Published in final edited form as:

AJOB Empir Bioeth. 2016 ; 7(1): 48–55. doi:10.1080/23294515.2015.1019018.

“Prefacing the Script” as an Ethical Response to State-Mandated Abortion Counseling

Mara Buchbinder, PhD,

Department of Social Medicine, University of North Carolina at Chapel Hill, 333 S. Columbia St., 341A MacNider Hall CB 7240, Chapel Hill, NC 27599

Dragana Lassiter, MA, ASN,

Department of Anthropology, University of North Carolina at Chapel Hill, 301 Alumni Building, CB 3115, Chapel Hill, NC 27510

Rebecca Mercier, MD, MPH,

Department of Obstetrics and Gynecology, Jefferson Medical College, 833 Chestnut Street, 1st Floor, Philadelphia, PA 19107

Amy Bryant, MD, MSCR, and

Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill, 4002 Old Clinic Building, CB 7570, Chapel Hill, NC 27514

Anne Drapkin Lyerly, MD, MA

Department of Social Medicine, Center for Bioethics, University of North Carolina at Chapel Hill, 333 S. Columbia St. 333 MacNider Hall CB 7240, Chapel Hill, NC 27599

Mara Buchbinder: mara.buchbinder@gmail.com

Abstract

BACKGROUND—Laws governing abortion provision are proliferating throughout the United States, yet little is known about how these laws affect providers. We investigated the experiences of abortion providers in North Carolina practicing under the 2011 Women’s Right to Know Act, which mandates that women receive counseling with specific, state-prescribed information at least 24 hours prior to an abortion. We focus here on a subset of the data to examine one strategy by which providers worked to minimize moral conflicts generated by the counseling procedure. Drawing on Erving Goffman’s work on language and social interaction, we highlight how providers communicated moral objections and layered meanings through a practice that we call *prefacing the script*.

METHODS—We conducted semi-structured interviews with 31 physicians, nurses, physician assistants, and clinic managers who provide abortion care in North Carolina. Audio-recorded interviews were transcribed verbatim and analyzed using an inductive, iterative analytic approach, which included reading for context, interpretive memo-writing, and focused coding.

RESULTS—Roughly half of the participants (14/31) reported that they or the clinicians who performed the counseling in their institution routinely prefaced the counseling script with

qualifiers, disclaimers, and apologies that clarified their relationship to the state-mandated content. We identified three performative functions of this practice: 1) enacting a frame shift from a medical to a legal interaction, 2) distancing the speaker from the authorial voice of the counseling script, and 3) creating emotional alignment.

CONCLUSIONS—Prefacing state-mandated abortion counseling scripts constitutes a practical strategy providers use to balance the obligation to comply with state law with personal and professional responsibilities to provide tailored care, emotional support, and serve the patient’s best interests. Our findings suggest that language constitutes a powerful resource for navigating and minimizing moral conflicts in healthcare.

Keywords

abortion; law; clinical ethics; communication; apologies; moral distress; qualitative research

Laws governing abortion provision are proliferating throughout the United States, including laws that impose gestational limits, waiting periods, physician and institutional requirements, restrictions on public funding and insurance coverage, and regulations for parental involvement for minors (Guttmacher Institute 2014a). Of particular interest for the field of bioethics are state-mandated counseling laws, which require that women receive counseling with specific information prior to obtaining an abortion, and often include a mandatory waiting period as well (Lazzarini 2008; Curfman and Morrissey 2008; Minkoff and Marshall 2009). At the time of this writing, 35 states require that women receive counseling before an abortion is performed and 27 of these states stipulate the information a woman must be given (Guttmacher Institute 2014b).

While such legislation has provoked heated debate among policymakers, women’s health advocates, religious authorities, and others, little is known about how these laws affect abortion providers. Abortion providers are already burdened by high levels of professional stigma (Harris et al. 2011; Harris et al. 2013; O’Donnell, Weitz, and Freedman 2011), harassment, and violence. Increasingly, they may face additional occupational challenges in complying with a growing number of laws governing how they practice. Several of these challenges raise ethical concerns. State-mandated counseling abortion laws may infringe on provider autonomy, by regulating specific aspects of patient-provider communication and clinical care. They also raise concerns about non-maleficence, insofar as providers may perceive the counseling procedure to cause emotional harms to patients. Finally, state-mandated counseling laws raise specific moral challenges for the patient-provider relationship, particularly the establishment of trust. Legal constraints on the ability to act in accordance with one’s sense of what is right or good can lead to moral distress (Jameton 1984; Epstein and Hamric 2009; Epstein and Delgado 2010), a sense of powerlessness that, if unaddressed, can have serious physical and psychological consequences, such as depression, feelings of worthlessness, and professional burnout (Jameton 1993; Ulrich, Hamric, and Grady 2010; Sundin-Huard and Fahy 1999).

This paper is based on a study that investigated the experiences of abortion providers in North Carolina practicing under HB 854 (2011 “Women’s Right to Know Act”), which mandates that women receive counseling from a qualified medical professional (i.e.

physician, nurse, or physician assistant) with specific, state-prescribed information at least 24 hours prior to an abortion. (See Table 1 for specific provisions of the law.) Unlike laws in some states, the North Carolina law does not require providers to state disputed or incorrect clinical information, such as a scientifically unsubstantiated link between abortion and breast cancer, infertility, and suicide, or the ability of a fetus to feel pain. We focus here on a subset of the data to examine one strategy abortion providers employed to minimize moral conflicts generated by the counseling procedure: prefacing the counseling script with qualifiers, disclaimers, and apologies that clarified their relationship to the state-mandated content. In particular, we highlight how abortion providers communicated moral objections and layered meanings through a practice that we term *prefacing the script*.

BACKGROUND: GOFFMAN, LANGUAGE, AND SOCIAL INTERACTION

The analytic lens that we apply in this article is based on sociologist Erving Goffman's work on the performance of everyday life. Because Goffman's work draws heavily on theatrical metaphors for human social life and is grounded in a fine-grained perspective on language use in social interaction, it is particularly useful for explaining the interactional dynamics of scripted abortion counseling. Here, we focus especially on the interrelated concepts of *frame* and *participant roles*.

The concept of *frame* refers to the situated meanings and normative expectations with which we implicitly define what is happening in a given social interaction (Goffman 1974). Goffman began with the assumption that what is actually going on in a social encounter could be something rather different from what appears on the surface, as in the case of jokes or misunderstandings. Consequently, a shift in frame refers to the possibility that we may suddenly find ourselves in a different sort of situation from the one we thought we started out in. Goffman identified and described various communicative strategies through which participants in a social exchange deliberately worked to transform how their interactional partners would understand a situation.

The concept of *participant roles* works more specifically to explain what people are doing when they read scripted text. Noting that the concepts of "speaker" and "hearer" are insufficient for adequately representing the complex communicative contexts in which words are sometimes spoken, Goffman (1981) differentiated between three distinct participant roles that we can attribute to speakers: 1) the *animator*, the person actively engaged in utterance production; 2) the *author*, the person who has selected the words that are expressed; 3) and the *principal*, the person whose views and sentiments the words express. Particularly relevant to the case at hand was Goffman's recognition that "*Reciting* a fully memorized text or *reading aloud* from a prepared script allows us to animate words we had no hand in formulating, and to express opinions, beliefs, and sentiments we do not hold" (1981:145; italics in the original).

Taken together, these concepts offer a unique window onto abortion counseling that illustrates how abortion providers may communicate several layers of meaning and complicate their orientations toward scripted content when they perform state-mandated

counseling. In what follows, after describing our research design and methods, we apply these concepts to analyze providers' descriptions of their counseling experiences.

METHODS

We conducted a qualitative, thematic study based on semi-structured in-depth interviews with individuals who provide abortion care in North Carolina. The study received approval from the Institutional Review Board at the University of North Carolina at Chapel Hill. Data were collected over a four-month period from September through December 2013.

Eligible participants—physicians, nurses, physician assistants, counselors, and clinic managers—were recruited through a combination of methods. We generated a list of 16 abortion clinics in the state in consultation with the National Abortion Federation, which maintains listings of US abortion providers for the purposes of research and patient referral. We mailed introductory letters to the clinics identified above, asking interested participants to contact the study research assistant (RA), a nursing graduate student with a background in reproductive healthcare. To increase the diversity of the sample, the RA made follow-up telephone calls to several clinics in which no providers responded to our mailing. We recruited several additional participants in this manner. We also employed a snowball sampling approach, asking participants to identify colleagues from within and outside their own clinical setting who might be willing to participate. We interviewed all willing participants.

Interviews were conducted by the RA and a medical anthropologist with expertise in qualitative research and the patient-provider relationship (MB), who trained the RA extensively in qualitative interviewing techniques. All interviews were audio-recorded and lasted between 35 and 90 minutes, with an average length of 60 minutes. With one exception, interviews were conducted in person. Participants chose whether to hold the interview in their workplace, the researcher's office, or an off-site location (e.g. coffee shop). The use of live interviews provided an opportunity to supplement audio-recordings with notes containing information about the interview setting, facial expressions, and other non-verbal cues.

We developed the semi-structured interview guide in consultation with the qualitative literature on providers' attitudes toward abortion. Prior to study enrollment, MB conducted four pilot interviews with abortion providers outside of North Carolina who had practiced in states with similar abortion legislation. We repeatedly refined the interview guide to incorporate topics not previously included until no new areas of inquiry were generated. We designed interview questions to capture a breadth of experiences and responses and to maintain a neutral stance toward the possible effects of the law. The final interview guide included questions in five domains: 1) general background on the provider's clinical experience and their current abortion practice; 2) general attitudes toward abortion legislation; 3) details about how the HB 854 "Women's Right to Know" (WRTK) Act counseling process operates in the provider's specific clinical context; 4) views toward WRTK ultrasound requirements (enjoined at the time of our interviews); and 5) views toward future or impending laws.

A professional transcriptionist transcribed the audio-recorded interviews verbatim. We analyzed transcripts using Dedoose (Dedoose Version 4.5, 2013), an online data management platform, and an inductive, iterative analytic approach, which included reading for context, interpretive memo-writing, and focused coding. During the first stage of analysis, we read transcripts closely to identify and discuss emergent themes, which we summarized in interpretive memos. We then developed a structured coding guide consisting of 75 thematic codes. Two coders reviewed and coded each transcript and any discrepancies were discussed and resolved. The conceptual framework for prefacing the script presented here focuses on codes relating to the WRTK counseling procedure.

RESULTS

The final sample of 31 participants included 17 physicians, 10 nurses and physician assistants, and 4 clinic managers. Eight participants were male and 23 were female. Eleven out of 16 abortion clinics in North Carolina were represented in the sample, including 3 hospital-based clinics and 8 freestanding abortion clinics in 8 counties. Of the providers interviewed, 19 reported that they had performed the state-mandated counseling themselves. In keeping with the stipulations of HB 854, all providers who had performed the counseling were physicians, nurses, or physician assistants.

Providers reported a variety of ways in which clinics met counseling requirements, but they typically implemented telephone counseling to minimize the burden on patients. In most cases, the counseling call was a patient's first point of entry into the clinic, and was performed by someone unknown to the patient. In all cases, clinics added state-mandated counseling procedures onto the abortion counseling protocols already in place in their clinics, which included informed consent for medical or surgical abortion, education about the procedure, and counseling about a patient's emotional experience (Joffe 2013). The state did not provide clinics with a script to be used in counseling. Instead, the legislative text of HB 854 stipulated the range of issues that the counseling must cover (See Table 1), after which individual clinics developed their own counseling materials, which often included a standardized script for counseling.

The practice of prefacing the script emerged in response to providers' moral objections to state-mandated counseling. These objections included concerns about: 1) non-maleficence, 2) the standardized nature of the script, and 3) patient and provider autonomy. Other objections to the state-mandated counseling procedures not framed in terms of ethics are reported elsewhere (Mercier et al. n.d.).

First, many providers suggested that some of the state-mandated content was potentially harmful under certain circumstances. As one nurse reflected:

“You have to let them know about child support, being eligible for child support. ... I don't know this person's situation. If they were raped, I mean, come on. Do I really have to tell them that the person who got you pregnant is responsible for child support? I don't want to trigger any PTSD in these patients if they've already gone through a really difficult situation.”

Here, the nurse suggests that the state-mandated counseling may re-traumatize rape survivors. Other potential harms focused on concerns that the counseling procedure might make women feel judged, leading to feelings of guilt or shame.

The potential for harm relates to a second commonly expressed concern, which focused on the standardized nature of the counseling script. For many participants, the use of a standardized script ran counter to their clinical training to provide patient-centered, tailored care. As one physician explained:

“A script that doesn’t take into consideration individual circumstances misses the point. The whole idea is to be woman-centered, in terms of counseling and informed consent. ... based on where that woman is coming from, based on what is going on in her life.”

Finally, many participants expressed concerns relating to the law’s infringement on patient and provider autonomy. Many participants interpreted the law as suggesting that women were not capable of making decisions for themselves and that providers were not capable of adequately informing women about abortions without legislative mandate. A physician summarized this set of concerns as follows:

“I find it very condescending. As if women aren’t being given proper informed consent or decision-making about their abortion care. While others, you know, like legislatures, are trying to take away their decision-making and autonomy.”

In light of these concerns, roughly half of study participants (14/31) reported that they or the clinicians who performed the state-mandated counseling in their clinical site routinely prefaced the counseling script with qualifiers, disclaimers, and apologies that clarified their relationship to the state-mandated content. The people who spoke most extensively about this practice were those for whom state-mandated counseling was a regular clinical duty, but even some providers who did not perform counseling themselves reflected thoughtfully on their observations of colleagues’ counseling. We identified three performative functions of prefacing the script: 1) enacting a frame shift from a medical to a legal interaction, 2) distancing the speaker from the authorial voice of the counseling script, and 3) creating emotional alignment. In practice, these performative functions of prefacing the script were interwoven and overlapping within providers’ accounts. However, we separate them below for heuristic purposes.

Shifting from a Medical to a Legal Frame

The most common prefacing strategy described by study participants was to explain that the counseling procedure was required by the state of North Carolina. In doing so, providers emphasized that the forthcoming counseling reflected a legal mandate rather than their personal clinical judgment. For example:

“And what I always do is, I start off by saying, ‘This is not the way that I would normally begin a clinical encounter, but *I’m required to go through these based on state law* and a hospital interpretation of our policy.’”¹ (physician)

¹In all cases, italicized content in participants’ quoted speech represents our emphasis and not that of the speaker.

“I will say, ‘I just want you to know that *this is a legal document that I’m required to read* by law. Please don’t mistake this for my personal judgment towards you. I’m here to offer you whatever support and help that you feel like you need.’”
(nurse)

“Before I start the script I say, ‘I just want you to understand that this script is not something I want to speak. It is something that *I must comply with according to the state.*’” (physician)

From the outset, casting the counseling as a state requirement that providers were legally obligated to perform enabled them to produce a shift from a medical to a legal frame for the counseling procedure. By prefacing the counseling with qualifiers that explicitly defined their discursive agenda in terms of this legal interactional frame, they differentiated the forthcoming counseling from other types of clinical counseling that patients had likely experienced, in which providers generally have considerable latitude to decide what to say and how to say it—and hence take ownership of the words they express. Framing the counseling as a state requirement worked to dissuade patients from mistaking the content of the mandated counseling procedure for the professional expertise and personal judgments often associated with routine medical counseling. As one physician put it:

“For the patients, I always preface it, I preface it by saying that this a necessary step before we can do the procedure, mandated by the North Carolina Legislature. ...
Just frame it that it’s not coming from me, basically.”

Shifting to a legal frame thus enabled providers to communicate to patients that the authoritative voice of the script was *not* the voice of professional medical authority.

Distancing from the Authorial Voice of the Script

The issue of voice is critical to the performance of scripted counseling because it is difficult to disavow the speech that one directly expresses. While framing the counseling procedure as a legally-mandated state requirement was a crucial first step for many providers, for some, such prefacing did not go far enough to create distance from the scripted content. As one physician explained:

“Even though we say at the outset that this is a requirement of the state, that this is not necessarily something that we would have felt relevant to provide before, *they’re still hearing it from our voice* and still—I think that affects the relationship with doctors and patients and really has no place in providing safe care.”

To understand how providers managed the discomfort associated with expressing, in their own voice, scripted content that they viewed as irrelevant or morally objectionable, it is helpful to turn to Goffman’s (1981) framework for participant roles. Although a provider might serve as the *animator* of scripted, state-mandated content, the *author* role was attributed to the clinic administrators who wrote the script, often with input from legal counsel, while the state served as the *principal*, the source driving this discursive production. From this perspective, a key function of prefacing the script was to reject the roles of author and principal. In a more colloquial sense, we might say that prefacing the script enabled providers to disclaim authorship of its words and ideas, as we see in the following examples:

“I would start out by saying that I am reading a script that’s been written by the North Carolina General Assembly and that it is not the same thing as the [name of clinic] consent process.² Because I hope that will go ahead and lay out there, like, *these are their words not mine.*” (nurse)

““I also need to, as required by the state, tell you a bunch of different things’ ... and try to preface what I was stating in that way so they would sort of know where we’re probably coming from and *not feel like it was something coming from me,* necessarily.” (physician)

Another strategy for repudiating the authorial voice of the script was to express uncertainty or ambivalence about how to interpret its content. For example, one physician reported having told patients that he did not understand the script’s logic:

“My favorite one is the [part of the script which says that] federal and state assistance may or may not be available to help with your prenatal care. I don’t even know what that means. You know, so I have to explain this. And they ask me. They say, ‘What does that mean?’ I’m like, ‘I’m sorry ma’am, I don’t know what it means, but it’s in the law.’”

As this example suggests, saying that one does not know what a statement means is a clear way of signaling that the words it contains are not one’s own.

Creating Emotional Alignment

The examples considered thus far all illustrate relatively neutral ways in which providers distanced themselves from the script. In some cases, however, providers worked to create emotional alignments with patients as they disaffiliated from the mandated counseling. For example, a physician recalled how a resident routinely gave explicit permission to patients to *not* listen to the script:

“I had one resident who would always preface the counseling by, ‘The next 15 minutes, I’m required to read you something that the state requires. You can listen. You can answer questions. You can lay the phone down and go do whatever you want to do, but I’m required to read this to you. You can—it’s your right to kind of listen as you please.’ So, and especially for patients that were already having a difficult time just making the decision, they sort of saw that as, ‘Okay, this person respects what I’m going through and kind of has sort of mixed feelings about this law.’”

Here, the physician suggests that by sanctioning a possible decision not to listen to the counseling, the resident communicated her own (negative) stance toward the law in the service of fostering respect for the patient.

²This statement is technically inaccurate, insofar as the North Carolina General Assembly did not produce a script for providers to use in counseling. It is not clear whether this provider misunderstood this aspect of the law or exaggerated the case for rhetorical purposes. However, this example nicely illustrates why we need to differentiate between *authors*, who physically write a script, and *principals*, who provide the occasion for its production—a distinction which the speaker interestingly collapses here.

Offering preemptive apologies for the scripted content to follow was a central strategy for creating emotional alignment. A nurse described her approach as follows:

“And I will say to people, ‘There may be parts of this script that are upsetting to you and concerning to you, and I totally understand that. And I apologize in advance, but we are required by state law to provide this information, and without doing it we can’t proceed with the termination, so we have to do it. And we’ll do it as quickly as we can. And obviously if you have questions or concerns, then let me know, but our hands are tied; we have to do it.’”

Of particular significance here is the nurse’s explicit recognition of the possibility that certain parts of the script may cause emotional harm, and the concrete explanation for why such harms must nevertheless be committed (Lazare 2004). Furthermore, the dedication to perform the counseling as quickly as possible represents an earnest attempt to minimize the extent of this potential harm.

Apologies were mentioned particularly frequently in relation to specific kinds of patients—chiefly, women with desired pregnancies for whom the decision to abort was often felt by providers to be especially distressing. In the following examples, participants highlight how discussing financial support for a baby could seem especially insensitive in cases of a severe fetal anomaly, and therefore warranted an apology.

“Say they have fetal anomalies, things like, ‘Just so you know the state provides financial support for your baby if needed.’ And certainly that was not something that someone who has lethal fetal anomaly needed. *So there were definitely things that I had to apologize for before saying, that really just are ridiculous.*” (physician)

“When I’m speaking to the women with anomalies, most of the content is not even relevant ... I feel as though I am misleading them because it’s not relevant to say to someone who has a fetus with no head, or we call it, an anencephalic fetus, that she has the option of carrying the pregnancy to term, and that the father will be held—that she could give the child up for adoption. And I’m like, no one is going to adopt this baby, the baby is going to die, no one is going to adopt the baby, so I don’t feel comfortable telling them this. *So, most times I will preface that sentence with something like, ‘I’m sorry this isn’t relevant to you, but I have to say it,’ and then I would make the statement.*” (physician)

These examples highlight how providers perceived the potential harms of counseling as particularly significant in cases in which women’s motives for seeking an abortion were thought to be particularly sympathetic or morally inviolable. Many providers viewed it as particular unconscionable to lead women in such circumstances to feel shamed.

Several providers indicated that preemptive apologies helped to prevent women from responding to the counseling negatively or emotionally. Noting that it was rare for a patient to get very upset, one physician said:

“Just talking over it so much, explaining, apologizing up front, I think the patients just haven’t had a dramatic response to it, and probably because I am so apologetic for having to do it in the first place.”

Similarly, a nurse noted, “I think the way I preface it could also help to establish a rapport with a patient.” Thus, although most providers viewed the counseling procedure as driving a wedge in the patient-provider relationship, prefacing the counseling script with apologies could help to counterbalance this process and, in an unanticipated way, even strengthen the relationship.

DISCUSSION

This article has described one key strategy through which some abortion providers have responded to the moral challenges raised by new abortion laws. Drawing on qualitative, in-depth interviews conducted with abortion providers in North Carolina and Erving Goffman’s analytic lens on language and social interaction, we have illustrated how providers worked to mitigate morally objectionable content in the state-mandated counseling by prefacing counseling scripts with disclaimers, qualifiers, and apologies. While the empirical focus of this study was on abortion, the practices we describe may be relevant to other areas of medicine in which healthcare providers increasingly find themselves constrained by legal mandates, such as laws mandating that physicians offer terminally ill patients information and counseling regarding palliative care and end-of-life options (Weinberger et al. 2012), and laws limiting the information that physicians can disclose about exposure to chemicals used in the process of hydraulic fracturing (“fracking”) (Tracy 2011).

Minkoff and Marshall recently proffered that abortion providers *can* contextualize counseling scripts to separate “medical fact from legislative conjecture” (2009, 23); this study provides the first empirical evidence that they often *do*. More specifically, we have shown how prefacing the script offers rich contextual information that adds another layer of meaning to the scripted material to follow, complicates providers’ orientations to the state-mandated content, and helps patients interpret the counseling context and information provided from a more fully informed viewpoint. Furthermore, from the perspective of providers, this practice also alleviates perceived harms and violations of autonomy, and reestablishes patients’ trust in providers.

Prefacing the script is a practical strategy abortion providers employed to balance the obligation to comply with state law with personal and professional responsibilities to provide tailored care, emotional support, and serve the patient’s best interests. It does not require special training or guidance in formal ethical deliberation, relying instead on practical communication skills that healthcare providers, particularly those trained in abortion counseling, by necessity already have. Moreover, although we do not have data on precisely how often this practice occurs, the fact that nearly half of the providers in our study referred to it suggests that it is a common communicative strategy.

Given that participants who spoke more extensively about prefacing the script were those that routinely performed the counseling procedure, our findings support work by Fisher et al. (2013) suggesting that frontline workers, such as call center operators, absorb a disproportionate share of what they call “moral stress.” Similarly, the fact that providers mentioned preemptive apologies more frequently in the context of cases of fetal anomaly suggests that providers may experience greater moral conflicts in counseling patients with

such diagnoses, potentially stemming from concerns about non-maleficence. That is, providers implicitly suggested that the content of the script could be particularly harmful to women seeking abortion due to a fetal diagnosis. While this possibility aligns with prior research showing that the context of abortion decisions influences the moral stances that providers take (Harris, Cooper, et al. 2011), further research is necessary to examine the relationship between patients' reasons for seeking an abortion and providers' experiences of moral challenges.

While prefacing the script holds intuitive appeal as a practical strategy for navigating moral challenges in state-mandated abortion counseling with minimal investment of time, we cannot discount its possible negative effects. Chiefly, framing abortion counseling as a legally-mandated state requirement might in some cases draw unnecessary attention to it being a morally problematic activity. For example, disclaimers about the state's role in counseling might lead some women to feel shame when they might not have felt shame in the absence of such disclaimers. Consequently, there is a chance that women who react negatively to the counseling procedure might be reacting negatively to the prefacing and not to scripted content itself. Although it seems to us that prefacing the script offers greater potential for benefit than harm, we did not interview patients about their experiences of state-mandated counseling, and there are limits to providers' insights about the impact of counseling on patients. Additional research with patients would help to illuminate this issue.

Conflicts between personal beliefs and professional responsibilities have a long history in reproductive healthcare (American College of Obstetricians and Gynecologists 2007; Lazarus 1997), and have led to heated debate about whether and under what circumstances a provider can ethically refuse to provide medically indicated or required care (Charo 2005; Lawrence and Curlin 2007; Little and Lyerly 2013; Wicclair 2007). Providers may also be constrained by situations in which state law or hospital policies preclude them from *actively offering* specific services when they are otherwise inclined to do so (Harris 2012; Freedman and Stulberg 2013). However, while this literature tends to frame care decisions in terms of conscientious refusal (or commitment) to provide a contested service, our findings suggest that abortion providers have other, more subtle strategies for minimizing conflicts of conscience or threats to moral integrity. This underscores that abortion providers are moral actors whose clinical actions are shaped by moral sensibilities, and not by an absence thereof (as some abortion opponents might suggest).

In healthcare settings and in ordinary social life more generally, apologies constitute an important means of redressing perceived harms or wrongdoing. Yet although such apologies are known to occur in clinical practice, theoretical attention to apologies in healthcare has focused primarily on physician disclosure of medical error and the possible implications for medical malpractice lawsuits (Alberstein and Davidovitch 2011; Cohen 2004, 2010; Davenport 2005; Dresser 2008; Gallagher 2003; Lazare 2006; Robbenolt 2009). The apologies examined here depart from prevailing trends in the literature in two noteworthy ways. First, most accounts of apology focus on harms that have already been committed. Here, we have shown how apologies can play a preemptive role in mitigating an interlocutor's response to a forthcoming harm. Second, contrary to definitions of apology emanating from speech act theory (Austin 1975; Bergman and Kasper 1993; Holmes 1990;

Owen 1985; Searle 1970), we do not presume that speakers must always express apologies for acts that they personally committed. Following Smith (2008), we suggest that the social power of apologies lies in their meaning and relational value, rather than in assuming personal responsibility for wrongdoing.

This study has several limitations. Although we recruited a geographically diverse sample of abortion providers from North Carolina from a range of clinical settings, our findings may not be generalizable to providers in states with different legal contexts. It is also possible that the providers who agreed to participate in the study may have stronger feelings about the ethical dimensions of state-mandated counseling, which could influence the representativeness of their responses. We do not know very much about the circumstances under which providers would choose to preface the script—or not—nor the ethical orientations to counseling of those who did not employ this strategy. Moreover, although the practice was described by about half of study participants, we do not know how frequently it occurs in clinical practice. It would be very informative to audio-record actual counseling sessions to explore this issue further, although this would potentially present methodological challenges given the importance placed on privacy and non-intrusiveness in the domain of abortion. Despite these limitations, this study provides valuable, much-needed information about how some abortion providers respond to legislative mandates that they find morally problematic, at a highly descriptive level that only qualitative research is likely to capture.

CONCLUSION

This article is the first to our knowledge to document relational strategies by which some abortion providers respond to moral conflicts emergent from state-mandated counseling. By reaching beyond what the script *says* to preface its content in ways that subtly challenge its clinical authority, providers added an additional layer of contextual meaning to the state-mandated, scripted material. Our findings demonstrate that language constitutes a powerful resource for navigating and minimizing moral conflicts in healthcare. This article thus suggests a promising new direction for empirical bioethics in which micro-level analyses of clinical communication might take center stage.

Acknowledgments

This research was supported by grants from the Society for Family Planning (SFPRF7- 15, Rebecca Mercier: PI) and the Greenwall Foundation (A15-0165, Anne Drapkin Lyster: PI). Mara Buchbinder's efforts were supported by a grant from the National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health (KL2TR001109). The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH. We thank Laura Britton for research assistance and Gail Geller for a helpful discussion at the onset of this analysis.

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Table 1Provisions of North Carolina's Woman's Rights to Know Act[/]

•	Mandates a 24-hour waiting period prior to an abortion
•	<p>Telephone or in person counseling must be performed by a physician, nurse, or physician's assistant at least 24 hours before the procedure. Among the disclosures that must be included to any woman seeking an abortion are:</p> <ul style="list-style-type: none"> – The medical risks associated with abortion and with carrying a pregnancy to term – The gestational age of the "unborn child" at the time of abortion – If applicable, the provider's lack of medical liability insurance for malpractice – The location of the nearest hospital and provider's admitting privileges – That medical assistance benefits for prenatal care, childbirth and neonatal care, and public assistance programs might be available – That the "father" is liable for child support even he offered to pay for abortion
•	Women who have undergone abortion and "fathers" of the "unborn children" subject to abortion may maintain an action for damages against providers in violation of the above requirements.
•	<p>Ultrasound provision (overturned in January 2014)</p> <ul style="list-style-type: none"> – Ultrasound must be performed at least 4 hours before the procedure – The provider must describe what the image is depicting, including the presence, location, and dimensions of the "unborn child," the number of "unborn children," and the presence of "external members" and internal organs – Ultrasound image must be displayed within the woman's view – The woman must be offered to hear fetal heart tone
•	The woman must provide a written certification that these requirements were met.

[/] Full legislative text available at: <http://www.ncleg.net/Sessions/2011/Bills/House/PDF/H854v6.pdf>