abortion, which of the following apply? (check all that apply)

- My partner or I have had an abortion _____
- I have accompanied a family member _____
- I have accompanied a friend _____
- I am aware that a family member and/or close friend has had an abortion _____



- My partner or I have considered abortion because of pregnancy _____
- I work in the abortion field _____
- My family or I picket at abortion clinics _____

Which of the above (if any) have had the most impact on your views on abortion?

Have any of these experiences challenged or assisted your objectivity as a health care professional when counseling a woman about her pregnancy options? If yes, describe:

2. If you or your partner has had an abortion, describe the most difficult aspects of this decision. _____

Describe the positive aspects of this decision.

If you could, what would you have changed about the experience? _____

Have any of these experiences challenged or assisted your objectivity as a health care professional when counseling a woman about her pregnancy options? If yes, describe: _____

3. If you have no personal experience with abortion, has this had any effect on your role as a health care professional counseling a woman about her pregnancy options? If yes, describe:

Pregnancy Prevention

Our attitudes about abortion sometimes have links to our views on the preventative side of pregnancy. Birth control failure, absence, or misuse is a complex topic too often simplified if we do not address the complexity of individual personalities, the power dynamics of relationships, cultural differences, and women's experiences with the side effects of medications. Take a moment to reflect on your own experiences and evaluate these in relation to your views on pregnancy prevention.

1. Considering your own experiences with birth control methods, have you experienced any of the following? (check all that apply)
- Difficulty accessing birth control _____
 - Parental disapproval _____
 - Partner conflict _____
 - Financial difficulties _____
 - Misinformation _____
 - Compliance difficulties _____
 - Lack of preparation _____
 - Failure of method _____
 - Medical contraindication _____
 - Use influenced by drugs or alcohol _____
 - Assumed partner was using _____
 - Cultural difference _____



If yes, how did you solve these problems?

If you have been pregnant, how many of your pregnancies are the result of any of the above difficulties with birth control? _____

2. Have you or your partner experienced any of the following side effects from a birth control method? (check all that apply)

- Allergic reaction _____
- Weight gain _____
- Mood changes _____
- Irregular bleeding _____
- Nausea _____
- Pain _____
- Change in sexual performance _____
- Acne _____
- Change in sexual pleasure _____
- Change in libido _____

If yes, how many times have you changed your method? _____

Has this caused stress in your life? If yes, describe: _____

3. Would you describe yourself as a risk taker in general? ___ Yes ___ No

Do you take risks with your health?
___ Yes ___ No

Smoker? _____

Overweight? _____

No exercise? _____

Seatbelts? _____

Sunscreen? _____

Drive too fast? _____

Always practice safe sex? _____

Safe oral sex? _____

Regular pap or other routine tests? _____

Ask potential partner about STD's before sex? _____

Have you taken risks with birth control? ___ Often? _____

Have you discussed this with a health professional? _____

Do you follow the same birth control advice you give to clients you counsel? ___ Yes ___ No

If no, why not? _____

Have your experiences strained or assisted your objectivity when you discuss birth control and pregnancies with clients? If yes, describe: _____



Section C: Self-Evaluation of Our Objectivity When Considering a Woman's Pregnancy Circumstances and Her Options

When a woman presents with a pregnancy and is examining her options, her circumstances will play a role in her decision. It is natural for a health care provider to be evaluating her choice along with her in order to provide objective and respectful professional care. It is important to examine our own comfort level with her choice and consider our reactions when our neutrality is challenged. We will begin by looking at the option of abortion and our personal responses to issues such as gestational age, and then follow with the circumstances of the individual woman who is making this decision.

Exercise C-1: Examining Our Comfort Level with Gestational Age

For some people the acceptability of a patient's abortion decision is dependent on the stage of pregnancy at which the abortion might take place. This exercise is designed to help you examine your own feelings about this very personal question and its possible influence on the exercises to follow.

1. Does gestational age affect how you feel about your patient's abortion decision?
 Yes No

2. If gestational age does affect your response, at what point do you feel uncomfortable with your patient's abortion decision?
 At conception _____
 At implantation _____
 At the end of the first trimester _____
 At quickening (i.e. point of fetal movement) _____

- At viability _____
- At the end of the second trimester _____
- At some point in the third trimester _____
- It depends on the reason for the abortion _____

3. Now consider this list again as it relates to your comfort level with three varying degrees of your professional involvement in abortion. At what point do you feel uncomfortable with:
 - a) making abortion referrals for patients
 - b) assisting with the provision of abortion services
 - c) providing abortions

Write your reasons for feeling this way about gestational age. How long have you felt this way? _____

If you had different cutoff points depending on the level of your involvement in providing services, what are the reasons for these differences? If your feelings were consistent across the different levels of involvement, what are the reasons for this? _____



Exercise C-2: Examining Our Comfort Level with Circumstances of Each Woman's Abortion Decision

Sometimes we are comfortable with one woman's abortion decision, but are challenged by the circumstances surrounding another woman's decision. This exercise is designed for you to reflect on your personal responses to the following situations. It also illustrates the wide range of circumstances that may influence a woman to decide to have an abortion.

- I can accept a woman's abortion decision in any circumstance when she has made an informed and voluntary choice for abortion.
- I can accept a woman's abortion decision in certain circumstances including: (check all that apply)
 - to end a pregnancy that threatened her life
 - to end a pregnancy that threatened her physical health
 - to end a pregnancy that threatened her mental health
 - to end a pregnancy involving significant fetal abnormality
 - to end a pregnancy resulting from rape or incest
 - to end a pregnancy resulting from birth control failure
 - to end a pregnancy if the woman is unmarried
 - to end a pregnancy if the woman is in an unstable relationship or is not in a relationship

- to end a pregnancy if the woman does not want any more children
- to end a pregnancy if the woman is not financially able to care for a child
- to end a pregnancy if the woman feels she is not ready for the responsibility of having a child
- to end a pregnancy if a child would interfere with educational or career goals
- to end a pregnancy if the woman is unready for how a child could change her life
- to end a pregnancy if the woman is very young
- to end a pregnancy if the woman has not had a previous abortion
- to end a pregnancy because of gender
- other(s): _____

I find abortion unacceptable under virtually any circumstances.

What are the reasons for your beliefs? How long have you held these beliefs? _____



Exercise C-3: Individual Cases: Examining Our Potential Biases

Parts 1 and 2 of this exercise individualize the circumstances of a woman's abortion decision by providing more details to expose the complexity of the decision. By putting yourself into the role of the health care professional responsible for providing access to abortion to only one of the following women, you are challenged to examine your personal views and to experience the difficulties associated with limited access on the health professional as well as the patient. This exercise also illustrates the difficulty with comparing one patient's circumstance with another. Until we are put in this position we may assume that determining a hierarchy of needs would be difficult but not impossible. Pay attention to your reactions to this challenge when putting yourself in the role of the decision-maker. Part 3 helps us identify our personal discomfort, if any, when faced with the circumstances of some women's abortion decision.

1. Before *Roe v. Wade* legalized all first trimester abortions in the U.S., some hospitals provided a very limited number of "special case" legal abortions. Hospital therapeutic abortion committees had the task of determining which cases were worthy of being granted a safe, legal abortion. You are on that committee and must determine which ONE of the following patients, all of whom are requesting an abortion, will be granted the one remaining legal abortion left in your yearly quota.

- ___ 12 year old incest victim
- ___ 15 year old rape victim

- ___ 22 year old carrying a fetus with severe deformity
- ___ 24 year old heroin addict who already has three children in state custody
- ___ 26 year old single mother who has a young child with leukemia
- ___ 30 year old with 2 children whose husband died recently in a car crash

What factors influenced your choice? How did it feel to have to make this choice?

2. The six women described below have come to you requesting a referral for abortion. Due to circumstances beyond your control, only one more abortion can be done and you must choose which one of your six patients is to receive the last abortion. Rank the cases from 1 (most want to refer for an abortion) to 6 (least want to refer).

- ___ Gloria is 14 years old, unsure about what to do. She has supportive parents.
- ___ Louise is 19 years old, has two children and has had two previous abortions.
- ___ Selma is 24 years old, a student in medical school and engaged to be married. She wants to begin her career before starting her family.
- ___ Eileen is 29 years old, single and pregnant with an IUD in place.
- ___ Margaret is 35 years old, divorced, pregnant from a one-night encounter, her first sexual experience following her divorce.



— Dorothy is 45 years old, married with three grown children. Neither she nor her husband wants any more children.

What guided your choice for number 1?

What guided your choice for number 6?

Was making your choices difficult or easy for you? Explain. _____

Below are some of the arguments often made for each of the women. In each case, if you needed to argue for your choice, how would you respond to or refute these arguments for the women you did not choose?

Gloria: She's just beginning her life and should have a chance to enjoy her childhood. She will have few coping skills and the child might suffer. At her age, childbearing could be damaging to her health.

Response: _____

Louise: She has her hands full with two children at such a young age. Her previous two abortions indicate she is clear about not wanting another child.

Response: _____

Selma: She is clear that she wants to concentrate on her career and her new marriage before starting a family.

Response: _____

Eileen: Her IUD failed and she is now faced with an unplanned pregnancy. She is also single and may not have the support she needs to raise a child.

Response: _____

Margaret: She is already coping with a high level of stress because of her divorce. To have a child without the emotional and financial support of a partner would be very difficult. She is clear that she does not want to have a child under these circumstances.

Response: _____

Dorothy: She and her husband are both clear they do not want another child and feel their family is complete with their three grown children. Additionally, at her age, the pregnancy is high risk.

Response: _____



As a health care professional, how do you think you would react to having to make choices like these? What unique qualifications do you have to make such choices? _____

3. Even health care providers who self-identify as pro-choice and are supportive of their patients' decision-making autonomy can be faced with circumstances that 'push their buttons' and challenge them personally and professionally. This exercise helps to identify the areas where you area most challenged.

I would feel most uncomfortable referring or providing an abortion for a woman who:

___ is ambivalent about having an abortion but whose partner wants her to terminate the pregnancy

___ wishes to obtain an abortion because she is carrying a female fetus

___ has had what I consider too many previous abortions

___ shows little emotion about becoming pregnant and choosing abortion

___ has indicated that she does not want any birth control method to use in the future

___ is a regular protestor at abortion clinics but feels her circumstances are different from those of other women seeking abortion.

___ is nearing the end of her second trimester

What factors influenced your choice? How did it feel to make this choice? How might you handle your discomfort in dealing with this patient?

Exercise C-4: Pregnancy Options Decision Making

Each woman with a pregnancy decision to make has to consider her obligations to herself, the impact of her decision on her family, partner and the children she already may have. This exercise is designed to involve you in the intricacies of balancing priorities in the decision-making process of a woman examining her options. The effort of prioritizing and selecting options forces us to expose our internal biases and challenge our neutrality.

You have been given the authority to decide the outcomes of the following six pregnancies. Only two of the women can carry their pregnancies to term and become parents, only two can make arrangements for adoption, and only two can obtain abortions. You must make these decisions and be able to justify them.

Jane is 17 years old and is 10 weeks pregnant. She comes from a supportive, working class family with strong ties to the anti-abortion movement. She has been accepted on an athletic scholarship to the University of Pennsylvania and is due to start her first semester there in two months. Her boyfriend wants them to get married and have the baby.



Mary is a 26-year-old lawyer and is 6 weeks pregnant. She and her boyfriend are planning to get married in a few years. She has high aspirations for her career and is uncertain whether she wants children at all.

Ruth is 34 years old, married with 3 children. She had just ended a month long affair and had committed herself to her marriage when she discovered she was pregnant. She is unsure with which man she became pregnant. Her husband is very loving and supportive but is unaware of his wife’s involvement with another man.

Leslie is 21 years old and is midway through the first semester of her last year of college. She is working 2 jobs to pay for her tuition and expenses and is just barely getting by financially. She has been with her partner for 2 months and is not sure where the relationship is going. Before she found out she was pregnant, she was thinking about breaking things off.

Sue is 37 years old and married. She and her husband had been trying to get pregnant for 3 years. She just got back the results of her amniocentesis and they indicate that the baby has a severe genetic abnormality. She is 16 weeks pregnant.

Tina is 14 years old. Although she wasn’t really planning to get pregnant, she was excited when the test came back positive. She hasn’t told her parents yet because she knows that they will be angry and will not think she

is ready to be a mother. She and her boyfriend, who is 17, have been together for 8 months. His parents are not very happy that their son is with Tina.

Which two women would you choose to continue their pregnancies and become parents?

What factors influenced your decision?

Which two women would you choose to continue their pregnancies and make adoption arrangements? _____

What factors influenced your decision?

Which two women would you choose to obtain abortions? _____

What factors influenced your decision?



Exercise C-5: Parenting and Adoption: Examining our Biases

Our biases about parenting and adoption can also challenge our neutrality when listening to the circumstances of a woman's pregnancy. This exercise is designed for you to examine your own responses to the following circumstances involving the choices of parenting and adoption to discover areas where you are the most and least comfortable. Our awareness of these "hot buttons" allows us to review how we would manage our feelings and responses in a professional role with women and to ensure respectful and non-judgmental care.

Indicate your *first emotional* responses to each woman described below **choosing to continue her pregnancy and become a parent** and circle the corresponding spot on the line to identify your feelings.

Cindy is 20, has been unsuccessful in her attempts to overcome her cocaine addiction of two years. She has one child in foster care. She is on welfare and does not have a steady boyfriend.

very comfortable very uncomfortable

Sarah is 16, living at home with her adoptive parents. Her birth mother was 13 when she gave her up for adoption. She feels she would be disloyal to her birth mother if she did not go through with the pregnancy because her mother continued her pregnancy.

very comfortable very uncomfortable

Kaiya is 36, has 3 children, all girls, ages 8, 6 and 4. She has not imagined having more than 3 children but her husband is hopeful that this pregnancy will be a boy. She feels her husband's wishes are important and is sympathetic to his desire for a boy. They are in a secure financial position.

very comfortable very uncomfortable

Liza is 30, pregnant for the first time. She has not told her husband she went off birth control because he says he is not ready for children and will be ready in a year or two. She states she is sure he will change his mind. She says she would not be emotionally or financially prepared to single parent.

very comfortable very uncomfortable

Karen is 46, broke up with long term partner who doesn't want a child, will have to go on welfare, but has always wanted a child. She has limited family support and has a history of depression, although it is now controlled with medication.

very comfortable very uncomfortable



Indicate your *first emotional* responses to each woman described below **choosing to continue her pregnancy and make adoption arrangements** and circle the corresponding spot on the line to identify your feelings.

Jen, age 28 has just found out she is 14 weeks pregnant. She was adopted at birth by an older North American couple who brought her from South America. She is an artist, her boyfriend is a student, both are carrying large student loans. She feels she has a responsibility to her birth mother to go through a pregnancy and place her baby for adoption. Her partner tries to remain neutral but is visibly very upset.

very comfortable very uncomfortable

Vicki, age 28, has a history of mental health problems but is capable of making her own decisions. She is 15 weeks pregnant and has not told the man involved in the pregnancy that she is pregnant. She is canceling her abortion appointment because she has seen a TV show about women who can't have children and she was very moved by their plight. She has decided she would like to place her baby for adoption to help infertile couples.

very comfortable very uncomfortable

Anna is a single parent of two children. She had sex with ex-husband who is remarried. She says she cannot afford another child and does not feel comfortable with abortion. She has not told her ex-husband about the pregnancy. She says she has decided to place the baby for adoption to a distant relative.

very comfortable very uncomfortable

Tiffany, age 15, wants to continue her pregnancy and place her baby for adoption to a loving couple she met at her friend's church. Her parents are upset and "want to talk some sense into her." They believe it is in Tiffany's best interest for her to have an abortion. Tiffany says she is not ready to be a parent and does not "believe" in abortion.

very comfortable very uncomfortable

April, age 33, has recently broken up with her boyfriend. She is devastated about the pregnancy but she does not think she could reconcile abortion with her spiritual beliefs. Her friends and family are trying to influence her to continue the pregnancy and raise the child with their help but she thinks she would not be able to provide a life that she has imagined for a child. She has decided to place her baby for adoption. Her boyfriend is upset but does not want to become a parent.

very comfortable very uncomfortable



Section D: Providing Abortion Care: Professional Values Clarification Exercises

Evaluating our professional obligations in all cases as we are presented with them can be a challenge. It can help if we take the time to ask ourselves some questions about the relationship between our personal views and our professional role beforehand as we make decisions about providing access to safe abortion services. Providing access can include providing referrals to appropriate services or providing abortions.

As a health care provider, your decision about providing abortion services ultimately determines whether women can access safe abortion care. As such it is important to assess your feelings about abortion and providing abortions in the context of your professional role and obligations. While in many countries physicians have traditionally been the providers of legal abortion care, the availability of medical abortion, also referred to as medication abortion, has opened doors for other health care professionals, for instance nurse practitioners and midwives, to play a larger role as providers of abortion care. Additionally, more physicians in specialties such as family medicine, primary care, and adolescent medicine are exploring ways to incorporate abortion care into their practices. In some cases, this has required practitioners to actively evaluate for the first time what it means to them to become an abortion provider. Exercises D-1 through D-4 are designed to help you critically examine the factors that might influence your choice to become trained and to provide abortion services. Although some of the exercises pertain specifically to clinicians who are deciding about becoming abortion providers, all health professionals, whether they are involved in abortion care specifically or provide care to women in other settings, may benefit from reviewing these questions. They are also intended to illustrate the possible consequences of your choice to provide or not provide abortion service.

Exercise D-1: Views about the Role of the Health Care Provider

A physician who practiced before the 1973 U.S. Supreme Court *Roe v. Wade* decision that struck down state laws prohibiting abortion says that she occasionally lied to colleagues on the hospital committee about a patient’s medical circumstances in order to help patients obtain legal abortions. She states “That’s part of the practice of medicine...you do what you feel is necessary to insure the safety of your patients.” (Joffe¹, p. 72).

What do you think of this statement? What are the reasons for your position? _____

Exercise D-2: Personal Assessment of Professional Obligations

Building on your thoughts from Exercise D-1, what obligation do you have as a *health care provider* to ensure that your patients can access safe abortion services? Check all that apply.

___ I have an obligation to talk my pregnant patients out of obtaining abortion services.

¹Joffe C. *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*. Boston: Beacon Press, 1995



- ___ I have no obligation to my patients with regard to abortion services.
- ___ I have no obligation to provide abortion services for my patients as long as other clinicians can do so.
- ___ I have an obligation to provide factual information about all pregnancy options to my patients.
- ___ I have an obligation to provide my pregnant patients with referrals for services I am not willing or able to provide.
- ___ I have an obligation to follow up on abortion referrals I make to ensure that my patients have been able to access safe, high quality care.
- ___ I have an obligation to provide whatever legal care my patients need and that I am competent to provide, as long as it does not conflict with my personal beliefs.
- ___ I have an obligation to provide whatever legal care my patients need and that I am competent to provide, regardless of my personal judgments about their choices.

- ___ Desire to provide comprehensive care for my patients
- ___ Need for a provider for patients in the community where I practice
- ___ Commitment to help my patients avoid the risks of self-induced, illegal, or poor quality abortions
- ___ Belief in the rights and responsibilities of my patients to make their own moral choices
- ___ Desire to see only wanted children brought into the world
- ___ Commitment to providing my patients with the care they need, rather than referring them out to a provider they do not know
- ___ Desire to be competent in as many aspects of reproductive health care as possible and thus expand my marketability and my career opportunities in this field
- ___ Desire to provide the same opportunity to obtain safe abortion services as I/my partner had when I/she needed an abortion
- ___ Commitment to ensuring availability of legal medical services for my patients
- ___ Desire to make a public commitment to abortion rights
- ___ Desire to foster a supportive environment for abortion rights and abortion providers within the medical community
- ___ Other(s): _____
- _____
- _____

Write the reasons for your views. How long have you felt this way? _____

Exercise D-3: The Decision to Provide Abortion Care: Motivations and Obstacles

1. Motivations:

Which, if any, of the reasons listed below might motivate you to provide abortions for your patients? Check all that apply.



2. Obstacles:

Which, if any, of the reasons listed below might deter you from providing abortions for your patients? Check all that apply.

- I find the idea of abortion personally objectionable.
- I believe that abortion is contrary to my oath to do no harm.
- Abortion is contrary to my religious beliefs.
- I might have to face the memory of my own previous abortion experience(s).
- I would worry about patients leaving my practice.
- My partners in my practice and/or the hospital where I have admitting privileges are not supportive of or have a policy against providing abortion services.
- I would worry about my reputation with medical colleagues.
- There are administrative barriers (e.g. malpractice coverage, third-party reimbursement, compliance with regulations about abortion practice and facilities).
- Significant people in my life oppose abortion.
- I would be concerned about my personal safety vis-à-vis harassment and violence by those opposed to abortion.
- I would be concerned about the safety of my loved ones.
- I am unsure about my competence if I provide abortions only occasionally.
- Other(s): _____

Exercise D-4: Overcoming Obstacles to Providing Abortion Care: A Self-Evaluation.

Given the perceived and real difficulties facing those who choose to provide abortions, it is not surprising that some clinicians choose not to become trained in abortion techniques or, even if they have been trained, choose not to provide abortions. At the same time, abortion providers have found ways to successfully overcome the obstacles they face. The following exercise is intended to provide some suggestions to help overcome obstacles to providing care and allow you to assess your feelings about these options.

Looking again at the concerns you checked in Part 2 of Exercise D-3, consider ways that some health care providers deal with those issues. This exercise is two-fold: First, create a hierarchy of your personal concerns by indicating #1 as your biggest concern, and #12 as your smallest concern next to the list of statements A-L. After you have established this hierarchy, refer to suggestions for each statement for further exploration.

A. I find the idea of abortion personally objectionable.

Suggestions for further personal exploration of this topic:

- Speak with abortion providers and learn how they deal with any discomfort they might have felt.
- Learn more about abortion procedures to pinpoint the source of this discomfort.
- Shadow an abortion provider.
- Observe some pregnancy options counseling sessions.



- Consider if there have there been other times when you had personal objections to aspects of medical care. How did you deal with those objections? Where do your objections stem from?

B.____ I believe that abortion is contrary to my oath to do no harm.

Suggestions for further personal exploration on this topic:

- Speak with abortion providers and learn how they reconcile this.
- Consult resources on the health consequences of illegal and inaccessible abortion.

Suggested resources:

Joffe C. *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade*. Boston: Beacon Press, 1995.

Poppema S. *Why I Am An Abortion Doctor*. Amherst, NY: Prometheus Books, 1996.

Dorothy Fadiman's Emmy-Award winning documentary trilogy *From the Back Alley to the Supreme Court and Beyond*.

Voices of Choice – A Multimedia Project from Physicians for Reproductive Choice and Health. Information available at <http://www.prch.org/voicesofchoice.shtml>

C.____ Abortion is contrary to my religious beliefs.

Suggestions for further personal exploration on this topic:

- Speak with abortion providers and learn how they reconcile this.

- Speak with supportive members in your religious congregation about how to reconcile this, if this is possible.
- Examine other areas of your religion that you may find contrary to your personal beliefs. How are you reconciling those issues?

Suggested resources:

Materials from Catholics for a Free Choice (<http://www.catholicsforchoice.org/>), the Religious Coalition for Reproductive Choice (<http://www.rcrc.org/>), or other religiously affiliated groups that support abortion rights. *Life Matters: The Story of an Illegal Abortioneer*. A documentary. More information available at <http://www.filmakers.com/indivs/LifeMatters.htm>

D.____ I might have to face the memory of my own previous abortion experience(s).

Suggestions for addressing this concern:

- Share concerns with trusted others who know about the experience or seek professional counseling or a support group to work to resolve feelings about an abortion experience.
- Reflect on the benefits of helping others through something you have experienced.

Suggested resources:

DePuy C & Dovitch D. *The Healing Choice: Your Guide to Emotional Recovery After an Abortion*. New York: Fireside, 1997.

Torre-Bueno A. *Peace After Abortion: A Pro-Choice Self-Help Guide for Women and Men*. San Diego: Pimpnel Press, 1996. www.peaceafterabortion.com/



E.____ I would worry about patients leaving my practice.

Suggestions for addressing this concern:

- Keep a low profile (e.g. separating an abortion practice in time or space from the rest of one’s practice).
- Use careful language (e.g. D & C rather than abortion).
- Educate patients about why this is an important part of medical practice.
- Network with colleagues who offer abortion to learn about the effect it had on their practices.
- Network with pro-choice groups, colleagues, or organizations to build support.
- Consider that offering abortion services could signal to other patients that you are open to all their concerns and lead to better patient-provider relationships.
- Consider that you may also gain new patients who come to you for abortion care and stay with you.

Suggested resources:

The Access Listserv is a network of family physicians who are interested in the integration of early abortion services into family practice. Contact grouponata@hotmail.com for more information.

The Center for Reproductive Health Education in Family Medicine has information about talking with patients about abortion services at www.reprohealthfamilymed.org.

F.____ My partners in my practice and/or the hospital where I have admitting privileges are not supportive of or have a policy against providing abortion services.

Suggestions for successfully addressing this obstacle:

- Network with pro-choice colleagues in your hospital and build support for providing abortion services.
- Network with colleagues in other hospitals who have successfully addressed policy restrictions.
- Use this guide as a starting point for discussion with colleagues.
- Reach out to pro-choice groups and individuals in your community or region to build support.
- Join a pro-choice professional organization.
- Consider adding abortion-related services first, such as post-abortion follow-up visits, options counseling, or even information brochures about abortion and pregnancy options.
- Consider assisting in a local clinic one or two days a week.

Suggested resources:

The Center for Reproductive Health Education in Family Medicine website has tools for beginning a dialogue with colleagues and staff, including staff attitude surveys at www.reprohealthfamilymed.org.

G.____ I would worry about my reputation with medical colleagues.

Suggestions for successfully addressing this concern:

- Network with pro-choice colleagues.
- Avoid discussing abortion with your other colleagues.
- Join a pro-choice professional organization.
- Speak out effectively in favor of abortion.



- Maintain an open mind and a willingness to talk to all colleagues, regardless of choice stance.

Suggested resources:

For suggestions for responding to common questions or comments people make about providing abortion services, an excerpt from “When People Ask ‘Where Do You Work?’” (Baker A. *Abortion and Options Counseling: A Comprehensive Reference, Revised and Expanded Edition*. Granite City, IL: Hope Clinic For Women, Ltd., 1995) is available at <http://www.ansirh.org/trainingworkbook/chapter9tools/Talking%20About%20Your%20Work%20With%20Others.doc>

H. ____ There are administrative barriers (e.g. malpractice coverage, third-party reimbursement, compliance with state regulations about abortion practice and facilities).

Strategies to address these issues:

- Network with colleagues who provide abortion services.
- Speak with staff of organizations that have expertise with abortion regulations, such as the National Abortion Federation, The Center for Reproductive Rights, and the American Civil Liberties Union.
- Join a pro-choice professional organization, such as the National Abortion Federation, for professional expertise.
- These barriers exist for other areas of medical practice, too. You or your staff may have already found ways to solve these issues.

Suggested resources:

See Chapter 9 “Office Practice” in Goodman S, Paul M, Wolfe M, Stewart FH and the

TEACH Trainers Collaborative Working Group.* *Early Abortion Trainers Workbook*. UCSF Center for Reproductive Health Research & Policy: San Francisco, CA (2004). * Hufbauer E, Schwarzman M, Curington J, Robinson S, Hastings J. Available at <http://www.ansirh.org/trainingworkbook/trainingworkbook.html>

The Center for Reproductive Health Education in Family Medicine has numerous administrative resources available at www.reprohealthfamilymed.org.

I. ____ Significant people in my life oppose abortion.

Suggested ways to handle these concerns:

- Do not discuss this aspect of your work with them.
- Listen to and acknowledge their sources of discomfort.
- Discuss with them the reasons for your decision to provide care.
- Provide written and media resources for them to consider on the topic of abortion and abortion providers.
- Be willing to discuss areas where you may also feel some discomfort. Perhaps it is the same area and your reconciliation of the issue may help them understand your work.

J. ____ I would be concerned about my personal safety vis-à-vis harassment and violence by those opposed to abortion.

Suggestions for addressing this concern:

- Keep a low profile about your involvement in providing abortion services.
- Study and assess the personal risk.



- Take extra personal security measures as well as for offices or clinics.
- Establish relations with the local police.
- Network with pro-choice organizations, such as the National Abortion Federation, that can provide help when needed.
- Reach out to pro-choice groups and individuals in your community or region to build support.
- Stop doing procedures if the threat felt too great.

Suggested resources:

Security staff at the National Abortion Federation work closely with providers on issues related disruption, harassment, and violence and provide security trainings, assessments, alerts, and 24-hour clinic support.

The website for the U.S. Department of Justice National Task Force on Violence Against Health Care Providers includes information about the enforcement of laws to protect reproductive health care providers and their patients, as well as security tips at <http://www.usdoj.gov/crt/crim/faceweb.htm>

De Becker, G. *The Gift of Fear: Survival Signals that Protect Us from Violence*. Gavin De Becker, 1997

K.____ I would be concerned about the safety of my loved ones.

Suggestions for addressing this concern:

- Keep a low profile about your involvement in providing abortion services.
- Study the facts and assess for yourself whether your family would be at risk.
- Ask your loved ones not to discuss your work.

- Establish relations with the local police.
- Reach out to pro-choice groups and individuals in your community or region to build support.
- Stop doing procedures if the threat felt too great.

Suggested resources:

See Suggested resources under J above

L.____ I am unsure about my competence if I provide abortions only occasionally.

Some suggestions:

- Refer patients elsewhere if at all doubtful.
- Obtain additional experience by working occasionally at an abortion clinic.
- Find a skilled provider in the community to work with you or provide extra training.
- Participate in continuing medical education courses about abortion and abortion techniques.
- Consider offering medical abortion as an alternative to vacuum aspiration until you feel competent with aspiration skills.
- Stop or scale back the scope of procedures if you did not feel confident in your competency.

Suggested resources:

The National Abortion Federation's website (www.prochoice.org) includes extensive professional education resources and materials, including an online CME program on medical abortion, information about training opportunities, and links to other organizations that provide training or have educational resources.



PART III – ADDITIONAL INSTRUCTIONS FOR USING SELECTED EXERCISES FROM THE GUIDE IN A GROUP SETTING

Facilitating group exercises and group discussion can be a daunting task, particularly when the subject under discussion is one about which people have strong and personal feelings. At the same time, however, the group process is invaluable in terms of clarifying one's own values and learning from others. Included at the end of this section is a list of resources for those who would like more guidance and information about the process of facilitating group discussions.

What follows are 1) tailored instructions for using in a group setting selected exercises from Part II that are most appropriate for this forum and 2) additional questions for prompting group discussion. We have included an estimate of the approximate time to allow for completing each exercise. However, the timing of these exercises depends very much on a number of factors including the size of the group, the level of participation, the diversity of opinions held by participants, and the dynamics among the participants.

Finally, it might be helpful to set the tone for group sessions by indicating that there is no need to reach group consensus, but striving to understand each other's views can be very useful. Further, hearing the ideas of colleagues might cause participants to reconsider their

initial thoughts. The way we expand our thinking and grow is by receiving more information from other viewpoints that make a lot of sense to us – it doesn't matter if we didn't think of it first. So feel free to let new thinking change your mind at any time.

Exercise C-1: Examining Our Comfort Level with Gestational Age:

(Suggested time allotment: 30 minutes)

Draw an imaginary line across the room and label the following points on the line: at conception, at implantation, at the end of the first trimester, at quickening, at the end of the second trimester, at some point in the third trimester. **Ask participants to stand on the line at the point** where they stop feeling comfortable with the idea of abortion. Ask participants at different points along the continuum to **share what made them choose their position while others in the group just listen**. Afterwards, open up the floor for **general discussion and reactions** to the ideas that were expressed. Repeat for different levels of professional involvement in abortion: 1) making abortion referrals, 2) assisting with abortion services, and 3) providing abortions.



Exercise C-2: Examining Our Comfort Level with Circumstances of Each Woman's Abortion Decision:

(Suggested time allotment: 45 minutes)

Conduct an anonymous poll by having participants write agree or disagree in response to five statements you have selected from the range of possible feelings about women obtaining abortions (e.g. I can accept a woman's decision in any circumstance when she has made an informed and voluntary choice for abortion, I can accept a woman's decision to end a pregnancy that threatened her physical health, I can accept a woman's decision to end a pregnancy if she is in an unstable relationship or is not in a relationship, I can accept a woman's decision to end a pregnancy if she is very young, I find abortion unacceptable under virtually any circumstance). **Collect the papers and redistribute them** so each participant has someone else's answers in front of them. Designate one side of the room as "agree" and one as "disagree," then **read each statement and have participants go to the side of the room corresponding to the answer on the sheet of paper they are now holding.** After each statement, ask a few participants from each side of the room to give a rationale for that position, reiterating that the person offering the explanation does not necessarily hold that opinion. After a few people from each side of the room have offered a rationale for that position, **open it up to general discussion** so participants can respond to the ideas which were expressed.

Possible discussion questions if participants are not talking:

- 1) What was most difficult about this exercise?
- 2) What was your reaction to the list of circumstances under which someone might find abortion acceptable? Did it seem like a wide range or did you expect a more extensive list?
- 3) Which circumstances seemed easiest to select or rule out? For what reason?
- 4) What are the possible reasons why the debate about abortion so often focuses on the woman's life, rape, and incest rather than on other circumstances which might be more common?

Exercise C-3: Individual Cases: Examining Our Potential Biases Part 1 and 3

(Suggested time allotment: 1 hour)

For each exercise, **label stations** around the room with the case descriptions for the exercise. **Ask participants to go to the station that represents their choice and discuss with others at the same station** their reasons for so choosing. After all stations have reported back to the full group their reasons, **participants can change stations if they have changed their choice.** Then ask the **full group to talk together in an effort to reach consensus.** Repeat for Part 3, although there is no need to reach consensus on this one.

Discussion questions:

- 1) Which choice was hardest to make (denying abortion access in cases where an abortion might be judged as generally socially acceptable OR providing abortion in cases where abortion might be judged as socially unacceptable)? Why?



- 2) How can a clinician handle personal discomfort in dealing with patients whose choices are beyond the clinician's personal comfort zone?
- 3) How, if at all, is a woman's choice to have an abortion for reasons a health care provider might not agree with different from a woman or man's choice to make other medically related choices, such as smoking or riding a motorcycle without a helmet, which a health care provider might not agree with?

Part 2

(Suggested time allotment: 45 minutes)

Ask participants to **rank their choices in writing**. Then **read the list of women aloud** asking how many people ranked each woman as their first choice by having **those who chose raise their hands**. Ask for someone who chose #1 to make the case for her; then for each of the other women, **have someone who chose her make the case**. Ask participants not to discuss or argue while the cases are being presented. How did you refute the arguments made for the women you did not choose?

Discussion questions:

- 1) How did having to choose make you feel?
- 2) Why is it so difficult to make these kinds of choices?
- 3) How could you avoid ever having to make choices of that sort in your practice?

Exercise C-4: Pregnancy Options Decision Making

(Suggested time allotment: 30 minutes)

Have participants break into small groups (3-5 participants) and read the six descriptions. Ask the groups to discuss and reach consensus about which two women they will "assign" to each of the three pregnancy options (adoption, abortion, parenting). After 20 minutes, have the groups report back the decisions they made and the reasons for their decisions. Allow each group to report their decisions without interruption and then open discussion up.

Additional discussion questions:

- 1) How did it feel to have to make these decisions as a group?
- 2) Which cases, if any, were fairly easy to assign? Why?
- 3) Which cases were most difficult? Why?

Exercise C-5: Parenting and Adoption: Examining our Potential Biases

(Suggested time allotment 25 minutes)

Label one end of the room "Very Comfortable" and the other end of the room "Very Uncomfortable" and explain that the line between those two extremes represents a continuum. **Read the descriptions** of 2-3 of the "Choosing to Parent" cases **one at a time** and **ask participants to go to the spot along the continuum that corresponds to the first emotional response they have to each description**. Have one or two people from each spot **share with the group their reasons** for so choosing. After all stations have reported back



to the full group their reasons, **participants can change stations if they have changed their choice.** Repeat with 2-3 of the “Choosing Adoption” scenarios.

Additional discussion questions:

- 1) If you had to choose one or the other, were you generally more comfortable with the parenting scenarios or with the adoptions scenarios? Why?
- 2) For those who had a change in comfort level after listening to others, what made you feel differently?

Exercise D-1: Views about the Role of the Health Care Provider

(Suggested time allotment: 20 minutes)

Have participants break down into small groups (4-5 participants) and read the excerpt. Ask participants to work on the discussion questions which follow in their small groups. **Have smaller groups report back to the group as a whole the most compelling or controversial issue this excerpt elicited in their small group discussions.**

No additional discussion questions.

EXERCISE D-2: Personal Assessment of Professional Obligations

(Suggested time allotment: 45 minutes)

Ask participants to **consider the scale** and decide which position best represents their view. Then, have them **cluster in different parts of the room according to the position they have chosen** and **discuss briefly** their reasons for their choice **with others in their cluster.** Then **ask individuals from each cluster to offer their**

reasons while others in the group just listen. Afterward, **open it up to general discussion** so participants can respond to the ideas which were expressed.

Additional discussion questions:

- 1) What is your reaction to this question?
- 2) What other medical services might a health care provider “opt out” of providing?
- 3) What are some of the ways that a health care provider can reconcile personal beliefs with a patient’s needs and beliefs?
- 4) What is the difference, if any, for denying medical services for medical reasons vs. personal reasons?

EXERCISE D-3: The Decision to Provide Abortion Care: Motivations and Obstacles to Practice

(Suggested time allotment: 45 minutes)

Have participants **complete Part 1 and Part 2 individually.** Then have participants **work in groups of two to three people and discuss their answers.** Smaller groups should **report back to the larger group** for further discussion one or two issues which were especially compelling or controversial in their small group discussions. Suggestions for discussion questions for each questionnaire are listed below.

Overall discussion question: The purpose of these particular exercises is to have you critically assess whether or not to be trained and ultimately provide abortion services. You have a greater responsibility to assess your feelings about abortion and providing abortion than people in other professions since, as a



health care professional, you will ultimately be the one to make or not make safe abortion services available. What are your thoughts about this statement?

Discussion questions for Part 1:

- 1) Which reasons for providing abortions are most compelling?
- 2) What makes them compelling?
- 3) Which reasons might a health care provider find more compelling than a lay person? (i.e. In what ways has your professional education and training influenced your beliefs?)
- 4) What is the importance, if any, of communicating the health care provider's perspective to the public?

Discussion questions for Part 2:

- 1) Which reasons for not providing abortions are most compelling?
- 2) What makes them compelling?
- 3) Which reasons might a health care provider find more compelling than a lay person? (i.e. In what ways has your professional education and training influenced your beliefs?)
- 4) What is the importance, if any, of communicating the health care provider's perspective to the public?
- 5) What other medical services might you "opt out" of providing? For what reasons?
- 6) If there are other services which you might opt out of providing, how are these similar or different from abortion? If you would not "opt out" of any other service, what about abortion makes it different from other medical services?

EXERCISE D-4: Obstacles to Providing Abortion Care: A Self-Evaluation

(Suggested time allotment: 45 minutes)

Have participants **complete the questionnaire individually**. Then **work on one barrier at a time**, asking participants to indicate which suggestions might enable them to overcome that difficulty.

Additional discussion questions:

- 1) Which reasons for choosing not to provide abortions can most easily be dealt with and overcome? Why?
- 2) Which reasons seem most difficult to deal with or overcome? Why?
- 3) How realistic are the suggestions for overcoming the reasons for choosing not to provide abortion?
- 4) Are there other suggestions not included in the lists that might be helpful?
- 5) What would make it easier to overcome the barriers to providing abortions?
- 6) What would make it harder?

Suggested References about Facilitating Group Discussions

- Beresford T. *How To Be a Trainer*. Baltimore, MD: Planned Parenthood of Maryland, 1980.
- Boyer RP with McCormick S. *Helping People Learn about Sexuality*. Bristol, PA: Planned Parenthood of Bucks County.
- Cook AT, Kirby D, Wilson P, and Adler J. *Sexuality Education: A Guide to Developing and Implementing Programs*. Santa Cruz, CA: Network Publications, 1984.
- Silberman M, Auerbach C, and Silberman ML. *Active Training: A Handbook of Techniques, Designs, Case Examples, and Tips*. San Francisco, CA: Jossey-Bass Inc. Publishers, 1997.

NOTES

