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Nurse Practitioners' and Certified Nurse Midwives' Experiences Providing Comprehensive Early Abortion Care in New England

Katherine Elisabeth Simmonds
University of Rhode Island, kathy_simmonds@hotmail.com

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NURSE PRACTITIONERS' AND CERTIFIED NURSE MIDWIVES'
EXPERIENCES PROVIDING COMPREHENSIVE
EARLY ABORTION CARE IN NEW ENGLAND

BY

KATHERINE ELISABETH SIMMONDS

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
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OF

KATHERINE ELISABETH SIMMONDS

APPROVED:

Dissertation Committee:

Major Professor: Debra Erickson-Owens

Donna Schwartz-Barcott

Alana Bibeau

Nasser H. Zawia

DEAN OF THE GRADUATE SCHOOL

UNIVERSITY OF RHODE ISLAND

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Abstract

Access to safe abortion care has been linked to better maternal and child health outcomes (Sedgh et al., 2012) and identified as essential for advancing women's economic and social equality (Bengsch, 2015; Lang, 2013). Around the world, nurses, including nurse practitioners (NPs) and certified nurse midwives (CNMs), are integral members of the health care teams that provide care to women considering or electing to have an abortion. Evidence supports NPs and CNMs as safe and effective providers of comprehensive early abortion care, and acceptable to patients (Barnard, Kim, Park, & Ngo, 2015; Kopp Kallner et al., 2015; Weitz et al., 2013).

Currently in the United States (US), almost one million women have an induced abortion each year (Jones & Jerman, 2017). National abortion data reveal significant disparities in rates, and inequities in access (Jerman, Jones, & Onda, 2016). An inconsistent legal and regulatory landscape precludes NPs and CNMs from providing comprehensive abortion care in many states, including some where there are few providers. Vermont and New Hampshire comprise two of the four states where laws and practice regulations allow NPs and CNMs to perform aspiration abortion, and across New England. These advanced practice nurses (APRNs) are extensively involved in providing and managing the care of women undergoing medication abortion.

Little literature describes nurses' experiences providing comprehensive early abortion care around the world, including in the US. The aim of this qualitative, exploratory, descriptive research study was to explore the experiences of NPs and CNMs who provide comprehensive early abortion care in New England. Data were collected through in-person individual interviews with seven NPs and one NP/CNM. Providing

comprehensive early abortion care was generally a positive experience for most participants, though it did include challenges. Critical influences to becoming an NP or CNM who provided comprehensive early abortion care included the era in which participants came of age, values of their family of origin, exposure to feminism, reproductive rights and social justice during emerging adulthood, having a role model or mentor, and a personal experience of having an abortion. Support at every level from interpersonal to societal was found to be a key enabling or constraining factor. Laws and regulations at the societal level were also noted to facilitate or impede abortion care provision by NPs and CNMs in the study. Finally, participants offered words of wisdom to others considering providing comprehensive early abortion care that ranged from clinical pearls to inspirational statements. They were universally encouraging in recommending this as a service to incorporate into clinical practice. This study has a number of implications for the future including the need for further research on NPs and CNMs experiences providing early abortion care in other regions of the US, and to remove state legislative and regulations that constrain practice for clinicians in this area of reproductive health care.

Acknowledgments

Carrying out a dissertation is no small undertaking. During the early stage, I likened it to jumping through a series of fiery hoops. After passing through one (Proposal!), another would appear (IRB approval!). It was a breathless but exhilarating run. In the later stage of analysis and writing, I found it to be more akin to running a marathon or enduring a prolonged birth. It required a level of focus and shutting out that felt partly luxurious and partly uncomfortably out of sync with the rhythm of the rest of the world. I am acutely aware that to have been able to dig in and tune out in this way required immense support from and extra work on the part of those around me. I am so very grateful to all who gave to me in this way. A few people deserve special mention in this regard.

Specifically, I was fortunate to have an extraordinary dissertation committee, headed by my major professor, Debra Erickson-Owens. An expert midwife-teacher-scholar, Deb deftly donned these various hats to help me through the agony and ecstasy over the days, months and years of my doctoral education. Ever patient, level-headed, clear-eyed, and deeply caring, I was so very lucky to have landed in her steady hands. The kindness and recognition she offered my family was also extraordinary. I cannot thank her enough.

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emulate in my own work with students and colleagues.

My other two Committee members, Alana Bibeau and Andrea Rusnock also contributed generously to this endeavor. Their feedback and support were particularly buoying, and I so enjoyed the unique disciplinary perspectives they brought to the Committee. It was a pleasure to get to know and work with them. Diana Taylor was also a valued behind-the-scenes original Committee member, who I missed having on for my entire dissertation journey but appreciate for her willingness to give me as much as she did.

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Dedication

To my mother, Anne, who's life taught me about the need for feminism and woman-centered care.

And to my father, Jim, who inspired and helped me believe I could do it.

Preface

In the qualitative research paradigm, it is considered good practice for researchers to acknowledge their positionality or situated knowledge as part of the research process. In this spirit, this dissertation begins with a description of the experiences with, relationship to, and assumptions about nursing practice and abortion care of the researcher.

As a nurse who has provided reproductive health care for over 25 years, including pre- and post-aspiration and medication abortion, my experiences in the field have profoundly shaped my interest in the research question “What is the experience of the nurse as a provider of comprehensive early abortion care?” Paradigmatically, I place myself as a critical theorist on the continuum between positivism and constructivism (Guba, 1990). I also, however, bring a strong pragmatist’s sensibility to the table, as my research interests tend to center on how to improve people’s health and lives. As someone who has nursing as my specific “practice paradigm,” I am drawn to research that investigates ways to alleviate human suffering and promote well-being.

Abortion is controversial. My care of women who were deciding whether and, in some cases, electing to have an abortion revealed to me that for some this health event provoked responses that other types of health care did not. From this, the question of what nurses “do” to address the particular needs of patients undergoing abortion emerged as an area of interest. In Kim’s typology (2010), this places my inquiry within the domain of the Nursing Practice.

In addition, my experience as a nurse who has provided abortion care led me to recognize that certain aspects of practice in this area extend beyond the clinical realm in

ways that seem to be unique. For example, whether, when, and how I told others – colleagues, family, friends, neighbors, others in my communities – that I provided abortion care in my role as a nurse and later as a nurse practitioner was different than how I revealed or discussed my other clinical responsibilities such as providing prenatal care or family planning. This seeded curiosity about what it was like for other nurses who provide abortion care. I became interested not only in what nurses do for patients undergoing abortion, but also in their experiences as health care workers and human beings, including with respect to their motivations, challenges, satisfactions, and preparation to become providers of abortion, as well as how this work affected their lives outside of work and relationships. There is little in the literature that describes these aspects of nurses’ experiences providing abortion care, particularly among those who provide comprehensive early abortion care in the US.

As a critical realist and pragmatist, my assumption is that the answers to my questions are “knowable,” and that research that engages nurses who provide abortion care can yield data to this end. My own unequivocal position on abortion is that all women should have access to safe, high quality care without consequences of shame or punishment, and that those who provide this type of health care also deserve safety and respect. These are values that undergird this research study.

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Chapter I

Introduction

Access to safe abortion care has been linked to better maternal and child health outcomes (Sedgh et al., 2012) and identified as essential for advancing women's economic and social equality (Bengsch, 2015; Lang, 2013). Nurses, including nurse practitioners (NPs) and certified nurse-midwives (CNMs), have been found to be safe and effective providers of comprehensive early abortion care (Barnard, Kim, Park, & Ngo, 2015; Kopp Kallner et al., 2015; Weitz et al., 2013). In many parts of the world, these trained, licensed health professionals are key members of the abortion workforce, providing essential access to care, particularly for vulnerable populations.¹

In the United States (US), abortion has been a legally protected constitutional right since 1973 (Balch Samora & Leslie, 2007). In 2014, 19% of all pregnancies in the US ended through induced abortion (Jones & Jerman, 2017a). Most (91%) occurred during the first twelve weeks of pregnancy (Pazol, Creanga, Jamieson, & Centers for Disease Control and Prevention [CDC], 2015). In spite of its legality and prevalence, abortion remains highly controversial in the US. Nurses at all levels of licensure are among the health professionals who provide direct care to the approximately one million US women who undergo this common yet contentious reproductive health event every year.

Examination of national abortion data reveal significant disparities in rates, and inequities in access. Three quarters of US women who have an abortion are classified as

¹ Vulnerable populations have been defined as consisting of “patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions” (Waisel, 2013, p. 186).

low income and almost half live at or below the federal poverty level (Jerman, Jones, & Onda, 2016). Black and Hispanic women, as compared to White women, are overrepresented among abortion patients (Jerman, Jones, & Onda, 2016). Emerging adults between 20 and 24 years old have higher rates of abortion than women of any other age group (Jerman, Jones, & Onda, 2016). Inequities in access to abortion services have also been observed, and attributed to factors including lack of public financing, restrictive legislation, and stigma (Bommaraju, Kavanaugh, Hou, & Bessett, 2016). Women from vulnerable populations have been found to experience particular difficulties obtaining abortions which have been linked to delays in care, and in some cases, continuation of pregnancies that are not wanted or attempts at self-abortion (Dehlendorf, Harris, & Weitz, 2013; Grossman et al., 2015; Mercier, Buchbinder, & Bryant, 2016; Roberts, Gould, Kimport, Weitz, & Foster, 2014; Stephens-Davidowitz, 2016; Upadhyay, Weitz, Jones, Barar, & Foster, 2014). In addition, women who live in rural areas have less access to health care compared to those who reside in urban areas (American College of Obstetricians and Gynecologists [ACOG], 2014a), and this pattern includes abortion services (Jones & Jerman, 2013; Jones & Jerman, 2017b).

Nurses have been found to be safe and effective providers of comprehensive early abortion care, as well as acceptable to patients (Barnard, Kim, Park, & Ngo, 2015; Kopp Kallner et al., 2015; Weitz et al., 2013). In a number of countries,² they have been

² Information on where nurses and midwives have legal authority to perform aspiration abortion and autonomously provide medication abortion is not readily available. Countries identified through the available literature include Bangladesh, Cambodia, Ethiopia, Ghana, India, Mozambique, Nepal, South Africa, Viet Nam and four states in the US (Barry & Rugg, 2015; Berer, 2009; Rominski et al., 2016; Skuster, 2015). This includes nurses at different levels of licensure/training in some countries, and in others, only at the advanced practice level (i.e. US). Nurses also have authority to autonomously provide medication abortion in many of these countries, as well as in some European countries including Sweden. In other European countries (i.e. France, UK) and other US states, nurses and midwives are extensively

granted authority to provide aspiration and medication abortion services with a high degree of autonomy and mobilized to expand access to abortion care, however, how many actually provide this reproductive health service around the world, and in the US specifically, is unknown.

In the US, an inconsistent legal and regulatory landscape precludes nurses, including those with advanced education and skills such as NPs and CNMs, from providing comprehensive abortion care in many states, including in some that have a limited extant provider pool (Barry & Rugg, 2015; Taylor, Safriet, & Weitz, 2009). Currently, NPs and CNMs are permitted to autonomously provide aspiration abortion in four states (Barry & Rugg, 2015), and to prescribe abortifacient medications in 16 (Guttmacher, 2018). Two of the four states where NPs and CNMs can legally provide aspiration abortion are in New England (VT, NH), and in five they are allowed to provide medication abortion either with complete autonomy (CT, NH, RI, VT) or with a requirement for physician oversight that is consistent with other prescriptive medications (MA). Even in states where they do not have authority to prescribe abortifacient medications, nurses, including registered nurses (RNs), NPs and CNMs, are extensively involved in providing and managing the care of women undergoing medication abortion in many healthcare delivery sites across the US. Removing legislative and regulatory barriers so these nurse clinicians can provide comprehensive early abortion care has been proposed as a strategy to expand abortion access, particularly for vulnerable and

involved in managing patients undergoing medication abortion, but do not have legal authority to provide this care autonomously.

rural women (ACOG, 2014b; APHA, 2011; Berer, 2009; Freedman, Battistelli, Gerdtz, & McLemore, 2015; Jackson, 2011; World Health Organization [WHO], 2012).

In addition to legislative and regulatory issues, other factors may impede or facilitate nurses' ability and willingness to participate in abortion care. Understanding what these factors are is valuable from a workforce planning perspective. Without this information, efforts to recruit and retain nurses to provide abortion care may be misguided or futile. Nurses with experience providing abortion care can offer essential insight into what is needed to initiate and sustain this work.

A review of the literature reveals that other than investigations into safety, efficacy, and acceptability, very little research has been carried out with nurses who provide comprehensive early abortion care. Only 25 studies from around the world could be identified that explored nurses' experiences of providing abortion care by querying those who actually do this work. Five of these studies focused on the provision of early abortion care. Just one was conducted in the US, the primary aim of which was to "explore the experience of clinicians learning to provide aspiration abortion, and how they develop confidence in performing this procedure" (Freedman & Levi, 2014, p. 78). Though the NPs and CNMs in the study, who were part of a health workforce training pilot project in California, reported the training had "moral and political significance" for them (p. 78), the main focus of the article was on the process of developing clinical confidence, and included little description of their experiences more broadly. The paucity of literature on the subject of nurses' experiences providing comprehensive early abortion care overall, and specifically of NPs and CNMs who are permitted to provide this service in some parts of the US, highlights a need for further research.

Purpose and Research Questions

The aim of this study is to describe nurses' experiences of providing comprehensive early abortion care in certain US states. The specific research questions are:

1. What is the experience of nurse practitioners (NP) and certified nurse midwives (CNM) who provide comprehensive early abortion care?
 - a. What leads them to provide comprehensive early abortion as part of their clinical practice?
 - b. What personal and/or professional factors enable and/or constrain them in providing comprehensive early abortion care, both initially and over time?
2. What recommendations do NPs and CNMs who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?

An inductive, exploratory, descriptive qualitative study was conducted to address these research questions. This particular approach was selected because it is considered suitable when attempting to explore and describe phenomena about which little is known or documented, as is the case with nurses who provide comprehensive early abortion care. In-depth interviews were conducted with seven NPs and one NP/CNM who provided comprehensive early abortion care in New England. This data collection method was selected because it is recognized as one that is well-suited to capturing participants' perspectives, which was a priority of this researcher since the "voice" of the nurse has been conspicuously absent in the literature on nurse-delivered abortion care.

Significance of the Study

This study is focused on nursing practice, one of four domains that comprise a typology created by Kim (2010) as a “way to structure conceptual fields for nursing” and help with “delineating and theorizing about phenomena of interest to nursing” (p. x). In order to prepare, recruit and retain nurses as a viable sector of the abortion workforce, it is essential to understand what leads some to provide this service, what factors enable and constrain them in providing (or attempting to provide) this care initially and over time, and what recommendations they have for others considering offering this service. This study helps to address these questions by exploring the experiences of NPs and CNMs who provide either comprehensive aspiration or medication abortion, or both, a subject about which very little research has been published.

Beyond their role as providers of care to individual women and their potential to increase population level access to services, nurses’ experiences providing abortion care is a subject worthy of investigation from a number of other vantage points. These include the perspectives of occupational justice, knowledge development in nursing, and holism. Occupational justice calls for safe, respectful work environments for all workers (Nilsson & Townsend, 2014). The contentious nature of abortion in the US, which has been marked by stigma, harassment and violence toward those who provide this care, including nurses (Harris, Debbink, Martin, & Hassinger, 2011), poses a challenge to these occupational standards. Findings from this study may contribute to efforts to promote occupational safety and dignity for nurses who provide abortion care, both in the workplace and outside of it.

Documenting and describing what nurses do, think and feel in their practice contributes to knowledge development within the discipline, and advances understanding of nursing practice among those outside it. This study contributes to understanding about nurses' experiences providing comprehensive early abortion care, a practice area that has been minimally described in the literature to date. Such research can be useful to the development of best practice guidelines and the education of future nurses. Findings may also be of interest to health care workers who provide abortion care irrespective of their disciplinary affiliation, as well as others seeking to advance abortion care through policy, public health and advocacy efforts. Ultimately knowledge generated by this study may contribute to enhanced care of women undergoing abortion.

Finally, this study adds to the extant literature by acknowledging nurses as complete human beings. Like the patients they care for, nurses also have complex affective and ethical responses, beloved partners and children, reside in neighborhoods, and are members of communities and organizations. By considering how providing abortion, a socially contentious, sometimes emotionally and morally stirring, often invisible type of care affects nurses in their lives, both within and outside of the workplace, we are reminded that they are more than just providers of care or a sector of the health workforce. Though holism is typically thought of as an approach to patient care within the discipline of nursing, in this study, this nursing gaze is turned to nurses themselves. In so doing, nurses, like the patients they care for, are recognized as whole human beings.

The following chapters include a review of the literature on the subject of nurses who provide abortion care around the world, in different settings, and across the

gestational age spectrum, with a particular focus on those who provide early abortion care. This is followed by a chapter on the methodology used in designing, conducting and analyzing this study. The next to last chapter presents the most pertinent findings of the study and discusses these in relation to the available literature. The final chapter includes a summary, conclusion, and acknowledgement of some of the limitations of this study. It ends with implications for the future, including in the areas of research, theory development, nursing education, administration and practice, and policy.

Chapter II

Literature Review

In the United States (US), abortion has been a legal right since 1973. At current rates, approximately one in four women will have an induced abortion by the end of her reproductive years (Jones & Jerman, 2017a). In 2014, close to one million US women had an abortion (Jones & Jerman, 2017b). Most of these were in early pregnancy and carried out or initiated in ambulatory clinical settings where a range of types of health care workers, including nurses, nurse practitioners (NPs) and certified nurse midwives (CNMs) provide care (Jatlaoui et al., 2016; Jones & Jerman, 2017b). Though it has been legal for almost half a century and is a common reproductive health event, abortion remains highly contentious.

Nurses and midwives have been recognized as capable of delivering safe and effective comprehensive early abortion care that is acceptable to women (Dawson, Bateson, Estoesta, & Sullivan, 2016; Weitz, et al., 2013; WHO, 2015). Around the world, they serve as a key sector of the abortion workforce, however, comprehensive country-level data about how many provide this reproductive health service are not readily available, including in the US. In some states, NPs and CNMs are permitted to provide comprehensive early abortion care, yet in most, laws and/or practice regulations prohibit them from doing so without extensive oversight or the direct involvement of a physician. Calls for the elimination of these restrictions have been made (Foster, Jackson, LaRoche, Simmonds, & Taylor, 2015; Freedman, Battistelli, Gerdtts, & McLemore, 2015; Jackson, 2011).

In order for nurses to provide safe, high quality abortion care, they must be skilled and supported in this clinical role (Global Health Workforce Alliance, 2010). Understanding what leads some to provide this care, what preparation they need, and what enablers and constraints they encounter is essential to recruiting and retaining them as part of the abortion workforce. In addition, nurses' experiences providing comprehensive early abortion care is of interest from an occupational justice perspective, and in terms of knowledge development in nursing. Finally, by holistically considering the experience of the nurse who provides abortion care, we are reminded that - like patients - she or he too is a human being.

The literature was reviewed to determine what is already known about the provision of abortion care by nurses, and about nurses who provide this type of reproductive health care. To that end, a broad search was executed using the key words "nurse," "advanced practice nurse," and "abortion," in the databases Web of Science (WoS), PubMed, CINAHL and Google Scholar. The terms "miscarriage," "pregnancy loss," and "spontaneous" were excluded, as were articles published in languages other than English. This yielded several hundred articles, which were scanned (titles and in some cases, abstracts) to gain a general sense of the focus and findings, and to eliminate those that were not relevant.

Literature identified through this search fell into one of two general categories. The first was comprised of publications that evaluated nurses as providers of abortion from an extrinsic or objective perspective, namely studies that investigated the safety, efficacy, and (in some cases) acceptability of nurse-delivered abortion care, or articles

that discussed the provision of abortion by nurses from a policy or public health perspective. The first half of this chapter provides an overview of this literature.

The second category consisted of literature pertaining to nurses' intrinsic or subjective experiences as providers of abortion. Because patient care is at the center, the *raison d'être*, of nursing practice, the literature that fell into the first category is presented as essential background, justifying a subsequent examination of literature in the latter category. In other words, without a rationale based in safe, effective acceptable patient care, nurses' subjective experiences do not really matter. On the other hand, if little is known about nurses' subjective experiences of providing patient care preparation, recruitment and retention for this clinical role may prove difficult. This is particularly likely in an area of clinical practice such as abortion that is socially contentious and can be ethically and emotionally stirring for some. The second half of this chapter describes what the literature does reveal about nurses' experiences of providing abortion care from *their* perspective, as well as about gaps in knowledge.

The Nature of Abortion Care

Abortion. Abortion is defined as the deliberate termination of pregnancy (Oxford dictionary, n.d.). Another frequently used term for this procedure (or act) is termination of pregnancy. Grimes and Stewart (2010) argue against the use of this term, stating that it is ambiguous, since all pregnancies terminate at some point. The terms inductive, elective, or therapeutic are sometimes used to distinguish this procedure (or act) from abortions that are spontaneous (also referred to as miscarriages). Hereafter in this paper, the term abortion will be used to refer only to the former category (i.e. not spontaneous abortions).

The Centers for Disease Control and Prevention (CDC) defines legal induced abortion as an intervention performed by a licensed clinician (e.g. a physician, nurse-midwife, nurse practitioner or physician assistant) that is intended to terminate an ongoing pregnancy (Pazol, Creanga, Jamieson, & CDC, 2015). Of note, this reporting system distinguishes two major categories of abortion, surgical and medical. Alternative terms for surgical abortion include aspiration, suction, curettage, and uterine evacuation. Regardless of the terminology, in this procedure suction is applied to remove a pregnancy and the surrounding endometrial tissue (also referred to as the products of conception or POC) from the uterus. For pregnancies of less than 14-15 weeks, this procedure does not typically require use of additional instruments. The CDC defines medical abortions as those that use medication instead of surgery to terminate a pregnancy (Pazol, Creanga, & Jamieson, 2015).

Weitz, Foster, Ellertson, and Stewart (2004) argue that the qualifiers surgical and medical abortion should be abandoned, and suggest use of the terms aspiration and medication abortion. In accord with Grimes and Stuart (2010) and Weitz et al. (2004), hereafter induction abortion is the general term, and aspiration and medication abortion the qualifiers used to describe specific sub-types of abortion.

Early abortion. The classification of an abortion as early, mid- or late- is based on gestational age (GA), however these terms are somewhat ambiguous in the literature (Grimes & Stuart, 2010). In this literature review and dissertation, early aspiration abortion has been operationalized as procedures performed for gestations of less than 14 weeks, criteria established by Barnard, Kim, Park, and Ngo (2015) as part of a systematic review relevant to this research topic. When referring to early medication

abortion, the US Food and Drug Administration's guidelines for use of mifepristone (an abortifacient medication) up to 70 days (10 weeks') gestation is used. Abortions that take place after those gestational ages (14 weeks for aspiration; 10 weeks for medication) are referred to as later or late abortion.

Comprehensive abortion. In a systematic review of the literature, Dawson, Bateson, Estoesta, and Sullivan (2016) define comprehensive abortion service delivery as the "provision of legal, safe, stigma free, high quality services that include abortion, post abortion care, contraception, and referral. This also involves attention to issues concerning information provision, initial assessment and arrangements for the procedure..." (p. 3). This definition has been adopted for this review of the literature and study.

Who has abortions? Worldwide, approximately 56 million abortions occur each year (Sedgh et al., 2016). It is estimated that nearly half (45%) of these are unsafe (Ganatra et al, 2017). In general, abortion rates tend to be higher in developing as compared to developed countries (also referred to as low-income and high income countries, or LICs and HICs), averaging 36 and 27 per 1,000 women (age 15-44 years) respectively. Most (97%) unsafe abortions take place in developing countries (Ganatra et al., 2017). Globally, 8-18% of maternal deaths are attributable to unsafe abortion (Kassebaum et al., 2014; Say et al., 2014). The World Health Organization (WHO) has recognized unsafe abortion as a significant contributor to maternal morbidity and mortality around the world, and is leading efforts to reduce it (WHO, 2012; 2015).

Trends in the United States. Approximately six million pregnancies occur in the US annually, and in 2014, one fifth ended in induced abortion. Overall, the rate of

abortion has been decreasing since it peaked in 1982 of 29.3 per 1,000 women (age 15-45) to 14.6/1,000 in 2014 (Finer & Zolna, 2016; Jones & Jerman, 2014; Jones & Jerman, 2017b). In 2013, most abortions (91.6%) in the US took place before 13 weeks' GA, and almost two-thirds (66%) were before eight weeks estimated gestational age (EGA) (Jatlaoui et al., 2016). This data, collected by the CDC, has been recognized as incomplete, yet is felt to be consistent with other estimates (Jones & Jerman, 2014).

Women who are poor, non-White, and/or young have disproportionately high rates of abortion in the US, signaling the presence of disparities that are inextricably linked to the broader social context of unwanted and mistimed pregnancies, and unequal access to health care, economic resources, education, and other social determinants of health (Jones, Finer, & Singh, 2010). Bommeraju and colleagues (2016) situate these observed differences in abortion rates within the larger landscape of pregnancy outcomes in the US, stating “abortion, along with fetal loss and infant death, is a far more common experience among women of color living in poverty than it is among middle-class white women.” (p. 63).

Abortion service delivery. Historically a variety of approaches have been used to induce abortion, including methods that women have applied to themselves (for self-induction) or have been used by others such as lay healers, midwives, and in more recent times, licensed health professionals (Ehrenreich & English, 1972; Joffe, 2009; Potts & Campbell, 2009) including physicians, midwives, nurses, and other “associate or advanced associate clinicians,” such as nurse practitioners (NPs) and physician assistants (PAs) (Freedman, Battistelli, Gerdtts, & McLemore, 2015; WHO, 2015).

Currently uterine aspiration is the most common method of abortion in the US, comprising approximately three quarters (77%) of all abortions (Jatlaoui et al., 2016). In all but five states, only physicians are legally permitted to perform this procedure (Barry & Rugg, 2015), however, in other parts of the world, nurses and midwives routinely perform uterine aspiration for early abortions and manage post-abortal complications (Barnard, Kim, Park, & Ngo, 2015). In gestations beyond 14-15 weeks, abortion is generally carried out through a method referred to as “dilation and evacuation” (or D & E), which is generally restricted to physicians with advanced clinical training and skill.

Alternatively, abortion can be induced through administration of medication. In many countries including the US, the most common regimen used in early pregnancy is a combination of the two drugs mifepristone and misoprostol (Jones & Jerman, 2017b). These drugs interrupt pregnancy development and promote expulsion from the uterus. Medication can also be administered to stimulate uterine contractions and the passage of a pregnancy in mid-trimester or later, however in the US, drugs other than mifepristone and misoprostol are typically used for this purpose (Paul et al., 2011). This approach, commonly referred to as “labor induction abortion,” is uncommon in the US (<1.0 %) (Jatlaoui et al., 2016).

Clinical settings and the abortion workforce. Most abortions (95%) in the US are performed or initiated outside hospitals in ambulatory or “free-standing” clinic settings (Jones & Jerman, 2017b). In 2014, 59% of all abortions were carried out or initiated in abortion clinics and 36% in non-specialized clinics that provided primarily family planning and other reproductive health services. The remaining abortions took place in hospital settings (4%) or private physicians’ offices (1%), respectively (Jones &

Jerman, 2017b). Those that occur in hospitals typically take place within dedicated abortion units, on labor and delivery floors, or in surgical suites. Globally, lack of available trained providers has been recognized as a key barrier in abortion access; this shortage is projected to increase over the decades ahead (WHO, 2015). Even in HICs, imbalances in the distribution of skilled health care workers contribute to inequities in access (Dawson, Bateson, Estoesta, & Sullivan, 2016; WHO, 2011).

In the publication, *Health worker roles in providing safe abortion care and post-abortion contraception* (WHO, 2015), types of health workers considered included specialist doctors, non-specialist doctors, advanced associate and associate clinicians, midwives, auxiliary nurse midwives and auxiliary nurses, doctors of complementary systems of medicine, pharmacists, pharmacy workers and lay health workers. The term physician will be used in lieu of doctor in this review. An alternative term to describe non-physician health care professionals used in some literature is midlevel providers. In the US, legal, comprehensive abortion care is provided by health professionals listed above in the first four categories. Midlevel providers, registered nurses (RNs) and APRNs, the terms that encompass the health care providers of interest in this review, are further described below.

Midlevel providers. Globally, the term midlevel providers (MLPs) is used to describe health care providers possess advanced clinical skills, including those related to abortion provision, but are not physicians. In a systematic review of abortion care by Barnard, Kim, Park and Ngo (2015), MLPS are defined as nurses, NPs, ayurvedic practitioners, PAs, midwives, auxiliary nurse midwives and CNMs. In the US, this term generally refers only to NPs, CNMs and PAs.

Nurses and APRNs. In the US, licensed vocational nurses and licensed practical nurses complete a post-secondary non-degree training program. These individuals work under the direction of a nurse with a higher level of education and licensure, or a physician. A registered nurse (RN) is someone who has completed either a Bachelor of Science degree in nursing or an associate's degree in nursing from an approved nursing program and has successfully passed the National Council Licensure Exam (NCLEX) (Bureau of Labor Statistics, 2018). A RN must be licensed in the state where they practice. According to the Bureau of Labor Statistics, "RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members" (2018, para. 1).

Advanced practice nurses (APRNs) are educated at a Master's or post Master's level and in a specific role and patient population. The four roles include NP, clinical nurse specialist, certified nurse anesthetist, and CNM, all of which are prepared to assess, order diagnostic tests, diagnose, promote health, and prevent and manage patient problems. In many states their authority includes the prescription and management of medication. The American Nurses Association (ANA) states that APRNs are "often primary care providers and are at the forefront of providing preventative care to the public" (ANA, n.d.). In the US, the regulation of nursing practice for RNs and APRNs varies from state to state. In this review, the term "nurse" is used to refer to both RNs and APRNs.

Quality of Abortion Care

The Institute of Medicine (IOM) has identified six domains that comprise quality health care (IOM, 2001). These include safety, efficacy, patient-centered, timely,

efficient and equitable. Literature that discusses these indicators of quality health care vis a vis abortion is considered here, with particular attention to those in which nursing care is represented. In addition, literature focused on patient access to and satisfaction with abortion services, which are closely related to quality, are discussed.

Safety and efficacy. When performed under conditions of legality, death due to abortion is rare. In the US, where abortion has been legal since 1973, the abortion mortality rate is among the lowest in the world. From 1998-2010, it was 0.7/100,000 women (Zane et al., 2015). Risk of mortality increases with advancing gestational age, rising from 0.3/100,000 for abortions at or before eight weeks to 6.7/100,000 at 18 weeks and above (Raymond & Grimes, 2012). In comparison, the mortality rate associated with delivery of a live neonate is 8.8/100,000 (Raymond & Grimes, 2012).

Induced abortion is highly effective. Aspiration procedures are nearly always successful (99.6%), even if completion requires involvement of a more experienced clinician (Ireland, Gatter, & Chen, 2015). Early medication abortion has an efficacy of 93-99%, with variation dependent on the method of misoprostol administration (oral versus buccal versus vaginal) and gestational age of the pregnancy (Chen & Creinin, 2015; Gatter, Cleland, & Nucatola, 2015).

Safety and efficacy of nursing care. A number of investigations into the safety and efficacy of nurses, as well as other “non-physician clinicians,” as providers of early aspiration and medication abortion have been carried out. Barnard, Kim, Park, and Ngo (2015) conducted a systematic review of studies published between 1980 and 2014 to compare the safety and effectiveness of early abortion delivered by MLPs, including nurses, midwives and others, and physicians. Primary outcomes were failure/incomplete

abortion (aka efficacy), and complications including hematometra, hemorrhage, endocervical injury, anesthesia-related reactions, uterine perforation, infection, injury to bowel, as well as complications requiring blood transfusion or hospitalization (aka “safety”). Of the 1273 unique citations identified, only eight met the final inclusion criteria. Together these studies represented a total of 22,018 participants in six countries (US, Nepal, India, South Africa, Viet Nam, Sweden). Three of the eight studies were randomized controlled trials (RCTs); the remainder were cohort studies. Five investigated aspiration procedures and three focused on medication abortion.

Findings of this systematic review included that there was not a statistically significant difference in rates of failure for medication abortion between the two provider groups (MLPs versus physicians). A higher risk of failed abortion was noted for aspiration abortions performed by MLPs, however, the strength of this evidence was deemed poor, leading the authors to call for more robust studies, rather than conclude that MLPs were less effective. Complications associated with aspiration abortion were equal across provider groups, and no complications were reported in any of the medication abortion studies. Four of the studies were conducted in LICs where death and disability due to abortion are, or until recently have been, quite high. In addition, providers in these studies included several types of non-physician clinicians that do not perform aspiration abortion in the US. Therefore, their applicability to the US, where death and disability due to abortion are low is somewhat circumscribed.

Of the three studies from the US that met inclusion criteria for this systematic review, only one included APRNs; the other two compared physicians and PAs. Weitz et al. (2013) investigated complication rates among 11,487 women who had aspiration

abortions up to 14 weeks' gestation performed by a physician or a newly trained NP, CNM or PA. Overall complications were rare (n=152), generally minor (96%), and though slightly higher among the non-physician group, were concluded to be clinically equivalent. The researchers noted that they anticipated this difference in complication rates to narrow over time as it was likely a reflection of experience rather than ability to perform the procedure safely as a function of professional affiliation. Findings regarding the acceptability to patients of care provided by the two provider groups is discussed further below.

One additional study in this systematic review warrants mention because of its HIC setting, which distinguished it from the other studies included. In this RCT, physician and CNM providers of medication abortion at an outpatient family planning unit in Sweden were compared (Kopp Kallner et al., 2015). The two groups were found to be equally safe, and effectiveness was higher when care was delivered by CNMs as compared with physicians.

Access to care. Bommaraju, Kavanaugh, Hou and Bessett (2016) assert that abortion is often more difficult to access than other types of reproductive health services in the US. Women who are members of vulnerable populations may have particular difficulty accessing abortion services (Dehlendorf & Weitz, 2011). Evidence indicates that such vulnerabilities lead to delays in care, and in some cases, the continuation of pregnancies that are not wanted (Roberts, Gould, Kimport, Weitz, & Foster, 2014; Upadhyay, Weitz, Jones, Barar, & Foster, 2014).

Women who live in rural areas generally have less access to health care than those who live in urban areas (ACOG, 2014), and this pattern is also evident with

abortion services. In 2014, 90% of US counties, where 39% of all US women resided, had no abortion provider (Jones & Jerman, 2017b). In 2008, 33% of women travelled over 25 miles to obtain an abortion, and more than half of those had to travel 50 miles or more (Jones & Jerman, 2013). More current data on average travel distances to an abortion provider are not available, however, given that legislation that restricts the provision of abortion has been increasing in recent years, it is unlikely that this trend has reversed (Nash, Benson Gold, Ansari-Thomas, Capello, & Mohammed, 2017). Laws collectively referred to as targeted regulation of provider (or TRAP laws) have been reported to cause providers in some states to stop providing abortion services, leading to increases in average travel distances for women in those areas (Fessenden, 2016). Overall, TRAP laws have been associated with delays in obtaining or forgoing abortion care altogether, as well as increasing attempts at self-abortion by women (Grossman et al., 2015; Mercier, Buchbinder, & Bryant, 2016; Stephens-Davidowitz, 2016).

Nurses and access to abortion. Though nurses provide abortion care in a variety of capacities and settings around the world, there has been relatively little exploration of whether and how their participation in the abortion workforce affects patient access to services (Aksel, Fein, Ketterer, Young, & Backus, 2013; WHO, 2015). Turk, Steinauer, Landy, and Kerns (2013) reported family planning physician subspecialists identified “lack of support from nursing colleagues” as the most common barrier to performing procedural abortions in advanced pregnancies.³ This finding was consistent with results from a small survey conducted in Massachusetts that reported nurses’ unavailability or

³ The delivery of later abortion services typically involves care delivery by nurses, including pre-procedure education, counseling, and obtaining informed consent; assisting during the procedure; and post-procedural recovery.

unwillingness to staff abortions in hospitals as problematic for patient access (Kade, Kumar, Polis, & Schaffer, 2003). In a study of barriers and enablers to abortion training for physicians in New York City, Guiahi and colleagues (2013) reported that “residents often cited examples of resistance to care for patients seeking abortion services from nursing staff members” (p. 242).

While these studies suggest nurses may influence patients’ access to abortions performed in hospital settings which typically are for later gestations, this evidence is limited and does not reveal anything about nurses and who provide abortion care in ambulatory, non-hospital settings, where most abortions take place in the US. On a methodological note, it is also noteworthy that none of these studies directly queried the nurses who provided abortion care in these sites. As Chiapetta-Swanson (2005) posits, this is not uncommon in research into nurses’ roles, particularly in hospital settings, which “focus on nurses’ work from the perspective of authoritative others concerned with what nurses ought to be doing and what role they ought to be playing” (2005, p. 93). In other words, insights about the role of nurses in facilitating and/or impeding patients’ access to abortion from the perspective of those who actually provide this care is absent from the literature.

APRNs and access to abortion. Globally, APRNs, along with other health care workers, have been identified as an important resource to “address health system shortages of specialized health-care professionals, improve equity in access to health care, and increase the acceptability of health services for those receiving them,” including abortion (WHO, 2015, p. 3). Though NPs and CNMs have been allowed to autonomously perform aspiration abortion in some US states since it became legal, and

medication abortion since mifepristone was approved in 2000 (Kishen, 2010), estimates of how many actually provide one or both of these types of abortion could not be found in the literature. This gap in data is not surprising, given that a broad gap in national nursing and health workforce data has been identified (Institute of Medicine, 2011; National Academies of Sciences, 2015).

Equitability. The IOM defines “equitability” as “care that does not vary in quality in relation to patients’ personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status” (IOM, 2001, p. 3). To date, little research has been conducted on this aspect of abortion care.

In one of the few published studies on this subject, Larsson, Fried, Essen, and Klingberg-Allvin (2016) interviewed 13 health care providers’ including 10 midwives who provided abortion care to immigrant women in Sweden. Researchers found participants acknowledged specific needs of immigrant women were challenging to deal with. They concluded that in order to achieve equitable abortion care, health care providers needed to be better equipped to handle encounters with these patients. They suggested more training could be an effective strategy for addressing this need.

Satisfaction. Few studies of patients’ satisfaction with abortion care have been carried out anywhere in the world, including the US (Taylor et al., 2013). The Picker Institute (1998) conducted a survey of 2,218 women at 12 abortion clinics across the US. Overall women were satisfied with the care they received. Researchers noted that investigation of women’s abortion experiences was difficult due to secrecy, reluctance to participate in studies about it, and the delivery of abortion services outside settings where patient satisfaction surveys are not routine.

Several more recent studies on patient satisfaction have been published, including by Taylor and colleagues (2013) and McLemore and colleagues (2014) as part of a workforce pilot project in California. Taylor et al. (2013) reported that the clinic environment, treatment by clinic staff, and management of pain were all significant contributors to the patient experience, whereas provider type was not. The latter finding is discussed in more detail below in the context of studies on the acceptability of providers. McLemore and colleagues' study involving 5,214 women found that for the majority, the abortion was better than expected. For those who did report their experience was worse than expected, clinic-level factors, such as pain management and wait time for appointments, were the most often cited reasons.

Wu, Godfrey, Prine, Andersen, MacNaughton, and Gold (2015) evaluated women's satisfaction with abortion care delivered in academic urban family medicine settings in the US. The study involving 210 women of diverse ethnic and racial backgrounds who had an abortion provided by a family medicine physician (attending or resident) found high rates of satisfaction (93%) with care received. The study did not explicitly examine or discuss nurse-delivered abortion care; however, it is still relevant to this literature review in that it suggested that, as long as the care is safe and otherwise of high quality, women may be satisfied with a range of providers. Other studies that also support this assertion are discussed below.

Patients' experiences of nurse-delivered abortion care. Very little literature explores the acceptability and satisfaction with nursing care for abortion among patients. Two studies included in the previously discussed systematic review on safety (Barnard, Kim, Park, & Ngo, 2015) did assess the acceptability of nurses as providers of aspiration

abortion. One conducted in Nepal (Basnett et al., 2012), and another in India (Jejeebhoy et al., 2011) reported that patients found nurses to be acceptable providers of first trimester aspiration abortion. No studies from HICs were found that explored the acceptability of RNs as providers of aspiration abortion. In addition, none of the previously mentioned studies from the US specifically teased out nurses' influence on patients' satisfaction with abortion care. McLemore and colleagues (2014) did report that the role of staff in women's experiences "could not be understated" (p. 597). Nurses were among the staff whose demeanor and non-judgmental stance were reported to be highly important by patients in that study.

While patients may not be aware or care about the professional identity of different health care workers they interact with when receiving care, determining specifically how nurses contribute to patients' experiences is important for the development of disciplinary knowledge, identifying "best practices," and preparing the workforce. The literature hints that nursing practice may influence patients' experiences, however it is not highly organized or intentional in this regard. No studies specifically investigated patients' experiences with the aim of elucidating nursing-delivered abortion care, however it can be inferred from the available literature that it does influence patients' experiences, both positively and negatively.

Acceptability of APRNs. In the aforementioned study by Kopp Kallner et al. (2015), most patients were indifferent as to whether their provider was a CNM or a physician, however those who were examined and counseled by a CNM reported that if they were to have another medical abortion in the future they would prefer a CNM provider. Those allocated to a CNM were also more likely to prefer their provider than

those who were allocated to a physician. These findings suggest that medication abortion delivered by CNMs may be superior to that provided by physicians in terms of efficacy as well as acceptability. While the investigators acknowledged the preference for CNM-delivered abortion care may be related to factors such as clinic wait times and a prevailing belief that “an uncomplicated TOP is not necessarily viewed as a medical condition that warrants the attention of a doctor” (p. 515), the findings also suggested there may be additional advantages for patients when CNMs provide this care.

Given that abortion service delivery and professional practice conditions are different from one country to another, findings from this study are not necessarily generalizable to midwives across international boundaries, or even more broadly to APRNs. However, it does provide rationale for further research to better understand CNMs’ abortion care practices, including how their unique professional knowledge and approach contribute to efficacy and positive patient experiences.

Both Warriner et al. (2006) and Taylor et al. (2013) reported on patients’ satisfaction with care received as part of having an aspiration abortion performed by either a MLP or physician. In the former, no significant differences in satisfaction were found between women in the two provider groups (Warriner et al., 2006). Taylor and colleagues (2013) sought to determine specifically whether clinician type has any influence on patients’ experiences of early aspiration abortion care with the rationale that “data not only on patient experience but also clinician acceptability are essential for achieving policy and practice change to improve access to and quality of abortion services” (p. 514). No significant differences in patients’ experiences as related to the type of provider who performed the abortion were found. In addition, investigators

reported the vast majority (81%) of women offered care by an NP/CNM/PA accepted it, which they concluded “suggests that—should these providers be permitted to perform abortions—women are likely to accept them, in addition to physicians, as their abortion care providers” (p. 514).

One other study warrants mention because its findings suggest that in addition to patients, other stakeholders’ opinions about the acceptability of non-physician providers may be pertinent to the makeup of the abortion care workforce and in shaping the experiences of non-physician abortion providers. The study, which was conducted in India, sought to “shed light on the views of a range of health care providers (HCPs) on the provision of medical abortion by nurses and AYUSH⁴ physicians” (Acharya & Kalyanwala, 2015, p. 37). Rationale for the study came from previous research that indicated physicians were often opposed to allowing non-physicians to provide abortion. The finding that “few certified physicians” thought patients would find nurses to be acceptable medical abortion providers suggests that physician attitudes and opinions may be important in other countries as well, including in the US.

Nurses and Abortion Care

In many countries and settings, nurses are key members of the health care teams that provide direct patient care before, during and after an abortion procedure or process. In addition to the absence of data that document nurses’ participation in the abortion work force, literature that describes nursing practice in this area is also scant, and includes only a few identifiable sources, described briefly here.

⁴ AYUSH is an acronym used within the health system of India that stands for Ayurveda, Yoga, Naturopathy, Unani, Siddah, Homeopathy.

WHO has developed evidence-based abortion care guidelines that specify tasks that can be safely, effectively and acceptably performed by health care workers including nurses, midwives and “other associate or advanced associate clinicians” such as NPs (WHO, 2015). These guidelines delineate activities that nurses and other health care workers may carry out in the course of caring for patients seeking an abortion, however these are not described in detail.

The Royal College of Nursing of the United Kingdom published a comprehensive guide on *Termination of Pregnancy* (2013) for nurses, which encompasses nurses, midwives and specialist community public health nurses. Though it is intended for those who practice in the UK, it is one of the few publications that outlines the role and responsibilities of nurses in abortion care. In South Africa, where RNs were granted authority to perform abortion up to 12 weeks’ gestation in 1996, a national certificate short course entitled “Termination of Pregnancy and related Reproductive Health Issues” that includes 14 specific learning outcomes was developed by the Limpopo College of Nursing.

Advancing New Standards in Reproductive Health (ANSIRH) has issued core competencies for comprehensive early abortion care for primary care providers, which is inclusive of NPs and CNMs. Other curricula and teaching and learning tools for primary care clinicians, including nurses and APRNs, have also been published in the US (Goodman et al., 2016), however no existing literature, including “grey” literature,⁵

⁵ Grey literature has been defined as material which is "not available through the conventional, commercial distribution channels" (Alberani, De Castro Pietrangeli & Mazza, 1990, p. 358). As such it encompasses publications that are “non-conventional, fugitive, and sometimes ephemeral” (New York Academy of Medicine, n.d.) such as reports, theses, conference proceedings, technical specifications and standards, non-commercial translations, bibliographies, technical and commercial documentation, and official documents not published commercially (Alberani, De Castro Pietrangeli & Mazza, 1990).

offers a comprehensive description of the scope and standards of nursing practice in abortion care in the US.

In the available literature, some descriptions of responsibilities and tasks that nurses perform as part of their role providing abortion care can be found, however none render this information in an exhaustive or systematic manner. Activities mentioned include (but are not limited to) pre-abortion screening, counseling and obtaining of informed consent; administration of medications; pain management; monitoring patients for stability and general well-being; and providing education about post-procedure self-care, complications, and contraception. In some settings, handling and disposing of the products of conception (POC) or fetus after an abortion are a duty of the nurse (Chiapetta-Swanson, 2005; Christensen, Christiansen & Petersson, 2012; Huntington, 2002). In addition, nurses provide abortion-related care by telephone and other modes of communication (i.e. electronic), including responding to patient inquiries following uterine aspiration or during a medication abortion. In some locales, nurses also play a central role in the delivery of medication abortion care through “telemedicine,” an emergent approach to care delivery (Grindlay, Lane & Grossman, 2013; Grossman & Grindlay, 2017). Providing emotional support to patients through all phases of an abortion is another aspect of nursing care (Chiapetta-Swanson, 2005; Huntington, 2002; Lipp, 2008). RNs are not permitted to perform aspiration abortion anywhere in the US.

APRNs as providers of comprehensive abortion care. In some states, APRNs can provide abortion care that goes beyond the responsibilities of RNs mentioned previously to include determining patient eligibility, prescribing abortifacient medications, managing post-abortion recovery, and comprehensively addressing other

primary health care needs, such as contraception, cervical and breast cancer screening, and other health issues. Currently, it is legal for APRNs to perform aspiration abortions in California, Vermont, New Hampshire and Oregon (Barry & Rugg, 2015).

Policy perspectives on nurses as abortion providers. Given the mounting evidence on safety, effectiveness and acceptability, there has been a growing global movement to expand provision of comprehensive early abortion care by nurses, particularly in countries with highly constrained health resources and high rates of maternal mortality (Berer, 2009; WHO, 2015). While these are not major influencers of abortion policy in the US, concerns about inequitable access have led some to advocate for nurses, in particular NPs and CNMs, to be able to provide this care (Berer, 2009; Freedman, Battistelli, Gerds, & McLemore, 2015; Jackson, 2011). Others have argued in favor of NPs and CNMs as abortion providers from the position of scope of practice parity: Advanced health care providers deliver other types of care that are equally or more complex than early abortion yet are not restricted. At present, RNs' and APRNs' authority to provide comprehensive early abortion care varies based on the intersection of credentialing, scope of practice and abortion laws in the state and health system in which they practice.

The cumulative evidence has led prominent national and international organizations including the American College of Obstetrics and Gynecologists (ACOG, 2014b), the American Public Health Association (APHA, 2011), and WHO (2012) to endorse APRNs as providers of comprehensive early abortion care. A substantial body of literature from public health and policy perspectives has also been published, converging on the need for policy changes to allow trained APRNs to autonomously provide

abortion, a shift that could expand access to services without compromising safety or satisfaction, or transgress scope of practice standards.

Occupational Justice, Knowledge Development, Holism and Flourishing

In addition to the centrally-important questions of efficacy, and patient safety and satisfaction with nurse-delivered abortion care, nurses' experiences providing this care is a subject that is worthy of investigation in its own right from a number of perspectives.

Occupational justice and abortion. Occupational justice calls for safe, respectful work environments for all workers (Nilson & Townsend, 2014). In the US, harassment and violence have been directed toward facilities and individuals who provide abortion services, including nurses. Research has also indicated that some abortion workers, including nurses, experience stigma related to their role (Harris, Debbink, Martin, & Hassinger, 2011). To foster conditions that promote safety and respect for nurses who provide abortion care, it is essential to consider their experiences of this work.

Building nursing knowledge in abortion care. Documenting, delineating, and describing what nurses actually do and think in their role as providers of patient care contributes to knowledge development within the discipline, as well as greater understanding of nursing practice by those outside of it. Such information is useful for developing best practice guidelines, and educating future nurses, processes that ultimately enhance patient care, but also are valuable for delineating "those approaches to reasoning, conceptualizing and interpretive application that differentiate 'a nursing lens' on the world from that of any other...even as it is applied and enacted within a shared or interdisciplinary universe" (Thorne, 2014, p. 1-2). Abortion care is an area of

nursing practice about which very little scholarly work has been published, and therefore its exploration holds great potential to contribute new knowledge to the discipline.

Holism applied to nurses who provide abortion care. Holism is a long-standing approach to patient care within nursing that has been traced to Florence Nightingale, who advanced the notion that nurses care for the whole person, not just their bodies (Dossey & Keegan, 2013). Many nurse scholars and practitioners have built on and further refined this idea and approach to nursing care, which has been termed holistic. The American Holistic Nursing Association (AHNA) defines holistic nursing as “nursing practice that has healing the whole person as its goal” and focuses on the principles of holism including “unity, wellness, and the interrelationship of human beings and their environment” (AHNA, n.d.). A concept that is closely related to holism is “human flourishing” which the National League for Nursing (NLN) defines as:

an effort to achieve self-actualization and fulfillment within the context of a larger community of individuals, each with the right to pursue his or her own such efforts. It encompasses the uniqueness, dignity, diversity, freedom, happiness, and holistic well-being of the individual within the larger family, community, and population. Achieving human flourishing is a life-long existential journey of hopes, achievements, regrets, losses, illness, suffering, and coping (NLN, 2014, p. 1).

Though the perspectives of holism and fostering human flourishing are typically considered in relation to nursing care of patients, this lens can be turned to consider nurses themselves, who are, after all, also human beings. By seeing nurses who provide

abortion care through this lens, a more complete and expansive vision of who they are, what they experience and what they need to thrive can emerge.

These three perspectives - occupational justice, disciplinary knowledge development, and holism/human flourishing - go beyond those that consider nurses only in terms of their safety, efficacy and acceptability to patients or their potential contributions to the abortion workforce, offering justification for a review of the available literature to determine what is known about nurses' subjective experiences of providing abortion care. Looking at the literature in this way can yield insights about what nurses actually do, think and feel in delivering abortion care, whether they feel safe and respected in this role, and how it contributes to or detracts from their lives overall. A review of the available literature from this vantage point is the subject of the next section.

Nurses' Experiences of Providing Abortion Care

In the previous section, the focus was on literature concerned with what nurses can safely, effectively, and acceptably "do" with regard to specific tasks and clinical duties that are part of comprehensive abortion care. The underlying rationale for much of that research comes from an imperative to address the high rates of maternal mortality due to unsafe abortion that persist in many parts of the world. In countries such as the US where abortion is no longer a significant cause of maternal morbidity and mortality, this research has been justified in relation to reducing access inequities and rectifying inconsistencies in the regulation of nursing practice. Most of the aforementioned literature considered nursing from an objective or "outsider" perspective, and deployed quantitative methods to evaluate their safety, efficacy, and acceptability as providers of

abortion care. These are centrally important issues that must be addressed before any HCP is given the responsibility or authority to provide a specific type of patient care. Sufficient evidence has been compiled to make a strong case for APRNs to be allowed to provide comprehensive early abortion care. This in turn opens possibilities for considering other aspects of nurse-delivered abortion care.

In the literature reviewed in the previous section, the “voice” of the nurse is absent. This is a serious omission: without knowledge about nursing practice and hearing about the experience of providing abortion care from the perspective of those who do this work, efforts to train, recruit and retain nurses as part of the abortion workforce may be misguided, and creating conditions that foster respect and dignity may be overlooked. On an even broader level, failure to recognize the full humanity of nurses who provide abortion reduces them to mere workers, rather than the complex embodied, relational, situated agents that they are.

With this rationale, studies identified through the broad search previously described were reconsidered, but this time only those in which the primary participants were nurses who provided abortion care were included. Those that described or investigated the opinions, attitudes, or perspectives of nurses who did not actually participate in abortion care were not considered. Ultimately, this yielded a group of 25 studies,⁶ which were closely reviewed to determine what they revealed about nurses’ experiences of providing abortion care from *their* perspective. (Appendix A, Table 1).

⁶ Publications by Lipp (et al.) and McLemore (et al.) were based on one original research study, which was then used as the basis for several different but related publications. For purposes of this review, these were counted as a single study.

The 25 studies in this group were carried out in 12 different countries. Four were conducted in the US, including in California, Michigan, and one cross-national sample (Hanna, 2005). Most (16) used qualitative methods, yet varied widely in their aims, designs, methods, and findings, as well as quality. In eleven studies, abortion care was delivered in hospitals; nine were among nurses and midwives who exclusively provided care in ambulatory, clinic-based settings; six either did not specify the setting or is was provided in a variety of settings (i.e. McLemore, Kools, & Levi, 2015a, 2015b). In six of the studies, participants provided abortion care across all gestational ages (up to the legal limit in the country). Ten did not indicate a specific GA range within which participants provided abortion care. Five focused on participants' who provided only early abortion care, and five provided later abortion care exclusively. Sixteen studies set out to investigate nurses' experiences broadly, while others had more focused aims related to a specific aspect of the experience, such as exploring nurses' "psychosocial, educational, and administrative support needs" (Parker, Swanson, & Frunchak, 2014, p. 478). The reasons abortion care was provided were varied or unspecified in most of the studies, however, four focused on the experience of providing abortion for fetal anomalies exclusively (Chiapetta-Swanson, 2005; Cignacco, 2002; Garel, Etienne, Blondel & Dommergues, 2007; Garel, Gosme-Seguret, Kaminski, & Cuttini, 2002). Fetal anomaly was explicitly mentioned as a common indication for abortions performed in two other studies as well (Christensen, Christiansen, & Petersson, 2013; Parker, Swanson, & Frunchak, 2014).

All of these studies were read to gather a general sense of what this body of research conveyed about nurses' experiences of providing abortion care. The wide

variations in aims, designs and methods were recognized as limiting the generalizability and transferability of most of these studies' findings. Nevertheless, as a body of literature, they were felt to project an overall impression that providing abortion care was generally difficult, stressful and morally perplexing for nurses. Factors including the level of economic development in the country, demand for abortion services, laws and prevailing attitudes regarding abortion and nursing practice, gestational age at which abortions were performed, and indications for abortion stood out as important and distinguishing influences on nurses' experiences of providing this care. Specifically, providing abortion care in LICs, hospitals, for later gestations and/or for reasons of fetal anomaly were noted to contain generally negative reports from nurses about their experiences.

Given the interest in expanding provision of comprehensive early abortion care by APRNs in the US, a further narrowing the focus of this literature review was undertaken. Of the 25 studies listed above, only five focused on nurses' experiences providing comprehensive early abortion (Birdsey, Crankshaw, Mould & Ramklass, 2016; Contreras, van Dijk, Sanchez, & Smith, 2011; Gmeiner, Van Wyck, Poggenpoel, & Myburgh, 2000; Möller, Öfverstedt & Siwe, 2012); four of these were conducted in LICs, including South Africa (2), Mexico, and Nepal, all of which were characterized by relatively short time periods (1-15 years) since abortion had been legalized prior to the published study. The transferability of these studies to high income countries (HICs) and those where abortion has been legal for an extended period of time is limited. These studies are summarized in Appendix A, Table 2.

Out of this group of five, the sole study conducted in the US sought to “explore the experience of clinicians learning to provide aspiration abortion and how they develop confidence in performing this procedure” (Freedman & Levi, 2014, p. 78). Participants included NPs and CNMs who had participated in a health workforce training pilot project in California. Researchers reported participation in the training had “moral and political significance for the trainees” (p. 78), however the main focus of this publication was on clinicians’ process of developing confidence. Thus, while the study contributes to “the discussion within the social science of health care and medicine about how clinicians know what they know and what expertise feels like to them” (p. 78), it does not provide a broad description of nurses’ experiences providing comprehensive early abortion, nor do its findings transfer readily to nurses outside of a formal training program, or to those who provide abortion in other regions of the US. The paucity of literature on this subject overall, and in the US specifically, exposes a need for further research on nurses who provide comprehensive early abortion care.

Chapter III

Methodology

The aim of this study was to describe the experience of nurses who provide comprehensive early abortion care in New England. Specifically, the research questions were:

1. What is the experience of nurse practitioners (NP) and certified nurse midwives (CNM) who provide comprehensive early abortion care?
 - a. What leads them to provide comprehensive early abortion as part of their clinical practice?
 - b. What personal and/or professional factors enable and/or constrain them in providing comprehensive early abortion care, both initially and over time?
2. What recommendations do NPs and CNMs who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?

Because of the exploratory nature of this study and the high priority given to hearing directly from nurses who actually provide comprehensive early abortion care, a qualitative, descriptive design was used. This approach has been identified as particularly useful for generating a “straightforward” summary of the “who, what, and where” of events (Sandelowski, 2000), and well-suited for conducting research into phenomena that are not already well-described or understood. As the previous chapter revealed, nurses’ experiences providing comprehensive early abortion care in the US is a subject that fits this criterion. In addition, a particular appeal of qualitative descriptive

research rests in its ability to obtain “straight and largely unadorned answers to questions of special relevance to practitioners and policy makers” (Sandelowski, 2000, p. 337), which also align with priorities of this researcher in answering the research questions.

Data Collection

Several considerations drove the selection of the interview as the approach for data collection in this study. These included that interviews can be structured to facilitate gathering a broad range of information which is desired when attempting to describe phenomena about which little is known or documented, such as nurses’ experiences of providing comprehensive early abortion care. In addition, interviews can capture a participant’s voice, allowing his or her perspective on important events and elements of a phenomenon to be relayed. This is particularly important when the subject of inquiry involves people who have historically been overlooked, oppressed, or misrepresented in research. It can be argued that the practice discipline of nursing – especially relative to medicine - has not been well-documented or understood overall, and that nurses’ voices are generally underrepresented in health care research. In this regard, interviews can be an optimal tool for gathering data about nurses and nursing, especially in areas of clinical practice that have rarely been the focus of research such as abortion care.

Interviews were conducted individually with participants in this study. This approach was chosen because it offered certain advantages over group interviews, including that it afforded participants greater privacy and minimized the risk of “groupthink” (Fontana & Frey, 2000), which may be heightened when the subject of inquiry is controversial. Because abortion is a highly charged topic, participants’ privacy and confidentiality were a high priority. These advantages were weighed against those

inherent in group interviews, namely the synergistic effect of participants building on one another's responses. However, when combined with the pragmatic issues involved in arranging a focus group (or groups) for a sample that included busy clinicians spread across a sizeable geographic area, the balance tipped in favor of individual interviews.

Selection of participants. Participants who were licensed NPs or CNMs currently providing comprehensive abortion care in New England were selected for this study. The decision to include these clinicians stemmed from several factors. First, though registered nurses (RNs) and other advanced practice nurses (APRNs) including Clinical Nurse Specialists (CNSs) and Certified Registered Nurse Anesthetists (CRNAs) are vital members of the abortion workforce in the US, at the time the study was conducted only NPs and CNMs had legal and regulatory authority to autonomously perform aspiration abortion or prescribe abortifacient medications in any state. Therefore, requiring licensure as an NP or CNM was based on the rationale that this subset of nurses held the greatest potential to expand patient access to abortion, including in non-traditional settings such as primary care clinics and rural outposts where underserved and vulnerable populations often present for care. Furthermore, because NPs and CNMs are regulated and educated differently than other types of nurses, narrowing the participants to these two groups was felt to be a reasonable tradeoff between homogeneity and variation, favoring depth over breadth in the data collected.

The decision to focus on NPs and CNMs in New England was also based on a number of factors. First, as a region New England had historically been on the forefront of nurse-delivered comprehensive early abortion care in the US, with Vermont and New

Hampshire allowing NPs and CNMs to provide aspiration abortion since it became a constitutional right. At the time of the study, those two states comprised half of those in the country where APRNs were permitted to perform this procedure. Thus, New England represented one of the few regions where nurses' experiences of providing comprehensive early abortion care could be explored. In addition, NPs and CNMs were extensively involved in the provision of medication abortion in all six of the New England states, and physician oversight was not required in Connecticut, Rhode Island, Vermont or New Hampshire (Guttmacher Institute, 2018). Conducting the study in this region was felt to hold potential to inform NPs and CNMs seeking to add medication or aspiration abortion to their clinical practice in other clinical agencies in the region, and other states in the country.

Finally, New England was chosen as the geographic area for this study because it was the investigator's professional home, which conferred several advantages to the data collection process. First, leveraging existing professional networks was identified as a strategy to counter possible difficulties with recruitment arising from the controversial nature of abortion. Furthermore, narrowing the sample to NPs and CNMs who practiced in New England made conducting in-person interviews more feasible. Given the sensitive nature of the subject, such direct face-to-face contact was felt to be vital to establishing rapport and trust with participants.

This study used purposeful convenience sampling, an approach that was favored because it yields "information rich" cases (Sandelowski, 2000). Recruitment for the study was carried out by sending an electronic letter describing the study's purpose and requesting individuals interested in participating to contact the researcher. (Appendix B).

This letter was sent to individuals known to the researcher from many years of working in the field of reproductive health in the region. These individuals were instructed to respond to the invitation as potential participants or to forward it to others they knew and thought might be interested and eligible to participate in the study. Some of the strengths and limitations of this recruitment approach are discussed below. Participants were informed of risks or potential harms associated with the study as part of the informed consent process. Institutional Review Board (IRB) approval of the study was obtained through the University of Rhode Island. (Appendix C). Eight individuals identified through this recruitment effort were willing and consented to participate in this study. (Appendix D).

Insiderness. Drawing a sample from people known to or familiar with a researcher was recognized as having potential consequences for the collection and interpretation of data, including that participants may respond in ways that are influenced by their relationship with the researcher. For example, they may say what they think the researcher wants to hear, or alternately, withhold their authentic or honest responses because of concerns about the researcher opinion of them. At the same time, such familiarity can promote greater openness and willingness to share, which again, may be particularly at play if the subject of inquiry is controversial. Schatzman and Strauss (1973) refer to this phenomenon as insiderness.

Insiderness can also come into play during analysis, as a researcher's interpretation of data may be influenced by pre-existing notions or perceptions about a participant or the subject itself. Given the recruitment strategy and the researcher's history of working in the field of reproductive health and abortion, such threats to

credibility were present, however, in the end the potential advantages of easier recruitment and maximizing trust and rapport with participants were felt to be greater. Acknowledging one's pre-existing relationship to and experience with an area of investigation, as this investigator has done in the preface to this dissertation, is a bulwark against this threat to the study's overall trustworthiness.

Participants. Seven NPs and one dually certified NP/CNM participated in this study. Two were licensed and practiced in the state of Vermont; two in Maine; three in Massachusetts; and one in Connecticut. No individuals who practiced in Rhode Island or New Hampshire were represented in the study. The number of years participants had been in clinical practice ranged from six to over forty. All had a minimum of a Master's degree (in Nursing); one had recently completed a Doctor of Nursing Practice (DNP) degree, and one was currently enrolled in a DNP program. One had completed a PhD (in Ethics) before becoming a nurse. The age range was from 31 to 68 years; two were in their early thirties, two in their mid-forties, two in their fifties, and two in their sixties. All of the participants were White females. Religious affiliations included atheist, Quaker, Jewish, Unitarian-Buddhist ("Buddha-tarian"), and no affiliation.

Data Collection and Analysis

The "negotiated" interview. Fontana and Frey (2000) describe the "negotiated interview" as an approach to conducting interviews that upends the traditional hierarchy between researchers and those being researched. This technique utilizes open-ended questions or is altogether unstructured, allowing the participant to have "control of sequencing and the language of the interview and...the freedom of open-ended responses" (Fontana & Frey, 2000, pp. 658-659). which helps promote understanding

without “imposing any a priori categorization that may limit the field of inquiry” (Fontana & Frey, p. 653). By using this strategy, the research endeavor moves away from the positivist tradition, which seeks to explain, and draws instead from relativist, post-modernist and feminist perspectives, where the focus is on simply understanding and describing. In making this shift, an effort is made to rectify the imbalance of power and position between interviewer and interviewee by relaying the authentic voice of those being studied. The radical belief that underlies this interview approach is captured by Fontana and Frey’s statement “to learn about people, we must treat them as people” (2000, p. 668).

Fontana and Frey’s general approach to the interview was used during this study, including through the use of open-ended interview questions and giving participants the opportunity to review their transcript and provide feedback. This approach to questioning elicited a broad range of responses from participants, some of which were very concrete or chronologically ordered, whereas in others it seemed to simply serve as a springboard for them to talk broadly or in a free-ranging way about the subject. Though transcripts were provided to the participants to review, none gave any feedback, nor made corrections or otherwise asked for any content to be added or removed. One did respond with the comment “Aside from the fact that it is shocking to see how many times I say “like,” I think it looks fine! Great transcription!...It seems very accurate.” As very busy clinicians, it was possible that providing feedback on the interview was simply not a priority for them, or that they did not feel comfortable commenting on the transcript, which represented an academic endeavor with which they were not particularly familiar or comfortable.

Overall Fontana and Frey's approach was felt to be beneficial to the research endeavor, as it led to insights about the participants as whole people. It also gave the study greater credibility. At the same time, in some instances the open-ended questioning proved challenging for the researcher who, as a novice, sometimes felt tension around curtailing participants' responses when they became long or were not clearly related to the research questions. Nevertheless, on the whole the use of open-ended questions yielded rich data and allowed each participants' unique voice to come through. Efforts were made to further uphold Fontana and Frey's guidance by staying close to participants' words during the analysis and write up. In this way, thoughts and perceptions of those who were at the center of the study - in this case, NPs and CNMs - rather than those of the researcher, were reflected.

The interviews. Participants were interviewed in sites that were mutually determined, with priority given to convenience (for the participant), privacy and confidentiality. The first interview was conducted in a private study room at a public library near the participant's home and worksite. The six subsequent interviews took place at the participants' homes. The last interview was carried out in a conference room at the participant's place of work, which she strongly asserted would not compromise her ability to speak freely about her experience. Interviewing participants in their homes was found to add particular depth and richness to the data, as it yielded information about them as whole people, including about their relationships with partners, the homes and the types of neighborhoods where they lived, that would not otherwise not have been available to the researcher. This information added to the study's findings,

particularly with respect to the overarching research question which sought to describe participants' overall experience of providing abortion care.

An interview guide was developed that included several open-ended questions that were aligned with the research questions. (Appendix E). All of the interviews started with an opening question about what it was like to provide abortion care. As mentioned, this open-ended question prompted a variety of types of responses from participants, including some that focused narrowly on the direct care of patients while others gave descriptions of their affective experience. Several immediately began to relay a chronologically ordered history of how they came to provide abortion. Other open-ended interview questions aligned with the research questions were asked unless participants had already offered this information in response to the first question. These included questions about what led them to provide abortion, had helped or made it hard for them to provide abortion care, and advice they had for others thinking about providing abortion care. Probes were also generated, but only when participants' responses to the open-ended questions were limited or strayed from the topic of interest.

All interviews were audio-recorded, and additional notes related to the setting, conditions surrounding the interview, and other relevant observations were made prior to and immediately after each interview. After the first two interviews were completed, transcribed and reviewed by the researcher and two of the dissertation committee members, one of the probing questions was modified slightly, shifting it from a query about a typical clinical day to a patient experience. (Appendix E). After the first two interviews, the researcher's increased proficiency was felt to be sufficient to preclude the need for follow up telephone interviews with the rest of the participants, however,

several follow up emails were sent to obtain specific data that was missing or required clarification.

Data analysis. Each interview was transcribed as soon as possible after it was conducted. The researcher transcribed the entire first and second interviews and, as mentioned. These were reviewed by the first and second dissertation committee members. At that point, the decision to conduct follow up interviews by telephone with the first two participants was made in order to elicit data that was felt to be missing from the initial in-person interviews. In both of those, the participants' descriptions about what led them to provide abortion care was felt to lack depth and a clear sense of the origin and trajectory. The follow up interviews provided an opportunity to revisit this topic with the participants. It was subsequently addressed more consistently during the rest of the initial interviews when participants did not spontaneously bring it up. The researcher transcribed the follow up interviews as well. For the other six interviews, a professional transcriptionist was engaged. Names of participants' and any additional persons, clinical agencies or other identifiers were removed from the transcripts to protect confidentiality. To ensure accuracy, each transcript was read in its entirety and edited by the researcher while listening to the audio-tape.

Analysis of all transcripts was then carried out in the following stepwise approach: First, each was read in its entirety several times by the researcher, as well as by the two dissertation Committee members. As mentioned, each study participant was also sent their interview transcript with an invitation to correct, add or offer any other changes that they felt were warranted to ensure that it was accurate and reflective of their experience. None requested that any changes or additions be made.

As each transcript was read, the researcher wrote a summary impression of each that included observational (ON), theoretical (TN), and observational notes (ON). This notation system is based on one developed by Schatzman and Strauss (1973), in which ON's are straightforward statements that capture the "who, what, where, when and how of the phenomenon" (Schwartz-Barcott & Kim, 2000, p. 142) with as little interpretation as possible. The transcript itself served as an ON in this case, and additional field notes written before and immediately after each interview were also added to each of these documents, as ONs. TNs provided a way to capture more interpretive or speculative thoughts and ideas that arose during the process of close reading of the transcript. Finally, MNs were made to record particular instructions about the interview that might inform the conduct of subsequent interviews or the analytic process.

The descriptive summary in this initial step of the analysis focused on the interview questions "What is it like for you to provide abortion care?" and "Can you tell me how you came to provide abortion care?" Participants' responses relevant to the research sub-question about enablers and constraints to providing abortion were compiled as an inventory of factors. For the second research question, "What recommendations do nurses who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?" a list of recommendations was generated. These initial summaries, inventories and lists of recommendations for each interview were then shared with the first and second committee members for review and group discussion.

The next step of analysis involved writing a summary "profile" about each participant. These summaries were also shared with the first and second committee

members, reviewed and discussed as a group. Finally, in attempt to capture the nature of the experience for each participant, the researcher wrote a summary of “What it is like to live as an abortion provider” for each participant. These were shared with the two committee members and discussed. According to Elo and Kyngäs (2008), such a process of “immersion” in the data leads to familiarity that is necessary for insights to “spring forth” (p. 109). Given the limited extant research and theory regarding nurses’ experiences providing comprehensive early abortion care, this inductive analytic approach was considered appropriate for this research endeavor.

After this process of analysis and review of each interview, cross-interview analysis was carried out. In this step, all of the interview summaries, lists, inventories, and profiles were re-read with the aim of detecting commonalities. First, overarching commonalities that manifested across all of the interviews were identified, and then commonalities that appeared among only some but not all were noted. Distinct differences or “outliers” were also noted during this final step of the analysis. These commonalities were clustered and considered in relation to one another, including to determine if there was a hierarchy or some other order between them.

Following this process, the results of this analysis were written up. These are presented in the chapter that follows.

Trustworthiness

In qualitative research, the notion of “trustworthiness” supplants those of validity and reliability that guide the design and evaluation of research in the quantitative tradition. Graneheim and Lundman (2004) identify three discrete, yet inter-related elements that comprise trustworthiness. These include credibility, dependability, and

transferability. The first of these (credibility) pertains to how well a study addresses what it set out to explore. As such, it encompasses matters related to a study's design – including the rationale for choosing a particular setting and type of participant, the method of data collection, and approach to analysis. These aspects of this study's design have been addressed above, providing evidence of its credibility.

Though one of the strengths of qualitative research is its flexibility and ability to be iteratively modified during the research process, this quality must be balanced against threats to consistency and stability, including over time. This study characteristic is referred to as “dependability.” In this study, several strategies have been used to guard against these threats, including that all of the interviews were conducted by a single researcher over a short period of time (3 months). The researcher also kept notes about the conduct of each interview (i.e. field notes). These notes were monitored to ensure consistency of interviews. The transcript from each interview was shared and reviewed with the first and second committee members. In addition, each participant was sent the transcript from her interview soon after it was completed, with an invitation to provide feedback, make corrections, or add content that was felt to be missing or deficient. Follow up interviews were conducted with the first and second participants after review with the committee members revealed the need to obtain additional data.

The third element of trustworthiness - transferability – is the judgment about whether a study's findings are applicable or relevant to other settings or groups. As such, this determination rests primarily with those who read the write up of a study, as opposed to those who conduct the original research. To aid readers in making this assessment, a “rich and vigorous” write up that includes a clear description of a study's

context, participant characteristics, process of data collection, and analysis is advised (Graneheim & Lundman, 2003). Every effort has been made to attain this standard in writing up the findings of this research. Nevertheless, given the unique and specific conditions surrounding the provision of comprehensive abortion care by NPs and CNMs in a particular state or region, it has been understood from the outset of this research endeavor that the findings may have limited applicability to other types of health care providers, and to NPs and CNMs who practice outside of this geographic region.

Summary

In this qualitative, exploratory descriptive research study, NPs and CNMs were individually interviewed to explore their experiences of providing comprehensive early abortion care in New England. Data were collected through in-person interviews using open-ended questions. Stepwise analysis was carried out using strategies described by Sandelowski (2000) and Elo and Kyngäs (2008). This process of inductive inquiry and analysis was selected because it held the greatest potential to capture the “voice” of the nurse who provides comprehensive early abortion care, and thereby address an identified critical gap in the extant literature. Findings from this research endeavor are presented in the next chapter.

Chapter IV

Findings and Discussion

Findings

The overarching purpose of this study was to describe the experience of the nurse as a provider of comprehensive early abortion care, a topic that has been minimally addressed in the literature to date. The specific research questions were:

1. What is the experience of nurse practitioners (NP) and certified nurse midwives (CNM) who provide comprehensive early abortion care?
 - a. What leads them to provide comprehensive early abortion as part of their clinical practice?
 - b. What personal and/or professional factors enable and/or constrain them in providing comprehensive early abortion care, both initially and over time?
2. What recommendations do NPs and CNMs who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?

To elicit data to answer these questions, participants were individually interviewed in person. Each interview began with the question “What is it like for you to provide abortion care?” which prompted extensive responses from most participants that were broad and wide ranging. In their responses, some also spontaneously offered content pertinent to the sub-questions about what led them to provide this type of care and what factors enabled or constrained them in providing it. For others, it was necessary to ask additional probing questions to obtain this more specific data.

In this chapter, a summary of the findings regarding participants' broad experience of providing comprehensive early abortion care is presented, organized into two groups, labeled "Providing abortion is a positive experience" and "Providing abortion is a challenging experience." This is followed by a summary of findings for each of the two sub-questions of this overarching research question. The latter, which is concerned with "enablers" and "constraints," is also presented in tabular format. A discovery about the original research question and the sub-question about enablers and constraints that emerged during the analytic process was that challenges participants experienced in providing abortion care were related to but distinct from external factors that constrained their provision of abortion care. This distinction will be further elucidated later in this chapter.

Lastly, in seeking to answer the second research question, participants were asked directly "What recommendations do you have for others interested in providing comprehensive early abortion care?" Findings for this question are presented at the end of the chapter as a narrative summary, and also as a list.

To protect confidentiality, participants' actual names and those of others they mentioned have been replaced with pseudonyms. These will be used throughout this chapter and dissertation.

The nurse's experience of providing comprehensive early abortion care. All of the participants in this study described providing direct comprehensive early abortion care to individual women. They recounted a variety of tasks and clinical responsibilities that were part of this work as listed below.

- Patient counseling, education and decision support
- Obtaining informed consent
- Determining patient eligibility for method
- Performing pelvic ultrasound and/or interpreting ultrasound results
- Ordering and interpreting laboratory diagnostics (i.e. quantitative hCGs)
- Prescribing and/or administering abortifacient medication
- Consulting with physicians and others in health care team (i.e. social work, behavioral health)
- Referring for additional services (i.e. housing, food support, other medical care)
- Post abortion care (immediate and in weeks following), routine and complications
- Contraceptive counseling/decision support, provision, management
- Uterine aspiration⁷

In their descriptions of these clinical tasks, safety was identified as a high priority. All of these activities entailed interacting closely with patients, as well as their partners, family members, friends and/or guardians, and/or with co-workers and colleagues in the department or health system where they worked. Participants relayed that their interactions with patients and their companions were often very personal and deep, as many expressed strong emotions during their abortion-related visits. In general, providing early comprehensive abortion care was a highly positive experience for all of the participants, although it also included some distinct challenges. Elements that contributed to these positive and challenging experiences are described further below.

This articulation of a role that centers on providing direct, safe, individualized care to humans, many of whom are “vulnerable,” reflected a common, core aspect of the

⁷ Only two of the participants reported performing uterine aspiration in their role as providers of abortion care, as they practiced in a state where aspiration abortion is within the scope of advanced practice nurses.

experience of these participants. It can be understood as the unique perspective or “gaze” that came from their education and socialization as nurses, and that served as the glue that connected their experiences of providing abortion care. This finding emerged out of the data, and the extent to which it was present across all of the participants’ descriptions was somewhat of a surprise.

Nursing also overlaps with other disciplines, and this was also apparent in the participants’ descriptions of their experiences. The three most prominent of these were medicine, public health, and policy/advocacy, which were expressed in varying degrees from one participant to another. For Carol, who contemplated becoming a physician as an undergraduate in college, a medical perspective was strongly evident, as she spoke about the “black and white” and “meticulous physical challenges” of procedures as elements that she “loves” in providing abortion. For others, a public health perspective in which population-level access to services were a priority loomed large. Jane exemplified this view with her statement, “I think, access is huge...access to equipment, access to personnel, access to facilities,” which she then related to her clinical practice and involvement in a lawsuit to overturn the state’s physician-only abortion law. Anne, Barbara, and Allie relayed similar concerns about access to abortion during their interviews and acknowledged these either directly or indirectly acted as a motive for their involvement in this type of care. Closely related, advocacy and policy also seemed to be a lens that informed the experience of all of the participants. For example, Sandy described a kind of seamlessness between her work as a women’s health care provider and her political activism, which encompassed her view that “there is no time that politics isn’t part of women's reproductive lives,” and sometimes compelled her to “go

march in Washington.” The rest of the participants also expressed in some way that providing abortion stemmed from a deep commitment to reproductive rights, women’s liberation and/or social justice, detailed further below.

A “typical” experience providing abortion for an advanced practice nurse in New England. Susan offers a view into the experience of providing early comprehensive abortion care for an advanced practice nurse (APRN) in New England. As a Women’s Health Nurse Practitioner (WHNP), she provides general gynecology, obstetrics, family planning and abortion care to an underserved population within a primary care setting in an urban health system. Initially in her clinical practice, providing abortion care included options counseling for patients who were undecided about how to resolve a pregnancy and, for those who elected to have an abortion, education about the procedure.⁸ Susan also performed pre-operative physical examinations and referrals for the procedure, and saw patients for follow up afterwards. All of these activities were still part of her clinical practice at the time of the interview. In addition, approximately five years ago,⁹ she started providing medication abortion. Although the state where she practices has a physician-only abortion law, this has been interpreted as allowing APRNs to provide medication abortion with a high level of autonomy. In practical terms, this meant that Susan was able to deliver all of the patient care, from the initial decision support to determining eligibility to handing the pills to aftercare, to those seeking medication abortions. A supervising physician was available for consultation and was expected to

⁸ At the time Susan began her clinical practice, the abortifacient medication mifepristone had not been approved by the Food and Drug Administration, therefore procedural abortion was the only method of abortion readily available in most clinical settings.

⁹ Mifepristone was only approved by the Food and Drug Administration in 2000, and therefore was only available in the US as part of clinical trials prior to that time.

review and sign off on the health record, but Susan was basically in charge of the patient's care throughout a medication abortion, initiating consultation only when she deemed it necessary.

At first, Susan told me she found offering this new clinical service “scary” because she “didn’t have much experience,” but with “more time under my belt” and the ability to consult with others, it became “a lot easier.” She now feels confident telling patients “This is good...This really works almost all the time.”

In sharing several specific patient cases, Susan illustrated how counseling and education were a central part of her role as a provider of abortion care. This clinical responsibility required skill and expertise to assist people in making an optimal, informed decision that took into account their current life situation, as well as culture, English language proficiency, and education level. As one example, she recounted an interaction with a woman and her husband who had recently immigrated from Nepal that involved clarifying misinformation they had been given about pregnancy spacing. This interaction ultimately led the couple to decide to continue their unplanned pregnancy. Susan also relayed that another aspect of her role was helping patients who had decided to have an abortion discern whether medication or aspiration, would be the best method for their particular circumstances.

For the most part, Susan and her nurse practitioner (NP) colleague with whom she had worked closely for a number of years were able to provide medication abortion efficiently and with minimal oversight even though they had initially encountered some challenges related to requirements for physician supervision. She felt full support for this role from her co-workers, including the receptionists, medical assistants, nurses,

physicians, and administrative members of the department, as well as the larger health system where they worked. As Susan put it, “It feels like a place we have support for doing abortion care.” She also reported feeling very comfortable talking about her role as a provider of abortion outside of her workplace, including with her husband, children, friends, and “anybody else...where it comes up.”

At the time of the interview, Susan’s biggest ongoing challenges in providing comprehensive early abortion care were primarily related to the vulnerable patient population she served, in which language differences and failure to return for follow up sometimes led her to worry if the patients “really get it,” or if their abortion was successful. Nevertheless, she felt “really good about” and was “glad to get to offer” this care. Her description of her experience providing comprehensive early abortion revealed that her clinical practice centered on patients’ individual wishes, concerns, and information needs within the broader context of their lives, and her advanced practice assessment and diagnostic skills allowed her to deliver this care safely, and with a high level of autonomy. Overall, she conveyed enthusiasm for providing comprehensive abortion care, and offered the following words of wisdom to others considering providing this type of care:

Go, do it...it's a good thing to do, it's great to be able to offer it to patients, they really appreciate it...As long as you have the supports you need...the satisfaction piece of being able to offer something that a woman really needs to do, to continue her life the way she sees it, she wants it to go....

Of course, not all aspects of Susan's experience were "typical," as there were some nuances related to her particular character, the setting where she worked, the relationships she had with others in her department, and the state where she practiced that distinguished it from others. Still, her description offers a snapshot of the general experience of an APRN who provides comprehensive early abortion care in New England in the year 2017.

Providing comprehensive early abortion care is a positive experience. For the most part, this common, core experience of delivering safe, one-to-one, and sometimes very intimate care to underserved women seeking to end a pregnancy, was largely positive for participants in this study. They expressed this in a variety of ways, including that it was "satisfying," "enjoyable," "important" and they were "happy" to be able to offer it. Carol enthusiastically mentioned at several different points during the interview that she "loved" providing early comprehensive abortion care. In her advice to others considering providing abortion, Barbara summed up this sentiment with the statement "It's going to make you feel like you did something really important for somebody, that you changed their life, and if you want to get to have that feeling in a really positive way...."

In their descriptions, participants verbalized several elements that contributed to their favorable experience, including that it gave them the opportunity to connect deeply with patients; to fully resolve a patient's concern; to actively express their beliefs about feminism, reproductive rights and/or social justice; and to feel support and encouragement from co-workers and others outside of work for their role in providing this service. While these elements were present in all of the participants' descriptions,

the degree to which they talked about any particular one varied. In other words, for some, the connection with patients was paramount, whereas for others, the ability to put their political beliefs into action through clinical practice seemed to drive their general sense that providing abortion was a good experience.

Connecting with patients. All of the participants either explicitly mentioned or alluded to connecting with patients as an element that made their experience providing abortion gratifying. Sandy, the only CNM in the sample, gave the most exalted description, reporting that she found providing abortion to be “a kind of emotional high, with like birth, that it’s really hard to contain - I'm just happy to be with them...I have a joy that I'm with her.”

Susan also voiced satisfaction that came from her interaction with patients going through an abortion:

...Seeing the patient afterwards, seeing that it went well for her, she feels good about her decision, she's relieved...that's satisfying. And you know, also just getting the thanks from the patient who is seeing me for this - they feel, vulnerable and scared and worried...and to be able to reassure them that “You have a right to do this, it's going be safe, you're going to be fine, you can trust me, I have experience doing this...”, that's also really satisfying to feel like I’m providing something for someone who is feeling very concerned....

Others also suggested that connecting with patients going through an abortion was a positive aspect of their experience providing abortion care. For example, Allie, who appeared somewhat burned out in her current position, brightened as she described

her interactions with adolescents going through a medication abortion, which included “texting a lot” with “kids who cannot tell anybody” to reassure them “what’s normal, what’s not normal.”

Resolving patients’ needs. Another closely related element that participants spoke about contributing to their positive experience of providing abortion care was the opportunity it gave them to fully resolve a patient’s concern. Emily described her experience as:

...a straightforward part of the day where someone has come with a need that they are clear about, and we are so setup well to respond to it, and just the relief of people and the gratitude of how simple the process for having a medication abortion seems to be to them. So, yea, I find it a very straightforward and enjoyable part of the day...

Allie, who worked with a particularly vulnerable patient population, noted “honestly, I’d rather do abortions all day and all night than have to deal with some of the social issues that they come with....” Given that all of the participants worked with underserved populations in which chronic disease and intractable issues such as unstable housing, violence, substance use, language barriers, and poverty were prevalent, this ability to fully resolve a patient need stands out as an element that distinguishes the experience of providing abortion from other types of care that may trigger feelings of frustration or futility.

Putting political beliefs into action. Participants universally expressed that providing abortion gave them a means to actualize their political beliefs through their professional role. As Allie put it, “I just can’t think of another seven minutes in medicine

that changes a woman's trajectory of her life, the trajectory of her family...I mean it is seven minutes that changes everything.” Another participant shared this perspective, stating:

It [abortion] seems so very, very important to women...to everything, to economic justice, to environmental justice, to us being able to go forward as a people, as a world. That without that, without women having control over their own reproduction, there is no hope for anything, there is no hope for a future. And, because I care about that, and I care about my child, and I care about children being born in a world where they are wanted and cared for, there isn't anything that could be more important than giving people the choice over that... [Jane].

Anne, one of the youngest participants in the sample, echoed this sentiment, stating:

This whole concept of reproductive justice - and women being able to decide their fate...and the right to decide what happens to their body...I think that has always been this underpinning or theme of my life from childhood to now...that women and people have the right to decide what happens to their lives and what happens to their bodies. And that's so abortion care, to a T.

Later in the interview, she went on to link this belief to her clinical practice as an abortion provider when she said: “To me that's really important, to be the person that can do this safely and provide the access.”

This ability to express political beliefs through clinical practice seemed energizing for at least four of the participants and to help them face challenges encountered in providing this care, such as enduring the demands and responsibilities as the main abortion provider in a large and busy clinic, or to continue pushing a supervising physician to complete requirements so APRNs in the site could offer medication abortion. This alignment of political beliefs and clinical practice was something all of the participants' mentioned in some way, and that gave them occupational satisfaction and a sense that their work was "important."

Receiving support for providing abortion. Another common element that contributed to participants' positive reviews of providing abortion came from a sense of support from others for their role as providers of abortion, both in the workplace and outside of it.

Most of the participants in this sample were employed in clinical sites where providing abortion was part of the agency's larger mission to uphold reproductive rights, and those who sought employment within them tended to identify with this mission. As such, almost all described or alluded to feeling camaraderie with their co-workers around this shared belief, which in turn conferred a feeling of support for their particular role within the abortion service.

The participants who worked in the two practice sites that were not explicitly or exclusively reproductive health focused spoke of a slightly different experience, in that their agencies' missions were focused on providing health care to the underserved. Three participants expressed that abortion was seen as fitting within this broad mission, and therefore was supported in a general way. However, one of the participants conveyed

that in her site this support was limited because there were many other competing demands for resources throughout the larger system.

Several participants shared that support from the administration at their agency was particularly critical to their experience providing abortion care, including in their ability to offer abortion at all. Jane told of how a senior administrator who was aware of her longstanding desire to provide comprehensive abortion strongly encouraged her to attend an out-of-state, weeklong medication abortion training even though she had declared plans to leave the clinic and move to a different part of the country. Similarly, Carol reported that senior staff in the agency where she worked approached her about providing aspiration abortion after the administration had decided to have APRNs start providing this service. Approximately two decades later in the same health system, Anne was similarly invited to be the lead clinician for a pilot model of care delivery in which aspiration abortion was integrated into the general schedule, rather than offered only during separate, exclusive abortion clinic sessions. For all of these participants, these overtures from administrators were interpreted as supportive.

Susan and Barbara, who worked in the same clinical site, also expressed that the administration in their clinic supported their interest in offering medication abortion, both initially and over time. As Barbara said,

We had at the time a really supportive nurse manager, who really wanted us to provide this care, so we had gone to her and said “Look, you know, we really want to do this,” she’s like “I’m so thrilled, I want you to do it....

Participants also described broad support for their role providing abortion outside of work, including from their partners, friends, family and neighbors. This seemed to contribute to the general feeling that providing this type of care was a positive experience. For Allie this was experienced as “everybody in my life is supportive...” although she also remarked that at this point in her 26-year career in the abortion field “my family is just tired of hearing about it.”

Anne reported vigorous, active support throughout her family:

My mom texts me periodically and says, “We just donated again to Planned Parenthood!” and is incredibly supportive of the work that I do, and my sister is incredibly supportive, and then my partner’s family is also really incredibly supportive....

Both Emily and Jane relayed that their fathers fiercely defended their daughters’ involvement in abortion care, even though it went against the prevailing views of their religious and political affiliations. As evidence of her father’s support, Emily reported, “He gets into fights with his Facebook friends when he puts things on there to support me....” Sandy reported that her 88-year old father in-law participated in anti-abortion protests at the clinic where she worked, but this seemed to be a source of humor rather than distress for her. As she laughingly told me, “I said to [her husband] “Why don’t you tell him not to go, because I don’t want to wave to him when I drive into work....”

Carol was the only participant who reported strong opposition to abortion from a family member (her in-laws), that compelled her to hide her involvement in providing abortion care. As she said, this “secret” caused her emotional pain, and precipitated an ethical dilemma after telling her son about her role. As she relayed:

I had to explain that this is a secret to your grandparents, and why. And isn't that putting them in a whole other weird spot? Like, "Mom and Dad have a secret to their own parents, and that means there might be something bad about it."

However, the strong support of her husband and co-workers seemed to far outweigh her in-laws "vehement" anti-abortion sentiments, and did not detract from her largely positive feelings about providing abortion overall.

In addition to Carol, the six other participants who had a life partner reported that their partner was fully aware and supportive of their role in providing abortion. Anne spoke of her partner's support as "amazing," but also noted a limit in his ability to fully relate to her experience because "he is not the real deal...not a nurse practitioner, not a clinician, not an abortion provider." Emily also told how a former love interest and some of her extended family members had expressed disdain for her provision of abortion, which she attributed to "an ick factor" that makes them "think this is especially icky." In further describing their response, she made the point that none of them are health care providers and that there was "not a sense of "why would you do that, it's wrong," but more like "isn't that so icky?"

Carol, Anne and Emily all described support from neighbors who knew about their role providing abortion. For Carol, this first came about when she decided to disclose her role to neighbors during a period when harassment and violence toward abortion providers was at a peak. As she explained, "I told the neighbors, and that was great because they were all just *proud*. Which, that was the first time that I really had that experience of people...feeling like people in my life could be proud." For Emily,

neighbors' demonstrations of support included "a local coffee shop that gives me free things sometimes because they know I work at [name of agency], and they love [name of agency]" and for Anne, it included propping the "I stand with Planned Parenthood" sign in her yard back up after it was blown over in a windstorm. Allie described several incidents in the past when she was targeted by anti-abortion protestors at her home, however she did not indicate whether her neighbors were aware or if they responded in any way to these acts of harassment.

For the most part, participants reported surrounding themselves with "like-minded" people, both in and outside of work, which gave them a feeling of general support for their role in providing abortion. As Barbara put it, "I sort of surround myself with people who think like I do...I think we all sort of do that." For Sandy, who as a military spouse had lived much of her adult life on multiple military bases, this strategy required identifying "on any particular assignment or base where I lived, one person at least with whom I could be a pro-choice person publicly...someone that would understand, be supportive, of like political mind."

In recent years since violence and harassment toward abortion providers seemed to have lessened and her children were no longer living at home, Carol reported that she had told more of her friends and acquaintances that she provides abortion. She described this as like "coming out" and that:

Most of them were just really shocked that they didn't know. It was more like, not shocked, but like "You're kidding?" and all of them are like "Wow!" or "Wow, that is so cool!" A lot of them were really proud...and that was really fun. I hadn't gotten that from anybody for all these years,

that was the downside of being so private about it.

In contrast, Allie shared that unlike earlier in her career, she was no longer:

...as out with it, for no other reason I think than just probably maturity

and long in the tooth. Certainly not for any feelings of fear or stigma - I

think I've done that and moved past it, now I'm just kind of...the just

matter of fact-ness of it.

Overall, participants in this study reported feeling broad support for providing abortion in their workplaces, and from their families and the communities of which they are a part, which contributed to a universally positive experience.

Providing comprehensive early abortion care is challenging. All of the participants indicated that providing comprehensive abortion care presented challenges, even though the experience was quite positive overall. The challenges identified included frustrations due to legal and regulatory requirements, the drain of patients' demands and overwhelming needs, fears related to harassment and violence, and isolation. As with other commonalities, these elements varied in both the manner and degree to which they seemed to influence participants' experience, as described further below.

Frustration due to legal and regulatory requirements. Six out of the eight participants found the existing laws and regulations in the state where they practiced to be challenging. Each state had its own specific set of laws pertaining to abortion and regulations regarding advanced practice nursing. For two of the participants, the state regulations were not challenging because they granted full practice authority to APRNs, and the absence of a "physician-only" abortion law also meant that NPs and NMs were

able to provide comprehensive early abortion without physician oversight. In contrast, the other six participants expressed frustrations related to the legal/regulatory environment in their state, all of which had “physician-only” abortion laws and one of which also limited NPs full practice authority,

For two participants, the intersection of the physician-only abortion law and the state’s practice regulations for NPs initially led the agency where they worked to require face-to-face contact between a physician and patients undergoing medication abortion, while the NPs provided the rest of the care. Barbara explained:

When we first started the protocol, it was a very long unwieldy visit, and then we would go get [the doctor], and she would pop her head in and say “This was all explained to you, we are going to be inducing a miscarriage, and...” but, it was a pain in the neck for her, because she was like running from room to room, and I was like “knock, knock, knock” [on the door], “Could you go in?” and I always felt a little like “I’m sorry to interrupt you, but I need you to do this.”

Over time, this requirement was eliminated and the process was streamlined so that currently, “We do it on our own, and we just sort of send the chart along when we remember to do it, which in my case is not always very quickly...” However, she emphasized that getting to that point in providing medication had been “a long road.”

Emily, who worked in a state where an Attorney General’s (AG) opinion opened the way for APRNs to provide medication abortion with a high level of autonomy, described her experience providing medication abortion as without “frustration.” However, when she attempted to gain training to perform aspiration abortion to “use for

miscarriage management or medication abortion complications,” a new medical director blocked her efforts, expressing concern about “nurses doing abortions.” The absence of an endorsement from the AG and her own lack of confidence about performing procedures, as well as her sense that no other APRNs in the practice were similarly motivated to provide uterine aspiration led Emily to give up this pursuit.

Jane and Sandy, who practiced within the same agency, both spoke of how the physician-only abortion law impeded their practice by requiring them to consult with a physician before providing the abortifacient medication mifepristone to women seeking medication abortion. After conferring about the case, the physician was required to observe the patient swallowing the mifepristone pill, which the agency had operationalized through use of “tele-medicine” technology. Nevertheless, Jane relayed frustration that this approach fell short in its potential to expand access to medication abortion for patients. She explained:

You have to have docs that are available. We thought this would really expand access much more than it has in that way. It has expanded access as far as geographical, because people don’t need to travel as far. But as far as days and times, it has not expanded as much as we kind of envisioned. And that would change greatly if we didn’t need a doc on the iPad.

Sandy similarly voiced that the requirement for physician consultation and oversight negatively impacted her practice by creating time pressure: “I’m aware that a physician is waiting for my data.” Both of these participants indicated that if the physician-only abortion law was struck down, they would be eager to provide

medication abortion autonomously, as well as aspiration abortion as part of their practice. As Sandy said, “I would be the first to say sign me up for whatever women need in terms of abortion care.”

Drain of patients’ demands and overwhelming needs. All of the participants worked in settings where at least some, if not all, of the patients who presented for care were “vulnerable,” due to demographic characteristics and issues such as poverty, immigration status, violence, substance use and/or residence in a remote rural area. Four participants specifically mentioned that providing care to these populations presented some particular challenges to an otherwise generally positive experience. As one example, Anne described a time when she made staff in her clinic stay late so they could accommodate a patient. Unaware of the “mountains that had to be moved” to make this care possible, the patient asked “Can you hurry up?” In relaying this story, Anne concluded “that part [of providing abortion] is really hard...” which she acknowledged “is just about...They are in crisis and you just have to realize that.” However, in spite of expressing understanding of the broader context of patients’ demands, it was apparent that for her, such demands were a challenging aspect of providing abortion.

Allie also conveyed that patient demands were a challenge in her experience of providing abortion. In her case, as the lead nurse provider in “the only hospital in the state that uses free care dollars for abortion” including for minors, and that also accepted “limited Medicaid” for undocumented women, she reported “we really take a lot of the people that can't go anywhere else.” The lack of availability of social workers to assist patients in the abortion service left Allie to provide much of this care, including helping to arrange housing, secure food, and addressing the patients’ other psychosocial needs.

While she did not verbalize that this was challenging, her affect and general tone when describing this aspect of her role suggested it was difficult.

Fear due to harassment and violence. Though harassment and violence directed toward abortion providers in New England seems to have waned in recent years, three of the participants mentioned their experiences providing abortion care when such activity was more prevalent. One relayed that she had been employed as a nurse at a clinic where a lethal shooting took place, and another worked at a Planned Parenthood when abortion provider Barnett Slepian¹⁰ was murdered. Anti-abortion groups' demonstrations frequently included tactics such as holding threatening signs at clinic entrances and providers' homes, mailing unidentified powder to clinics, and other verbal and physical threats, some of which were then acted upon. Though six of the eight participants were involved in providing abortion care during those years, only three spoke about this as contributing negatively to their experience overall. Allie described several incidents in which she was targeted by anti-abortion protestors at her home, but concluded:

I don't know that I ever felt personally threatened...I'm sure I must've. I can't imagine that I didn't, I mean I think everybody did. But it's not anything when I look back on that that I focus on. I focus on - when I think back to the late 90s and early 2000's - it's just like, how different it is to get yourself an abortion now compared to then, and how much easier it is now. So, I'm sure that I must have felt threatened, but that's not what I recall.

¹⁰ Barnett Slepian was a physician who provided abortion in upstate New York. He was murdered in his home in 1998 by James Kopp, a US citizen who was involved in anti-abortion groups.

Carol told of how at one point she and the physician she worked with “were pondering getting bulletproof vests so that we could safely and comfortably go into the clinic,” but did not go on to suggest that this diminished her experience providing abortion care. She did acknowledge that “If that were to happen again now, I’d get scared again, but, and I probably wouldn’t talk about it as much...”

Anne, who as one of the younger participants in the study had not directly experienced the violence and harassment of the 1990’s or early 2000s, stated:

I certainly don’t disclose that I’m an abortion provider to anyone that I kind of don’t know, just because you do open yourself up to potential for violence or potential for retaliation. And the one place that I often hesitate to even say where I work is when I’m on a plane. I really notice, I’m like “Ok, I’m out of my community; I’m stuck in a metal tube at 35,000 feet. And what if the person sitting next to me is a crazy anti-choice?”

However, for the most part harassment and the threat of violence did not seem to be a major detractor in participants’ experiences of providing abortion, but rather, as Barbara stated is something she doesn’t “worry about from day to day...I never even think about it to be totally honest.”

Isolation. Three participants made comments either explicitly or indirectly during their interview about isolation as part of their experience providing abortion care. Allie, the only participant whose clinical role largely revolved around providing abortion care across all gestational ages, expressed this feeling primarily in relation to her role in later abortion care. She explained, “It’s at that end of the spectrum that it gets lonely for

providers here....” This sentiment did not seem to extend to the early abortion care she provides.

Carol relayed that after more than 25 years of providing aspiration abortions, she had only recently started broadly telling friends and acquaintances in her community about her role. She acknowledged that this had kept her from previously receiving their support: “I hadn’t gotten that from anybody for all these years...that was the downside of being so private about it.”

Anne identified her feelings of isolation and the challenge it presented very directly and almost with a sense of urgency. As the lead, solo aspiration abortion-providing clinician in a new service delivery model (mentioned previously), she described how her clinical role precipitated a kind of distance between her and the other workers in the clinic. As she explained, “the feeling that there isn’t really anyone here that is my equal, that is doing the same thing as me, that I can like dive into this with is really hard...” In particular, as one of the only staff who actually performed aspiration abortions, she outlined how her responsibilities and burdens were unique. As an example, she relayed how even the “amazing,” experienced nurse anesthetist she works with and often goes out for a beer with after work had expressed distaste for the “blood and guts” of aspiration abortion, to which “Anne” opined she herself did not have such “a choice” about. As she put it, “I can’t be like “I don’t want to do that! I don’t want to deal with that.”

Additionally, as one of the only clinicians who performed aspiration abortion at her clinical site, she described feeling intense pressure to not take time off:

So, I feel a lot of pressure to not take vacation and to not be unavailable,

because it is a time sensitive issue and there's so few of us that if I leave town or if one of us is out of town, or one of us takes a vacation, like you think about the ripple effect or the repercussions of that, of how many women are not going to get this procedure or not going to be able to make this choice because I need a vacation. So, part of the pressure thing is just feeling like you're *it*, and you're their only safety net and if you're gone, what do they do? How many miles do they have to travel? You know how much money do they need to kick in to be able to get this because you're out of town? So, I think that's one of the harder parts for me for sure, is that feeling of pressure, of "you're it."

She summarized her feelings with the following statement:

The isolation piece has been really big for me, just in the last few months. Of just "Wow - this feels so alone"- we're so isolated and really seeing the mirroring of that in women's experiences. And how we're fighting so hard against that, fighting against the isolation and fighting against the stigma and fighting against those feelings that women come in with. And then it's like "But oh! But we have that! What do we do for ourselves?" We are working so hard to help women not feel alone and not feel isolated but, then it's like - "Jesus! What about us?"

What leads nurses to provide abortion care? A sub-question of the overarching research question about nurses' experience of providing comprehensive early abortion was "What leads nurses to provide this care as part of their clinical practice?" An overarching influence in participants' responses to this question was found to be related

to second wave feminism and the legalization of abortion in the US. Two distinct groups emerged: those who came of age during the peak of second wave feminism and the movement to secure abortion rights, and those who came of age after this period. In this analysis, the latter group is referred to as “descendants or beneficiaries”¹¹ of second wave feminism. In addition, irrespective of which group they belonged to, half of the participants identified that a specific role model or mentor was key to their decision to become a nurse and/or provide abortion care. A descriptive summary of these findings follows.

Era and conditions when coming of age. For four of the participants, emergence into adulthood during the peak of second wave feminism in the late 1970’s and early ‘80s and the concomitant movement to legalize abortion seemed to be a common, seminal factor that led to their involvement in abortion care, either at that time or later in their career. Sandy, the oldest participant in the study, pinpointed the beginning of her journey to becoming an abortion provider to her work-study position in college, in which she was tasked with delivering weekly counseling and education sessions “on birth control and sex to women and their partners.” This job as a “peer educator” led her to join a kind of “underground railroad,” in which she and others helped women who wanted an abortion get to states where it was legal. Sandy acknowledged that this formative experience eventually prompted her to seek certification as a WHNP and later a CNM, and to provide comprehensive abortion care.

¹¹ This view of abortion as both a given right and an available health service is what O’Brien Hallstein (2010) refers to as a “second-wave beneficiary” perspective.

For Barbara, her lacrosse team's victorious Title IX¹² lawsuit in high school was a life-shaping experience that she identified as pivotal to her career trajectory, ultimately resulting in her becoming a WHNP and provider of abortion care. Both Susan and Carol recounted that when they finished college and were trying to decide what to do with their lives, a growing awareness of "women's health" as a social issue coincided with the emergence of the NP profession. This convergence wound up leading them to the same decision: to pursue a WHNP degree, a professional path that eventually brought each to provide abortion as part of her clinical practice.

The other four participants in this study all came of age after second wave feminists and the reproductive rights movement had achieved a number of significant gains, including the legalization of abortion nationwide. For them, the trajectory to providing abortion care seemed to originate with exposure to ideas or close relationships in which feminism was valued. One of these participants also had an abortion as a young woman, and therefore, can be considered a "beneficiary" of these social movements.

Anne described being raised in "a very feminist and very justice-centered and fairness-centered household" where "conversations about what it means to grow up as a woman, as a female" were common. Similarly, Jane's family was actively engaged in the reproductive rights movement, including most notably her step-father who was a prominent OB-GYN physician who performed abortions. Emily traced her path to becoming a nurse who provides abortion care to college, where she concurrently took women's studies courses and went through a "very typical college girl health crisis" that

¹² Title IX is a statute that was enacted in 1972 to "protect people from discrimination based on sex in education programs or activities that receive Federal financial assistance." (Office for Civil Rights, 2015).

brought her to discover a “love” for women’s health. In time, this passion led her to pursue a graduate degree to become a WHNP. In that program, she identified that upon graduation she wanted to work at Planned Parenthood and include abortion in her clinical practice. Allie was the only participant in the study who shared that her own abortion at age 17 was a key event that likely propelled her into her 26-year career in the field of abortion, including the past twenty as a nurse.

Mentors and role models. Across both of these groups, four participants relayed that a specific person had been particularly important in inspiring or mentoring them to become a provider of abortion care. For Sandy, this was the nurse who supervised her in her college work-study position. As she described her, “Adele was the muse, the mentor, the person who got me from a high school kid from [name of city where she grew up] to what I do today, by showing me the importance of women’s health care.” Jane’s stepfather was also clearly an influential role model and mentor for her, both in his work providing abortion which included providing care to women who were not already his patients, as well as by giving her a job in his practice when she was a teenager. As she reported, he “was always showing me like yeast under the microscope and different things.” For Barbara, this person was her mother, who she described as “a feminist,” and “probably instilled me with values that led to my interest in women's reproductive rights.” Allie also mentioned “a lone NP...the first one I'd ever met, who was doing abortion care,” in a clinic where she worked “probably” inspired her to become an NP and abortion provider. While the other participants may also have encountered role models and mentors who contributed to their decision to become a nurse and an abortion

provider, these four participants specifically expressed this as influencing their path to this role.

Enablers and constraints. The research question, “What personal and/or professional factors enable and/or constrain nurses who provide comprehensive early abortion care, both initially and over time?” yielded findings that overlap with those previously presented about participants’ experience providing abortion care. However, there is a subtle yet important distinction between these questions and their related findings. With the overarching research question, the aim was to broadly capture nurses’ experiences of providing comprehensive early abortion care, an area of practice that has scarcely been described in the literature. The latter question was designed to identify specific factors (people or “things”) that made it possible or, conversely, difficult or impossible for participants to provide comprehensive abortion care. Thus, the two questions represent different but related lenses through which to consider participants’ experiences. The first is exploratory and open-ended; the second focused and purposeful, which is pertinent to workforce recruitment and retention, as will be discussed further in the subsequent section. While these enablers and constraints may contribute to participants’ general experiences, they alone do not make up the overall experience.

By re-examining the interviews through this lens, a concise and comprehensive inventory of factors that enabled or constrained participants in providing abortion care could be assembled. Enablers were “people” or “things” that made it possible to provide abortion initially, or to sustain this work over time, whereas constraints were “people” or “things” that made it difficult or impossible to provide abortion initially or to sustain it over time. These findings are presented as a table in which the factors have been

aggregated and grouped according to the level at which they manifested (individual, interpersonal, organizational, community, societal). In addition, if a factor was present only during a specified period of time (i.e. initially), and/or if it arose only in relation to providing medication or aspiration abortion this is noted (Appendix A, Table 3).

Factors that emerged as either enabling or constraining participants' efforts and ability to provide abortion included a range of internal character traits or tendencies; interpersonal interactions; institutional missions, policies and practices; and attitudes, laws and regulations, and other dynamics at the broader community and societal levels. For each participant, the unique intersection of these factors determined what type(s) of abortion they were able to provide initially, over time, and at the time of our interview, as well as the specific way(s) in which they delivered this care. For example, for two of the participants the initial interpretation of the physician-only abortion law in the state where they practice constrained their ability to provide medication abortion by requiring direct, in-person involvement of a physician in patient visits. However, over time a looser interpretation emerged, allowing these nurse clinicians to provide this service with a high degree of autonomy. In other words, a constraint to their medication abortion practice was eliminated.

In addition, these factors influenced the sustainability of providing abortion for these clinicians, a key in workforce retention. As an example, Anne reported feelings of isolation and a high burden of responsibility related to her role as the only nurse who provided comprehensive abortion care in her clinic. Though she endured this aspect of her role, her words and affect suggested she might be at risk for burnout in the future. Conversely, the strong support from colleagues, family and friends that she and all of the

participants described seemed to be critical to their ability to continue providing abortion care over time.

Similarly, support from neighbors was widespread, and likely contributed to participants' ability to sustain their involvement in providing abortion. Barbara was one of the only ones who suggested that her neighbors might not be supportive of her work providing abortion: "I bet some of my neighbors are probably anti-choice, so it's not something I talk about really publicly." Sandy described a strategy she had developed to get social support on the various military bases where she had lived in the US and abroad, which involved finding "at least one person" with whom she could share her "pro-choice" views. At the time of our interview, she had settled in a civilian community, and though she was aware some of her neighbors did not share her beliefs about abortion, she conveyed that they were all "well-behaved" at neighborhood social gatherings. For the most part, support from co-workers, administration, friends, family, and neighbors was an often-mentioned factor that likely helped participants sustain, and also initiate providing comprehensive early abortion as part of their practice.

The role of a mentor or role model, described earlier in the context of what led participants to provide abortion care, is also listed here as an enabler, as some participants identified it as a key factor in their becoming an abortion provider. Similarly, two participants spoke about their close peer relationship (with one another) at work, as enabling them to persist in the face of obstacles to their provision of abortion. It was apparent that this relationship also sustained them in this effort. As Susan put it, she and her NP colleague started the process of providing medication abortion "kind of side-by-side" which allowed them "to compare notes and celebrate when we got the quant

that had like plummeted”¹³ which she described as “one of those little satisfactions of our work, that we can share, and that's really fun....” The availability of other APRN and physician clinicians who had experience providing abortion that they could consult with was another interpersonal factor that most of the participants expressed directly or intimated was important to sustaining them in this work. One specifically mentioned reaching out to an APRN colleague within her larger professional network as something that helped her when she first started providing medication abortion.

Legal and regulatory requirements were an overarching factor that affected all of the participants’ ability to provide abortion. Six of the eight clinicians expressed these as constraining their practice, and the other two noted that the absence of a physician-only abortion law and regulatory limits on APRNs as providers of abortion made their involvement in this care possible. This societal level constraint stood out as one that probably most profoundly affected participants’ ability to provide the type of abortion care that they wanted to, and in the way that they felt would be best for patients.

In sum, a number of different individual, interpersonal, organizational, community and societal level factors made it possible, difficult, or in some cases, impossible for participants in this study to provide medication and/or aspiration abortion, both initially and over time. At the individual level, a mix of personal or professional factors were identified. Similarly, a variety of interpersonal enablers and constraints both within and outside of the workplace, including interactions with patients, co-workers, consulting physicians, administrators and family, friends,

¹³ A quant is a term used to refer to a quantitative hCG test, a measure of the pregnancy hormone human chorionic gonadotropin that is measured as means of determining a successful abortion.

neighbors and fellow churchgoers influenced whether and what type of abortion participants provided, both initially and over time. At the organizational level, missions, policies and the general stance toward advanced practice nurses of the agencies where participants worked were key in their ability or inability to provide and sustain their provision of abortion. Community support was often spoken of by participants, and though it may seem like a rather minor enabler, its presence may actually be quite influential and a somewhat unique feature of the New England region. Finally, the legal and regulatory environment in the states represented in this sample highlighted the eclipsing effect of this factor. In the state where there was no physician-only abortion law and the Board of Nursing supported APRNs full practice authority, the participants were able to provide comprehensive early abortion care without constraint. The other six participants did not enjoy this luxury, but instead had to configure their practice to fit within these constraints, which often proved cumbersome and was identified as a barrier to patient access by one participant.

Among this set of APRN providers, enablers obviously outweighed constraints, as they were all providing comprehensive early abortion care at the time of the interview (a requirement for participation in the study). A different group of NPs and CNMs might very well identify a different set of enabling and constraining factors that wound up preventing or leading them to give up providing abortion.

Recommendations for others interested in providing abortion. The final research question proposed in this study was “What recommendations do nurses who provide comprehensive early abortion have for others interested in providing this type of reproductive health care?” Participants’ responses ranged from very specific advice

about personal, clinical, and professional aspects of providing abortion care, to inspirational statements. For example, Susan shared her perspective that patients undergoing medication abortion don't often experience nausea, and so may not need anti-emetic medication, whereas Barbara proffered "It's going to make you feel like you did something really important for somebody."

Participants' recommendations fell into four clusters that pertained to: a) initiating and sustaining the work of providing abortion care; b) professional growth and skill development; c) providing safe, effective, patient-centered abortion care; and d) inspirational statements. A summary list organized by these groupings is presented below.

In offering recommendations for others considering providing comprehensive early abortion care as part of their future practice, the participants drew from their own experiences. Given that these were generally positive (as described at the beginning of this chapter), it is not surprising that their recommendations for others also tended to have an upbeat tone. At the same time, many of their words of advice were practical "tips of the trade" or strategies for initiating or sustaining this work over time. These ranged from "Have really good staff" to "Join organizations" that support nurses and APRNs who provide abortion care and are working to change laws and regulations that obstruct their participation. Ways of optimizing patient care were also a central focus of many of the participants' responses to this question, reflecting the unique nursing perspective that was identified as undergirding and connecting all of the participants' descriptions of their general experience of providing abortion care, mentioned earlier in this chapter. Here in their recommendations to others, we see further evidence that the

provision of direct, individualized care to humans as they go through a health event is at the core of nursing practice.

As was seen with the analysis of enablers and constraints to providing abortion, for the most part, participants' responses to this question were highly specific. The recommendations they offered are particularly relevant to both the implementation of patient-centered clinical services and to workforce recruitment and planning. These implications of the findings will be further addressed in the chapter that follows. Overall, participants' responses to this question offer the kind of unique wisdom that comes from listening to those who have "gone before," revealing important, previously unrecorded insights about nursing practice in the area of comprehensive early abortion care.

Recommendations included:

1. Initiating and sustaining work as an abortion provider

- "Don't be afraid"^ε
- "Just be yourself"
- Learn where your "buttons" are; be forgiving of yourself about them.
- Figure out "how to lay it (abortion work) down" at the end of the day
- "At first it seems really cumbersome but it's not...it doesn't take that much time"^ε
- Might feel scary at first, but actually very safe, and over time not so scary^ε
- "It's easy & safe"^ε
- "Have faith...it's going to be fine"^ε
- "Take it slow. If you aren't comfortable with..." then specific suggestions about strategies to get more comfortable with different aspects of providing AB care, i.e. performing procedures alone, viewing fetal tissue, etc.
- "Be very conservative at first because it makes people feel better, and then chip away when you feel more comfortable" (referring to establishing protocols for a medication abortion service)^ε
- Don't ever forget (abortion) patient's "stories" (who they are as people), otherwise "they will just make you mad and sad"
- "Have really good staff"

2. Professional growth and skill development

- Find a mentor
- Join specific organizations to make connections: National Abortion Federation/Clinicians for Choice, Nursing Students for Sexual and Reproductive Health
- Get ultrasound training
- Get a good counseling skill set
- Find the best place for training
- Get support, including from co-workers, APRN peers, and other clinicians (MDs, APRNs) with experience providing abortion
- Find an agency/site with MDs who are supportive and willing to participate in providing
- Find support from NP peers if you are trying to change practice laws or regulations

3. Providing safe, effective, patient-centered abortion care

- Figure out strategies to be able to emotionally “connect” with patients in a time-constrained clinical environment
- Have different options available for patients (referring to offering both medication and aspiration abortion)
- Establish a 24/7 call number (for patients) and solid plan for back up (in case needed)^ε
- Have consent forms and educational materials in languages spoken by your patient population(s)
- Learn where your “buttons” are...learn to manage them so you don’t provide poor care to patients
- It’s not that painful for many patients; they may not need as much pain medication as standard protocols suggest^ε
- It rarely actually causes nausea; patients may not need nausea med^ε
- “Protocol should be really simple”^ε
- “You don’t have to be very selective about who you give this to...”^ε
- “You don’t even have to do a pelvic exam”^ε
- Know the resources in your area so you can refer patients if needed (i.e. for aspiration abortion in sites that only provide medication)

4. Inspirational statements

- “It really works”^ε
- Work is very rewarding & satisfying
- “It’s going to make you feel like you did something really important for somebody”

^ε Referring to medication abortion

Discussion

The paucity of literature on the experience of nurses who provide comprehensive early abortion care provided the impetus for this study of NPs and CNMs in New England, the main findings of which were presented earlier in this chapter. Some of these are discussed further in relation to the available literature, and with particular attention to the interests of workforce planning, occupational justice, disciplinary knowledge development and holism/human flourishing.

Providing comprehensive early abortion is a positive experience and an act of conscience. One major finding of this study was that providing comprehensive early abortion care was a generally positive experience for participants. This finding contrasts with the overall tone of the previously reported literature that broadly described nurses' experiences of providing abortion care, including across different gestational ages, settings, and for indications including fetal anomaly. In that group of 25 original studies (reviewed in Chapter 2), findings leaned heavily toward negative experiences, with terms such as stress, ethical confusion, moral distress, suppression of emotions, frustration, and tension invoked. A number of those studies were noted to have serious design flaws, including several that started with the assumption that the experience was negative. For example, Mauri et al. (2015) sought to explore midwives' perceptions of the "burden" of providing late abortion care in Italy, while Garel and colleagues investigated French midwives "emotional, clinical and moral difficulties" when providing abortion for a prenatal diagnosis of anomaly (2002). While providing abortion care may have been a difficult experience for many of the nurses in those studies due to work conditions or later GA, the researchers' failure to acknowledge their own

standpoint was problematic. Similarly, Hanna's phenomenological study (2002) that sought to explore "the essence, properties, and full content domain of the concept of moral distress" by querying nurses who had provided abortion care was based on an assumption that nurses' experienced moral distress because of this role. That study went on to influence subsequent literature in the field with little recognition that moral distress had been a selection criterion for participants. Regardless of their methodological limitations, this group of studies conveys an overarching impression that providing abortion care is difficult and unsatisfying for nurses, particularly as a consequence of the emotional demands and ethical complexity entailed in this area of clinical practice.

In contrast this study, which drew its sample from a region in the US where attitudes and laws regarding abortion are relatively favorable and the focus was on care provided only for early gestations, a very different picture of nurses' experiences emerged. These participants reported satisfaction in their work providing abortion care. They enjoyed close connections with patients going through an abortion, were glad to be able to fully resolve patients' needs and relayed that offering this service felt important in that it changed the trajectory of their patients' lives for the better. They also expressed feeling strong support from others for their role providing abortion care, both at work and outside of it. Even concerns about violence and harassment, which have led to fatalities of some abortion workers in the US, were minimal or not an issue for most. Rather than stressed or morally distressed, for the most part this group of providers conveyed a sense of energized, moral conviction about their role providing abortion care, an impression that seemed to be undergirded by the alignment between their clinical practice and political beliefs. These were exemplars of nurses who were making

a difference in the world through their clinical practice and felt “really good” about the care they delivered to women for this health issue. From an occupational justice perspective, providing early comprehensive abortion care did not seem to impinge on their safety or dignity as workers. In terms of holism and human flourishing, this role seemed to contribute to rather than detract from the lives of these participants overall.

The picture that emerged of this group was one of “conscientious provision,” a concept that has been advanced by Harris (2012) to describe the act of purposefully offering a health service, in this case abortion care. This serves as a moral counterpoise to “conscientious objection,” which has been invoked by health care workers in refusing to participate in the care of women undergoing abortion. In this study, one of the participants articulated this moral stance with her statement, “Nobody accidentally becomes an abortion provider... it has to be something you are dedicated to.” To date, there are few examples in the literature of nurses who exemplify this active moral position in abortion care, however, describing the experience of NPs and CNMs in this study contributes to this end.

The trajectory to providing abortion care. Given that little literature was identified that explored the experience of nurses who provide abortion care overall, it was not surprising to find that almost none described what led some to include this type of reproductive health care in their clinical practice. In one of the only published studies that has explored this question among nurses at any level of licensure, McLemore, Levi and James (2015) reported that RNs willingness to participate in abortion care was influenced by exposure through volunteer experiences prior to entering nursing school, during their nursing education program, on-the-job, or having a personal experience.

These findings were similar to those of several studies carried out among medical residents and trainees (Steinauer et al., 2014; Turk, Steinauer, Landy, & Kerns, 2013).

One of the research questions in this study was “What leads nurses to provide comprehensive early abortion as part of their clinical practice?” Findings revealed two distinct groups: in one, participants were noted to have come of age during the peak of second wave feminism. For that group, this social movement appeared to have a strong influence on their decision to become women’s health nurses and to provide abortion care. For some, nursing preceded their involvement in abortion care, while for others it followed. For the second group, who came of age a bit later, exposure to ideas about feminism and justice through their family of origin and/or college courses were instrumental in setting them on the path that brought them to women’s health nursing and abortion care. One participant also acknowledged that her own abortion as a teenager likely had “something to do” with her later employment in the abortion care field. In addition, another key finding in this study was that for a subset of participants, a role model or mentor had played an important role in their decision to become a nurse and/or provide abortion, regardless of when they came of age.

These findings add to knowledge about what prompts some nurses to include abortion in their clinical practice. In this study, participants located their willingness and motivation to provide abortion care as beginning with a developmental period that preceded career decisions they made as emerging adults. Their identification of social movements, families of origin, and mentors and role models as key influences in their trajectories that brought them to provide abortion as nurses has not been identified in the

previous literature. From a workforce planning perspective, these findings may be of particular interest.

Enablers and constraints to providing abortion care. In this study, a number of factors were identified as contributing to participants' ability to provide abortion care initially, and to sustaining this work over time. Among these, laws and regulations at the state level stood out as having a major impact on participants' experiences overall, and on their clinical practice and patient care more specifically. Support was another key factor noted by all participants in this study, including at levels from interpersonal to societal. Both of these factors have also been noted in the available literature on nurses and abortion care, as discussed below.

State laws and regulations. The literature is replete with calls to remove laws and regulations that block APRNs from being able to legally provide comprehensive early abortion care (Freedman, Battistelli, Gerds, & McLemore, 2015). In this study, except for the two NPs who practiced in a state that does not limit APRN involvement in comprehensive abortion care, all of the participants acknowledged that the legal and regulatory environment in their state had constrained their ability to provide abortion care in the manner that they felt they were capable of and was optimal for patients. Several participants relayed that the law prevented them from including aspiration abortion in their clinical practice, while others indicated that the constraint was related to expectations for physician involvement in patients' visits for medication abortion. In one setting, this requirement had eased at the time of the interview, but it was reported to be a continuing problem by another participant. In general, the consensus of participants

was that these laws and regulations did not enhance patient care, were not based in evidence, and that they should be revised or eliminated.

With this study, the voice of nurses who provide comprehensive early abortion care is added to those of policy makers, professional organizations, public health advocates and others who have argued for the removal of practice barriers for APRNs. Documenting the perspective of nurses who work in abortion care is an important contribution to the available literature, and for increasing awareness about nurses' role and experience of providing this care.

Support. At every level from interpersonal to societal, participants in this study expressed that support was a key aspect of their experience and in enabling them to provide abortion care, including by overcoming hurdles to providing it in the first place and for sustaining this work over time. This dual-nature of support - as both an element that contributed to participants' overall subjective experience and an external factor that temporally acted upon their ability to provide abortion care - was recognized and addressed earlier in this chapter. Here, it is simply noted that the two are deeply intertwined: support both contributes to a nurse's holistic experience and acts on their ability to initiate and/or sustain the role.

In much of the available literature on nurses' experiences providing abortion care around the world, the need for more support was a common theme. Conditions nurses identified as making their work providing abortion care difficult included high demand for services and complex social needs among patients seeking abortions; expectations that abortion care be delivered concurrently with labor support for desired pregnancies; ambivalence about offering abortion services on the part of the administration of their

institution; absence of guiding professional ethical codes; and provision of abortion in advanced gestations, especially in cases of fetal anomaly. They identified a need for greater support from co-workers, administrators, physicians, and professional organizations. Little mention was made in any of these studies about the presence or absence of support from outside of work. In considering this literature, it is important to point out that the countries, settings, GA range and indication for abortion represented were broad, and included LICs, hospitals, abortions for advanced gestations and fetal anomalies, characteristics that are different than in this study. Nevertheless, that support was a commonly cited issue across these studies is noteworthy as it was also a key finding in this study.

In this study participants described high levels of support for their role providing abortion care overall. This included support from APRN colleagues, other staff in the department, physicians, and administrative personnel at the agencies where they worked. Two participants who worked in the same clinical site identified that their close supportive relationship had been particularly important in their success incorporating medication abortion into their practice and that added to their satisfaction in the role. In addition, participants reported broad support from family, friends, neighbors, and others from non-professional communities of which they were a part. This description of support outside of work adds to the available literature by describing a previously unexplored aspect of support in nurses' experiences providing abortion care.

Several participants did report that lack of physician support either directly or indirectly constrained their abortion practice. In one case, this slowed efforts to offer medication abortion and in another prevented the participant from providing uterine

aspiration for failed medication abortions altogether. However, overall participants described relationships with physicians as supportive and collaborative when it came to their provision of comprehensive early abortion care. This contrasts with reports about APRN-physician relationships in other areas of clinical practice.

One participant reported feeling extensive support for her role both in and outside of work, yet at the same time strong feelings of isolation as the only NP who provided abortions in the busy site where she worked. She shared a vision of gathering with other APRNs who provide abortion care as a way to lessen this feeling. These conflicting feelings indicate how complex providing comprehensive early abortion care can be for APRNs who are among the first to include it in their practice: even with abundant support, it still entails challenges that go beyond technical or patient-focused aspects of providing this service.

Finally, one characteristic of these participants' experience of support in the workplace that distinguished it from the aforementioned studies is that they provided care in agencies where abortion was an explicit part of the mission or was felt to be in line with the agency's broader mission of providing care to underserved populations. As several participants noted, such mission-driven workplaces attract like-minded individuals. The delivery of abortion services in free-standing, mission-focused clinical settings may be a feature that is unique to the US, which is likely to foster a mutually supportive environment for all of the workers. From a workforce perspective, this may contribute to retention; from a holistic/human flourishing perspective, it may help those who provide abortion care to feel validated in their work and connected with co-workers with whom they share common values.

What nurses know and recommend about providing comprehensive early abortion care. Nurses are extensively involved in providing comprehensive early abortion care around the world, and in many places, including the US, some do so with a high level of autonomy and authority. And yet, descriptions of what this role entails beyond lists of tasks, or about nurses' unique knowledge and ways of approaching the care of patients undergoing early abortions are scant in the literature. Finally, little has been written about what nurses would advise others considering offering this service in their clinical practice, which is pertinent in the US, as abortion is both contentious and not commonly provided by APRNs.

This study has begun to address these gaps by engaging nurses who provided comprehensive early abortion care in New England to explore their experiences broadly, and more pointedly, to elicit their advice for others. The findings included an array of responses in which some participants described specific patient cases that reflected their unique knowledge, skills and nursing approach in providing this care, while others talked about specific clinical aspects of providing abortion care - such as performing ultrasound or examining pregnancy tissue. When invited, all of the participants also offered insights and tidbits of wisdom for others, which ranged in focus from patient care to professional development to inspirational statements. These have been detailed earlier in this chapter. Several aspects of these findings are particularly noteworthy and warrant further discussion.

Providing comprehensive abortion care is more than carrying out tasks. The WHO and the Royal College of Nursing (RCN) have published guidelines that include lists of tasks that nurses may execute in their role as providers of abortion care including

at early gestational ages (RCN, 2013; WHO, 2015). While these are helpful for giving a thumbnail sketch and delineating what nurses can and cannot do based on evidence, and national laws and policies, they fail to relay the texture and depth of what nurses actually do in this role. They also do not convey what nurses who provide this care convey is unique and important about their actions and interactions with patients. The aforementioned literature also offers little about nurses' provision of care in early pregnancy.

In this study, participants described care they provided to patients seeking and undergoing early abortions, many of whom were vulnerable due to their age, immigration status, English language fluency, socio-economic status, race, educational level, and/or residence in a remote rural area. In their descriptions, they relayed that counseling, or as one participant put it, "getting into people's stuff," was a key aspect of the care they delivered. While tasks such as administering medication, performing and interpreting ultrasounds, and interpreting lab results were mentioned as part of what they did in their role, attending to the psychosocial needs of patients who presented for abortions, and in some cases their partners or other family members, was clearly paramount. This seemed to be particularly true of medication abortion, in which the nature of the method which is partially self-administered by patients at home, necessitates extensive counseling and education.

In describing their actions and interactions with patients, these participants conveyed a unique skill set that combined understanding of the larger social context from which patients came to their abortion visit with what one participant described as her ability to read the room, by which she meant picking up on the emotional state of the

patient as well as others who accompanied her to the visit. While different participants may have possessed different levels of skill in this regard, they all spoke of it in some way during their interview, and as a result it came through as a centrally important aspect of the abortion care they provided. This holistic “putting together” of patients having an abortion by attending to both their physical and psycho-social and relational needs within the larger social context of their lives encapsulates the truly unique approach and contribution of nurses to abortion care. In contrast with medicine where the focus is on cure and the execution of procedures, or public health in which it is population level access to services, this “meeting the patient where she is” and “being with” women as they go through this life-changing experience is at the core of nursing and midwifery care. So, while the completion of tasks, ensuring of safety, facilitating access, and even execution of procedures is part of what nurses “do” in their role providing comprehensive early abortion care, the provision of intimate, individualized care to patients and their friends and family with awareness of the broader societal context in which they live their lives is where these participants’ distinct disciplinary gaze comes through.

Words of wisdom. Participants in this study did not hesitate to offer words of advice for others considering providing comprehensive early abortion care, and most of these were highly positive and encouraging. Their reports of support, that abortion is a type of care that enables them to completely resolve a patient’s need and to change someone’s life in “just seven minutes” contributed to a generally enthusiastic endorsement of comprehensive early abortion as a desirable and important clinical

offering. At a time when many health care workers in the US and around the world report high levels of occupational stress, this is a noteworthy finding.

In all but one of the participants' clinical practices, abortion was but one type of service offered, along with other types of sexual and reproductive health (SRH) care, and in one site, obstetric care. Though none of them explicitly mentioned including abortion as just one offering in a comprehensive SRH or OB-GYN practice as a recommendation, they left the impression that this was a key factor in what made this work enjoyable and sustainable over time. By integrating abortion into a diverse practice, they were able to see patients at different points in their reproductive lives and for a variety of needs. As one participant asserted, this has an effect of normalizing abortion care, both for patients and providers. As she so eloquently put it, "We provide *care*. Whatever that means, we provide *care* for you."

Summary

This study begins to document the experience of NPs and CNMs who provide comprehensive early abortion care in the New England region of the US. The finding that participants described the experience as generally positive contrasts with the overarching sense that comes from the limited available literature on nurses who provide abortion care around the world, in a variety of settings, across all gestational ages, and for indications including fetal anomaly. The study describes the trajectory to becoming an abortion provider among this group of APRNs, adding a new layer to findings from previous studies in reporting that exposure to ideas about feminism and reproductive rights through social movements, families of origin, and women's/gender studies courses in college were influential, as were relationships with a mentor or role model

who embraced or enacted these values. Enablers and constraints to providing abortion were noted, and key among these were legal and regulatory barriers, as well as broad support both within and outside of work. NPs' and CNMs' recommendations to others about providing comprehensive early abortion care included strategies for initiating and sustaining the work, specific clinical pearls about how it can be delivered in ways that are best for patients, and professional development as well as words of inspirational encouragement.

By documenting and amplifying the voices of those who do this work, this study adds to the existing literature that so far has only outlined tasks and skills entailed or conveyed a general sense that providing abortion is difficult and stressful work. This study offers a holistic glimpse of the experience and begins to reveal some of the wisdom of NPs and CNMs who provide early abortion care in the US. It offers an image of nurses who are moved to provide abortion care because of their beliefs in feminism and reproductive rights, and in so doing, find satisfaction and energy.

Chapter V

Summary, Conclusions, Limitations and Implications

The purpose of this study was to explore and describe the experiences of nurse practitioners (NPs) and certified nurse midwives (CNMs) who provide comprehensive early abortion care in the United States (US). In this chapter, a summary of this study is presented along with conclusions, limitations and implications for the future.

Summary

At current rates, nearly one million women in the US have an induced abortion every year. Most take place early in pregnancy, and are carried out or initiated in ambulatory, free-standing clinical settings. Although abortion has been legal for over 45 years and is a common reproductive health event in the US, it remains highly contentious.

Nurses, including nurse practitioners and certified nurse midwives, are integral members of the health care teams that provide care to women undergoing abortion. In the US, NPs and CNMs have practice authority to perform early aspiration abortion in four states, and to autonomously provide medication abortion in 16 states. Two of the states where NPs and CNMs are able to legally perform aspiration abortion are in New England (VT, NH). In all six states, they can provide medication abortion either without physician oversight (VT, NH, CT) or with a high level of autonomy. Evidence has shown NPs and CNMs to be safe and effective providers of early abortion and acceptable to patients. They have been endorsed as providers of early abortion by prominent national and international organizations and recognized as a sector of the workforce that can help to reduce inequities in access. Calls have been made for the

elimination of laws and regulations that prevent NPs and CNMs from being able to autonomously provide this service to patients in the US.

Given that the efficacy, safety and acceptability of NPs and CNMs as providers of early abortion care has been established, shifting the focus to determine what is known about the experience of those who provide this contested type of reproductive health care is of interest from the perspectives of workforce planning, occupational justice, disciplinary knowledge development and holism/human flourishing. A review of the literature revealed that very little has been published on this subject. Some 25 studies carried out around the world in both hospital and ambulatory clinic settings, across the gestational age spectrum and for indications including fetal anomalies, showed that stress, dissatisfaction, and ethical and moral concerns among nurses and midwives who provide this care were common. Very little literature could be found that described the experiences of NPs and CNMs who provide early abortion care in free-standing, ambulatory settings, which are the most common gestational age and location of abortions in the US.

An exploratory, descriptive qualitative study was proposed to address this gap, with the aim of describing the experience of NPs and CNMs who provide comprehensive early abortion care in New England. The specific research questions for the study were:

1. What is the experience of nurse practitioners (NP) and certified nurse midwives (CNM) who provide comprehensive early abortion care?
 - a. What leads them to provide comprehensive early abortion as part of their clinical practice?

b. What personal and/or professional factors enable and/or constrain them in providing comprehensive early abortion care, both initially and over time?

2. What recommendations do NPs and CNMs who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?

Institutional Review Board approval was obtained from the University of Rhode Island for this study. Seven NPs and one NP/CNM were recruited through convenience sampling and all consented to participate. Participants were all female between the ages of 31 and 68 years, White, and had a minimum education of a Master's degree. Their duration of practice as APRNs ranged from 6 to 40 years. They were licensed to practice in one (or more) of six New England states including Vermont (2), Maine (2), Massachusetts (3) and Connecticut (1). At the time of the interview, each participant provided comprehensive early medication abortion care in the clinical practice where she was employed; two of the participants also performed aspiration abortion.

Data were collected through in-person, individual, face to face interviews. Two follow up interviews were conducted over the telephone. Interviews were audio-recorded, transcribed and identifiers were removed from the written transcripts. Transcripts were analyzed by the researcher and two members of the dissertation committee. Each participant was provided a copy of their interview transcript with an invitation to make corrections, add content they felt was missing, or follow up with the researcher if they had questions or concerns. All of the participants reported they were satisfied with the transcript and none suggested changes or requested to follow up.

Findings revealed that the experience of providing comprehensive early abortion care was generally positive, with participants using terms such as “enjoyable,” “satisfying,” and “important” as descriptors of their experience. One participant reported she “loved” providing abortion and another said she was “happy” to be able to offer it. Some of the common elements they described as contributing to these feelings included that it offered them opportunities to connect deeply and fully resolve a patient’s need. They also expressed that the alignment between their beliefs about feminism, reproductive rights and social justice and their clinical practice made the role satisfying and meaningful. In addition, they universally reported a high degree of support for their role providing abortion both from people in and outside of work, including co-workers, collaborating/supervising physicians, and the administration in their clinical agencies, as well as family members, friends, neighbors and others in communities in which they were members. Overall, this group of NPs and CNMs seemed energized and morally unconflicted about their role providing comprehensive abortion care. In this sense, they can be seen as exemplars of “conscientious providers,” a term that has been used to describe health care workers who purposefully offer abortion based on their moral convictions.

At the same time, participants reported that providing this service included challenges. They described frustrations and stresses that arose from having to adhere to legal and regulatory requirements, deal with patients’ demands and overwhelming needs, endure harassment and violence, and feeling isolated in this role. Some of these were manifest in their practice at the time of the interview, while others had been at the time they tried to initiate providing abortion or at some other point in the past. State legal and regulatory requirements were noted to be both an external factor that constrained their

practice as well as a negative influence on their subjective experience of providing this care. Violence and harassment directed toward abortion workers had been a concern for a subset of participants who had worked in the abortion field during previous years when it had been particularly widespread in New England. At the time of the interview, none reported it as a constraint to their current abortion practice. On the whole, the challenges participants relayed did not appear to overshadow the enabling factors or their positive perceptions of providing comprehensive early abortion care. This finding contrasted with much of the available literature that left an overarching impression that nurses' experiences providing abortion around the world in a variety of settings and across all gestational ages for indications including fetal anomalies was difficult and stressful.

Other notable findings of this study included that the era in which participants came of age, the values of their family of origin, exposure to feminism, reproductive rights and social justice during emerging adulthood, and a personal experience of having an abortion were critical to their trajectory to becoming an NP or CNM who provided comprehensive early abortion care. For a subset, a particular role model or mentor also influenced this career path. This finding adds to the limited literature on this subject, which reported exposure to abortion through volunteer experiences, a health profession educational program, on the job or personal experience contributed to health professionals' willingness to provide this care.

With regard to enablers and constraints to providing comprehensive early abortion care, participants described a number of factors at the levels of individual, interpersonal, organizational, community and societal. This mix of factors varied from participant to participant, however ultimately enablers outweighed constraints as

evidenced by the fact that they all were providers of comprehensive abortion care at the time of the interview. Most striking among these factors were laws and regulations at the societal level, which six of the participants identified as constraining their ability to provide abortion care in a manner that they felt they were capable of and was optimal for patients. The influence of support at every level also stood out as key to these clinicians' ability to initiate and sustain the provision of abortion care. At the organizational level this included the explicit identification of abortion as part of the agency's mission, which seemed to both validate them in their role and also create a supportive work environment comprised of like-minded staff. At the societal level, in addition to extant laws and regulations, support from the Board of Nursing in one state and an Attorney General in another were noted as enablers, while the anti-choice stance of the Governor in another was a constraint. This study reveals the importance of support at multiple levels for the recruitment and retention of APRNs as part of the abortion workforce.

Finally, participants' recommendations for others considering incorporating comprehensive early abortion into their clinical practice ranged from specific clinical pearls to loftier inspirational statements. Most of their words of wisdom and advice were positive and encouraging in tone, while only a few were cautionary. One participant's counsel to "Just do it, just go for it!...It's going to make you feel like you did something really important for somebody" reflected the general sentiment expressed by this group of clinicians. Their recommendations were generally consistent with the overarching finding that providing comprehensive early abortion care was a generally positive experience.

Overall findings from this study contribute to the extant research in ways that may be particularly useful for workforce planners, occupational justice advocates, and the discipline of nursing. They also support the notion that nurses are not simply providers of care and a sector of the workforce, but are also complex human beings who have deep emotional and ethical responses, personal and professional relationships, belong to communities, and deserve to flourish in their lives.

Conclusions

Providing comprehensive early abortion care was a generally positive experience for the NPs and CNMs who participated in this study, though they did also experience some challenges. They identified the career trajectory that led them to provide this type of reproductive health care as stemming from exposure to the feminist, reproductive rights and social justice movements, ideas and values in their families of origin, women's studies courses at college, role models or mentors, or the personal experience of having an abortion. Factors that enabled and constrained their provision of this service manifested at levels from individual to societal. Key among these were state laws and regulations pertaining to abortion, and support at every level. Participants offered enthusiastic encouragement as well as clinical pearls to others considering adding comprehensive abortion care to their clinical practice, and only a few expressions of caution were voiced. This study contributes to the available literature by adding a description of NPs' and CNMs' experiences providing comprehensive early abortion care, a topic that has scarcely been addressed to date. Further research is warranted, as are interventions to enhance the recruitment and retention of NPs and CNMs into the abortion workforce, and to promote their flourishing as human beings.

Limitations

Several limitations in this study warrant mention. First, convenience sampling was used to recruit participants, an approach that introduces certain tradeoffs and in turn, leads to compromises. This particular approach was chosen because it offered advantages including that it can reduce difficulties with recruitment, which can be particularly problematic when the subject of inquiry is sensitive, as was the case with this study. Though using this approach did lead to successful recruitment, its potential downside came from what has been referred to as “insiderness” (Schatzman & Strauss, 1973). This particular threat to the study’s trustworthiness was discussed in the earlier chapter on methodology.

Other limitations of this study came from its small and relatively homogeneous sample. While small samples are common in qualitative research, tensions arise with regard to choices between breadth and depth, and homogeneity versus diversity. These polarities force difficult decisions about how many participants to engage. In this exploratory study, depth was a priority over breadth, with the rationale that spending more time interviewing each participant would yield richer data than spending less time with more individuals. Of course, in an ideal world, both would be possible, however given the broad nature of this research study and the sensitive subject, the choice tipped in favor of the former: “Less is more.”

Similarly, the question of whether to opt for a more homogenous versus diverse group of participants was important in designing this study. There are many types of diversity, and in this study the decision to limit the sample to NPs and CNMs who practiced in New England was made for both pragmatic and methodologic reasons. In

this relatively unexplored area of nursing practice, determining if there were commonalities in participants' experiences was a priority. By restricting the sample to those who practiced in New England, it was felt that there would be less variation in the prevailing societal attitudes, as well as laws and regulations about both abortion and advanced practice nursing that influenced participants' experiences. Other characteristics of the participants, including that all were female, White, had a Masters' degree (or higher), and worked in agencies where abortion or serving the underserved were central to the mission, were similarities that were not intentional in the study design, but rather were a consequence of the recruitment approach. These also circumscribe the study findings. Together, the small size and homogeneity of this sample limit its transferability to other types of work settings, states outside of New England, and non-White NPs and CNMs, as well as those who have less than a Masters level education.

Implications

Future research. Based on the findings from this exploratory, descriptive study there are many possible areas and directions for future research. This may include ones with particular relevance from the perspectives of workforce planning, occupational justice, disciplinary knowledge development and holism/human flourishing.

As noted earlier, there is essentially no baseline data that indicates how many APRNs provide this care throughout the region or across the US. For this sector of the health workforce to contribute to reducing inequities in access to abortion in a meaningful way, developing a clear sense of how many already provide this care, how many are interested in providing it in the future, and what their training needs are in this area would be valuable. Collecting such data would be in line with the broader need to

address “major gaps in numbers and types of health professionals, where they are employed, and what roles they fill” identified in the progress report on *the Future of Nursing* (National Academies of Sciences, 2016, p. 3).

In addition to workforce planning, investigation of the experience of APRNs who provide or are interested in providing comprehensive early abortion care in regions outside of New England is of interest from the vantage points of occupational justice and human flourishing, and could yield important information about the work conditions, enablers and constraints, and quality of life for those who provide this health service. It is highly possible NPs and CNMs who practice in states where abortion is more contentious and where access issues are acute, such as the south and Midwestern US, have very different experiences than those in this study. These geographic areas should be priorities for future research. Deeper exploration of how the type of setting enables and/or constrains APRNs ability to provide comprehensive abortion care in any region of the US is also pertinent. Specifically, whether an abortion-inclusive agency mission is a critical factor in recruitment and retention of APRNs is an important question, as is whether there are major differences in experience when providing abortion care outside of such settings. Investigation of these questions could help inform efforts to expand access beyond settings where it is typically offered (i.e. Planned Parenthoods and other abortion/family planning clinics) and other regions in the US.

From the perspective of disciplinary knowledge development, much is still unknown about the nursing approach to comprehensive early abortion care, including at the advanced practice level. This study only began to scratch the surface in cataloguing and describing the unique knowledge and skills APRNs possess in this area of patient

care. While it was found that the nursing approach distinguishes it from other disciplinary perspectives, further research is warranted to understand more about what this approach entails and how it benefits patients. Such research could be useful to education, practice and policy efforts as well, as discussed below.

Theory development. Much of the research on nurses who provide abortion care approaches this subject from a pragmatist's perspective, concerned with finding solutions to pressing problems, which in the global context revolve around decreasing maternal mortality due to unsafe abortion, and in the US to reducing access inequities. These are important issues that often take precedence over theory development. Nevertheless, this study makes small contributions on this front. One is in the aforementioned area of disciplinary knowledge development. Dr. Suzy Kim (2010, 2015) has developed a systematic framework that can be used to explore essential features of phenomena of interest to nursing. This framework proposes a typology of four conceptual domains to advance knowledge development in nursing, which include client, nurse-client, nursing practice and environment. The domain of nursing practice is one that is important to continue to develop, as nursing is a practice based discipline. In general, much is still unknown about how nurses approach the care of patients that distinguishes it from other disciplines.

Further elucidation of what NPs and CNMs do and think (or deliberate) in their practice providing comprehensive early abortion care would add to the broader effort to inventory and describe nursing practice as part of developing a foundation of disciplinary knowledge. Because it is socially contentious, and ethically and emotionally charged for both patients and caregivers, abortion is a particular, unique area of nursing

care, and one about which very little has been written. Shining the light to reveal what nurses do and think in their work providing direct care to women contemplating and undergoing abortion would further knowledge in this area of nursing practice, as well as to nursing practice more broadly. For example, cataloguing the variety of ways nurses act to ease emotional distress among patients undergoing abortion and explaining why they select certain ones in a given situation would add to understanding about nurses' unique "ways of knowing" (Carper, 1978). Discovery in this realm may be relevant to other areas of nursing practice that are similarly charged, or conversely, to understanding what distinguishes nursing practice in areas that are controversial from those that are not. By describing and explaining actual manifestations of nursing practice, knowledge development within the discipline is advanced.

Results from this study also suggest it is an area that holds relevance to theory development beyond the discipline of nursing. For example, some findings are pertinent to role theory, a sub-area of symbolic interactionism. This topic also holds potential to add to sociological discourse on the meaning of work, and the relationship between occupational satisfaction and dissatisfaction. Emotion work/labor is another theoretical area that has been invoked in a number of studies on nurses, including among those who provide abortion care. However, based on the results from this study further consideration of nursing practice in abortion care could add even greater depth to the development of this theory. Similarly, though abortion work has begun to be considered *vis a vis* stigma, examination of the experiences of nurses as a particular group of abortion care providers could generate important new perspectives for this theoretical work.

Education. There are a number of implications for education. The finding that exposure to ideas and beliefs about feminism and reproductive rights through courses in college influenced some to become women's health care providers and to provide abortion supports the importance of continuing to offer such courses. Allowing or even encouraging nursing students to take women's/gender studies courses during their pre-licensure baccalaureate education might also raise awareness among future nurses about employment in this field.

Exposure to abortion care in nursing curricula and through clinical opportunities has been reported as influencing nurses' willingness to participate in abortion care (McLemore, Levi, & James, 2015). Only one participant in this study explicitly mentioned the topic of abortion in relation to her nursing education, which she described as largely "self-directed." As one of the more recent graduates of an NP program, her comments suggested that abortion was not a standard curricular offering at the time of her NP education. Further investigation to determine what nursing education programs currently include about abortion care is warranted.

Findings from this study could help inform future curricula, particularly by highlighting nursing's unique approach to abortion care, offering clinical pearls from experienced clinicians, and simply showcasing that those who provide comprehensive early abortion care find it to be a satisfying and enjoyable area of clinical practice. Exposure to such content as part of a formal educational program or post-graduate education offering could prompt some nurses and APRNs to enter this field.

Nursing administration. Support from nursing administration at the individual, organizational and societal levels was a factor that influenced participants' ability to

initiate and sustain providing abortion, and that contributed to their sense that it was a generally positive experience. Several participants spoke of their nurse manager or other nursing leaders in their agency as enthusiastically encouraging them to pursue offering this service, and one participant mentioned that support from the Board of Nursing in the state had been key to her role as one of the first NPs in the country to provide aspiration abortion. This study describes that support from nursing leadership at the level of the department, institution and state is vital to nurses' ability to provide abortion care, and that it also enhances the quality of their experience.

In addition to demonstrating support through verbal encouragement, facilitating professional development opportunities, and issuing regulations and position statements, nursing leaders and administration can support nurses who provide abortion care by creating opportunities for them to connect with others who provide abortion care in their department, the larger agency or even across institutions. This could include protecting time in clinical schedules so that workers can gather to discuss patient cases or best practices and securing resources for them to attend professional conferences or other venues where APRN abortion providers come together.

Practice. There are a number of implications for clinical practice that emerged from this study. Some are quite specific pearls related to patient care, such as one participant's advice to limit the amount of pain medication prescribed for medication abortion, which was based on her clinical experience providing this service and her understanding of the emergent opioid crisis which is the social context within which many of her patients live. Other recommendations for clinical practice were discussed in

the previous chapter, and further research among APRN abortion providers is likely to yield more.

On a broader level, it appears that APRNs may offer a unique and important approach to abortion care that distinguishes it from other disciplines. As previously mentioned, further exploration of this practice approach is an important area for future research. Best practices that draw on these findings could be developed to guide nursing practice in the future, as well as the care delivered by providers from other practice disciplines. Ultimately this could enhance patient care.

Policy. Findings from this study resonated with other literature that indicates laws and regulations prevent adequately trained NPs and CNMs from providing comprehensive early abortion care, and do not promote patient safety or well-being. Participants in this study favored revising or eliminating these laws and regulations and felt that this would benefit patients and decrease some of their on-the-job frustrations.

Beyond removing restrictive laws and practice regulations, findings from this study could contribute to the development of standards and scope of practice guidelines for nurses in abortion care, including APRNs, in the US. Such guidelines exist in the United Kingdom, and for other practice areas in the US. These could have an overarching effect of validating abortion care as a legitimate area of nursing practice, and of establishing an evidence-and expert-practice based resource for nurses seeking to add this offering to their clinical practice. In addition, endorsement of APRNs as providers of early comprehensive abortion care by prominent national nursing organizations such as the American Nurses Association might both enable and positively

influence those who already provide or are considering providing this type of reproductive health care in the future.

Appendix A

Tables 1–3

Table 1

Literature on nurses' experiences providing abortion care: All countries, settings, gestational ages and indications

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Andersson, I. M., Gemzell-Danielsson, K., & Christensson, K. (2014) Sweden	“Explore experiences and perception” of nurses/midwives; Qualitative, semi-structured interviews	Hospitals; 2 nd trimester Labor induction/medical TOP; Indication not specified	2 main themes: Professional self & personal self
Birdsey, G., Crankshaw, T. L., Mould, S., & Ramklass, S. S. (2016) South Africa	Explore the content and quality of pre-abortion counseling among women accessing an abortion service; Mixed methods including interviews with nurses	Clinic (ambulatory) at district level hospital; Up to 12 weeks; method and indication not specified	Counseling = key nurse role but wide variation in training & experience. Provider training in IPV recommended as well as establishing referral pathways for women experiencing IPV
Chiapetta-Swanson, C. (2005) Canada.	Focus on nurses' experiences of work that is viewed as unpleasant or undesirable (“dirty work”) Qualitative, grounded theory; Interviews 41 genetic termination nurses from 4 hospitals	Hospital based service; mid- to later in pregnancy; labor induction method; indication = Fetal genetic anomaly	Absence of institutional support led to dilemmas/frustration for nurses, but work also found to be professionally rewarding & personally gratifying. “Dirty work” aspect of work transformed to find dignity and satisfaction.

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Christensen, A. V., Christiansen, A. H., & Petersson, B. (2013) Denmark	Explore Danish midwives' experiences with & attitudes towards late TOP Exploratory qualitative Semi-structured interviews Midwives (10)	Hospitals (assumed); "late" Method: induction Indication: any, but many related to genetic anomaly (increase in PN screening for anomalies noted as cause for increase in rates of late TOP)	Ethical dilemmas related to status of fetus and emotional reactions of the women/couples going through late TOP difficult. Other professionals and structural factors at hospitals influenced midwives' ability to organize their work; Need for more investigation of creating better working conditions for midwives
Cignacco (2002). Switzerland	Describe midwives' experiences in relation to termination of pregnancy for fetal abnormalities & corresponding professional and ethical position Qualitative, inductive, descriptive Interviews with 13 midwives	Hospital (delivery unit); Mid- to late; fetal anomalies	Conflict between women's right to self-determination and right to life of fetus leads to emotional stress & subsequent professional identity problems
Contreras, X., van Dijk, M. G., Sanchez, T., & Smith, P. (2011). Mexico	Examine opinions and experiences of HCPs following legalization of AB Qualitative Interviews with 64 health care providers including nurses (20%)	Public hospitals (Mexico City) Up to 12 weeks (legal limit) Aspiration ab Indication not specified	Program implementation difficult because of lack of personnel, space and resources; many conscientious objectors and large influx of women seeking services → work overload for participating professionals Recommend improving family planning campaigns & post-procedure contraceptive use, and opening primary health-care facilities dedicated to providing abortion

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Freedman, L. (2014). US	Explore the experience of clinicians learning to provide vacuum aspiration abortion & how develop confidence in performing procedure Qualitative Interviews NPs (23) & CNMs (5) (+PAs)	Ambulatory clinics Up to 12 weeks Aspiration; Indication not specified	High level of motivation to train: Without may not have embraced challenges and increased responsibilities presented by training Training incremental and individualized Confidence in competence; critical self-reflection and accountability
Gallagher, K., Porock D, & Edgley A. (2010). Wales	Explore perceptions of nurses who work in AB services Qualitative Semi-structured interviews with 9 nurses	3 AB clinics Up to 24 weeks Aspiration/ D & E; varied indications	2 global themes: Attitudes toward AB & Coping 6 organizational themes: <ul style="list-style-type: none"> • Society • Nurses • Reasoning • Role Clients • Late gestation Abs “Ability of participants to care for clients as individuals illustrates nature of empowerment of nurses to attain goals of the client.”

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Garel, M., Gosme-Seguret, S., Kaminski, M., & Cuttini, M. (2002). France	Exploring conflicts and ethical problems experienced by professionals involved in prenatal diagnosis and termination of pregnancy (TOP) in order to improve understanding of decision-making processes and medical practices in the field of prenatal diagnosis Qualitative In-depth interviews with 30 midwives (+ 17 obstetricians)	3 maternity wards in tertiary care hospitals; No upper gestational age limit (specified); Fetal anomalies	Health professionals involved in prenatal diagnosis face complex ethical dilemmas; raises important personal conflicts. Need for more resources for counselling women and open debate about consequences for current practice
Garel, M., Etienne, E., Blondel, B., & Dommergues, M. (2007). France	Identify clinical, emotional, and moral difficulties French midwives encounter while performing TOP for fetal abnormality in labor wards; determine factors related to such difficulties Mixed methods: Survey with fixed & open-ended questions 92 midwives	6 public hospitals (maternity wards); Gestational age: not specified Method: labor induction Indication: Fetal anomalies	65% reported role in labor ward during TOP was difficult; Contributing aspects: responsibility to provide psychological support to patients; emotional distress of midwives themselves 75% concerned re: fetus being alive; 25% with moral conflicts d/t personal, cultural or religious background. Professional experience, training and those working in referral center have fewer difficulties

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Gmeiner, A. C, Van Wyk, S., Poggenpoel, M., Myburgh, C. P. (2000). South Africa	Exploration/description of nurses' experiences being directly involved with women's termination of pregnancy; 2) Description of support needed to assist nurses who provide; in order to describe guidelines to support nurses Qualitative, explorative, descriptive Phenomenological interviews & field notes Nurses (# not reported)	Clinics where reproductive health and AB services provided; Up to 12 weeks Aspiration; indication not specified	Focused on proposed plan for providing support to nurses (Findings not well-described)
Halldén, B. M., Lundgren, I, Christensson, K. (2011). Sweden	Illuminate meaning of teenage abortion care prior to, during & after abortions from perspective of caregiver (=midwives) Qualitative Phenomenological hermeneutic analysis: naïve & structural analysis 10 midwives	Youth or AB clinics; method not identified; gestational age not specified; indication specified (presume range of reasons)	Themes: Respect for others' views of when life begins; Figuring out the life-conditions of a pregnant teen; Creating space and time for the pregnant teen; Encouraging teen to come in contact with feelings of being pregnant; Teaching a lesson about life as not infinite (teaching girls responsibility) "Internal conflicts of values" for midwives when professional and personal belief systems clash + emotional reactions (efforts not enough to change teens risk-taking)

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Hanna, D. R. (2005). US	<p>What is the lived experience of moral distress related to nurses' participation in legal, elective, surgically induced AB?</p> <p>Qualitative</p> <p>Semi-structured interviews with 12 nurses</p>	<p>No info about setting where abortion care delivered, gestational age, method, or indication</p>	<p>Focus on phenomena of moral distress</p>
Harris, L. H., Debbink, M., Martin, L., & Hassinger, J. (2011). US	<p>“Provide new window” into experiences of abortion workers; Evaluate intervention designed to ameliorate stigma burdens to HCWs who work in AB</p> <p>Qualitative</p> <p>Participant observation of Providers Share workshops</p> <p>17 health care workers including nurses</p>	<p>Ambulatory out-patient AB clinic; gestational age not specified; indication not specified (assume range)</p>	<p>AB stigma experienced both inside and outside clinic</p> <p>Threat of violence identified as form of stigma</p> <p>Responses to stigma: negotiation of disclosure/disclosure management = “singular, stressful challenge,” leads to disconnection</p> <p>Workshop “increased interpersonal connection” within clinic, but no evidence increased outside</p> <p>Did not observe HCWs specifically mobilize “dirty worker identity”</p>

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Huntington, A. D. (2002; 1999) New Zealand	Consideration of mid-trimester AB from feminist perspective to see if feminist theory can assist in management & be integrated into practice; recommendations for practice Methods not described in 2002 article (based on 2000 dissertation) Qualitative Interviews and participant observation	GYN wards in hospitals; 12-20 weeks GA; method and indication not specified	Recommendations: When applying for job, nurses should be fully informed about procedure, expertise required, and expectations re: involvement All staff should be involved in formal discussion re: possible effects of AB on nurses Formal and/or confidential discussions (individual/group) with nurses to clarify values & emotions + mentorship Ensure continuity of care Debriefing for nurse after termination complete/discharge of patient essential/crucial “Valuing nurses, recognizing the difficult aspects of their work, and possible trauma could alleviate considerable amount of stress”
Lindstrom, M., Wulff, M., Dahlgren, L., & Lalos, A. (2011). Sweden	a. Elucidate midwives/nurses & GYN MDs experiences, perceptions & interactions working in AB services; experiences of medical abortion & abortions performed at women’s home. b. Illustrate professionals’ visions of future roles within AB service Qualitative Focus groups 15 nurses/midwives; 17 MDs (not all had participated in AB care)	Hospital, clinic & home Range of GA Method: Medication and aspiration Indication not specified	Medication abortion – opportunity to stay in contact with woman for whole day; MDs not aware of their duties; Felt “chain of care” very good; Late term abs: “emotionally very hard”; Repeat abortion difficult to understand – feelings of failure, frustration, sorrow evoked; Rare ongoing guidance or professional development offered

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Lindström, M, Jacobsson L, Wulff, M, & Lalos, A. (2007). Sweden	Describe midwives clinical and emotional experiences of working with termination of pregnancy; study midwives' perceptions of women's motives for having AB Quantitative with 1 open-ended question Survey sent to 258 midwives in country (84% response rate); every 3 rd had no experience with TOP	Setting not specified; Method: Presume med AB primarily (? both) Indication not specified	2/3 agreed shift from surgical to medical AB good. Few reported abortion made them consider leaving job Working in AB currently and for longer period evoke positive experiences in 50%; 1/3 felt inadequacy in providing AB ~1/2 reported misgivings with late abortions; 2/3 with positive feelings re: AB overall; more likely if worked in AB in past 2 years
Lipp, A. (2008). Wales	a. How nurses & midwives perceive role with women undergoing TOP; b. How nurses & midwives cope with increased involvement with women undergoing medical termination of preg Qualitative, grounded theory Open ended interviews 12 nurses	National health service sites; Gestational age: presume range; Method: not specified but assume primarily medication Indication: not specified	Nurses' perception of role: facilitate woman's <i>own</i> decision; provide comprehensive info in neutral manner; appreciating context of woman's decision; How nurses' cope with role: contain emotions, compassion, dedication & justice for women they cared for; Few acknowledged emotional impact of med AB on themselves
Lipp, A. (2011a) Wales	Same aim as 2008 study though this article reviews findings through lens of stigma	Same as 2008, 2009 by same author	Women who have abortions and nurses' experience affiliate stigma through their close association with procedure
Lipp, A. (2011b).	To seek explanation re: why nurses concede & conceal their judgments towards women having an abortion	Same as 2008, 2009 by same author	"Self-preservation" found to be key phenomenon and major reason why nurses concede and then conceal judgment

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Lipp, A., & Fothergill, A. (2009).	Examine psychological and emotional impact on nurses and midwives with specific reference to med ab	““	Mini-labor may be distressing to woman & nurse (viewing fetus). <u>Stressors for nurses:</u> Complexity of patient decision-making; intimacy of medical AB (> surgical); being non-judgmental; “suppressed distress” evidenced by statement re: seeing fetus; nature of pregnancy loss (wanted v. unwanted preg); describes moderators and managing of stress
Mauri, P. A., Ceriotti, E., Soldi, M., & Contini, N. N. G. (2015). Italy	Explore midwives’ perception of burden of care while assisting termination of preg after 16 weeks’ gestation Qualitative phenomenologic-hermeneutic study Semi-structured interviews 17 midwives	Hospital Labor induction After 16 weeks’ gestation Indication: not specified but presume many fetal anomalies	Conscientious objection to termination of pregnancy does not influence experiences and memories. Important to share experiences with colleagues, discuss cases together and with team. Strategies to improve care suggested. Help from other professionals fundamental to manage clinical and emotional complexities related to terminations
Mayers, P., Parkes, B., Green, B., & Turner, J. (2005). South Africa	Explore lived experience of midwives who assist with terminations of pregnancy in a tertiary level hospital Qualitative study using phenomenological approach In-depth interviews with nurses/midwives (3)	GYN wards in Tertiary level hospital; Gestational age: between 13-20 weeks Labor induction Indication not specified.	Five themes emerged: obstacles experienced by midwives; feelings evoked by the experiences; conflicts encountered; coping mechanisms utilized; and need for support systems. Recommendations: provide support structures for midwives in this setting

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
McLemore, M. R., Kools, S., & Levi, A. J. (2015a). US	To thickly describe decision-making, using abortion as the clinical context to elucidate how nurses approach ethically challenging work. Qual, thematic analysis/grounded theory Interviews 25 nurses	Variety of settings including AB clinics, EDs, L&D and PACUs. Gestational age not specified; Method not specified; Indication not specified.	Nurses used multifaceted, real-time calculi when making decisions about participating in emergent or routine abortion care; tacked back and forth between personal and professional, and/or held multiple contradictory positions simultaneously; weighed role and opinion of others to determine if know how to or why they would provide abortion care. Parameters of nurse-patient relationship complex and specific to experiences of both nurse and patient
McLemore, M. R., Levi, A., & James, E. A. (2015b). US	Describe recruitment, retention and career development strategies for expert nurses in AB care Otherwise same as 2015a	Same as 2015a	Recruitment: Exposure to AB care key; Retention: need for personal flexibility, “growing our own” Career development: need for including engagement in “activities of legitimacy”; expand skill set in AB care
Mizuno, M., Kinefuchi, E., Kimura, R., & Tsuda, A. (2013). Japan	Relationship between ProQOL, emotion work and stress factors related to AB care in Japanese OB-GYN RNs and midwives Quantitative Cross-sectional survey 255 midwives	Hospitals Up to 21 weeks EGA Method not specified. Indications: rape, physical health of mother or socioeconomic hardship	ProQOL scores significantly associated with stress factors and emotion work; FEWS-J score (for negative emotions display) most significant positive predictor of compassion fatigue & burnout Key finding re: locus of decision to provide

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Mizuno, M. (2011). Japan	Describe midwives clinical and emotional experiences in providing care in both pregnancy termination and childbirth in Japan Qualitative with thematic analysis Semi-structured interviews with 11 midwives	Hospital delivery unit (AB and delivery) Up to 21 weeks Method not specified. Indications: “Justifiable” reasons = rape, physical health, or socioeconomic hardship”	Two major themes with subthemes: experience of midwives involved in childbirth and pregnancy; termination and professional awareness and attitude as a midwife Midwives isolated in this issue and its accompanying professional confusion. Suppressing feelings most common way of dealing with ambivalence of role. Improved working conditions and enhanced training on ethics would help reduce professional confusion
Möller, A., Öfverstedt, S., & Siwe, K. (2012). Nepal	Investigate experiences, opinions and attitudes of health care staff working with induced abortion in Kathmandu Valley; b) identify areas that health care staff believe need improvement Qualitative Interviews w/doctors (11) & nurses (4)	Safe AB clinics (outpatient) Gest age: 1st trimester Method: Aspiration and medication Indications: not specified (assume range)	Core category ‘Proud, not yet satisfied’ comprised a strong perception of providing an important service beneficial for women’s health and feeling of pride in providing quality service. Four related categories identified: ‘Beneficial legal framework’, ‘A will to reach out to all women’, ‘Frustration about misuse’ and ‘Dilemma of sex-selective abortion’

Table 1 (cont.)

Author, year, country	Purpose, method/design, participants	Clinical setting; gestational age of AB care delivered; type of ab provided (if noted); indication for AB (if noted)	Major findings
Nicholson, J., Slade, P., & Fletcher, J. (2010). UK	Identify the experiences of GYN nurses involved in termination of pregnancy Mixed method Interviews + questionnaire using “Experience of terminations survey,” Jefferson scale of physician empathy, ProQoL & SF-36 health survey 7 GYN nurses	Nurse-led public-sector ward service; Up to 20 weeks; medication AB & or “surgical” (under general anesthesia) and MVA (up to 13 w) Indication not specified	Participants experienced high levels of empathy, average compassion satisfaction, fatigue and burnout, and average or above average health/well-being + wide variability in compassion fatigue.
Parker, A., Swanson, H., & Frunchak, V. (2014). Canada	Explore psychosocial, educational & administrative support needs of L&D nurses who care for women undergoing pregnancy termination Qualitative, descriptive Interviews 10 nurses	L & D unit in large, university affiliated hospital Gest age: not specified but assume later (due to fetal anomalies) Indication: fetal anomaly	Valued interpersonal support from colleagues & guidance from experienced nurses. Raised concerns about effect of workload and patient-to-nurse ratios on patient care. Desire for knowledge & skill-building. Expressed need for more information regarding the genetic counseling & community resources
Yang, C., Che, H., Hsieh, H., & Wu, S. (2016). Taiwan	Explore the experiences of nurses involved with induced abortion care in the delivery room in Taiwan Qual Semi-structured interviews	L& D in hospital Gest age: Up to 24 weeks Method: Med and aspiration Indication: not specified	One main theme & 5 associated subthemes: Concealing emotions: inability to refuse, contradictory emotions, mental unease, respect for life and self-protection.

Table 2

Literature on nurses who provide comprehensive early abortion care in which nurses are participants

Author, year	Research question/aim	Method/Design, Participant type & #	Country; clinical setting; Gestational age (max); AB method	Findings
Birdsey, Crankshaw, Mould, & Ramklass. (2016)	Explore content & quality of pre-abortion counseling among women accessing an abortion service	Mixed methods Interviews with nurses (4)	South Africa Abortion clinic (ambulatory) at district level hospital Up to 12 weeks Method not specified	Counseling = key nurse role, but wide variation in training & experience. Provision of training in IPV recommended, as well as establishing referral pathways for women experiencing IPV
Contreras, van Dijk, Sanchez, & Smith. (2011)	Examine opinions & experiences of HCPs following legalization of AB	Qualitative Interviews with 64 health care providers (20% nurses)	Mexico Public hospitals Up to 12 weeks (legal limit) Aspiration ab	Program implementation difficult d/t of lack of personnel, space & resources; great # of conscientious objectors; & enormous influx of women seeking services → work overload for participating professionals; Program improved over time; legal abortion should continue to be offered. Recommend improving family planning campaigns & post-procedure contraceptive use; open primary health-care facilities dedicated to providing abortion
Freedman & Levi. (2014)	Explore clinicians experience learning to provide vacuum aspiration abortion & development of confidence performing	Qualitative Interviews NPs (23) & CNMs (5) (+PAs)	US Ambulatory/outpatient ab clinics Up to 12 weeks Aspiration	High level of motivation key: might not have embraced challenges & increased responsibilities presented by training if not present Training incremental & individualized Confidence in competence; critical self-reflection & accountability

Table 2 (cont.)

Author, year	Research question/aim	Method/Design, Participant type & #	Country; clinical setting; Gestational age (max); AB method	Findings
Gmeiner, Van Wyk, Poggenpoel, & Myburgh. (2000)	Explore & describe nurses' experiences of direct involvement with women's termination of pregnancy; 2) Describe support needed to assist nurses who provide	Qualitative, explorative, descriptive Phenomenological interviews & field notes Nurses (# not reported)	South Africa Clinics where reproductive health & AB services provided Up to 12 weeks (?) (=Legal limit in SA) Aspiration	Legalization seen as positive Direct involvement results in reliving of trauma (for nurses) Psychological defense mechanisms as shield of protection against own emotional pain Hosting secretiveness way of protecting against victimization & stigmatization Need for support voiced by nurses Focused on proposed plan for providing support to nurses (Findings not well-described)
Möller, Öfverstedt, & Siwe. (2012).	Investigate experiences, opinions & attitudes of health care staff working with induced abortion in Kathmandu Valley; b) identify areas health care staff believe need improvement	Qualitative Interviews MDs (11) and nurses (4)	Nepal "Safe" abortion clinics (outpatient) 1st trimester Aspiration & medication	Participants with strong perception providing important service beneficial for women's health & feeling of pride for providing quality service. Four related categories: 'Beneficial legal framework;' 'A will to reach out to all women' 'Frustration about misuse' & 'Dilemma of sex- selective abortion'.

Table 3

Factors that enabled or constrained participants' ability to provide comprehensive early abortion care

Manifestation level	Enablers	Constraints
<i>Individual:</i>		
<i>Personal</i>	Determination Strong personal belief that abortion is an essential right	Feelings of isolation
<i>Professional</i>	Strong professional commitment to incorporating abortion care into practice Belief that delivery model is good (for patients and staff) Already possessed relevant skills (ultrasound, counseling)	Heavy responsibility as lead/only abortion provider Fear/lack of confidence about performing procedures
<i>Interpersonal:</i>		
<i>Outside of work</i>	Strong role model Mentorship Life partner supportive Family supportive Friends supportive Neighbors supportive Found "at least one pro-choice person" on each military base (where husband was stationed) Surround self with "like-minded" people	Personal safety/threat of harassment/violence (especially with children living at home)

Table 3. (cont.)

Manifestation level	Enablers	Constraints
<i>Within work</i>	<p>Supervisor encouraged/provided opportunity for training</p> <p>Peer APRN colleague also eager to provideϵ</p> <p>Co-workers in department supportive</p> <p>Nurse manager supportive</p> <p>Medical director and supervising physician(s) supportive</p> <p>Availability of APRN peers and MDs experienced in abortion care (for consultation/support)</p>	<p>No other APRN colleagues expressed interest in performingγ</p> <p>Physician lackadaisical about completing requirements to supervise NP providers</p> <p>Medical director not supportiveγ</p> <p>Patients with high level of social needs</p>
<i>Organizational</i>	<p>Agency where works committed to providing AB (mission-driven)</p> <p>Agency supportive of APRNs providing</p> <p>Agency actively sought to have APRNs provide</p> <p>Training provided by employer</p> <p>Supplies and equipment available (medication, ultrasound machine, etc.)</p> <p>APRNs included in establishing protocols, systems for delivery of service, & hiring of supervisory personnel (nurse manager)</p>	<p>Requirement for MD to have in-person interaction with patient prior to administration of medicationϵ, α</p> <p>Requirement to have MD observe patient swallow mifepristoneϵ</p> <p>MDs have limited availability for tele-medicine approach</p> <p>Little time to discuss (“process”) patient cases with co-workers due to demands of clinical environment</p>
<i>Community</i>	<p>Religious community supportive</p> <p>Supportive neighborhood environment</p> <p>Supportive environment in town where lives/works</p>	<p>Rise in anti-abortion sentiment on military bases</p>
<i>Societal</i>	<p>State without physician-only abortion law</p> <p>State regulations grant full practice authority to APRNs</p> <p>Board of Nursing supportive of APRNs providing</p> <p>Attorney General opinion endorses APRNs as providerδ</p>	<p>State with physician-only abortion lawβ</p> <p>State had not enacted full practice authority for APRNs</p> <p>Governor openly opposed to abortion</p>

ϵ Medication abortion only; γ Aspiration abortion only; α Initially (only); β No longer a major factor; δ Encompassed organizational legal interpretation that MD must observe patient swallow pill or have in-person face-to-face contact

Appendix B

Recruitment E-mail

Date

Dear xxxx,

I am reaching out to ask for your participation in a qualitative research study entitled “Experiences of nurses who provide comprehensive early abortion care¹⁴ in New England.” The purpose of the study is to explore the experiences of nurse practitioners (NPs) and nurse midwives (NMs) who provide this type of reproductive health care in New England. Findings are anticipated to contribute to understanding about their experiences, and to inform future efforts to prepare, recruit and retain NPs and NMs as part of the abortion workforce.

Participation will involve one in-person interview that lasts approximately 45-90 minutes. It may also include one follow up interview (15-30 minutes) by phone or video-call (i.e. FaceTime or Skype). The interview(s) will be audio-recorded. Participants’ identities will be kept confidential from anyone other than the interviewer. Participation in the study is completely voluntary, and participants may withdraw at any point if they do not wish to continue.

To be eligible to be in the study you must be:

- 1) A nurse practitioner or nurse midwife licensed to practice in one or more New England states (CT, MA, ME, NH, RI, VT);
- 2) Currently provide medication and/or aspiration abortion care in your clinical practice;
- 3) Age 18 or older;
- 4) Proficient in English.

If you meet the eligibility criteria and are willing to participate, please contact me at ksimmonds@my.uri.edu or 617-596-2087. Together we will determine a date, time and location for the interview that is convenient for you, and where you will feel comfortable talking about your experience providing abortion care.

If you have questions about the study that you would like answered before deciding whether to participate, please also contact me. Finally, if you know others who might be eligible and interested in participating, I would appreciate it very much if you would forward this email and encourage them to contact me.

Thank you for your help in the success of this study!

Sincerely,

Katherine Simmonds, PhD(c), MPH, WHNP-BC
Graduate student, University of Rhode Island College of Nursing

¹⁴ Defined as “legal, safe, stigma free, high quality services that include abortion, post abortion care, contraception, and referral” (p.3) in Dawson, A., Bateson, D., Estoesta, J., & Sullivan, E. (2016). Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. *BMC health services research*, 16(1), 612.

Appendix C

IRB Approval

THE
UNIVERSITY
OF RHODE ISLAND
DIVISION OF RESEARCH
AND ECONOMIC
DEVELOPMENT



OFFICE OF RESEARCH INTEGRITY

70 Lower College Road, Suite 002, Kingston, RI 02881 USA

p: 401.874.4328 f: 401.874.4814 web.uri.edu/researchcondev/office-of-research-integrity

FWA: 00003132
IRB: 00000599
DATE: August 5, 2017

TO: Debra Erickson-Owens, PhD
FROM: University of Rhode Island IRB

STUDY TITLE: Nurses' experiences providing comprehensive early abortion care
IRB REFERENCE #: 1079933-2
LOCAL REFERENCE #: HU1718-008
SUBMISSION TYPE: Revision

ACTION: APPROVED
EFFECTIVE DATE: August 5, 2017
EXPIRATION DATE: August 5, 2018
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # 6 & 7

The above referenced human subjects research project has been APPROVED by the University of Rhode Island Institutional Review Board (URI IRB). This submission has received Expedited Review Review based on the applicable federal regulation 45 CFR 46 and 21 CFR 50 & 56. All research must be conducted in accordance with this approved submission.

INFORMED CONSENT

The URI IRB requires the use of IRB STAMPED consent/assent documents only. Stamped documents are located on IRBNet under Board Documents. Federal regulations require each participant receive a copy of the signed consent document.

MODIFICATIONS AND AMENDMENTS

Changes to the protocol or its related stamped consent/assent documents must be approved by the URI IRB before implementation.

RECORDKEEPING

Federal regulations require all research records must be retained for a minimum of five years after the project ends.

PROTOCOL EXPIRATION

Based on the risks, this project requires Continuing Review by this office by **August 5, 2018**. Please use the CONTINUING REVIEW FORM for this procedure.

REPORTING

Unanticipated problems involving risk to subjects or others, adverse events, and other problems must be reported to the IRB using the **Appendix S - Event Reporting** form. Additionally, all FDA and sponsor reporting requirements must be followed.

URI IRB RESEARCH POLICIES

All individuals engaged in human subjects research are responsible for the compliance with all applicable URI IRB policies (<http://web.uri.edu/researchcondev/office-of-research-integrity/human-subjects-protections/general-guidance/>). The Principal Investigator of the study is ultimately responsible for assuring all study team members review and adhere to applicable policies for the conduct of human subjects research.

If you have any general questions, please contact us by email at researchintegrity@etal.uri.edu. For study related questions, please contact us via **project mail through IRBNet**. Please include your study title and reference number in all correspondence with this office.



Matthew J. Delmonico, PhD, MPH
IRB Chair

Appendix D

Consent Form



◆ White Hall, 39 Butterfield Road, Kingston, RI 02881-2021 p: 401-874-2766 f: 401-874-3811
www.uri.edu/nursing ◆

Consent to participate in research study

Project title: Nurses' experiences providing comprehensive early abortion care in New England

You have been asked to volunteer for a research study. It is important that you know the following:

- Your participation in this study is entirely voluntary
- You can ask questions now or anytime during the study
- If you join the study, you can change your mind later and quit the study at any time

Before you decide whether to join this study, you should understand:

- The purpose of this study
- What is expected of you during the study
- Any risks you may face while being in this study
- Confidentiality of your study data
- How the study may help you or others

You have already been determined to be fully eligible for this study. This document is the informed consent. You will need to indicate that you voluntarily agree to participate in the study by signing this document. All of your questions will be answered before you sign.

What is the purpose of the study?

The purpose of this study is to explore the experiences of nurse practitioners (NPs) and nurse midwives (NMs) who provide comprehensive early abortion care in New England.

What are the requirements to be in this study?

Requirements to participate in this study include:

- 1) licensure as a nurse practitioner or nurse midwife in one or more states in New England (CT, MA, ME, NH, RI, VT);
- 1) Currently provide medication and/or aspiration abortion care in your clinical practice;
- 2) Age 18 or older;
- 3) Proficient in English.

How long will the study last?

Participation in the study is expected to require a total of approximately 2-5 hours over several weeks.

The University of Rhode Island is an equal opportunity employer committed to the principles of affirmative action.



IRB NUMBER: HU1718-008
IRB APPROVAL DATE: August 5, 2017
IRB EXPIRATION DATE: August 5, 2018

Who is conducting this study, and where is it being conducted?

This study is being conducted by Debra Erickson-Owens, PhD, CNM, RN (Principle Investigator) who can be reached at (401)874-5344. You will be contacted and interviewed by Katherine Simmonds, PhD(c), RN, (Student Investigator) a doctoral student from the University of Rhode Island, College of Nursing. The interview will be conducted at a site determined by you in conjunction with Ms. Simmonds.

What do I have to do if I am in this study?

Participation in the study will involve one in-person, face-to-face interview that lasts approximately 45-90 minutes. The interviewer will ask you about your experiences providing abortion. In addition, one shorter, follow up interview (15-30 minutes) may be requested by you or by the researchers. This interview will take place by phone or video-call (i.e. FaceTime or Skype). The interview(s) will be audio-recorded. You will also be invited to review the transcript from your interview. Each participant will be able to decide how much time they want to spend reviewing their transcript.

What are the risks and discomforts associated with this study?

There are minimal risks to participation in this study. Some of the topics covered in the interview could make you cause you some distress. You will be free to skip any question that you'd rather not answer. You are also free to stop participating in this study at any time.

Although the risk is low, a break in confidentiality of your research records could occur. Only members of the research team will have access to your study records.

For more information, see the section: How will my confidentiality and privacy be protected?

What are the benefits of participating?

Although it is not likely that you will personally benefit from taking part in this study, you may find it reflective and insightful. The researcher hopes to learn more about Town Nurses and their role in keeping the community safe and healthy.

Will I receive any payments?

No, no payments are available

How will my confidentiality and privacy be protected?

Your confidentiality and privacy are our top priorities. To maintain privacy, the interview for this study will be held at a site that is agreeable to you. We will keep all the information you give us confidential as provided by law. Access to electronic and hard copy files is restricted to relevant study staff. All study records will be kept confidential and maintained on a password protected computer and stored in a locked cabinet in the office of the principle investigator.

Data will be identified by a unique participant code only. A password protected electronic document linking names and codes will be kept but only study staff have access to this document. Any document with your name on it will be stored separately from research data. All information disclosed to the researchers will remain confidential. No individual identities will be used in any reports or publications that may result from this study. The study will maintain all study documentation for at least five years after the completion of the study.

What if I decide to end the study visit early?

The decision to take part in this study is voluntary. You do not have to participate. If you decide to take part, you may decide to withdraw at any point during the study by letting the investigator know.



IRB NUMBER: HU1718-008
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What do I have to do if I am in this study?

Participation in the study will involve one in-person, face-to-face interview that lasts approximately 45-90 minutes. The interviewer will ask you about your experiences providing abortion. In addition, one shorter, follow up interview (15-30 minutes) may be requested by you or by the researchers. This interview will take place by phone or video-call (i.e. FaceTime or Skype). The interview(s) will be audio-recorded. You will also be invited to review the transcript from your interview. Each participant will be able to decide how much time they want to spend reviewing their transcript.

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Although it is not likely that you will personally benefit from taking part in this study, you may find it reflective and insightful. The researcher hopes to learn more about Town Nurses and their role in keeping the community safe and healthy.

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No, no payments are available

How will my confidentiality and privacy be protected?

Your confidentiality and privacy are our top priorities. To maintain privacy, the interview for this study will be held at a site that is agreeable to you. We will keep all the information you give us confidential as provided by law. Access to electronic and hard copy files is restricted to relevant study staff. All study records will be kept confidential and maintained on a password protected computer and stored in a locked cabinet in the office of the principle investigator.

Data will be identified by a unique participant code only. A password protected electronic document linking names and codes will be kept but only study staff have access to this document. Any document with your name on it will be stored separately from research data. All information disclosed to the researchers will remain confidential. No individual identities will be used in any reports or publications that may result from this study. The study will maintain all study documentation for at least five years after the completion of the study.

What if I decide to end the study visit early?

The decision to take part in this study is voluntary. You do not have to participate. If you decide to take part, you may decide to withdraw at any point during the study by letting the investigator know. Researchers may continue to use information already collected to protect the integrity of the study.



IRB NUMBER: HU1718-008
IRB APPROVAL DATE: August 5, 2017
IRB EXPIRATION DATE: August 5, 2018

Who do I contact if I have questions or problems?

If you are not satisfied with the way this study is performed, you may discuss your concerns with the Principle Investigator, Dr. Debra Erickson-Owens (401-874-5344), or deo@uri.edu anonymously, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research and Economic Development, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4576.

- 1. I voluntarily consent to participate in this study.
_____ I do _____ I do not

- 2. I consent to being audio-recorded during the interview(s).
_____ I do _____ I do not

- 3. I give consent for the investigators to contact me in the future for further research studies.
_____ I do _____ I do not

Signature _____ Date _____

Name (please print) _____

Person who explained study: _____ Date: _____

Print name



IRB NUMBER: HU1718-008
IRB APPROVAL DATE: August 5, 2017
IRB EXPIRATION DATE: August 5, 2018

Appendix E

Interview question guide

Questions		
Research	Interview	Probes
1. What is the experience of the NP and CNM as a provider of comprehensive early abortion care?	What is it like for you to provide abortion care?	<p>Can you tell me about a typical clinic day that includes providing abortion? What is that like for you?</p> <p>REVISED PROBE: Can you tell me about one specific patient encounter where you provided abortion care that was positive? Or challenging?</p> <p>Can you tell me what it's like to provide abortion in terms of other parts of your life (outside of the clinic)? (e.g. with your family or community, or with colleagues who don't work in this area?)</p>
a. What leads them to provide comprehensive early abortion as part of their clinical practice?	Can you tell me how you came to provide abortion care?	<p>What was the process for you to becoming an abortion provider?</p> <p>Did you approach your employer about providing or did someone in your agency ask (or tell) you that you were expected to provide abortions? What was that like for you?</p> <p>Do you remember how you learned to provide abortion?</p>
b. What personal and/or professional factors enable and/or constrain them in providing comprehensive early abortion care, both initially and over time?	<p>Was there anything or anyone that helped you with being able to provide abortion initially? How about over time?</p> <p>Was there anything or anyone that made it hard for you to be able to provide abortion initially? How about over time?</p>	<p>Can you tell me - do you find anything challenging about providing abortion?</p> <p>Can you tell me - do you find anything satisfying about providing abortion?</p>

Questions

Research	Interview	Probes
2. What recommendations do NPs and CNMs who provide comprehensive early abortion have for others who are interested in providing this type of reproductive health care?	Do you have advice or words of wisdom for others who are thinking about providing abortion?	<p>Can you tell me some of the most important things you have learned about providing abortion care since you began?</p> <p>Are there specific ways of doing things or of taking care of patients having an abortion that you know now but didn't when you first started?</p> <p>Some of the themes from research on nurses who work in abortion mention the importance of professional ethical codes, support and guidance from more experienced nurses; the effects of professional hierarchy & organizational structures; the importance of administrative support; and managing disclosure about working in this field (when and to whom you tell you provide abortion care). I'm wondering if you have any comments about your experiences related to any of these?</p> <p>NEW/REVISED PROBE re: ETHICS: IF you were charged with creating an ethical standard for nurses related to abortion, what might it be?</p>

Demographics questions:

How old are you?

In what state(s) do you currently practice?

How many years have you been in clinical practice as an NP/CNM?

How many years have you been in your current clinical practice (where you provide abortion care):

- What type of clinical setting is it?
 - How would describe the predominant demographic characteristics of the patients you see?
 - What specific services do you provide as a clinician in that setting?

How many years have you been providing AB (total)?

What is the highest educational degree you have completed in any field? What is the highest educational degree you have completed in Nursing?

What is your current gender identity?

What is your racial and ethnic identity?

Are you of Hispanic, Latino or Spanish origin?

Do you have a religious affiliation?

Is there anything else that you feel is important about your identity you would like to share with me?

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