# STRENGTHENING ABORTION REFERRALS:

## Best Practices, Competencies, and Recommendations for Training Health and Social Service Professionals

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## INTRODUCTION

### Background and Purpose

In 2011, *Provide* commissioned a report on fostering abortion referrals in health care and social service settings (Janiak 2011). This report consisted of both a review of the literature on abortion referral practices and a synthesis of findings from informants who work with *Provide* in least-access states. The author concludes that abortion referral behavior among health care and social service professional is often inadequate and that strengthening such referral behavior is critical factor in improving access to abortion in states where such access is constrained.

A recent report by Dodge et al (2012) supports this conclusion. These authors carried out a simulated patient study to test referring behavior among frontline staff at reproductive health care facilities located reasonably close to abortion providers. The authors found that even after prompting staff members for a referral, less than half (45.8%) of calls resulted in a direct referral (name or telephone number of a facility that provided abortion services); another 19.0% resulted in indirect referral (suggesting Planned Parenthood without additional details); 8.5% led to an inappropriate referral (to a facility that did not provide abortion); and 26.8% offered no referral. The authors report that "Facilities in the least restrictive states were significantly more likely to provide unprompted direct referrals . . . and significantly less likely to provide no referral than facilities in most restrictive states though these differences disappeared after prompting the staff member to provide a referral" (246).[1]

In addition to her review, Janiak generated a conceptual model of Factors Influencing Referral Behavior (for abortion). *Provide* further generated a "Barriers to Referral-Making" matrix that reframes these factors as six key barriers to referral-provision. This matrix also highlights training tools and possible resources for building competency for overcoming each barrier. To help develop this matrix into a training curriculum, the present review was undertaken, with the following aims:

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[1] The facilities called were in eleven states, five of which were determined to be the most restrictive and six determined to be the least restrictive; the authors describe the rubric by which they scored restrictiveness but do not identify the states included in the study.

- Survey existing curricula, competencies, evidence, and best practices regarding pregnancy options counseling and referrals practices;
- Develop recommendations regarding implementation of these practices in relevant settings;
- Propose curriculum content and learning modalities for a 1-3 module curriculum on abortion referral.

## Organization of the Report

The report is in two parts. The first part draws from field experience, peer-reviewed research, and professional norm-setting entities for guidance on best practices for abortion referral, including options counseling. This section ends by translating these findings into a list of the competencies required for achieving best practices.

The second part of the report moves toward thinking about training health care and social service professionals to make appropriate referrals. While it keeps in mind the overall list of competencies, it is organized around the six barriers to referral-making identified in the *Provide* matrix. Because these barriers place some emphasis on beliefs (and because addressing beliefs in a training program is a complex challenge), this section begins with a discussion of values clarification and cognitive dissonance theories that can inform learning modalities.

The report then suggests an overview of learning objectives and content for each barrier. Much of the content draws from existing curricular materials but it is supplemented based on other findings and insights presented here or in earlier sections. In addition, each competency and set of specific learning objectives is followed by a series of "Content Notes" with comments related to teaching methods or other further detail.

## I. BEST PRACTICES IN ABORTION REFERRAL (including options counseling)

## Methods

Examples of peer-reviewed, programmatic, and professional guidelines related to options counseling and abortion referral were reviewed. The peer-reviewed literature search was accessed primarily through Medline/PubMed, Google Scholar, and cited references in extant literature. Programmatic materials (including PowerPoints, manuals, handouts, videos, etc.) were accessed either directly or through the websites of various organizations, including: *Provide* and its state team members; Cardea Services;[2] International Planned Parenthood Federation/Western Hemisphere Region; Ipas; National Abortion Federation; Planned Parenthood Federation of America; Abortion Care Network; and Hope Clinic for Women. Professional guidelines were drawn from professional associations for nurses and physicians and from individual authors published in book or peer-reviewed literature.[3] Several interviews were also held to supplement available information.

## Findings

*Options counseling competencies*

There is an absence of rigorous evaluation research on abortion counseling. O'Reilly (2009, 598) conducted an extensive literature search that "provided no research studies. Simmonds and Likis (2005, 379) document this dearth of evidence, summing up an article reviewing steps to facilitate options counseling by writing, "Research is sorely needed to identify the most effective approaches for providing quality care to women with unintended pregnancies."[4]

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[2]  Cardea Services is funded by the Department of Health and Human Services Office of Population Affairs under Section 1003 of the Title X Public Health Service Act to provide training for personnel working in family planning services projects described under Section 1001. The purpose of this training is to promote and improve the delivery of family planning services. Cardea also receives funds from the DHHS Health Resources and Services Administration; CDC/Division of STD Prevention; and DHHS Substance Abuse and Mental Health Services Administration; and from state departments of health, social services and criminal justice, as well as and private foundations.

[3]  An interview with Planned Parenthood Federation of America is still pending.

[4]  A search generated only two "reports," neither of which is reliable. The first is a dated study King (1975) in which students favorably rated the impact on their lives of a call made to a college-based telephone counseling center. However, pregnancy was only one of the issues that callers presented. This study is mentioned in part because Planned Parenthood Federation of America is shifting toward internet-based hotline counseling. The second "report," identified via Google, not Google Scholar, was a web page of Compass Care, an anti-abortion site. This site claimed that the use of a pregnancy counseling "optimization tool" had increased visits to a

Nevertheless, there is an ample literature describing in varying detail (and style) the competencies required for options counseling. In the four decades since *Roe v. Wade*, a steady flow of peer-reviewed articles and books have advocated, and provided concrete guidance that explicitly or implicitly identify a general set of competencies (Canfield 1974; and Cowan 1982; Landy 1986; Stephenson 1989; Baker 1995; Surman 2001; Moos 2003; Simmonds and Likis 2005; O'Reilly 2009; Singer 2010; Perrucci 2012).[5] Based on sound counseling theory and professional norms, these can be summarized as (1) possessing knowledge about all options (terminating the pregnancy, continuing the pregnancy with the intent of parenting, and continuing the pregnancy with the intent of placing the baby for adoption) and where to refer clients; (2) nonjudgmental, respectful, and empathetic attitudes toward clients and their choices; and (3) skill in counseling clients about all options and in helping those who are dealing with difficult feelings or ambivalence move toward satisfactory resolution.

While there is general consensus about these competencies, some variation exists. For example, not all programs address what a counselor needs to know about how the wider social context (gender inequality, poverty, rural residence, etc.) may affect sexual and reproductive behavior and choices.[6] Similarly, programs frame the options in different ways: A number of materials present adoption first – whether this is out of political cautiousness or a nod to alphabetical order (where abortion is under T for termination) is unclear. No studies emerged in this review about possible negative effects on clients who are wanting to parent

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"pregnancy resource center" and led to a reduction in the abortion rate. The report was presented in quasi-scientific visual format, with an "abstract" as follows: *"The OT has significantly increased the number of abortion minded women coming to our Center for services. The OT has also given us an effective tool to measure performance metrics which have allowed us to see how well we are reaching our target market. . . Because of a dramatic increase in the effectiveness of AAA Center for Pregnancy Counseling, Omaha went from Abortion-Hub status in 2005 to Non-Abortion-Hub status in 2010. In just 5 years the abortion rate dropped from 16% to 10%."* Not surprisingly, the report included no discussion of methods and no details to back up this finding. Also of note is that the fourth non-paid link generated by a Google search for 'options counseling for pregnancy' is to a an site called contracept.org; this is an anti-abortion site with content framed as a 'balanced perspective' comparing Planned Parenthood and Pregnancy Crisis centers. See <www.contracept.org/options-counseling.php>.

[5] The same principles have been adapted in handbooks and tools for clients. See for example Johnston (2009).

[6] Dehlendorf and Weitz (2011) describe the ways that abortion care for low-income women and women of color is impeded. These authors highlight lack of financial support, including the travel and time costs associated with mandatory waiting periods (especially for women with no nearby abortion provider, These barriers operate on top of reduced access to contraceptive services among women in marginalized communities, thus increasing these women's vulnerability to unintended pregnancy and their need for abortion access.

or to terminate a pregnancy of having a counselor suggest they may wish to consider carrying the pregnancy and placing the baby for adoption; however, a separate comprehensive search of this topic was not conducted.

*Abortion counseling*

Given the increasing stigmatization of abortion, a number of authors have revisited the model of abortion counseling. Joffe (2012) describes the Head and Heart counseling model that seeks to give voice to—and thereby help resolve—women's internalized conflicts. This model is built on recognition that some women find their abortion experience deeply troubling; it also responds to the reality that some women have become anti-abortion activists after a regretted abortion (Freedman and Weitz 2012). In a similar vein, Upadhyay et al (2010) report on a literature review to identify evidence-based, patient-oriented counseling approaches used for providing emotional care to individuals for other stigmatized or sensitive issues, such as HIV. Using a grounded theory approach to code their findings, the authors identify nine models that may be useful for counseling abortion clients: Two help establish a supportive client–provider relationship (self-awareness assessments and peer counseling). Three assist with decision-making (decision aids, encouraging active client participation, and supporting decision satisfaction). Three offer supplemental sources of support (support groups, internet-based support, and ongoing telephone counseling). Finally, two address stigma (addressing stigma and public artistic expressions).

Another outcome of the highly charged political climate for abortion is a certain rigidity about addressing all options that appears in some training materials. In some cases, these approaches blur the line between offering pregnant women *the opportunity to be provided* with information about all three options, and just going and *providing* that information, whether or not it is desired.[7]  Although official regulations (i.e., Title X) do not require such judgmental approaches (which appear to meet the needs not of the woman but rather of the anti-abortion movement), institutional mandates may be otherwise. The result is that the "all-options" model can become a tyranny. A woman who is happy about being pregnancy and is asking for an OB may have to listen to a counselor tell her that she might want to consider

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[7]  For example, see video on the US DDHS Office of Population Affairs Family Planning National Training Centers. http://www.fpntc.org/training-and-resources/exploring-all-options-pregnancy-counseling-without-bias

placing her baby for adoption or terminate the pregnancy. Similarly, a woman asking for an abortion referral may be asked to discuss prenatal care and adoption. Best practices suggest that a provider follow a client's lead about what she wishes to discuss.

*Abortion Referral*

In fact, the evidence that not all women want or need "counseling" suggests that providers need to understand the circumstances under which such counseling is indicated and assess the needs of individual clients for such counseling. For example, in a retrospective study, Littman et al (2012a) interviewed women presenting for a post-abortion follow-up visit about whether they would have wanted various abortion-related information and counseling services. Fully 42 percent responded negatively to "talking to someone (like a social worker) after deciding to have the abortion." In contrast, 100% stated that they preferred "a list of websites with good, reliable information about abortion." This finding echoes the report by Foster et al (2012) that close to 90% of abortion patients reported high confidence in their decision before receiving counseling.[8]  While counseling at an earlier stage may have helped some of these women move toward that confidence, it points to the need for a professional at any stage of testing, referral, and service provision to first assess whether a client appears to have made a decision and whether she wants further help in coming to terms with, or reconsidering, her decision—or if she mostly needs nonjudgmental and accurate information, and useful referrals.

The competence of the referral provider has become particularly important for several reasons. First, as noted earlier, many women do a home pregnancy test and then seek referral information from a wide range of sources, including so-called 'pregnancy crisis centers.' Second, referral providers have a critical role to play in helping clear up common misconceptions about the legality and safety of abortion. For example, many women, even those who choose abortion, have internalized misconceptions about the risk of cancer, depression, obstetric problems, and infertility stemming from abortion; among abortion clients, these misperceptions seem to be greatest among those who consider themselves anti-

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[8]  Those with less confidence about their decision tended to be younger than 20, less educated, African-American, to have a fetus with an anomaly, a history of depression, general difficulty making decisions, and/or spiritual concerns about abortion. Having a supportive mother or male partner was associated with high confidence.

choice (Littman et al 2012b; Wiebe and Littman 2012).    Grossman et al (2010) found that among women who had self-induced abortion, some reported that their decision had been influenced by unrealistic fears about uterine perforation and mistaken beliefs that general anesthesia was required. Referral-making competence is also urgent because of the consequences to women whose access to abortion is delayed (Taylor and James 2011; Foster et al 2013).

However, because abortion referral-making has traditionally been embedded as a minor element within full-options counseling, the competencies for abortion referral have been less developed. The conceptual model that Janiak (2012) presents indirectly identifies the most salient competencies; slightly reorganized, these are:
- o   Knowledge about all options
- o   Knowledge about where clients can get quality abortion care;
- o   Adherence to the belief that abortion referral is proper and that it is called for by professional norms;
- o   Awareness of barriers clients face and what is needed to overcome these barriers;
- o   Skill in nonjudgmental counseling; and
- o   Skill in carrying out a full spectrum of referral behaviors.

Another way to consider abortion referral competencies is in terms of the behaviors manifested by the competencies, that is, what is actually involved in the abortion referral process. Janiak identifies these as the end-point of her conceptual model, as "behaviors along a spectrum of referral behaviors."    These include:
1. Provision of information
2. Assistance in scheduling services
3. Assistance in accessing supportive services (transportation, childcare, abortion funding or insurance)
4. Follow-up on service utilization and outcomes
5. Assessment of patient satisfaction with referral
6. Evaluation of referral quality and continual updating and improvement of referral resources.

Simmonds and Likis (2009), within an article with a wider lens, include an entire very strong section on "Referral and Care Coordination," in which they articulate both the rationale for active, thorough referral and provide concrete guidance and information to enable such referral-making behavior. They recommend checking that a woman is able to act on information she has received and working with her to establish a plan and timeframe for implementing that plan, and then following through as needed. Describing going from a passive to an active caring role, they identify components of the referral behavior spectrum similar to those identified by Janiak, as appropriate:

1. Making follow-up appointments or phone calls
2. Arranging transportation or child care
3. Securing legal counsel, as in the case of a minor seeking judicial bypass
4. Provide advice about financing an abortion, whether by gathering resources or applying for health care coverage. [Citing Title X, p. 4128, they note that providers in Title X-funded sites cannot "take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient unless the abortion is medically indicated" (802-803).].
5. Verifying if the woman was able to successfully carry out her plan and the degree of her satisfaction with care received, as well as any ongoing follow-up needs.[9]

These authors add that women with multiple or complex social and/or medical circumstances may have further needs. They also highlight the risk that clients may seek referrals from pregnancy crisis centers.

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[9] The authors note: "This strategy has the potential not only to improve the referral process and thereby close gaps in care that lead to untoward delays, but also promote continuity of care that may contribute to greater patient satisfaction and success in efforts to prevent future unintended pregnancies. Evidence that nurses' engagement in this type of active referral and care coordination improves outcomes among women with unintended pregnancy is lacking but should be a research priority.

*Professional norms relevant to abortion referral[10]*

Health providers receive guidance about their responsibilities in several ways, including during their pre-service and continuing education training, from the official statements issued by their professional organizations, and from the peer-reviewed literature. This review did not include a search of professional training, however, two items are noted: First is the content analysis of nursing textbooks commissioned by *Provide* (Capiello, undated); the author found wide variation among texts, with inadequate or even inaccurate treatment of the subject in many texts. With regard to continuing education, is noted that in 2012, UCLA began convening annual National Nursing Ethics Conference on the "Ethics of Caring." (The Second National Nursing Ethics Conference is March 21-22, 2013.) Sexual and reproductive health issues do not appear on either program brochure agenda.

Another important source of norms for professionals is ethics statements from the professional associations. For example, associations representing nurses, physicians, social workers, and community health workers issue codes of ethics and/or formal Committee Opinions. Most notably, these official statements seek to balance principles of patients' rights —to information and to autonomy—with providers' right to honor their own personal ethical code. A review of professional codes of ethics suggests overall support for the responsibility to refer for abortion but the guidance is not always as explicit as one might like. (The language in more explicit in physician committee opinions.)[11] The Appendix includes excerpts from these documents that bear upon the obligation to (counsel and) refer for abortion.

Further research with professional associations might help inform a training program for these providers. It would be useful to secure more *explicit written clarification* from the American Nursing Association that nurses must provide abortion referral information, in a manner that is respectful, accurate, timely, and nonjudgmental. In addition, it would be helpful to produce case studies where health professionals have intervened to address inadequate referral for abortion, if such examples can be identified via informal research.

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[10] There is an enormous literature on professional responsibilities and conscientious objection with regard to abortion; the present discussion is limited to abortion referral, with an emphasis on nursing norms.

[11] The issue of providers' bias and paternalism of course applies not only to abortion but to other aspects of options counseling and referrals, for example, if a provider does not believe a certain patient should have a(nother) child.

## COMPETENCIES FOR ABORTION REFERRAL

The following expanded set of cognitive, affective, and skill-based competencies for abortion referral. As the need for fuller reproductive health counseling may arise for some referral-makers, the following list includes some competencies (especially knowledge) related to other important sexual and reproductive health issues.

### Cognitive Competencies: Accurate up-to-date knowledge

For serving all clients, this includes knowledge about:
- o Professional norms and other regulations regarding responsibilities to provide information and respect clients' autonomy
- o How poverty and marginalization affect access to information and services
- o Factors leading to unprotected sex and unintended pregnancy; how intimate partner violence interacts with sexual and reproductive health[12]
- o Local agencies providing financial assistance, including for the costs of abortion
- o Local agencies providing nonjudgmental services related to violence, drug abuse, Medicaid, mental health, and legal services
- o Familiarity with referral systems and workplace referral procedures

Specifically for abortion referral, this includes knowledge about:
- o Women's general preferences for referral information alone vs. counseling
- o Medical and surgical abortion options, including gestational limits for each
- o Information about the use and potential risks of self-induction, including with misoprostol.
- o Medical providers (including contact information, prices, location, etc.) for competent, nonjudgmental local health providers
- o Prevalence of abortion
- o Factors influencing, and consequences of, delayed access to abortion
- o Widely disseminated misinformation about abortion safety, and consequences of misinformation for women[13]
- o The presence and practices of anti-abortion centers that may manipulate clients and provide misinformation; and examples of official actions to document, censure, and eliminate unethical practices by such centers.

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[12] Some curricula also include familiarity with sexuality. Because this is a complex topic that may be beyond the scope of brief training programs, the issue is addressed more briefly under affective competencies.
[13] This information is sometimes presented as "Myths about abortion" or "Safety of abortion." The latter framing avoids a defensive responsiveness but does not cast misinformation campaigns for what they are. Drawing from Littman et al (2012) and Wiebe and Littman (2012), the language above was chosen to establish a negative association with misinformation.

- Levels of public support for, abortion access in different relevant communities (ethnic, religious, national, etc.) and by respected leaders
- .Federal and state laws on abortion and how these laws affect prevalence and safety
- Options available to women who are undecided or ambivalent about their choice and who ask for services (e.g., additional resources on options, support, and post-decision counseling) exceeding a provider's expertise.

Specifically for referral for continuing a pregnancy, information including:[14]
- Medical providers (including contact information, prices, location, etc.) for competent, nonjudgmental local providers of prenatal care, fertility awareness education and infertility care, contraceptive services, and STI testing/treatment
- Social service providers (e.g., for different types of adoption if desired, Medicaid, etc.)
- Health behaviors for early prenatal health (e.g., substance abuse, vitamins, nutrition)
- Options available to women who are undecided or ambivalent about their choice

For women who wish a referral for help becoming pregnant, contraception, or STI services:[15]
- Updated information about health providers (including contact information, prices, location, etc.) for competent, nonjudgmental local providers of prenatal care, fertility awareness

## Affective Competencies: Attitudes

For serving all clients:
- Empathy for women facing difficulties in exercising their autonomy (in relationships, in health care access, etc.)
- Empathy for women facing unintended pregnancy, failure to conceive a desired pregnancy, or difficult feelings related to their sexual or reproductive health and lives
- Respect for clients' autonomy
- Awareness of one's own values and beliefs and the need to avoid having them influence client interactions
- Understanding that it is unethical for anti-abortion centers to manipulate clients and misinform them about abortion
- Recognize that abortion is part of reproductive health care[16]
- Respect for clients whose belief, identity, and/or sexual practices vary from their own

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[14] Because there is significant information that a competent referral-maker needs for other pregnancy options (and for referring women who have a negative pregnancy test – see next set of knowledge competencies), a separate category is included here for women continuing a pregnancy. How options are broken down and presented in a training would depend on the context.

[15] This category is added in part to remind referral-providers that women may have these related needs; including help for becoming pregnant can also reduce defensiveness among some referral-providers.

[16] Levi et al (2009) and Taylor and James (2011) argue for a public health framing that normalizes abortion as part of reproductive health care.

- Comfort discussing sexuality

For abortion referral
- Open to internalizing new information about abortion
- Appreciates shared values with abortion clients and referral-makers
- Openness to building relationships with providers
- Comfort referring for abortion
- Commitment to refer for abortion, regardless of the workplace environment
- Where feasible, willingness to report behavior that violates professional norms and patient rights

## Skill-Based Competencies

For serving all clients:
- General referral procedures
- How to build or strengthen a referral system
- How to ask if a client wants additional information or counseling
- Screening for individuals at risk of interpersonal violence
- Use of nonjudgmental counseling techniques[17]

For abortion referral
- How to complete all the steps in an active abortion referral[18]
- Effective counseling approaches for avoiding unintended pregnancy
- How to create a more supportive environment at one's workplace
- How to cope with, and address, stigma among one's peers

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[17] This item could be elaborated in further detail, but given that *Provide* staff are already keenly aware of the nature and importance of this competency, and because the emphasis here on referral-making, the reference to counseling skills is presented here in summary form.

[18] This item can be elaborated to reflect either the Janiak model or the similar Simmonds and Likis model, or a synthesis of the two.

## LEARNING MODALITIES: THEORETICAL CONSIDERATIONS FOR ADDRESSING VALUES AND BELIEFS

While existing curricula include many activities to help learners explore their beliefs related to abortion, as noted, there is an absence of evidence about which training modalities are most effective. Hence, this section backs up to examine two theoretical frameworks—cognitive dissonance theory and of values clarification theory— that can help guide a review of existing materials and recommendations for training objectives, content, and modalities.

The overall recommendations from both the Janiak report and the emphasis in the Barriers to Referral-Making matrix emphasize the role of values clarification exercises in training providers. Additionally, four of the five respondents to the questionnaire sent out to members of the *Provide* state-based network identified the need to engage participants in reflection about their attitudes, specifically about professional norms, abortion, and wider social attitudes (e.g., about poverty, race, or gender) that may affect their counseling and referral behavior.[19]  Several of them added relevant comments:

> *Values clarification has been useful in helping providers differentiate personal religious beliefs from their professional obligation to provide the best care to patients.*
> *We have heard from several participants that the trainings have pushed them to evaluate their own personal values and biases, and to be aware of them to not push them upon their clients . . .*

Moreoever, Janiak's informants agree that while improving referral systems may affect access for a small number of women, the training process and follow-up can reduce stigma among providers more widely.   One informant highlighted another attitudinal issue: "general paternalism," i.e., providers' assuming they know what is best for a patient (2011, p26).   Finally, Janiak (p30) adds that values clarification can benefit providers as well, increasing their "comfort in coping with patients' emotions associated with unintended pregnancy." All of this input argues for an emphasis on addressing values and beliefs training.

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[19]  A caveat: Janiak comments, "Most informants did *not* cite potential referring providers' own bias against abortion as a major barrier to referral provision" [italics added]. She qualifies this finding by commenting her informants may avoid contacting providers perceived to be staunchly anti-abortion.

A brief note on terminology: *Beliefs* are generally defined as what one holds (accurately or not) to be true, whereas *values* are principles or qualities one deems intrinsically desirable.[20] Turner and Page (2008) describe values as " . . . closely related to and affected by our beliefs, ideals and knowledge, and they can affect our attitudes and behaviors." The literature on social and political attitudes often examines beliefs and values together.[21] In the same vein, many of the options-counseling training resources in this review refer somewhat interchangeably to values and beliefs (and often, to attitudes). What is important for this review is that values clarification exercises – as well as other learning activities – may be designed to change both what learners hold to be *true* and what they hold to be *dear*.[22]

## Values Clarification

Values clarification draws on social psychologist Louis Raths (himself influenced by educational theorist John Dewey); Raths theorized the process by which we value, how we come to our beliefs and establish our behaviors. Raths' model of value-making involves: 1) "prizing" certain beliefs and behaviors (at times publicly); freely "choosing" our beliefs and behaviors (considering alternatives and consequences); and "acting" on our beliefs, with some consistent pattern. As such our values involve cognitive, affective, and behavioral dimensions.

Kinnier (1995, p19) describes values clarification theory as holding that "[T]he individual who is confused or unclear about his or her values will tend to behave in immature, overconforming, or overdissenting ways. In contrast, the clarified person is likely to exhibit many of the characteristics of Maslow's self-actualized person, such as behaving in a calmly confident and purposive way."

Values clarification theory was an extremely popular subject in social psychology in the

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[20] Ipas also cites leading social psychologists in defining values: Schwartz et al (1987): ". . concepts or beliefs about desirable end states or behaviors that transcend specific situations, guide selection or evaluation of behavior and events and are ordered by relative importance; Rokeach (1973): ". . .enduring beliefs that a specific mode of conduct is personally or socially preferable to an opposite or converse mode of conduct"; and Allport (1961): " . . . the dominating force in life because of the central role they play in directing a person's activity and influencing their perception of reality" (in Turner and Page 2010, 2).

[21] See for example: Stanley Feldman (2007).

[22] This interrelationship between values and beliefs is also evident in *Provide*'s documents. For example, Janiak's analytic review of the literature and of informant interviews refers throughout to *values*, while her conceptual model identifies *beliefs* (about the acceptability of abortion and the propriety of referral provision) as drivers of intention to refer. In the same vein, the Barriers to Referral-Making matrix identifies certain beliefs and attitudes as *barriers*, to be addressed by sessions that clarify *values*.

1970s; however, by the 1980s, it had fallen out of favor as a topic of scholarly attention. Kinnier attributes this fall to four factors: religious conservatism (opposition to moral relativism); political conservatism (opposition to critical thinking); the parallel decline of humanistic psychology and the rise of decision-making and problem-solving theories; and lack of rigor and definition. He defends for the potential of values clarification but draws on studies to argue that it should not address a general value in the abstract but should identify and resolve specific perceived values conflicts, one at a time.[23] This line of argument seems to support the practice of addressing abortion-related conflicts in context-specific ways, as is often the case with case scenarios activities.

The ambition of values clarification has also been subject to debate in the options counseling training field. Most options counseling training seeks to help providers *identify* their values so as to keep those values in check, *modifying their behavior* from judgmental to non-judgmental approaches. They do not aim, at least not explicitly, to change providers' values or beliefs about abortion and abortion referral.

For example, the Abortion Access Project Full Options PowerPoint identifies the objectives of values clarification as to "understand your own thoughts and feelings; identify any biases you may have; and learn how to keep those biases to yourself during a counseling session. In the same vein, the Reproductive Options Education (ROE) Consortium PowerPoint slide on attitudes identifies the need to "inform and educate self on providing care in a sensitive, respectful manner, acknowledging the need for privacy and confidentiality; and using language that is sensitive and respectful." Similarly, the National Abortion Federation's (NAF) values clarification guide (a workbook for health professionals) seeks to enable such providers to "examine [their] beliefs about abortion so that [they] may be better able to care for women considering this option" (NAF 2005, i). The National Latina Initiative for Reproductive Health goes a bit further: After explaining the purpose of a values clarification exercise as "to give us each a chance to recognize and reflect on those biases. By being aware of them we can leave them out of options counseling so we can give women the very best help for her to make her

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[23] This argument resonates with Carol Gilligan's theory of moral development, which holds that women tend to make moral decisions in context. See Gilligan (1982).

own decision," it adds, "Also, this exercise helps us explore our own feelings around these issues, which we often don't do in our work" (NLIRH 2009 p4).   A number of activities from these resources are revisited in subsequent sections of this paper.

In contrast, Ipas actively sought a more ambitious conceptual model, one that explicitly seeks to "help participants discover or potentially <u>transform</u> their attitudes on abortion. To build this model, Ipas conducted an exhaustive review of the values clarification and attitude transformation literature, of existing values clarification materials, and available evaluation reports. (The peer-reviewed literature was found lacking and outdated.) In addition, they carried out a critical review of theory and constructs related to values, attitudes, norms, beliefs, behavioral intention and behavior change. In addition to drawing on theories of values and values clarification of social psychologists Louis Raths and Milton Rokeach (value-making as prizing, choosing, acting), Ipas also incorporated Icek Ajzen's Theory of Planned Behavior.

The Ipas model posits that values clarification – discovering our "values through honest, open-minded self-examination . . . of one's basic values and moral reasoning" – leads logically to attitude transformation. For this to happen, the authors clarify that the learner must have motivation for change, which then allows the learner to pass through the follow cognitive processes:

- gain new knowledge;
- deepen understanding of existing or new knowledge;
- experience empathy for people affected by or who provide abortion;
- acknowledge current values on abortion;
- examine alternative values;
- recognize barriers to change; and
- remain open to change.

The authors argue:

"Unlike the traditional approach to values clarification, which does not posit any universal set of preferred values, the Ipas values clarification and attitude transformation process and toolkit were designed with an agenda: to move participants toward support, acceptance and advocacy for comprehensive abortion care and related sexual and reproductive health care and rights. The abortion approach recognizes that values affecting attitudes and beliefs

about abortion and related issues can change over time in response to new experiences and a deeper understanding of the issues and context . . ." (p3).

The result of this process is *Abortion attitude transformation: A values clarification toolkit for global audiences* (Turner and Page 2008). In addition to reviewing the theoretical underpinning and development process that informed the toolkit, this 186-page resource contains thirteen values clarification activities focused on abortion attitudes. Some of these activities are revisited in subsequent sections of this paper.

## Cognitive dissonance

While the values clarification models discussed above theorize a cognitive process leading from values clarification to attitude and behavior change, some questions remain. For example, what kind of information will foster "motivation," as opposed to triggering defensiveness? What kind of information will encourage empathy or and examination of alternative values, and under what circumstances? In other words, what cognitive and psychological factors promote or inhibit learning and reflection?

Here the theory of cognitive dissonance may be useful. Cognitive dissonance theory has influenced numerous educational interventions aimed at changing attitudes, beliefs, or behavior. While a full treatment of cognitive dissonance, or how it may affect beliefs about abortion, is beyond the scope of this report, the following overview can raise some issues germane to designing workshops that address participant values.

Cognitive dissonance theory holds that when we experience a conflict in our ideas, beliefs, values, or emotions, it makes us uncomfortable and we will look for a way to resolve the conflict and reduce this discomfort by lowering the importance of one factors (for example, factual evidence, or someone's feelings), adding factors that are more consonant (such as a reward system), or changing one of the dissonant factors (say, modifying one's belief or behavior).[24]

One way that individuals employ cognitive dissonance is to denigrate something that seems

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[24] The International Working Group on Sexuality and HIV Curricula based a number of learning activities in *It's All One Curriculum* (2009, 2011) on this theory.

unattainable. An example for some women might be: "Having a fancy career is not as valuable as staying home and raising your kids." Indeed, "homemakers" are far more likely to become anti-abortion activists (Jelen et al 2002). And some feminist analyses suggest that for women for whom professional careers are not an option and who draw their identity (and economic security) more fully from marriage and motherhood, the availability of abortion for any woman can create dissonance. Another way that people reduce dissonance is by shielding themselves from information that is "uncongenial," meaning it is likely to challenge their beliefs, attitudes, and behaviors. One example might be a woman who reduces her anxiety about becoming pregnant by telling herself that her periods are not too regular and so her chances of getting pregnant are low. Change, then, involves weakening our congeniality bias (the tendency to select information that supports our pre-existing beliefs, attitudes, or behaviors).

What, then, feeds the congeniality bias and prevents people from becoming interested in receiving information that challenges their attitudes, beliefs, or behaviors? Hart et al (2009) carried out a meta-analysis titled "Feeling Validated Versus Being Correct: A Meta-Analysis of Selective Exposure to Information." The authors found that the bias toward congenial information is moderated by variables that affect 'defense' motivation (the desire to be validated) and 'accuracy' motivation (the desire to be correct).' Several variables associated with a weaker defense motivation, and thus, reduced congeniality bias. These include: ". . . when participants' attitudes, beliefs, or behaviors were supported prior to information selection; when participants' attitudes, beliefs, or behaviors were not relevant to their values or not held with conviction; when the available information was low in quality; when participants' closed-mindedness was low; and when their confidence in the attitude, belief, or behavior was high. [In contrast,] an uncongeniality bias emerged when uncongenial information was relevant to accomplishing a current goal." (555).

The authors found that individuals are more likely to demonstrate a congeniality bias (i.e., choose information that reinforces their current beliefs, attitudes, behaviors) when faced with large amounts of information, which they suggest may result from cognitive overload. In the same vein, being asked to rank preferences rather than respond with yes/no increases individuals' congeniality bias. The authors also point to preliminary evidence that an individual's motivation to seek congenial information may become "deactivated" once their

defense motivation is "satisfied."

Several of the findings in the meta-analysis strike a note of caution regarding interventions to change attitudes, beliefs, or behavior by encouraging nuanced critical reflection. First, in weighing these moderating variables, the authors found that "defense motivation" (protecting oneself) is a more powerful moderator than "accuracy motivation" (seeking quality information); that is, we want to feel validated more than we want to have correct information. They conclude: "Whereas defense motivation facilitates psychological stability and personal validation, accuracy motivation promotes accurate perceptions of reality. Given current evidence, however, it appears that tendencies toward congeniality prevail" (p.583).

Hart et al conclude with further recommendations (articulated with an eye to planning health promotion interventions):

- Defensive motivation or resistance to participate if a participant has a perceived goal; in fact, people seek uncongenial information if that information facilitates their achieving a goal.    [Consider the sea change in attitudes toward gay rights: As tens of millions of gay Americans came out to conservative family members, these family members had to resolve the tension between their homophobia and their wish to have a relationship with their beloved child, sibling, etc.] Hart et al also suggest that the opportunity to build rapport with 'uncongenial' audiences may provide a goal in some circumstances.
- Interventions should minimize cues that can trigger defense motivation.
- Although the evidence is sparse, asking individuals to prepare to debate a topic provides an incentive to seek out uncongenial information. (Whether this could apply to the topic of abortion is questionable, especially since political issues and highly value-oriented issues tend to reinforce congeniality bias.)

Matz and Wood (2005) looked specifically at how interactions within groups may cause, or provide strategies to reduce, cognitive dissonance – which is relevant to designing an effective workshop. The authors report that in a series of experiments, "emotions became more favorable when participants influenced others or joined an attitudinally congenial group, but not when they yielded to others' opinions."

## Applying Theoretical Perspectives to Abortion-Referral Training

Taken together, the above theories and findings suggest that seeking to change beliefs related to abortion or sexuality and reproduction among workshop participants is a challenge. However, to the degree this remains even an implicit aim, the findings argue for a range of approaches, many of which can be found in existing curricula:

- *Minimize cues that can trigger defense motivation*. This corroborates the comments by informants to Janiak and to the questionnaire circulated for this review that it is important not to "lead" by talking about abortion (what Janiak calls "lowering the threshold for engagement" and to establish legitimacy and leverage personal connections (p.18) The authors of the study also suggest that the intention to produce change (using "such words as intervention and counseling may automatically strengthen defense motivation") (p.583)

- *Key in on individuals' emotional needs at least as much as their rationality*. Carefully designed values clarification and case study exercises may be very effective (perhaps even asking participants why some anti-abortion activists seek abortion). Especially in group settings, sharing experiences (by trainers and participants) of change in one's beliefs and attitudes in areas other than abortion may create a congenial group, which fosters favorable emotions and reduces a sense of dissonance in the group.

- *Keep information simple but useful* – Such information may include statements of professional norms (and consequences of violating those norms); clarifying that one in three women have abortions, that most women having abortions are mothers, that abortion is safe.

- *Identify goals that increase openness to uncongenial information*. For example, just as millions of Americans responded to the dissonance of homophobic beliefs and learning that a loved one was gay by changing their beliefs, some learners may reconsider their feelings about abortion to reduce the dissonance that arises from learning that someone they love needed an abortion. It is possible that activities built around the "1 in 3" message, as well as case studies guiding participants to "imagine that your favorite niece …" might open some learners to uncongenial information.

- *Help learners identify specific situations where their values are in conflict*. This might call for reconfiguring an activity so that rather than having participants respond about their

beliefs on a series of situations, to have each participant identify a situation in which they experience some degree of inner conflict.

- *Find possible values to which participants can link uncongenial information* – This is difficult with learners who are opposed to abortion. However, possible values for linking:
  - Useful and sincere messages that express respect for the difficulty and value of the job may link to providers' pride in caring well for clients and patients.
  - Information about attacks against abortion providers might strike a nerve with the value participants place on nonviolence.
  - Information about conservative opposition to contraception may resonate with beliefs in contraception without creating dissonance with values about 'sacredness of life.'
  - Information characterizing certain anti-abortion messages as stereotyping of participants' own community (e.g., see Talking to Latinos about Abortion PowerPoint slide 23) can connect to participants' values about dignity and to their self-esteem.
  - Early mention of responding to the needs of women who are disappointed by a negative pregnancy test can establish shared value in helping women become pregnant.
  - Case studies of the 'most desperate' women (cases of rape, the life of the mother, or a severe fetal abnormality, a 13-year old, etc.) may resonate with values of compassion; however, such exercises run the risk of devaluing – and hardening opposition to – women whose circumstances do not meet this 'values' test.

With these theoretical perspectives in mind, this report turns to a review of existing curricula and related materials and competencies, and a set of recommendations about proposed objectives and content for training providers to refer for abortion.

## PROPOSED CONTENT FOR TRAINING SOCIAL SERVICE AND HEALTH CARE PROFESSIONALS TO REFER

Sample curricula and other relevant program documents were accessed through *Provide*, from a search of the grey literature (organizational websites), and through direct contact with selected organizations. Options counseling books were identified through different means and purchased online or accessed by library loan. Feedback was also collected from members of *Provide*'s network in five states with least access to abortion services. Several interviews were conducted where written documentation was unavailable or incomplete.

Options counseling training programs were identified that are delivered in various formats: in-person (e.g., Cardea; *Provide*; Backline; and others); in webinars (Planned Parenthood Federation of America has mandatory training for all affiliates, out of its Center for Affiliate Learning); and in workbooks. Videos exist that are used in combination with training workshops (e.g., Kentucky Health Justice Network; Cardea) and that are available as stand-alone resources online (U.S. Department of Health Office of Population Affairs).

These trainings vary in duration.    Online and workbook formats depend on user progress. In-person workshops also vary but have generally diminished in duration in recent years. For example, Cardea, which provides training to many publicly-funded family planning and community health clinics, for many years conducted four-day options counseling training, as two workshops a month apart, each consisting of two days. Today they provide that training as a single-day workshop, and have experienced some pressure to reduce it to a half-day, because of the cost to clinics.

*Provide*'s training goals, however, are more specifically focused on expanding abortion referral (including, where appropriate, options counseling). Moreover, specific learning priorities have already been identified in the Barriers to Referral-Making matrix.
- Values and beliefs about abortion
- Values and beliefs about professional norms (the obligation of service providers to refer to all legal medical care)
- Values and beliefs stemming from peer stigma
- Knowledge and attitudes about women's experience with barriers to abortion care

- Knowledge and skills for all-options counseling

- Knowledge and skill for identifying and referring to providers

For this reason, the following section is organized into learning objectives and content for each of the six barriers. For each set of objectives, specific content notes are added to guide curriculum development. Many of the content notes address learning modalities or other comments expanding on how the content might be best fleshed out or delivered. This material is taken from existing curricula or training workbooks, supplemented where appropriate by from insights in the literature. Further thought is needed to determine whether and how much to follow this organizational structure in a curriculum. Of course, the duration and other details about specific training contexts will determine final decisions.

*Learning Modalities*

Given that provider values and beliefs have been somewhat prioritized as barriers to address, attention is given in the previous section to theoretical perspectives informing learning in this area. Specifically, the appendix considers in some depth how the theory of values clarification and the theory of cognitive dissonance bear upon the topic of abortion and abortion referral.

That said, this report takes as a given that a training would will adopt participatory, interactive, and experiential methods; such methods have long been in use for adult learning workshops in the field, including for pregnancy options training. Such a training would draw on Freirian approaches that emphasize horizontal and empathetic dialogue, posing of problems in our lives or world; and critical thinking and analysis to resolve the problems.[25] Further, recognizing the charged nature of abortion for some, a training curriculum should recall the characterization by educational theorist Robert Pianta (1999) of "the substrate" of the learning environment as "social and emotional."

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25 A Freirian approach engages learners to question prevailing norms through critical thinking and analysis about their social context, to create "critical consciousness." See: Freire, Paulo (2007). In seeking to transform attitudes toward abortion, Ipas explicitly adopts Freirian approaches. See Turner and Baker (2008, 8).

## BARRIER 1: PROVIDER BELIEFS ABOUT ABORTION

As noted above, activities to help participants clarify their values and beliefs about abortion beliefs are a core element of virtually every pregnancy options or abortion counseling/referral curriculum. Many of the curricula reviewed include similar objectives and activities, and some activities address multiple, usually interrelated learning objectives. In fact, most of these objectives and activities drawn from existing materials (or supplemented from insights in the literature) resonate with the theoretical frameworks discussed in detail above.

Following are some common, and useful, objectives:[26]

### Creating an optimal learning environment for values exercises, for example, by helping learners to:
- Feel comfortable and safe in the group

*Content notes:*
o Model "leading with values" and allowing participants to do the same.
o Include icebreakers that build a sense of safety and of common ground.
o Content-less icebreakers may waste precious time: For example, where possible, seek activities that build rapport among participants while tapping empathy for females, e.g., reflecting on the experience of growing up female.
o Keep in mind that interpersonal activities can reduce 'defense motivation' and increase openness to 'uncongenial' information (that challenges their current attitudes and beliefs)
o Ensure adequate time to process activities and, as needed, for participants to express what they are thinking/feeling, especially after an activity that creates some dissonance or engages them in processing uncongenial information.
o The Ipas toolkit has an icebreaker that also helps learners identify how stigma functions in regard to abortion.

### Cognitive objectives
- Recognize common myths about abortion, related to: the safety and consequences of abortion, demographic profiles of women who have abortions, the reasons women have abortions (and unintended pregnancy), the consequences of stigma, support for abortion in their own community

*Content notes:*
o Use case examples.

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[26] Some curricula clearly define the objectives of each activity, whereas in other cases the aims have been inferred from the content of the activity.

- Emphasize simple information. Share more nuanced or detailed information in written handouts.
- As part of the newer "woman-friendly" framing of anti-abortion propaganda, junk scientific reports have been widely disseminated. One problem with refuting these myths is that it forces scientific discourse into a responsive or defensive mode, while the anti-abortion message has framed the debate.   Rather than beginning by refuting myths, it may be more effective to state that we are all bombarded by information that makes it difficult to sort out the accurate from the highly irresponsible, and to invite participants to ask questions (anonymously, if needed), which can then be addressed at a Q&A session, "along with other questions that have been asked at similar sessions." This may allow the trainer to address myths, for example, about the emotional consequences of abortion,[27] without increasing congeniality bias.
- Cross the Line, Reasons Why, Four Corners, and other activities in the Ipas toolkit address how stigma affects women's access to and experience of abortion.

**Affective objectives**, specifically helping learners to reflect on their beliefs about abortion:
- Recognize their own biases;
- Recognize the relativism in their own attitudes about the acceptability of abortion in different circumstances;
- Recognize the diverse perspectives of different individuals within a participant group;
- Appreciate the difficulty of assigning an abstract moral hierarchy to women's situations.

*Content notes:*
- To tailor a workshop to the current values and beliefs participant group, if possible, ask participants to provide input on their beliefs prior to the workshop.
- Help participants identify *specific issues* about which they have some degree of dissonance or internal values conflict. To start, this could be an issue they choose that is unrelated to sexual and reproductive health. It could also be presented as a 'decision-making model' activity in which participants have to resolve a decision in their lives that entails some moral dimension.
- There are many useful activities that engage participants in assessing and sharing (sometimes anonymously) their support for abortion under diverse circumstances. These activities include case studies (including "The Last Abortion" exercises), forced choice activities, worksheet questionnaires. However, activities that ask participants to rank the acceptability of one abortion over another can de-value the majority of women, who choose abortion in less desperate circumstances. Some trainers address this risk by allowing sufficient time to "process" the activity.
- Use activities involving reproductive health examples in which dissonance may be minor and is often resolved by people distancing themselves from the religious dogma, e.g., "Not

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27  See, for example, Foster et al 2013; Guttmacher 2011; Steinberg and Finer 2010.

all religions approve of in-vitro fertilization (or contraception). What is your view? Should insurance cover it?"

- o The Ipas *Transforming Attitudes* toolkit, though aimed at a global audience, suggests that it may be useful to address the issue of religion directly. (Identifying as Christian, always a factor linked to abortion attitudes, has become particularly salient in recent years, as evangelical Christianity and conservative political ideology have become somewhat conflated.) The following (the first two taken from the toolkit) may be useful in addressing religious beliefs that impact on abortion referral behavior:
  - o Addressing common beliefs about religious objections to abortion, and support for religious individuals who are involved in some aspect of abortion care and advocacy.
  - o An activity called "Thinking About My Values" that helps participants examine the role of religious beliefs along with other external influences on the formation of their values about abortion. It also includes a reference section to additional training resources, some of which address religion.
  - o Another activity that may be useful is to focus on reproductive health examples in which dissonance may be minor and which many people resolve by distancing themselves from religious dogma. For example, participants could be asked to respond and discuss in pairs or small groups a question like: "Not all religions approve of in-vitro fertilization. What is your view? Should insurance cover it?" (The same questions can be posed about contraception.)
- o In addition to the Ipas *Transforming Attitudes* toolkit, there are other good activities addressing abortion beliefs through values clarification. See for example, Vicki Breitbart and Jini Tanenhaus *Values Clarification Workshop*, developed at Planned Parenthood/NYC.

<u>Fostering empathy with women choosing abortion and respect for providers referring to or performing abortion,</u> by helping participants to:

- Reflect on women's access to means to deal with unwanted pregnancy
- Remind themselves that reproductive health problems can affect women whom they know personally and that we should address such issues as if all affected clients were our daughters or relatives.
- Describe the biological and social factors that influence a woman's health decisions
- Gain knowledge of the reasons women have unprotected intercourse
- Move toward viewing abortion as choice that one of every three women part of reproductive health care[28]

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[28] The salience of this issue is highlighted in the following comments by two informants to Janiak (p.29):
*"Any time that we spend reconnecting abortion to mainstream medicine, it's oxygen we're stealing from…politics because you have more and more people seeing abortion discourse where it belongs."*
*"I think they're extremely important…to normalize the word and the conversation, to normalize that into the spectrum of reproductive healthcare, and to not avoid it, is extremely important. For this patient to*

- Reflect on providers' ethical reasons for performing abortions
- Increase awareness of the importance of their own role in providing timely referrals to ensure early, safe care.

*Content notes:*
- De Bruyn and Packer 2004 (p38) include a case study in which the 16-year-old protagonist is positioned as the participant's favorite niece. This activity can use cognitive dissonance and values of compassion and familial love to encourage empathy and specific-situation values clarification.
- Many curricula ask participants to reflect on such questions as:
  - Why would a woman who doesn't want to be pregnant <u>not</u> use birth control?[29]
  - Why would a man who doesn't want to be a father <u>not</u> use birth control?
  - Why would a woman who doesn't want to have a child <u>want</u> to be pregnant?
  - Why do people have sex?
  - What is the difference between sex that is 'voluntary' and sex that is 'wanted'? (See, for example, Abma et al 1998)
- Include information about the prevalence of IPV and contraceptive sabotage.
- Finding a normalizing discourse that does not create defensiveness may be a challenge with some groups. With participants who are not absolutely opposed to abortion, some of the strategies that may help normalize abortion without triggering defensiveness are the same as are mentioned for addressing provider values in general, e.g., case studies of women that participants are likely to identify with and/or care about; "1 in 3" messages about the prevalence of abortion; information showing public support for abortion (where applicable).
- Few curricular resources address the issue of gender.[30] Certainly, sexuality are inextricably linked with gender ideology. In addition, some topics (such as intimate partner violence) may help build common ground among participants around shared values of women's dignity and gender oppression. The Ipas toolkit "*Abortion attitude transformation*" *(*Turner and Page 2008) is one of the few resources that include an activity explicitly engaging learners in reflecting on how gender norms affects their lives. Specifically, this guided-imagery activity enables participants to:

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- o Describe how their upbringing and socialization affects how they think about gender roles and sexuality;
- o Explain the ways in which we are socialized to have different and sometimes unequal expectations for male and female sexuality;
- o Articulate how gender stereotypes affect their values and attitudes related to sexual and reproductive health, pregnancy and abortion care.

- o For providers to recognize that a woman who asks for referral information only may not need more, include clarifying that choosing an abortion is a difficult decision for some and an easier decision for others, just like the decision to place a child for adoption or to become a parent, or that she may have processed her decision before calling for a referral.
- o Consider sharing results of the UCSF/ANSIRH Turnaway Study (not yet available) about emotional consequences to women who carry a pregnancy to term after presenting for abortion too late.
- o Many activities explore attitudes about all pregnancy options together. These take the form of forced choice responses to statements about abortion and related sexual health issues, role-plays, structure debates, and trigger-videos. Because such activities ask participants to rank the merit of women's situations and choices, they should be avoided.
- o Shift from using the term "multiple" abortions to "repeat" abortions, which Weitz and Kimport (2011) argue is less charged and that reflects the diverse experience of each abortion.
- o As noted elsewhere, expose participants to case studies from *Doctors of Conscience* (Joffe, 1996) and/or Linda Prine (Prine 2008, Sweet 2013), or and/or invite an abortion provider to meet with them.
- o Where possible, it may be useful to have one or more participants who can share their positive experience in referring.

## BARRIER 2: VALUES AND BELIEFS ABOUT PROFESSIONAL NORMS

Based on the obligations to respect patients' rights to information and their autonomy in decision-making, in balance, professional codes offer support to the idea that providers must refer for abortion. And most options counseling curricula include objectives and content to address professional norms. However, the codes are general principles that can be somewhat ambivalent in how they are applied specifically to abortion referral. It would be helpful to seek more formal and explicit clarification for a training curriculum.[31]

**Cognitive objectives**, enabling learners to:

- Describe what they were taught about abortion care in their professional training.
- Cite sections of the code describing their responsibilities to refer in a timely and nonjudgmental manner; describe conscience clauses related to abortion provision.
- Define informed consent and patient/client autonomy in decision-making
- Discuss their responsibility to report unethical behavior at their workplace, and the implications this has for abortion referrals.

*Content note:*

o Review and make available copies of social work or other professional ethics codes pertaining to participants' professions.

**Affective objectives**, preparing learners to:

- Recognize how their feelings and attitudes might influence care given to women seeking abortion care.

*Content note:*

o Many nurses and social workers have themselves faced such paternalistic attitudes and advice from medical providers; it may be that drawing on those experiences can help providers become more open to recognizing their own tendency in that direction.
o Offer participants a safe opportunity to recall a specific situation in which they were not sure what was professional and ethical to do (not necessarily related to a sexual or reproductive health matter).

**Skill-based objectives**, enabling learners to:

- Demonstrate referral scenarios that do/ do not reflect their professional ethics codes.

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[31] More precise clarification would be useful for updating this section.

## BARRIER 3: ALL-OPTIONS COUNSELING

Overview: This section is not highly detailed, as various existing curricula already include sample learning objectives and activities for how to counsel women considering abortion. Moreover, some of the objectives for this barrier are also addressed under other barriers. However, key objectives and content notes are included below:

**Cognitive Objectives**, enabling learners to:
- Describe factors that may indicate whether a woman is likely or not to want counseling as opposed to referral support.
- Describe the goal of options counseling.
- Describe all options for women with a positive, and negative, pregnancy test.
- Explain why it is important—where institutional regulations allow—to ask women if they want to hear about options they have not mentioned, rather than automatically presenting those options.
- Explain the purpose of basic counseling techniques, e.g., open-ended questions, reflecting, affirming/demonstrating empathy, normalizing, reframing, examining consequences, problem-solving (including identifying barriers and solutions), and planning implementation. (These may be collapsed into fewer items within a model.)
- Discuss at least five factors (including poverty and gender inequality, including IPV) that may increase women's vulnerability to unintended pregnancy.
- Describe how gender norms intersect with social, cultural, or economic marginalization to affect a woman's choices about sexuality and reproduction.
- Explain how delaying a referral can undermine a patient's health

*Content notes:*
- Expanding to address negative pregnancy tests is time-consuming, but a) allows many providers to move into a feeling of shared values about contraceptive counseling; and b) allows trainers to establish shared values related to women seeking help conceiving.
- For positive tests, refer to options as: abortion (or termination of pregnancy); continuing the pregnancy with intent to parent; and continuing the pregnancy with intent to place the baby for adoption. Do not use: abortion, adoption, parenting.
- Women experiencing abuse face additional constraints: Moore et al (2010) cite various forms of abuse by male partners, including purposely sabotaging contraception, threatening her with violence if she does not carry out his desires vis-à-vis a pregnancy, and refusing to pay for an abortion.

**Affective Objectives**, helping learners to:
- Appreciate the importance of informed consent and nonjudgmental counseling
- Respect that some clients do not want counseling, while others may need special attention and support

- Appreciate that for all of the options, some women may find their situation and plan troubling and difficult, while others do not.
- Understand why some women would resent having a counselor tell her about options she has not indicated an interest in hearing about.

*Content notes:*

o As noted earlier, the "all-options" model can become a tyranny. Activities can surface the inherently judgmental quality of transmitting information about options that they do not indicate an interest in hearing about. For example, a role-play or case scenario can depict a woman who is happy about being pregnancy and is asking for an OB being offered information about adoption and abortion. Beginning with this example can help learners appreciate equally consider whether the woman asking for an abortion provider should be asked to discuss obstetric care and adoption? The understanding that best practices mandate providers' asking women if they wish to receive this information may, however, need to be combined with explaining any official or unofficial regulations requiring such judgmental counseling approaches.

o Case scenarios can address situations beyond unwanted pregnancy, e.g., a client who plans to parent with a same-sex partner and wants a referral to a sperm bank, a woman facing a possible prison sentence who wants to continue a pregnancy so she can be released earlier from incarceration, an alcoholic planning to keep a pregnancy.

**Skill-based objectives**, preparing participants to:

- Demonstrate appropriate and inappropriate counseling practice in scenarios related to unintended pregnancy and other sexual/reproductive health scenarios.

*Content notes*:

o There are various counseling models and approaches, some of which are already in use at *Provide*. These include:
  o For nonjudgmental counseling: Transactional Analysis Ego State approach
  o For dealing with sensitive/stigmatize health issues: Nine evidence-based emotional care models (see Upadhyay et al 2012)
  o For dealing with emotional difficulty related to abortion: Head and Heart model (see Joffe 2012)
  o For addressing difficult questions about abortion: "Answering tough questions in abortion care," which may be available from PPFA (undated)
  o For putting ore-conception prevention in context: Reproductive Life Planning model

o There is no substitute for observation and practice-with-feedback for learning these skills. Particularly useful is if participants can see themselves on videotape.

o Counseling skills are an asset that participants can use across their work and in their own lives; as such, they can therefore contribute to the value they place on a training. This is another reason that, despite the time consumed in teaching these skills, they may be worth including in a training.

## BARRIER 4: JUDGMENTAL ATTITUDES AMONG PEERS

Janiak (2012) found that providers in a position to make referrals may experience fear of visibility, "perceived or actual "gag rule," or fear of backlash if they signal openness to discussing abortion (25). She also shares informants' view that normalizing abortion referral can exert a positive effect, destigmatizing abortion for all women – presumably including the referral-makers.

**Cognitive Objectives**, enabling learners to:
- Describe what they view as the range of beliefs and attitudes about abortion among their peers, at work and in their community.
- Describe actual levels of support for abortion access.
- Explain why doctors and nurses provide abortion care, even when they are not particularly well-remunerated to do so.
- Define 'gag rules' and Title X institutional policies (based on handout)

*Content Notes*
- Because a focus on stigma can undermine efforts to introduce a normalizing frame, the topic of stigma should either be omitted or managed very carefully.   If it arises, recommendations include:
    - Shift the frame to discussing stigma*tizers*. For example, sociologist Gerhard Falk writes that stigma "at its essence is a challenge to one's humanity- for both the *stigmatized* person and the *stigmatizer."*
    - The Ipas webinar on stigma, presented by ANSIRH, provides a useful review of stigma theory. There is also a body of literature on abortion stigma, which was beyond the scope of this review.
- Where helpful, share information showing that support for abortion may be broader than assumed. For example, national polling by Belden Russonello Strategists (2012) found that among African-Americans, ". . .80% agree that "regardless of how I personally feel about abortion, I believe it should remain legal and women should be able to get safe abortions." Agreement with this statement crosses political and religious lines, with 74% of self-identified conservatives concurring as well as 88% of liberals. Three-quarters (76%) of those who attend religious services weekly, along with 84% of those who attend less regularly, also agree."

**Affective Objectives**, helping learners to:
- Remember how it feels to have others judge you, and to behave in a principled fashion despite that judgment.

- Recognize the role of the professional in upholding (or undermining) respect and nonjudgmental behavior at work.
- Clarify their feelings about whether and under what circumstances to disclose and discuss abortion issues with their peers, including the consequences of their decisions.
- Appreciate the value of complying with professional norms about referral.
- Identify sources of support to help cope with negative judgments from peers, and strategies for seeking that support.

*Content Notes*
  o Share an excerpt from *Doctors of Conscience* or another source that helps learners appreciate the importance of compassion in the decision to provide abortion.
  o Also see *It's All One*, Vol. 2, p.168 ('Walking in Her Shoes') for a set of quotes about judging others; this may be useful for building an activity that fosters positive feelings about oneself (or others) behaving in a way that is proper even when it others are judgmental.

**Skill-based Objectives**, enabling the learner to:
- Demonstrate scripts for deflecting and for responding to judgmental comments about abortion from peers

## BARRIER 5:   KNOWLEDGE ABOUT APPROPRIATE PROVIDERS: DIRECTORIES AND RELATIONSHIP-BUILDING WITH ABORTION PROVIDERS

*We've come to … a working definition that says, it's connecting people to a resource that can meet their identified need.*     -Informant E (Janiak 2012, p.16)

The Barriers to Referral-Making matrix identified lack of knowledge of an appropriate abortion provider as a key barrier, with both directories and relationship-building as essential tools to build providers' capacity to refer. Janiak (2012, 27) notes that introducing potential referring clinicians to abortion practices and providers has bolstered confidence in referring for abortion.

**Cognitive objectives**, enabling learners to:
- Describe what information about area abortion providers should be included in a directory, including location, hours or days of operation, phone numbers, insurance accepted, gestational limits, languages spoken, costs; in low-access, rural, or large cachement areas, this should also include a regional map to help potential referring clinicians locate the provider closest to their clients.
- Describe financial support avenues, legal frameworks, and judicial bypass information needed for a referral notebook.
- Discuss any additional referral materials that would be helpful to them, and how.
- Name at least two recommended local sources for each of the following: abortion, prenatal care, adoption services, fertility awareness education, infertility care, contraceptive services, STI testing and treatment.
- Describe a system for maintaining and updating referrals, and for workplace procedures and protocols about making referrals.
- Describe strategies for building relationships with unknown providers, e.g., deciding whom to target, whether to target more than one individual, identifying who fields requests for referrals, etc.

*Content notes:*
- Receiving referral materials in usable written form may be perceived by many participants as the type of "useful, simple" information that reduces congeniality bias. Assuming that trainers are able to provide some of this information at a local level, it may be helpful to let participants know in advance of the training that they will secure such information, and to remind them at the start of the training as well.
- If actual provider information is not available (or advisable to share), templates based on the South Carolina Referral materials could be constructed and shared; allow

participants to brainstorm the categories of information that an abortion referral notebook should have, but then give clients a handout with all important categories included.

o Further, if it is useful to participants, additional sample or template materials could be distributed. For example, infertility organizations share sample letters that clients can use to request information from their insurer about coverage for infertility-related care.

o In some settings, abortion providers supply a pad of referral forms to primary care and family planning providers (Marie Stopes 2007). If such a form conforms to professional practices in a social service or health care agency, in addition to facilitating the referral process, it may also normalize the process.

**Affective Objectives**, to enable learners to:

- Describe what will make them feel more familiar and comfortable about referring to specific abortion providers, for example: meeting them in person, hearing an abortion provider speak at an in-service, getting client feedback, visiting a clinic, etc.
- Develop greater familiarity and comfort with someone involved with abortion care
- Develop greater comfort with referring by practicing using a referral book and making a simulated referral during the training

*Content Notes*

o Give participants an opportunity to recommend specific providers in the area to each other.

o Help providers become more familiar and comfortable with an abortion provider – one in their area or one in a film or written excerpt. Janiak (2012) notes that such an introduction can take many forms, including in-clinic training and in-person provider introductions. As noted, it is feasible and safe, it may be helpful to invite someone from a clinic that provides abortion to a workshop. If is not appropriate or safe to have someone from a provider clinic present, consider an excerpt from Doctors of Conscience (as noted above) or sharing a video about an abortion provider, such as *Live Free or Die*.]

**Skill-based objectives**, preparing participants to:

- Demonstrate use of a referral book in multiple role-plays;
- Demonstrate ability to ask an abortion provider about services offered.
- Establish rapport with potential providers to include in a referral notebook.
- Offer constructive feedback to a provider.

*Content Notes*

o Demonstrating ability to ask an abortion provider about services offered could be based on role-plays, or –if a local provider is able to be present and if it is deemed appropriate and safe – on an actual Q&A.

## BARRIER 6: KNOWLEDGE OF BARRIERS WOMEN FACE IN SEEKING ABORTION CARE

Women face a range of often-invisible barriers to getting abortion care.   Some of these barriers are related to barriers to accessing other reproductive health services; others are related to provider attitudes and stigma. While learning objectives for those factors are addressed above, helping referral agents understand the web of barriers women face can motivate them to make a more thorough, timely, and active referral.

Dodge: (2012) reports:

"The Institute of Medicine defines access to health services as "the timely use of personal health services to achieve the best possible health outcomes" Healthy People 2020 identifies four components of access to care, all of which are important for abortion care: coverage, timeliness, services and workforce. Service means that people have a source of care. This is important for abortion because even if a woman has a regular source of primary care, the low number of abortion providers nationwide make it unlikely that her primary care provider (PCP) will provide abortion services, thus forcing her to find another source of care. Ideally, if her PCP does not provide abortion services, she will be given a referral to a facility that does provide abortion services. Timeliness is the system's ability to provide care quickly after a need is recognized. Abortion is a time-sensitive procedure, as both the costs and risks increase with gestational age. Appropriate referrals for women who are seeking abortion services are necessary to ensure that patients' needs are met quickly."

**Cognitive objectives**, enabling learners to:
- Describe at least six barriers that a local woman or girl might face in accessing reproductive health care [See *Content notes*]
- Describe the evidence that thorough, timely referral for abortion improves women's health, and the consequences of delays in access and for the likelihood of self-induced abortion (which itself may be ineffective and/or unsafe, and which may lead to delays in needed care).
- Explain avenues for women to seek timely support in paying for an abortion, seeking judicial bypass, finding the gestational age of her pregnancy, and other key steps she may need to take.
- Define service, and describe best practices for referrals
- Identify measures that will facilitate their being able to provide such referrals at work

*Content notes:*
o Common barriers to accessing *reproductive health care* include: cost; language limits; legal residence status; transportation; threats from partners; not having full information (about the cost, hours, location). Additional barriers for accessing *abortion* include:

parental consent or judicial bypass; waiting periods; not knowing one's gestational state and the importance of getting care quickly; not understanding that abortion is legal; lack of privacy; fears about confidentiality; and lack of awareness that some local 'women's health' or 'pregnancy crisis' centers will not provide the abortion referrals or care she was seeking. Additional or different access barriers for *continuing a pregnancy, with intent to parent or to place for adoption* may include: fears about being judged; fears of undue pressure about her decision; fears of interacting with the social service system among women whose legal status is vulnerable.

o Various curricula include case scenarios that participants can study and then identify the functional barrier.

o Janiak reports on the effects that easing access to appointments had on lowering average gestational age of abortion in Britain (Stenson 2010 in Janiak 2012).

o Janiak reports: "Because many women prefer the anonymity of seeking abortion care from an abortion specialist unaffiliated with other providers who care for them, standard best practices such as referral tracking and follow-up may not be desirable to all women (Weitz and Cockrill 2010).

o There are several similar models for thorough, active referral. These include:

1. Janiak's spectrum of abortion referral behaviors (described earlier in this report)
2. Simmond and Likis (2009) "active" referral model (described earlier in this report)
3. Janiak writes that "best practice recommendations tend to include the following":
   ✓ Assessment of individual client needs
   ✓ Identification of a resource that is appropriate for the needs of the client (for example, vis-à-vis its language services, hours open, and insurance accepted)
   ✓ Provision of complete contact and eligibility information for the resource identified
   ✓ When necessary, scheduling of services or more intensive connection to care
   ✓ Assessment of patient needs for supportive services to enable utilization of care (for example transportation or childcare)
   ✓ Connection of patients to supportive services for which a need is identified
   ✓ Follow-up with provider and/or patient to determine whether care was utilized
   ✓ Follow-up with patient to assess satisfaction with care received
   ✓ Integration of service utilization and patient satisfaction data into referral databases, enabling continual reappraisal of propriety of referrals offered by the provider/ organization

4. Foster et al (2013) Turnaway Study recommendations. These authors have been carrying out a longitudinal prospective study of women who receive an abortion and women who are denied an abortion because they present for care after the provider's gestational limit. The study examines the consequences – including short-term physical health, mental health, socioeconomic, substance use and exposure to intimate partner violence -- to women carrying an unwanted pregnancy to term versus receiving a wanted abortion. The authors conclude by recommending better referral systems. These are detailed in the article but include:

- ✓ When making referrals, consider gestational age, provider limits, sources of funding and less expensive providers who may be farther away.
- ✓ Maintain a current list of abortion providers with contact information and corresponding gestational age limits in your area.
- ✓ Estimate patients' pregnancy gestational age relative to clinic limits prior to providing referrals to help facilitate access to care.
- ✓ Help patients set up appointments and obtain directions to appropriate clinics.
- ✓ Inform patients who desire an abortion that costs usually increase with increasing gestational age.
- ✓ When providing care for adolescent girls, provide additional support and tailor pregnancy options counseling to their unique circumstances (e.g., legal restrictions, limited transportation and psychosocial developmental stage). Be familiar with any parental notification or consent laws for minors in your state.
- ✓ If possible, routinely follow up with your patients and make referrals as needed so that they receive care in a timely manner, including prenatal care if abortion was not selected or is no longer an option.

5. The <u>Considerations for Women's Health in Kentucky Power Point</u> also recommends:
   - ✓ Make sure referrals are up to date and accurate
   - ✓ Know where you are giving the client
   - ✓ Be able to give the client information on what to expect


**Affective objectives**, enabling learners to:

- Appreciate that parental consent laws and mandatory counseling/waiting regulations have disadvantages for different clients
- Take pride in perceiving themselves as able to help women be safe
- Develop opposition to 'pregnancy crisis centers'


*Content Notes*
- o Shared safety concerns can establish common goals and enhance accuracy motivation with participants, as well as fostering their sense of agency
- o A group of young women in California has stopped using the term 'pregnancy crisis centers.' Instead, they have rebranded these operations with a campaign called End Fake Clinics.


**Skill-based objectives**, enabling learners to:
- Demonstrate referral-making behaviors that address various circumstances and barriers women face.

*Content Notes*
- o As noted above, supplying a pad of referral forms and a referral guide to primary care and family planning providers can facilitate their referral process (as well as reduce stigma associated with abortion referral).

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## APPENDIX: CODES OF ETHICS AMONG PROFESSIONAL ASSOCIATIONS OF NURSES, PHYSICIANS, COMMUNITY HEALTH WORKERS, SOCIAL WORKERS

### I. Nursing Associations

American Nursing Association[32]

The ANA Code of Ethics clarifies patients' rights to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment (statement 1.4), to examine the conflicts arising between their own personal and professional values (statement 2.2), and to retain their professional boundaries (statement 2.4). However, the Code also allows that:

> "Nurses have a duty to remain consistent with both their personal and professional values and to accept compromise only to the degree that it remains an integrity-preserving compromise . . . . Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds" (statement 5.4).

An independent two-part guide to using the ANA Code of Ethics was published by Lachman (2009a, 2009b); however, the words abortion, pregnancy, and referral do not appear in this guide. In response to a brief telephone communication question about whether nurses are required to provide referrals for abortion, Laurie Badzek (2013), who directs the Center for Ethics and Human Rights at ANA, stated that she "thinks" so. In a follow up email framing the question the opposite way, her responses were still a bit indefinite; the only categorical reply was about nurses' right to object to "participate":

> Q: *Do nurses have a right to refuse to provide referrals for abortion*?
> A: Nurses can refuse "to participate" if they consciously object – there is much literature and the code supports this; however, patients have the right to make autonomous decisions and nurses must give patients all the necessary information. Nurses may not agree with every treatment option but patients have the right to know them.
> Q: *Must such referrals be provided with the same thoroughness and respect as referrals for other health services*?

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[32]   American Nursing Association. *Code of Ethics*. Revised 2001. www.nursingworld.org/codeofethics. Accessed March 1, 2013.

A: I would say yes

Q: *Does the conscientious objection clause apply to referrals?*

A: I don't think *[the conscientious objection clause]* applies to referrals in the sense the patient should be given all of the information to be informed and make their own choice. The nurse has no right to impose her personal beliefs on the patient.

Regarding the obligation to respect patients' autonomy in decision-making, Janiak (2012) reports on comments that providers may believe they know best what the client should do. Here again, nurses may understandably interpret the code in different ways. For example, Interpretive Statement 1.4: The right to self-determination, states:

> "Respect for human dignity requires the recognition of specific patient rights, particularly, the right of self-determination. Self-determination, also known as autonomy, is the philosophical basis for informed consent in health care. Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment; to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or penalty; and to be given necessary support throughout the decision-making and treatment process."

Interpretive Statement 8.2 (Responsibilities to the public) states:

> "The nurse also recognizes that health care is provided to culturally diverse populations in this country and in all parts of the world. In providing care, the nurse should avoid imposition of the nurse's own cultural values upon others."

Similarly, Statement 8.3 includes the sentence:

> "In situations where nurses' responsibilities include care for those whose personal attributes, condition, lifestyle or situation is stigmatized by the community and are personally unacceptable, the nurse still renders respectful and skilled care."

On the other hand, Interpretive Statement 5.3 (Wholeness of character), also includes the following text:

> "In situations where the patient requests a personal opinion from the nurse, the nurse is generally free to express an informed personal opinion as long as this preserves the voluntariness of the patient and maintains appropriate professional and moral boundaries. It is essential to be aware of the potential for undue influence attached to the nurse's professional role. Assisting patients to clarify their own values in reaching informed decisions may be helpful in avoiding unintended persuasion."

Association of Women's Health, Obstetric and Neonatal Nurses (revised 1999):

"Nurses have the right, under responsible procedures, to refuse to assist in [. . .] abortion or sterilization procedures, in keeping with their personal moral, ethical, or religious beliefs. Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in *emergency situation*,[33] regardless of the nurses' personal beliefs [. . .] and to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referrals" [italics added] (cited in ROE Pregnancy Options Counseling Power Point, slide 25).

The National Organization of Nurse Practitioner Faculties (2006):

"Acknowledges the need to prevent personal biases from interfering with the delivery of quality care to persons of differing beliefs and lifestyles" (cited in ROE Pregnancy Options Counseling Power Point, slide 25).

The American College of Nurse Midwives has within its core competencies:

". . .a list of 16 'Hallmarks of Midwifery,' two of which presume midwives will offer objective counseling. The sixth hallmark, 'empowerment of women as partners in healthcare,'" and the eleventh hallmark, 'advocacy for informed choice, shared decision-making, and the right to self-determination,' require separation of personal and professional values when offering assistance to women grappling with an unplanned pregnancy" (cited in Singer 2004, 236).

A number of authors have sought to reinforce the understanding that nurses have responsibility to counsel and refer for abortion. In 2011, McLemore and Levi conducted a literature review of articles addressing nurses' role in abortion care; this review found three subthemes: (a) the right of nurses to determine their own moral and ethical participation (or not) in providing care to women seeking abortion; (b) explanation of current abortion law; and (c) workplace issues caused by the provision of abortion care. Other authors have published commentaries in nursing journals similarly referencing nurses' professional responsibility to counsel and refer nonjudgmentally for unintended pregnancy (O'Reilly 2009; Levi et al 2009; Simmonds and. Likis 2011; Taylor and James 2011). Most of these articles reference public health and nursing frameworks, although Taft (2000) writes within the formal domain of ethics.

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[33] "Emergency situation" is not defined here; it may be spelled out elsewhere.

Beyond an individual provider's referral-behavior is the matter of the protocols and culture of the provider's workplace.    This is not only a matter of stigma the referring provider may face the or the lack of well-maintained referral systems; there is also the question of whether and how a provider should properly respond when a co-worker fails to refer as guided by the professional association norms (or workplace protocols). There is a basis to suggest that suggest that nurses have not only the right, but the obligation to address questionable practices. For example, the ANA Ethics Code Interpretive Statement 3.5 (Acting on questionable practice) states [underline added]:

> "The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which health care needs are addressed. <u>As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy</u>. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state and local laws and regulations, and the employing organization's policies and procedures.

> "When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice. Attention should be called to the possible detrimental affect upon the patient's well-being or best interests as well as the integrity of nursing practice. When factors in the health care delivery system or health care organization threaten the welfare of the patient, similar action should be directed to the responsible administrator. If indicated, the problem should be reported to an appropriate higher authority within the institution or agency, or to an appropriate external authority.

> "There should be established processes for reporting and handling incompetent, unethical, illegal, or impaired practice within the employment setting so that such reporting can go through official channels, thereby reducing the risk of reprisal against the reporting nurse. <u>All nurses have a responsibility to assist those who identify potentially questionable practice.</u>"

## II. Physicians

American College of Obstetricians and Gynecologists Committee Opinion (2007) issued an Committee Opinion entitled *The Limits of Conscientious Refusal in Reproductive Medicine,* which states that:

> ". . . physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request" (cited in Dodge et al 2012).

According to *Provide* options counseling training materials, a separate 2009 Committee Opinion further reinforced that ACOG ". . . supports education in family planning and abortion for both medical students and residents and abortion training among residents." In addition, ACOG supports availability of reproductive health services for all women, including strategies to reduce unintended pregnancy and to improve access to safe abortion services. According to Dodge et al (2012), there is no explicit recommendation from ACOG about the referring responsibilities of frontline staff who work with the physicians.

Dodge (2012) reports a recent study in which Rasinski *et al.* examined the opinions of 1800 OB/GYN physicians regarding these recommendations and found physician support for providing referrals. Using a vignette where an OB/GYN physician refused a requested induced abortion, the authors found that while 70% of respondents rated the vignette doctor as acting appropriately when a referral was made, only 12% believed the doctor acted appropriately when the doctor disclosed personal objections to abortion and refused to provide a referral.

The American Academy of Pediatrics Committee on Adolescence (1998) issued a paper on counseling adolescents about pregnancy that repeatedly calls for pediatricians not to impose their own values on adolescents and to refer in a timely and helpful way.

The American Academy of Family Physicians (AAFP) (2008) endorsed a revised set of "Recommended Curriculum Guidelines for Family Medicine Residents: Medical Ethics." This document provides a set of competencies that family medicine residents should achieve at the completion of their residency training, including to:
  o Provide care that is sensitive to the belief systems of the patient;

o Act as an effective patient advocate;
o Demonstrate personal ethical standards . . . Understand and avoid potential ethical conflicts . . . in personal conduct with patients, staff and colleagues.

Attitudes required of family medicine providers include:
o An understanding of cultural, social and religious customs and beliefs that may differ from his or her own.
o An understanding of individual, cultural, institutional and societal biases that may affect ethical decision-making.
o A commitment to ethical medicine in every patient encounter.
o Selfless work on behalf of every patient's well-being.
o A self-awareness regarding personal ethical strengths and vulnerabilities as they affect one's own professional practice.

Knowledge that residents should be able to apply are:
o Principles of ethics
  o Autonomy— patients' rights and physicians' rights
  o Responsibilities and duties of patients and physicians
  o Beneficence— acting in the best interest of patients
o Informed consent
o Application of ethical principles, government laws and regulations to specific patient care scenarios (including but not limited to the following cited examples)
  o Consent and decision-making: Withholding or withdrawal of treatment; Informed consent and right to refuse; Adolescents and emancipated minors (consent to treat)
  o Human reproductive issues: Contraception and abortion; Perinatal ethics; Sterilization

It is noted that these Guidelines also emphasize the role of the family medicine provider in addressing and helping to resolve complicated situations. While the competencies below presumably are not intended to address abortion, anti-abortion providers might seek to draw on them to justify inappropriate interference in a patient's decision.   These are cited below:

Competency:
Provide counseling that reflects an understanding of ethical principles regarding decisions that have potential and ethical implications.

Attitudes:
An appreciation for the value and dignity of human life.

Knowledge:

2. *Analysis and decision-making*: a) Identification of the ethical issues in a case and the underlying opposing components

3. *Principles of ethics*:

d) Non-malfeasance— to do no harm (or the least harm possible)

e) Honesty as an absolute vs. situational good— when withholding information is appropriate in the context of culture, patient emotional and cognitive status, etc.

h) Patient competency and capacity:
   o Competence is a legal state, not a medical one. Competence refers to the degree of mental soundness necessary to make decisions about a specific issue or to carry out a specific act. All adults are presumed to be competent unless adjudicated otherwise by a court.
   o Capacity is defined as an individual's ability to make an informed decision.
   o Any licensed physician may make a determination of capacity.

i) Medical reasonableness as a factor in whether to offer or withhold treatment

j) Best interests of patient vs. autonomy (e.g., a patient chooses discharge to home when nursing home would be advisable)

k) Principle of double effect— it is acceptable to perform an action that is good in itself that has two effects (an intended good effect that is otherwise not reasonably attainable in another way, and an undesirable negative effect) provided there is a due proportion between the intended good and the permitted negative effect (e.g., it is acceptable to treat pain with narcotics even if that will hasten death in a patient who has a terminal illness)

Skills

Present differing priorities and options to the patient and his or her support group (e.g., family, legal guardian) when dealing with conflicting ethical issues.

## III.   Community Health Workers[34]

The Code of Ethics approved by the American Association of Community Health Workers in 2008 includes the following language that may bear upon abortion referral:

The Code of Ethics is based upon commonly understood principals that apply to all professionals within the health and social service fields (e.g. promotion of social justice, positive health, and dignity).

*1.4     Quality of Care:* Community Health Workers strive to provide high quality service to individuals, families, and communities. They do this through continued education, training, and an obligation to ensure the information they provide is up to date and accurate.

*2.1     Cultural Humility:* Community Health Workers possess expertise in the communities in which they serve.     They maintain a high degree of humility and respect for the cultural diversity within each community.

*2.3     Respect for Human Rights:* Community Health Workers respect the human rights of those they serve, advance principles of self-determination, and promote equitable relationships with all communities.

*3.2     Conduct:* Community Health Workers promote integrity in the delivery of health and social services. They respect the rights, dignity, and worth of all people and have an ethical obligation to report any inappropriate behavior (e.g. sexual harassment, racial discrimination, etc.) to the proper authority.

*4.1     Continuing Education:* Community Health Workers should remain up-to-date on any developments that substantially affect their ability to competently render services.

*4.3     Enhancing Community Capacity:* Community Health Workers help individuals and communities move toward self-sufficiency in order to promote the creation of opportunities and resources that support their autonomy.

The one statement regarding spiritual conflict reads:

*4.4     Wellness and Safety:* Community Health Workers are sensitive to their own personal well-being (physical, mental, and spiritual health) and strive to maintain a safe environment for themselves and the communities they serve.

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[34]   American Association of Community Health Workers (2008). American Association of Community Health Workers (2008) Code of Ethics for Community Health Workers. <machw.org/documents/CodeofEthics_approvedfinalJune2008.doc> Accessed March 21, 2013.

## IV.  Social Workers

The National Association of Social Workers Code of Ethics[35]  includes a number of items that client autonomy and rights. These include:

*Regarding to expand choice and opportunity, and to end social injustice*
- o  Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. [from Preamble]
- o  (b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups. [from Ethical Standard 6.04/ Social Action]

*Regarding the primary responsibility and goal of the social worker:*
- o  Social workers' primary goal is to help people in need and to address social problems. [from Ethical Principles/ Value: Service]
- o  Social workers' primary responsibility is to promote the wellbeing of clients. [Ethical Standard 1.01]

*Regarding Self-Determination*
- o  Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people. [from Ethical Principle: Value/ Social Justice]
- o  Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. [from Ethical Principle: Value/Dignity and Worth of the Person]
- o  Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. [from Ethical Standard 1.02]

However, it should be noted that the Code also states:
- o  Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. [from Ethical Standard 1.02]

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[35]  *National Association of Social Workers Code of Ethics*, 1996, revised 2008. Washington DC: NASW Press. http://www.socialworkers.org/pubs/code/code.asp. Accessed March 12, 2013.

*Regarding Informed Consent:*
- o Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. [from Ethical Standard 1.03]

*Regarding the responsibility to update knowledge and not participate in dishonesty.*
- o Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception. [from Dishonesty, Fraud, and Deception: 4.04 (b)]
- o Competence: (b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. (c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.
- o Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency. [From Misrepresentation 4.06 (a)]

*Regarding handling of conflicts of interest:*
- o (a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. (b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests. [From Conflicts of Interest 1.06 (a) and (b)]
- o Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this Code. [From Purpose Statement]

However, it should be noted that the language in the Purpose Statement continues as follows:
- o If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision. [From Purpose Statement]

*Regarding respect for colleagues:*
- o Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues. [From 2.01/ Respect (a)]

- Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. <u>Unwarranted negative criticism may include demeaning comments</u> that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. [From 2.01/Respect (b)]
- Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the wellbeing of clients. [From 2.01/ Respect (c)]

*Regarding the responsibility to intervene with conduct by colleagues*[36]
- Social workers should <u>take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues</u>. [From 2.11 Unethical Conduct of Colleagues (a)]
- Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. [from 2.11 Unethical Conduct of Colleagues (b)]
- Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive. [from 2.11 Unethical Conduct of Colleagues (c)]
- Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action. [From Incompetence among colleagues (a)]
- Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations. [From Incompetence among colleagues (a)]
- Social work <u>administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance</u> with the *NASW Code of Ethics*. [From 3.07 Administration (d)]

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[36] The NASW Code of Ethics has additional language on responsibilities and rights to intervene.