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Reframing Conscientious Care: Providing Abortion Care When Law and Conscience Collide

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Abstract

While the concept of conscience has broad philosophical underpinnings relating to moral judgment, agency, and discernments of right and wrong, debates in bioethics have tended to engage the concept primarily vis-à-vis rights of conscientious refusal. Here, we suggest a broader frame for thinking about claims of conscience in healthcare. Drawing on empirical findings from our research with abortion providers in North Carolina, we elucidate an empirically grounded approach to ethically justified care when healthcare providers face legal or institutional policy mandates that raise possible moral conflicts. We highlight, in particular, how providers may be motivated by matters of conscience, including relational concerns, in the active provision of certain forms of care. In so doing, we challenge the dichotomy between conscientious refusal and morally compromised action, demonstrating how providers may work within the constraints of laws or institutional policies that raise moral challenges *and* act in accordance with conscience.

"It's almost like putting salt in a wound, for this person who's already made a very difficult decision," offered Dr. Meghan Patterson,[1] a licensed obstetrician/gynecologist whom we interviewed in our qualitative study of the experiences of North Carolina abortion providers practicing under the 2011 "Woman's Right to Know" (WRTK) Act (HB 854). Similar to

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laws in 26 other states,[2] HB 854 requires that women receive counseling with state-mandated information at least 24 hours prior to obtaining an abortion. In its initial form, the law also required that women obtain an ultrasound and have the images displayed and described, but a federal judge overturned this portion of the law in 2014 following a lawsuit filed by several providers and a temporary injunction.[3]

After HB 854 was passed, Dr. Patterson worked with clinic administrators, in consultation with a lawyer, to write a script to be used in the state-mandated counseling procedure. In drafting the text of the counseling script, Dr. Patterson and her colleagues took particular steps to mitigate the effects of what she described as HB 854's "forced language" —such as referring to the "father of the child" when a woman seeking an abortion might prefer not to reify those putative social roles. Furthering this effort, while HB 854 stipulated that patients must be informed of the medical risks associated with the particular abortion procedure as well as those of carrying the child to term, Dr. Patterson took care to make explicit the magnitude of comparative risks, emphasizing in her own script that the risks of carrying a pregnancy to term are substantially greater than the risks of an early-term abortion.

Dr. Patterson also noted that, when performing the counseling, she and her colleagues were careful to state at the outset that the procedure was a requirement of the state, and that not all of the information was relevant to the patient's decision. Relevant information about the risks of an abortion had already been included as part of the clinic's standard informed consent protocol, and was simply redundant. Other required information struck Dr. Patterson as not medically relevant, such as the requirement to inform women about the "father's" financial liability for child support. Despite the use of preemptive disclaimers, Dr. Patterson maintained, "they're still hearing it from our voice, and I think that affects the relationship with doctors and patients and really has no place in providing safe care." She described one coworker who routinely told patients that it was their right to listen (or not) as they pleased, conveying, in Dr. Patterson's view, respect for the patient, and a less-than-positive stance toward the law. She felt that these contextualization strategies helped to facilitate trust and rapport in a clinical care situation that proved relationally and morally challenging.

In this article, we take up and expand on this point by elucidating an empirically grounded approach to ethically justified care when healthcare providers face legal or institutional policy mandates that raise possible moral conflicts. Our approach builds on recent bioethics discourse addressing conscience in the practice of medicine. While the concept of conscience has broad philosophical underpinnings relating to moral judgment, agency, and discernments of right and wrong,[4] debates in bioethics have tended to engage the concept primarily vis-à-vis rights of conscientious objection or refusal. Here, we suggest a broader frame for thinking about claims of conscience in healthcare. Our approach draws on the feminist bioethics and the ethics of care literatures[5] to highlight how providers may be motivated by matters of conscience, including relational concerns, in the active provision of certain forms of care. In so doing, we challenge the dichotomy between conscientious refusal and morally compromised action, demonstrating how providers may follow laws or institutional policies that raise moral challenges *and* act in accordance with conscience. What emerges are two possibilities for ethical action in response to morally challenging legal or policy mandates: not only *conscientious refusal* to comply with a policy mandate,

but also *conscientious compliance*—working conscientiously within a mandate's confines. While providers in our study rarely entertained the former, they described multiple strategies for minimizing conflicts of conscience through far more subtle means, as Dr. Patterson's case suggests.

Conscience Claims in Healthcare

One way that healthcare providers have responded to professional requirements to participate in medical services that they find morally objectionable is by asserting appeals to conscience.[6] Broadly speaking, conscience is an individual's moral judgment about what is right and wrong and a commitment to act according to core moral values. While some view conscience as informed by religious or secular ethical traditions,[7] Wicclair argues that what gives conscience its force is its origination in personal beliefs that do not necessarily align with the values of one's community.[8] In contrast, Childress defines conscience as an active process of moral discernment, as opposed to the application of fixed principles or beliefs.[9] Many scholars and practitioners view conscience as crucial to the ethical practice of medicine, suggesting that it undergirds multiple aspects of routine clinical care, even in the absence of moral conflict. Sulmasy, for example, maintains that moral life without conscience is simply unimaginable.[10]

Popular and scholarly debates about the role of conscience in healthcare emerged during the 1970s with the appearance of "conscience clauses,"[11] but have been reinvigorated with the recent proliferation of abortion and contraception regulations.[12] In bioethics, much of the discussion has centered on ethical justifications for conscientious refusal—that is, abstaining from participating in certain treatments and procedures because doing so is incompatible with one's core moral values. Arguments that support providers' rights of conscientious refusal often center on respect for moral integrity.[13] According to Wicclair, preserving the moral integrity of healthcare providers is important because medicine is a moral enterprise in which physicians should be at liberty to rely on moral values to guide clinical action. Furthermore, the loss of moral integrity can result in guilt or shame, and may ultimately lead to a decline in moral character—obviously an undesirable outcome for healthcare providers and deeply problematic if part and parcel of responsible medical care.[14]

Much of the debate on conscience has considered two stark alternatives: the rights of providers to refuse to perform procedures to which they morally object, and the interests of the patients who might be harmed by such refusals. Supporting the primacy of patient welfare, professional organizations have generally argued for "balancing" interests of providers and patients and placing limits on rights to refuse.[15] However, while some have argued that pharmacists who refuse to fill emergency contraception prescriptions should refer patients to a pharmacy where they can receive the service,[16] others have suggested that even the act of referral is morally problematic and would compromise integrity.[17] Still others have criticized this approach as an unethical compromise because of its potential to cause harm to women—for example, by delaying the use of a time-limited treatment—and its neglect of patients' values.[18]

Some have suggested that the dominant debate around conscientious refusal has neglected certain areas of moral concern. The first stems from the narrow focus on refusal to provide medically indicated (if morally complex) care. Largely missing from debates that pit the individual rights of providers against those of patients are conscience-based claims for *offering* care. Harris has critiqued prevailing approaches to conscience in arguing that providers may also be driven by moral concerns in their desire *to provide* certain forms of care, such as abortion.[19] From this perspective, and as we will further elaborate, abortion laws or other restrictive policies may in fact constrain the ability of providers to align their clinical practice with conscience; yet few policies protect proscribed actions undertaken by providers that are motivated by a conscientious commitment to care.[20] In addition, while refusal itself is typically conceptualized as refusal of medically indicated care, we suggest refusal may occur and can be productively considered in other contexts —e.g. care in the context of institutional or legal mandates, which also raise issues of conscience. These settings challenge the dichotomy between conscientious refusal, on the one hand, and provision of care with a compromised conscience, on the other hand, pointing to a third possibility: conscientious compliance in the setting of mandated but objectionable actions.

The idea that conscience may be animated in the active provision of care is connected to a second critique of dominant approaches to conscience. While conscience is typically articulated at the individual level, particularly vis-à-vis concerns about the potential loss of moral integrity, we follow Charo in noting that the emphasis on individual rights and autonomy has diminished the role of relationships and mutual responsibilities.[21] Drawing on our empirical findings, we build on the feminist relational perspective on conscience developed by Carolyn McLeod[22] to offer a broader framing of conscience claims in healthcare. In addition to traditional bioethics approaches that emphasize a need to maintain providers' moral integrity,[23] our approach incorporates a relational perspective, in which individuals are understood as enmeshed in a web of relationships, and conscience claims in medical care are motivated by a concern for maintaining such relationships, including protecting and caring for patients.

Background and Methods

Our framework is based on data from our investigation of the experiences of abortion providers in North Carolina following the implementation of the 2011 Woman's Right to Know Act (House Bill 854). HB 854 requires that women receive counseling with specific information prescribed by the state at least 24 hours to obtaining an abortion. State-mandated content includes: 1) the name of the physician who will perform the abortion; 2) the medical risks of an abortion and carrying a pregnancy to term; 3) the gestational age of the "unborn child" at the time of abortion; 4) if applicable, the provider's lack of medical liability insurance for malpractice; 5) the location of the nearest hospital and provider's admitting privileges; 6) that medical assistance benefits for prenatal care, childbirth, and neonatal care, and public assistance programs "may or may not" be available; 7) that the "father" is liable for child support even he offered to pay for abortion; and 8) that the woman has alternatives to abortion.[24] Unlike similar laws in other states, HB 854 does not require providers to state incorrect medical information, such as a scientifically unsubstantiated link between abortion and breast cancer, infertility, and suicide, or the ability of a fetus to feel

pain.[25] It does require that the woman be offered printed educational materials and that she provide a written certification that these requirements were met.

In 2013, we conducted a qualitative, interview-based study to explore the perspectives and experiences of North Carolina abortion providers practicing under HB 854. Our sample included 17 physicians, 10 nurses and physician assistants, and 4 clinic administrators from 11 out of 16 abortion clinics in North Carolina. Our study design has been described in detail elsewhere.[26]

To develop our framework, we read interview transcripts with particular attention to the moral issues raised by providers in this context. As issues that evoked considerations of conscience emerged, we considered them alongside bioethics discussions about how healthcare providers navigate moral conflict, and noticed a gap between the ways participants talked about their ethical challenges and the ways that these challenges are framed in the conscience literature. To broaden our perspective on conscience and better capture our participants' experiences, we incorporated feminist perspectives into our literature review.[27] We complemented this analysis with a close reading of relevant themes in the medical ethics and philosophical literatures aimed at critically assessing and expanding understandings of the role of conscience in medical care.

Providers' Ethical Objections to the NC Woman's Right to Know Act

Providers in our study often articulated the negative effects of the WRTK Act in organizational terms, noting that it generated additional duties and bureaucratic challenges that they had to address within an already hectic clinical practice. Yet most who felt deeply affected by the law also discussed its impact on patients and on the patient-provider relationship. Providers objected to the state-mandated counseling on the grounds that it: 1) held potential to cause women emotional harm; 2) appeared to question women's judgment and decision-making capacities; 3) undermined providers' efforts to provide individualized, patient-centered care; and 4) interfered with their ability to develop rapport with patients.

Many providers emphasized that the process of seeking an abortion is already emotionally draining. Some viewed the state-mandated counseling procedure as specifically designed to make women feel guilty, shamed, or judged. This potential to cause unnecessary emotional harm to women in a position of particular vulnerability was a central ethical objection to WRTK. Providers were especially concerned about the risk of emotional harm in cases of rape or fetal anomaly, for which some of the state-mandated content (e.g. the father's financial liability) seemed particularly inappropriate to mention.

Many providers were also critical of what they perceived as a legislative intent to interfere with women's abortion decisions. From the perspective of many providers, the language of the state-mandated counseling was biased to dissuade women from obtaining an abortion, which ran counter to their ideals of supportive, non-judgmental care. As one nurse put it, "I feel like there's a reason for laws governing all medical care…but there is a point when the law interferes with patient autonomy and can really deeply emotionally impact a patient."

A similar objection concerned the ways in which the WRTK counseling process undermined efforts to provide tailored, patient-centered care. Some providers argued that using a standardized counseling script that neglected the patient's circumstances directly contradicted their training to provide individualized counseling and informed consent. A physician explained: "A script that doesn't take into consideration individual circumstances misses the point. The whole idea [of abortion counseling] is to be woman-centered."

Finally, many providers suggested that the state-mandated counseling interfered with their capacity to build rapport with patients and gain their trust. In abortion care, where providers often meet patients for the first time when they come in for the procedure, the ability to foster rapport quickly holds particular moral salience. Providers perceived WRTK as generating an additional barrier to developing the patient-provider relationship in a context where providers could ill afford the extra time needed to develop intimacy and trust, especially once upended by harmful, state-mandated language.

Providers' ethical objections to the law were deeply shaped by the context of abortion care. Notably, while many providers upheld a general belief in a woman's right to choose, they did not express their objections to WRTK principally vis-à-vis personal values, but rather through the immediate needs of their patients and their ability to respond to them. Given that conscience claims have typically been couched as objections to core moral principles or morally contested practices as a whole, the objections expressed by providers in our study moved us to rethink traditional bioethical frameworks for conceptualizing conscience claims.

The relational approach to conscience that we develop here is informed by the ethics of care literature, which puts ethical primacy on caring for a person rather than caring for particular moral ends.[28] Current bioethics debates on conscience have largely privileged what Gilligan has called the justice perspective in moral development.[29] The justice perspective organizes self and other—the basic elements of moral judgment—around the principle of equality, in which people are conceived as detached, independent individuals with equal rights but separate interests that must be balanced in moral reasoning. Our findings evoke what Gilligan calls the care perspective, which organizes the relationship between self and other in terms of attachment rather than equality. In this view, the interests of self and other are not necessarily pitted against each other, but instead may be enmeshed.

From Moral Integrity to Conscientious Care

Through examining abortion providers' perspectives on the NC WRTK Act, we identified two overarching categories for ethical action among healthcare providers faced with moral conflicts raised by legal or institutional policy mandates: 1) *conscientious compliance* with the legal or policy mandate, or 2) *conscientious refusal* to comply with the legal or policy mandate. (See Table 1.) The latter term recognizes that providers may choose to violate laws or institutional policies, and that moral considerations may compel them to do so. In contrast, the designation *conscientious compliance* highlights that providers have strategies for minimizing moral distress while working within legal or policy constraints. Conscientious compliance, as we are defining it here, goes beyond simply following the

'letter of the law' to include strategic efforts to mitigate the threats that compliance with a law or policy poses to one's conscience.

We further subdivided conscientious compliance into additional ethical categories. First, providers may employ conscientious compliance by *acting within constraints*, through either procedural or relational strategies. *Procedural strategies* are undertaken to distance oneself from the law or policy in question, while *relational strategies* are undertaken to affiliate with the patient in the face of policy obstacles. Procedural strategies thus highlight one's orientation toward the law or policy in question, whereas relational strategies foreground one's orientation toward the patient in context of an objectionable procedure. Second, providers may work to *modify constraints* by working within legal boundaries to adapt objectionable procedures. Together, these possibilities comprise four distinct ethical strategies for healthcare providers faced with morally objectionable law or policy mandates: 1) *procedural strategies*, 2) *relational strategies*, 3) *modification strategies*, and 4) *non-compliance*.

Procedural Strategies

The first type of conscientious compliance we identified entails what we call *procedural strategies*. We use this broad category to refer to measures taken to adapt work processes and protocols to distance oneself from the law or institutional policy viewed as morally objectionable. This category of ethical action aligns with traditional understandings of conscience claims in healthcare as emanating from a desire to preserve one's moral integrity in the face of threats from institutional mandates. Procedural strategies include efforts to reduce the moral distress that a healthcare provider may experience when doing or saying something that contradicts personal beliefs or values. The primary purpose of such procedural strategies is for the provider to distinguish herself from the institutional authorities responsible for the law.

As Dr. Patterson described, and as we report in more detail elsewhere,[30] many providers in our study explicitly stated that the WRTK counseling was a state requirement that did not necessarily represent the provider's own judgments of medically-relevant information. When introducing the state-mandated counseling to patients, providers frequently differentiated it from the informed consent procedures they had already employed prior to the law as part of standard clinical practice. For example, one physician noted: "I explain to them very frankly this is not the way I would begin a clinical encounter but I'm required to go through these things." Such explanations communicated to patients that the script was legally mandated and that the provider was not personally responsible for its content. Similarly, inviting patients to listen or not, as they chose, distanced providers from the script's content and the intended outcomes of counseling. One physician explicitly linked such contextualization to her own moral integrity. Noting that she tended to editorialize the counseling script with her own views on its content, she explained, "That helps me in a way not feel as guilty for having to tell them something that I think is wrong. … I refuse to just read the consent and not tell them which part I think is true and which part isn't." Such comments highlight how healthcare providers may reconcile seemingly opposing desires: to act within the offending constraints and to act in accordance with conscience.

Relational Strategies

The second form of conscientious compliance we identified consists of *relational strategies*. This category refers to measures taken to affiliate with patients when laws or institutional policies threaten to drive a wedge in the patient-provider relationship, and encompasses efforts to gain patients' trust and attend to their emotional experience in the face of interactional challenges. In contrast to procedural strategies, in which the focus is on the provider's moral integrity, the primary purpose of relational strategies as articulated by the providers we interviewed was to mitigate the distress that a patient might experience as a result of laws or policies. These strategies thus hinge on a relational view of conscience claims in healthcare that places primacy on the patient's experience as a source of possible ethical tension.

Providers in our study recognized that validating patients' experiences could go a long way toward establishing rapport and warding off some of WRTK's potential negative effects. Providers frequently noted that when patients reacted negatively to the counseling procedure and the state-mandated content, responses such as "I understand," "I hear where you're coming from," or "I am with you" could allay patients' concerns and foster goodwill. One nurse explained that if women responded negatively when she began reading the counseling script, "We'll stop and say, 'What's going on? How does that make you feel?'" Another nurse said, "If women say to me, 'I've already made up my mind,' I say, you know, 'I understand.'" Several offered preemptive apologies to "soften the blow" of scripted content perceived to be inappropriate or potentially harmful.

Some of these strategies might overlap with the procedural strategies described above. For example, some providers in our study reported contextualizing the script with additional information about the counseling procedure to ameliorate a potentially negative response. One physician wrote in her clinic's counseling script that a first-trimester surgical abortion is similar to a dilation and curettage (D&C), a less stigmatized obstetrical procedure frequently performed as treatment for miscarriage. This strategy was designed to assuage patients' anxieties by normalizing the abortion procedure. Adapting the state-mandated content with "neutralizing" language (e.g. "the person who got you pregnant" instead of "father") similarly aimed to protect patients from potential harms.

Sharing one's personal stance on the law also helped some providers in our study affiliate with patients in opposition to the perceived intent of the law. Some achieved this by simply expressing a belief that the law was unfair. One physician noted that sharing her views on the law provided an opening for patients to express their own responses: "I think for the patient it denigrates it a little bit so that maybe they can also sneer at it. I'm sneering at it is basically what I'm doing. And I'm going to let them sneer at it, too."

Finally, to foster rapport, several physicians made it a point to perform the counseling themselves, although they were not legally mandated to do so. One physician explained, "I am willing to clean this place… I'm willing to talk to these people on the phone. And do all this twenty-four hour [WRTK counseling] stuff. I committed to that when I committed to do this." While standard bioethical arguments about respect for moral integrity might suggest that a provider abstain from a treatment or service that posed a conflict of conscience, this

physician offered a very different perspective—one in which the best way to maintain his conscience was to engage more directly in the morally problematic activity.

Ultimately, the assignment of counseling duties hinged on clinic workflows, staffing constraints, and other practice-level variables. Yet several physicians acknowledged that counseling patients themselves helped to establish trust with patients prior to the abortion and reassure them about any concerns. In this way, the state-mandated counseling occasionally offered the unanticipated benefit of another point of contact for supportive patient care. Such findings challenge the stark dichotomy between conscientious refusal and morally compromised care.

Modification Strategies

In addition to working within the constraints of the law, providers described efforts to modify legal or policy constraints that provoke ethical challenges through active engagement in legal or policy arenas. *Modification strategies* refer to providers' attempts to adapt laws or policies so that they may act in line with their conscience while still following the law. Modification strategies constitute conscientious compliance because they enable providers to work within established legal boundaries; in other words, they do not require providers to resort to illegal action to redress affronts to conscience.

Physicians commonly testify as expert witnesses on behalf of, and in opposition to, proposed abortion laws. Even after a law is passed and implemented, however, there are often opportunities for active intervention. One physician described how he had offered critical feedback on an early draft of the informational pamphlet about pregnancy and gestational development that the state produced in accordance with the Woman's Right to Know Act's stipulations for patient education. He had objected to the pamphlet's use of biased language and what he perceived as an inaccurate portrayal of the relative risks of abortion and pregnancy. After sharing his views with state authorities, he was invited to help revise the document. Recalling this experience, he said: "[When] I see something misinforming and misleading my patients, I'm ethically obliged as a clinician to say, 'Wait a minute, that's not the way it is.'"

Seeking legal action represents another strategy, albeit an extreme one, for modifying legal constraints. Several North Carolina abortion providers were plaintiffs in a lawsuit against the state following the implementation of the Woman's Right to Know Act, which resulted in the ultrasound measures being enjoined, and ultimately, overturned. Taken together, these approaches illustrate that providers may work to modify ethical concerns while acting within the constraints of legal boundaries. Rather than refusing to obey a law due to a claim of conscience, they are better able to provide conscientious care as a result of their own legal engagement outside of the clinic setting.

Non-Compliance

The last possible possibility for responding to legal mandates that raise moral conflicts is to ignore policy constraints and *not comply with the law*. As one physician put it, "I think if we have anything to learn from Mahatma Gandhi and Martin Luther King, it is that we as responsible citizens have an ethical obligation to not comply with unjust laws." No providers

in our study reported following this approach, noting that the stakes were too high because they could lose their medical license or risk institutional censure. One physician stated that he had occasionally forgotten to sign the form documenting that he had performed the state-mandated counseling, and wondered whether this might constitute a form of passive non-compliance.

However, when reflecting on how they might respond if the enjoinment of the ultrasound measures were lifted—thus requiring them to perform an ultrasound and display and describe the images prior to abortion, even on women who refuse—several providers indirectly raised the possibility of active non-compliance. One physician and clinic owner had interpreted the ultrasound provisions as offering a space for informed refusal. Because the legislative text specifically stated that women might choose *not* to receive the information offered—"nothing in this section shall be construed to prevent a pregnant woman from averting her eyes from the ultrasound images required to be provided to and reviewed with her"[31]—he had interpreted the law liberally as permitting women to opt out of the ultrasound altogether. Another physician relayed that despite being a self-professed "rule follower" who told his children "the law is the law," he would have a very difficult time enforcing the ultrasound requirement and was not sure what he would do. Although these possible forms of non-compliance were only hypothetical, they highlight the ways in which the ethical course of action may elide the legal course of action.

Reframing Refusal

The bioethics dialogue on conscience has tended to focus on the moral contours of refusal, seeking to define when providers may reasonably refuse and when there are limits to refusal. The presumption underlying such discussions is that if a healthcare provider does *not* refuse, she will violate her moral integrity. The conceptual framework we propose here articulates an ethical middle ground that challenges this stark dichotomy, illustrating instead how providers may align their care with conscience despite legal and ethical challenges. By exploring the conscientious provision of care, our framework accommodates a broader understanding of conscience claims in healthcare. Seen from this perspective, conscience is not only something that operates negatively—that is, to keep one from doing something—but is also a positive, productive force in ethical medical practice.

In a recent article in this journal, Davis and Kodish argued that physicians should challenge laws that undermine their capacity to provide good medical care, and that they may be morally justified in breaking the law on some occasions.[32] In thinking about how medical providers ought to respond to laws that are unjust, there has been some attention devoted to the concepts of evasive noncompliance[33] or conscientious evasion[34]—that is, covert action undertaken, for moral reasons, in violation of a law. Conscientious evasion may make sense under certain circumstances: for example, healthcare providers may be justified in declining to report women for drug use during pregnancy when legally required to do so.[35] In the abortion domain, however, noncompliance appears to account for a small proportion of provider responses to ostensibly unjust laws. While it is possible that abortion providers adopt strategies of evasive noncompliance more frequently than reported in our study, we

believe that this is unlikely, given that the heightened level of regulatory scrutiny that these providers routinely face encourages strict compliance with laws.

Our conceptual framework provides alternatives to evasive non-compliance by describing several additional strategies adopted by abortion providers in their clinical practice to act conscientiously within legal constraints. Procedural strategies undertaken by providers in our study to distance themselves from the law give empirical weight to Davis and Kodish's speculations about "undignified scenes of exaggerated winks and nods or perhaps of the physician reading the required 'information' while shaking her head in a violent negative."[36] Likewise, the relational strategies we identified are particularly fitting for abortion care, which has a long history of providing supportive, non-judgmental counseling designed to make women feel welcome and safe.[37]

Our framework reflects more than a middle ground between conscientious refusal and morally compromised action, however. To the extent that it encompasses, but also stretches beyond, a purely individualist orientation to conscience, our framework also offers a new perspective on debates about conscience that have turned on notions of moral integrity. By illustrating how relational concerns may compel abortion providers to participate in laws or policies that they might otherwise deem to be morally objectionable, we complicate prevailing ways of thinking about the relationship between conscience and the provision of medical treatment. In doing so, we delineate how a relational understanding of conscience may reframe the dominant moral questions about the limits of refusal, inviting new questions about conscience and the ethics of care.

Abortion is the most frequent target of attempts to legislate patient-provider interactions, but our framework has potential relevance to other medical arenas as well. For example, our framework may offer guidance to pediatricians facing prohibitions on asking parents about the possession of firearms in the home.[38] In addition to evasive noncompliance with such laws, providers might follow the procedural strategy of giving gun safety information to all families without asking about the presence guns in the home. Such information could be prefaced with an explanation of the legal prohibition on asking about guns. Our framework may also be relevant to debates about physician aid-in-dying. We can imagine that relational strategies, in particular, could be useful to willing providers for whom such aid is legally sanctioned but institutionally proscribed, as well as to providers who do not want to participate in assisted deaths, but do not want to abandon patients, either.[39]

We recognize that the cultural politics of abortion in the United States create unique ethical and legal challenges for providers working in this domain. Yet insofar as abortion providers may serve as what anthropologist Rayna Rapp has called "moral pioneers,"[40] charting an ethical pathway forward when faced with new clinical terrain, the ethical strategies they employ in their everyday work may have practical relevance beyond their particular field. As such, we have much to gain from listening to their voices and the moral wisdom they have to share.

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Table 1

Conceptual Framework

	Ethical Possibilities	Strategy	Examples
Conscientious Compliance with Legal/Policy Mandate	Act within constraints	*Procedural strategies*: Distance oneself from the law/policy while following mandated yet objectionable procedures.	• Explain the role of the state • Distinguish from routine clinical procedures • Insert disclaimers • Invite patients not to listen
		Relational strategies: Affiliate with the patient while following mandated yet objectionable procedures.	• Affirm patient's emotional experience • Use neutral, non-judgmental language • Share personal moral stance on the law/policy • Perform the counseling oneself
	Modify constraints	*Modification strategies:* Work within established legal/policy boundaries to adapt objectionable procedures.	• Rewrite WRTK booklet • Consider legal actions
Conscientious Refusal to Comply with Legal/Policy Mandate	Don't act within constraints	*Non-compliance*: Do not follow mandated yet objectionable procedures.	• Passive non-compliance (e.g. forget to sign forms) • Active non-compliance (intentionally violate law)