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Abortion

The Space in the Middle: Attitudes of Women's Health and Neonatal Nurses in the United States about Abortion

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A B S T R A C T

Introduction: Despite playing an integral part in sexual and reproductive health care, including abortion care, nurses are rarely the focus of research regarding their attitudes about abortion.
Methods: A sample of 1,820 nurse members of the Association of Women's Health, Obstetric and Neonatal Nurses were surveyed about their demographic and professional backgrounds, religious beliefs, and abortion attitudes. Scores on the Abortion Attitudes Scale were analyzed categorically and trichotomized in multinomial regression analyses.
Results: Almost one-third of the sample (32%) had moderately proabortion attitudes, 29% were unsure, 16% had strongly proabortion attitudes, 13% had strongly antiabortion attitudes, and 11% had moderately antiabortion attitudes. Using trichotomized Abortion Attitudes Scale scores (proabortion, unsure, antiabortion), adjusted regression models showed that the following characteristics were associated with proabortion attitudes: being non-Christian, residence in the North or West, having no children, and having had an abortion.
Conclusions: Understanding nurses' attitudes toward abortion, and what characteristics may influence their attitudes, is critical to sustaining nursing care for patients considering and seeking abortion. Additionally, because personal characteristics were associated with antiabortion attitudes, it is likely that personal experiences may influence attitudes toward abortion. A large percentage of nurses held attitudes that placed them in the "unsure" category. Given the current ubiquitous polarization of abortion discourse, this finding indicates that the binary narrative of this topic is less pervasive than expected, which lends itself to an emphasis on empathetic and compassionate nursing care.

As experts in clinical care and public health, nurses play a key role in sexual and reproductive health care in the United States (McLemore & Levi, 2017; Santa Maria, Guilamo-Ramos, Jemmott, Derouin, & Villarruel, 2017). Sexual and reproductive health care encompasses the full range of services and care related to reproduction and sexual health, including but not limited to contraception, prenatal and birth care, sexually transmitted

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infection care, infertility treatment, and abortion. The largest group of health care providers in the United States, nurses are involved in the majority of direct health care interactions, including patient education, patient advocacy, and helping patients navigate complex health systems (AACN, 2019). However, despite the well-documented role of nurses in providing sexual and reproductive health care in the United States, little is known about their views of abortion specifically.

Although abortion is one of the most common medical procedures in the United States, with approximately 800,000 abortions occurring annually (*Induced Abortion in the United States*, 2019), and is considered by the World Health Organization to be a key part of comprehensive sexual and reproductive health care (Van Look & Cottingham, 2013), nurses' attitudes about this common experience have thus far been largely overlooked. Most of the studies on nurses' views of abortion are from countries other than the United States, where social views of abortion differ, and where there may be universal health care systems that include the provision of abortion care (Gallagher, Porock, & Edgley, 2010; Yang, Che, Hsieh, & Wu, 2016). Because research on abortion and nurses in international settings is of limited applicability to nurses domestically, this article provides national, cross-sectional data on women's health and neonatal nurses' attitudes regarding abortion within the context of domestic clinical care.

Registered nurses' (RNs) opinions of, knowledge of, and attitudes about abortion care are critical to understand, because nurses are the most frequent providers of direct patient care for abortion in the outpatient setting as well as in the labor and delivery, operating room, emergency department, and inpatient settings (Mainey, O'Mullan, Reid-Searl, Taylor, & Baird, 2020). A recent study of advanced practice clinicians in Colorado, including nurse practitioners and certified nurse-midwives, suggests that a lack of knowledge about abortion care explained much of providers' unwillingness or inability to counsel patients about abortion (Coleman-Minahan, 2021).

In addition to the lack of knowledge about abortion, direct refusal to participate in abortion-related care has increased among nurses since abortion was decriminalized nationally with the Supreme Court's decision in *Roe v Wade* (1973) (Ventura, 1999), and may be especially common among nurses providing care in labor and delivery units (Marek, 2004). Refusal may represent discomfort with abortion, indicate a lack of knowledge about abortion care, or reflect the social undesirability of participating in a stigmatized role (Harris, 2012a). However, the published literature specific to conscientious objection and refusal to provide care related to abortion has largely excluded nurses from its analysis (Fleming, Frith, Luyben, & Ramsayer, 2018), so the frequency and reasons for nurses' objections are unknown.

Refusals to provide care may result in delayed access to care. These delays can be particularly harmful for Black, Indigenous, and other people of color (BIPOC), who often experience racism and ineffective informed consent processes within the health care system (Altman et al., 2019; Altman, McLemore, Oseguera, Lyndon, & Franck, 2020), as well as for lesbian, gay, bisexual, transgender, and/or queer-identified people (LGBTQ), whose experiences of sexual and reproductive health care can be complicated by homophobia and transphobia (Wingo, Ingraham, & Roberts, 2018). Disproportionately higher rates of unintended pregnancy among BIPOC and LGBTQ individuals indicate that the current sexual and reproductive health care system in the United States does not adequately meet the needs of these populations (Everett, McCabe, & Hughes, 2017; Finer & Zolna, 2016). As in much of health care, RNs make up a large part of the matrix on which sexual and reproductive health care depends.

A lack of knowledge related to nurses' attitudes about abortion is problematic in part because increasing nurses' role in abortion is considered a potential solution to the problem of limited abortion access in the United States (Glenton, Sorhaindo, Ganatra, & Lewin, 2017; Mainey et al., 2020). Currently, 90% of U.S. counties have no abortion provider (Jones & Jerman, 2017) and pregnant people must often travel significant distances to access abortion care (Barr-Walker, Jayaweera, Ramirez, & Gerdts, 2019; Fuentes & Jerman, 2019). Most states in the United States continue to restrict abortion practice to physicians only, despite the demonstrated safety of clinical abortion when provided by advanced practice clinicians (National Academies of Sciences, 2018). Only 16 states allow advanced practice RNs or physician assistants to perform abortions as of December 2020 (*Medication abortion*, 2021). Because advanced practice RNs are disproportionately likely to serve low-resource communities, including rural areas, it is critical to better understand the relationships of nurses to abortion care to build the nursing workforce in abortion care (McLemore, Levi, & James, 2015).

Abortion care has historically had a stigmatized role in health care, and that stigma may affect the risk of burnout among RNs who participate in abortion care (Harris, 2012b; Martin, Debbink, Hassinger, Youatt, & Harris, 2014). Maintaining the well-being of RNs in abortion care requires understanding their opinions and experiences with abortion care, and this understanding may also extend to supporting nursing workforce well-being in other specialties (Lipp & Fothergill, 2009). Ensuring the well-being of nurses is a critical task for health care systems to undertake, but requires understanding the perspectives and knowledge of the nurses in question (Burton, 2016). Therefore, the aims of this analysis were to 1) describe attitudes about abortion among a national convenience sample of U.S. women's health and neonatal RNs, and 2) identify possible associations between RN characteristics and abortion attitudes, with the overall goal of better understanding the existing and potential nursing workforces in abortion care, as well as those who provide patient education and care in other settings.

Methods

Study Design and Study Population

We conducted a cross-sectional survey of licensed RNs in the United States who were members of the Association of Women's Health, Obstetric and Neonatal Nurses, a national organization, between December 2017 and January 2018. The study was approved by the institutional review board (#17-23544). Inclusion criteria included residing in the continental United States and Hawaii.

Data Collection

An overview of data collection is included in Figure 1. We sent an email to the Association of Women's Health, Obstetric and Neonatal Nurses membership distribution list with an introductory message and link to the online survey (*Qualtrics*, 2019). Respondents received a $5 gift card upon completion of the survey. To maintain confidentiality, the survey was anonymous and no identifying information, including Internet protocol addresses, was collected. The first page of the survey included an

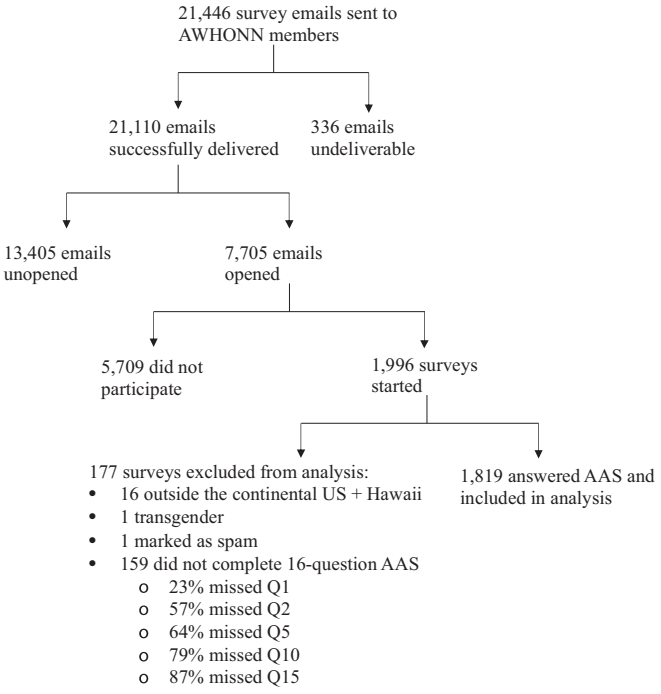

Figure 1. Data collection process.

electronic informed consent. If potential participants declined to participate, they were shown a thank you message and could not progress through the survey.

Measures

We used two different instruments to collect online data for this study. The first instrument collected demographic and employment information for each participant. The second instrument explored attitudes about abortion. Both instruments are available in Appendix A.

Demographic and Professional Characteristics

First, participants were asked to complete a 30-question survey developed for a previous study (Swartz et al., 2020) that had been modified slightly for a national audience. This section included questions on personal and professional characteristics. Validated questions were taken from the California Board of Registered Nurses Survey (*2016 Survey of Registered Nurses*, 2016) and the National Nursing Workforce Survey (*The National Sample Survey of Registered Nurses*, 2008). Details of this survey have been published elsewhere (Swartz et al., 2020). Domains included basic demographic information such as gender, age, race/ethnicity, education, religious orientation, geographic residence, and reproductive history, as well as professional characteristics about current employment. Three true/false questions on religious beliefs developed by Sandroff (1980) were included: 1) "I try to carry my religious beliefs through all aspects of my life," 2) "My approach to my life is entirely based on my religion," and 3) "My approach to life is based on moral/ethical principles, not on the values of organized religion."

Attitudes about Abortion

Participants were then asked to complete the Abortion Attitudes Scale (AAS), a 14-item questionnaire to assess attitudes about abortion (Sloan, 1983). This scale was designed for use by health educators and has been shown to be both valid and reliable. Slight modifications were made to some of the original questions to reflect more neutral, person-centric language. This scale was selected because it provides a strong foundational understanding of abortion attitudes in a given population.

Analysis

For this analysis, we restricted surveys by gender and geographic residence. We included respondents who identified as female or male. One design flaw of our survey, which will be corrected in future work, was the inability to specify detailed gender information for those who checked transgender. Because of this, we excluded the single respondent who identified as transgender because their gender identity (e.g., transmale or transfemale) was unknown and the count for this category was too small to analyze on its own. Respondents were required to answer all 14 items of the AAS. Of those who did not answer all questions of the AAS, more questions were missed toward the latter part of the survey, suggesting survey fatigue instead of a problem with the survey itself. Items were scored on a 6-point Likert scale and were assigned values from 5 for strongly agree to 0 for strongly disagree. One-half of the items were reverse scored. Scores were summed with a range of 0 to 70. We used the five scoring categories suggested by Sloan (1983): 70 to 56 as strongly proabortion, 55 to 44 as moderately proabortion, 43 to 27 as unsure, 26 to 16 as moderately antiabortion, and 15 to 0 as strongly antiabortion. The original scale used the term prolife, which we have replaced with antiabortion to more accurately describe the sentiments expressed. In addition, for some analysis we collapsed these five categories into three categories for ease of interpretation (combining moderately and strongly antiabortion, and moderately and strongly proabortion).

We calculated descriptive statistics for personal and professional characteristics. We used χ^2 tests to examine associations between personal characteristics (gender, age, race/ethnicity, education, religious orientation, geographic residence, number of living children, number of abortions, and number of miscarriages) and the five AAS categories. We used a multinomial logistic regression model to determine if characteristics were independently associated with trichotomized AAS proabortion, unsure, or antiabortion attitudes and estimated multinomial odds ratios, building a stepwise model with a p value of less than .05. Results from a multinomial logistic regression model using the five-category AAS are included in Appendix B. Missing data were handled in a listwise deletion model; individual variables had less than 1.6% missing data, and the multivariate model had 3.6% missing data. Statistical significance levels were set at a Bonferroni correction for 12 tests ($p < .0042$); associations reaching a p value of less than .05 were noted as suggestive. Statistical analysis were conducted using R v4.0.0 (R Core Team, 2020) with the mlogit v1.1.1 (Croissant, 2020) and nnet v7.3.13 packages (Venables & Ripley, 2002).

Results

Demographic Characteristics

Of the 21,446 surveys sent via email, 1,996 surveys were initiated, resulting in a response rate of 9%. After exclusions (see

Methods), the final sample included 1,819 participants. Approximately 99% of the sample was female, more than 60% were 40 years old or older, and 81% identified as non-Latinx White (Table 1). Fifty-eight percent of participants had a bachelor's degree or higher and 70% identified as Christian. Three-quarters of the sample had one or more child. Almost one in five (18%) reported at least one abortion, and 29% reported at least one miscarriage. Using U.S. Census regions (Bureau of the Census, 2010), one-third of the sample resided in the South, followed by the West (29%), Midwest (19%), and Northeast (17%). Sixty-one percent of participants were staff RNs, and more than two-thirds (68%) worked in a hospital setting, with one-half of these nurses working in labor and delivery.

Although more than one-half (55%) of participants agreed with the statement, "I try to carry my religious beliefs through all aspects of life," only 18% agreed that their "approach to life is entirely based on my religion" and 83% agreed that their "approach to life is based on moral/ethical principles, not on the values of organized religion" (Table 2).

Abortion Attitudes and Demographic and Nursing Characteristics

The five-category AAS score that places participants on a spectrum of views on abortion shows the complexity of participants' abortion attitudes (Table 3). Although almost one-third of the sample (32%) had moderately proabortion attitudes, 29% were unsure, followed by 16% with strongly proabortion attitudes, 13% with strongly antiabortion attitudes, and 11% with moderately antiabortion attitudes. Participants aged 40 to 59 years old were the age group least likely to hold strongly (13%) or moderately proabortion (30%) attitudes and the most likely to be unsure. Participants with a bachelor's degree or higher were more likely than those with an associate-level degree to have strongly (18% vs. 13%) or moderately proabortion attitudes (35% vs. 26%) and less likely to be unsure (26% vs. 35%); both groups had similar percentages of participants with strongly antiabortion attitudes (13% and 13%). Participants who identified as non-Christian were substantially more likely to have strongly proabortion attitudes than those who identified as Christian (27% vs. 6%). However, more than one-third of Christians were unsure, a greater proportion than those who had proabortion or antiabortion attitudes. Similarly, although more than one-half of participants in the Northeast and West held strongly or moderately (59% and 58%, respectively) proabortion attitudes, participants in the Midwest and South were almost evenly distributed between having proabortion attitudes (both 38%), being unsure (34% and 33%, respectively), and antiabortion attitudes (27% and 30%, respectively). There was no association between gender or race/ethnicity and abortion attitudes.

Participants with at least one child and participants who had ever miscarried were less likely than those without children to hold strongly or moderately proabortion attitudes (43% and 50% vs. 61%) and more likely to be unsure (31% and 32% vs. 24%) or hold antiabortion attitudes (26% and 26% vs. 15%). Participants who had had an abortion were more likely than those who had never had an abortion to have proabortion attitudes (66% vs. 44%). Strikingly, almost one-quarter of those who had had an abortion were unsure and 10% reported antiabortion attitudes.

Examining nursing characteristics, the percentages of participants with antiabortion attitudes were similar among those in management and those not in management, although those in management were more likely to be unsure (35% vs. 26%) and less likely to hold moderately proabortion attitudes (28% vs. 34%).

Table 1
Demographic and Nursing Characteristics of Participants ($n = 1,819$)

Characteristic	N*	Percent
Demographic characteristics		
Gender		
Male	18	1.0
Female	1,797	98.8
Age (years)		
20–29	230	12.6
30–39	470	25.8
40–49	375	20.6
50–59	450	24.7
≥60	290	15.9
Race/ethnicity†		
American Indian, Alaskan Native	4	0.2
Asian, Native Hawaiian, Pacific Islander	51	2.8
Black	92	5.1
Latinx	68	3.7
Multiracial	85	4.7
Some other race, ethnicity, or origin	28	1.5
White	1,476	81.1
Education		
Associates/diploma/30-unit	739	40.6
Baccalaureate/accelerated baccalaureate	987	54.3
Masters/doctoral	84	4.6
Other‡	9	0.5
Region		
Midwest§	339	18.6
Northeast‖	305	16.8
South¶	604	33.2
West#	532	29.2
Religion		
Catholic	419	23.0
Nothing in particular/agnostic/atheist	395	21.7
Other Christian**	533	29.3
Other religion††	127	7.0
Protestant	317	17.4
Number of children		
0	425	23.4
1	247	13.6
2	608	33.4
3	355	19.5
≥4	178	9.8
Number of abortions		
0	1,485	81.6
1	246	13.5
≥2	82	4.5
Number of miscarriages		
0	1,286	70.7
1	339	18.6
≥2	188	10.3
Nursing characteristics		
Job title		
Charge nurse or team leader	143	7.9
Education and research	279	15.3
Middle management	170	9.3
Nurse	1,105	60.7
Other	93	5.1
Senior management	29	1.6
Unit/work area		
Labor and delivery	907	49.8
Nursery/well-baby nursery/NICU	76	4.2
Other	325	17.9
Postpartum/mother and baby	225	12.4
Public health/community	68	3.7
Women's health inpatient/ambulatory	195	10.7
Employment setting		
Academic education program	181	9.9
Ambulatory care setting	140	7.7
Birth center	91	5.0
Hospital	1,244	68.4
Other	86	4.7
Public or community health setting	76	4.2

Abbreviation: NICU, neonatal intensive care unit.
* Category counts do not all sum to 1,819 due to item nonresponse.

Compared with participants who did not work in maternal/child inpatient settings (e.g., public health), participants working in maternal/child health inpatient settings were slightly less likely to hold strongly or moderately proabortion attitudes (45% vs. 51%) and more likely to hold strongly antiabortion attitudes (14% vs. 9%), but similar percentages held unsure (30% vs. 29%) and moderately antiabortion attitudes (11% vs. 11%). There was not a significant association between employment setting and abortion attitudes ($p > .05$).

In the adjusted multivariable analysis (Table 4), having had an abortion (multinomial odds ratio [OR], 2.36; 95% confidence interval [CI], 1.50–3.69) was positively associated with unsure attitudes as compared with antiabortion attitudes. Living in the Northeast versus the South (OR, 1.75; 95% CI, 1.14–2.69) and not having had a child (OR, 1.45; 95% CI, 1.00–2.10) were suggestively and positively associated with unsure attitudes as compared with antiabortion attitudes. Participants identifying as non-Christian (OR, 0.71; 95% CI, 0.54–0.94) had suggestively lower odds of being unsure than participants with antiabortion attitudes.

Having a bachelor's degree (OR, 1.44; 95% CI, 1.11–1.87), being non-Christian (OR, 2.90; 95% CI, 2.23–3.76), residing in the Northeast (OR, 3.20; 95% CI, 2.12–4.83) and the West (OR, 2.21; 95% CI, 1.61–3.04) versus the South, not having children (OR, 2.23; 95% CI,1.58–3.13), and having had an abortion (OR, 4.94; 95% CI, 3.24–7.53) were significantly associated with having proabortion attitudes. Not having had a miscarriage was suggestively associated with proabortion attitudes (OR, 1.42, 95% CI,1.06–1.89). Results from the adjusted multinomial logistic regression model using the five-category AAS indicated that the magnitude of these associations is generally stronger for those having strongly proabortion than moderately proabortion attitudes (Appendix B). For example, the OR of having a strongly proabortion attitude (OR, 10.30; 95% CI, 7.14–15) was higher than the OR of having a moderately proabortion attitude (OR, 2.89; 95% CI, 2.22–3.74) among those identifying as non-Christian compared with Christian.

Table 2
Assessment of Religious Beliefs

Religious Beliefs	Response	*N*	Percent
I try to carry my religious beliefs through all aspects of my life.	True	1,009	55.4
	False	798	43.9
	Missing	12	0.7
My approach to my life is entirely based on my religion.	True	331	18.2
	False	1,476	81.1
	Missing	12	0.7
My approach to life is based on moral/ethical principles, not on the values of organized religion.	True	1,509	83.0
	False	298	16.4
	Missing	12	0.7

Discussion

The scope and importance of the role of nurses in U.S. health care cannot be overstated, and the need for nursing care in all aspects of reproductive and sexual health care—including abortion care—is as great as in other areas of nursing. Understanding how nurses think about and consider abortion care, and what characteristics may influence these considerations, is critical to sustaining nursing care for patients considering and seeking abortion. The results of this study offer several novel insights in this area.

First, nearly one-half (48%) of the study sample reported having strongly or moderately proabortion attitudes. This proportion is slightly lower than in the study by Swartz et al. (2020), who found that 64% of California nurses held proabortion attitudes, and prior studies that suggest 60% to 80% of advanced practice nurses support people's right to abortion (Coleman-Minahan et al., 2020; Hwang, Koyama, Taylor, Henderson, & Miller, 2005). These studies did not capture ambivalence around abortion attitudes and, in our study, respondents fell into more categories than simply proabortion or antiabortion; notably, almost one-third of the sample held abortion attitudes that were unsure. Moreover, geography and educational levels of the samples may explain differences in abortion attitudes across studies. Most prior research on abortion attitudes among nurses has been conducted in states with relatively supportive abortion policies (Coleman-Minahan et al., 2020; Hwang et al., 2005; Swartz et al., 2020) and with advanced practice nurses whose higher level of education may explain more supportive abortion attitudes (Coleman-Minahan et al., 2020; Hwang et al., 2005).

Second, similar to prior research, we found that demographic factors and personal history were associated with abortion attitudes. Swartz et al. (2020) found race and religion predictive of attitudes about abortion, with those who were White being more likely to be supportive of abortion and those who were Christian being less likely to be supportive of abortion. Although we did not find an association between race or ethnicity and attitudes about abortion in the current study, identifying as Christian was associated with being less supportive of abortion and, adding nuance to prior work, with having unsure attitudes. In our larger and more geographically diverse sample, we identified other factors associated with attitudes on abortion, namely, geographic residence and personal obstetric history.

Advancing prior literature, we found that the reproductive histories of respondents were related to their attitudes about abortion. Those who reported multiparity and those who reported experiences of miscarriage were more likely to have negative attitudes toward abortion and those who never had a child were more likely to have uncertain or positive attitudes toward abortion. This finding is a further indication of how personal attributes may influence nurses' attitudes toward abortion, regardless of professional or practice guidelines. This point is particularly interesting in the context of feminist nursing ethics, because this school of thought argues that social contexts and influences should be transparent in nursing care (Peter & Liaschenko, 2020). Feminism in nursing ethics has particularly focused on the centrality of relationships and the importance of social and political contexts to women's health, including the idea that the inherent moral qualities of nurses' working

† Race/ethnicity categories were not mutually exclusive; participants could select more than one.
‡ Other education includes programs outside the United States and certificate programs.
§ Midwest: Ohio, Michigan, Indiana, Wisconsin, Illinois, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas.
‖ Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania.
¶ South: Delaware, Maryland, Virginia, West Virginia, Kentucky, North Carolina, South Carolina, Tennessee, Georgia, Florida, Alabama, Mississippi, Arkansas, Louisiana, Texas, Oklahoma, and District of Columbia.
# West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, California, Oregon, Washington, Alaska, and Hawaii.
** Other Christian includes: Jehovah's Witness, Mormon, Orthodox Christian, Unitarian, and other Christian.
†† Other religions include: Buddhist, Hindu, Jewish, Muslim, and other religion.

Table 3
A χ^2 Analysis of the AAS by Demographic and Nursing Characteristics

Characteristic	AAS Score Category					Test Statistic	
	Strongly Proabortion ($n = 289$)	Moderately Proabortion ($n = 574$)	Unsure ($n = 533$)	Moderately Antiabortion ($n = 194$)	Strongly Antiabortion ($n = 230$)	χ^2	*p* Value
Demographic characteristics							
Gender ($n = 1,815$)							
Female	284 (15.8%)	568 (31.6%)	526 (29.3%)	192 (10.7%)	227 (12.6%)	0.8	.94
Male	4 (22.2%)	6 (33.3%)	4 (22.2%)	2 (11.1%)	2 (11.1%)		
Age (years) ($n = 1,816$)							
20-39	122 (17.4%)	226 (32.2%)	183 (26.1%)	84 (12.0%)	86 (12.3%)	26.5	.00087
40-59	110 (13.3%)	244 (29.6%)	280 (33.9%)	78 (9.5%)	113 (13.7%)		
≥60	57 (19.7%)	104 (35.9%)	67 (23.1%)	32 (11.0%)	30 (10.3%)		
Race ($n = 1,805$)							
Non-White	45 (13.7%)	105 (31.9%)	108 (32.8%)	35 (10.6%)	36 (10.9%)	4.0	.41
White	242 (16.4%)	467 (31.6%)	418 (28.3%)	158 (10.7%)	191 (12.9%)		
Education ($n = 1,820$)							
Associate degree or lower	100 (13.4%)	197 (26.3%)	259 (34.6%)	96 (12.8%)	96 (12.8%)	34.0	<.0001
Bachelor's degree or higher	189 (17.6%)	377 (35.2%)	274 (25.6%)	98 (9.1%)	134 (12.5%)		
Religion ($n = 1,792$)							
Christian	54 (5.7%)	264 (27.7%)	369 (38.8%)	126 (13.2%)	139 (14.6%)	222.4	<.0001
Non-Christian	228 (27.1%)	304 (36.2%)	154 (18.3%)	67 (8.0%)	87 (10.4%)		
Region ($n = 1,781$)							
Midwest	33 (9.7%)	97 (28.6%)	116 (34.2%)	42 (12.4%)	51 (15.0%)	95.7	<.0001
Northeast	54 (17.6%)	124 (40.5%)	85 (27.8%)	25 (8.2%)	18 (5.9%)		
South	69 (11.4%)	159 (26.3%)	198 (32.8%)	79 (13.1%)	99 (16.4%)		
West	128 (24.1%)	180 (33.8%)	123 (23.1%)	43 (8.1%)	58 (10.9%)		
Has children ($n = 1,814$)							
No	104 (24.4%)	156 (36.6%)	102 (23.9%)	31 (7.3%)	33 (7.7%)	51.2	<.0001
Yes	185 (13.3%)	418 (30.1%)	426 (30.7%)	163 (11.7%)	196 (14.1%)		
Had abortion ($n = 1,814$)							
No	194 (13.1%)	452 (30.4%)	449 (30.2%)	182 (12.2%)	209 (14.1%)	82.1	<.0001
Yes	95 (29.0%)	122 (37.2%)	79 (24.1%)	12 (3.7%)	20 (6.1%)		
Had miscarriage ($n = 1,814$)							
No	210 (16.3%)	431 (33.5%)	361 (28.0%)	138 (10.7%)	147 (11.4%)	12.0	.018
Yes	79 (15.0%)	143 (27.1%)	167 (31.7%)	56 (10.6%)	82 (15.6%)		
Nursing characteristics							
Job title ($n = 1,820$)							
Nurse	184 (16.6%)	374 (33.8%)	286 (25.9%)	118 (10.7%)	144 (13.0%)	17.28	.0017
Management/other	105 (14.7%)	200 (28.0%)	247 (34.6%)	76 (10.6%)	86 (12.0%)		
Unit/work area ($n = 1,797$)							
Maternal/child in-patient (L&D, nursery/NICU, postpartum)	178 (14.7%)	370 (30.6%)	358 (29.6%)	130 (10.8%)	173 (14.3%)	11.44	.022
Other (public health, WH inpatient, other)	106 (18.0%)	196 (33.3%)	169 (28.7%)	62 (10.5%)	55 (9.4%)		
Employment setting ($n = 1,819$)							
Hospital	181 (14.5%)	385 (30.9%)	377 (30.3%)	141 (11.3%)	161 (12.9%)	8.336	.08
Other	108 (18.8%)	189 (32.9%)	155 (27.0%)	53 (9.2%)	69 (12.0%)		

Abbreviations: AAS, Abortion Attitudes Scale; L&D, labor and delivery; NICU, neonatal intensive care unit; WH, women's health.

Table 4
Unadjusted and Adjusted* Results for Final Stepwise Regression for Proabortion Attitude Using Three Categories of the Abortion Attitudes Scale ($n = 1{,}754$)

Characteristic	Unadjusted			Adjusted		
	Unsure (vs. Antiabortion)	Proabortion (vs. Antiabortion)	Composite p Value	Unsure (vs. Antiabortion)	Proabortion (vs. Antiabortion)	Composite p Value
	OR (95% CI) p Value	OR (95% CI) p Value		OR (95% CI) p Value	OR (95% CI) p Value	
Education†			<0.0001			<0.0001
Bachelor's degree or higher	0.85 (0.65–1.10)	1.52 (1.19–1.94)		0.82 (0.63–1.07)	1.44 (1.11–1.87)	
	0.22	0.0007		0.14	0.0067	
Religion‡			<0.0001			<0.0001
Non-Christian	0.72 (0.54–0.95)	2.90 (2.27–3.71)		0.71 (0.54–0.94)	2.90 (2.23–3.76)	
	0.019	<0.0001		0.018	<0.0001	
Region§			<0.0001			<0.0001
Midwest	1.13 (0.80–1.60)	1.12 (0.80–1.56)		1.14 (0.81–1.62)	1.31 (0.92–1.86)	
	0.48	0.52		0.45	0.14	
Northeast	1.80 (1.18–2.75)	3.25 (2.20–4.81)		1.75 (1.14–2.69)	3.20 (2.12–4.83)	
	0.0065	<0.0001		0.01	<0.0001	
West	1.11 (0.79–1.55)	2.45 (1.81–3.32)		1.06 (0.76–1.50)	2.21 (1.61–3.04)	
	0.55	<0.0001		0.72	<0.0001	
Has children‖			<0.0001			<0.0001
No	1.35 (0.95–1.92)	2.47 (1.80–3.37)		1.45 (1.00–2.10)	2.23 (1.58–3.13)	
	0.098	<0.0001		0.047	<0.0001	
Had abortion¶			<0.0001			<0.0001
Yes	2.28 (1.46–3.55)	4.38 (2.93–6.56)		2.36 (1.50–3.69)	4.94 (3.24–7.53)	
	0.0003	<0.0001		0.00018	<0.0001	
Had miscarriage#			0.01			0.045
No	1.08 (0.82–1.43)	1.43 (1.11–1.86)		1.11 (0.83–1.48)	1.42 (1.06–1.89)	
	0.59	0.0065		0.49	0.018	
Work Area#			0.016			-
Other (public health, women's health inpatient, other)	1.25 (0.94–1.66)	1.45 (1.12–1.88)		-	-	
	0.13	0.0048				

* Referent is Associate's degree or lower.
† Referent is Christian.
‡ Referent is South.
§ Referent is does have children.
‖ Referent is has not had an abortion.
¶ Referent is has had a miscarriage.
# Referent is maternal/child in-patient (labor and delivery, nursery/neonatal intensive care unit, postpartum).

environments must be made transparent for those operating therein (Burton, 2020; Peter & Liaschenko, 2020). This finding implies that nurses must be aware of and consciously engaged with their personal values, including the recognition of when those values are shaped by internalized oppression—including devaluation of women's bodies, disregard of personal agency in reproductive health, and disempowerment of nurses within health care systems and institutions (McCarthy & McGuinness, 2020). Such awareness may be especially important for recruiting and retaining nurses in settings that may provide abortion care to ensure that such care is safe, effective, and nonjudgmental.

The recognition of values and experiences is especially interesting within the context of our finding that, among participants who reported having an abortion, almost one-quarter were unsure and 10% reported antiabortion attitudes. This finding suggests that people's attitudes about abortion are not necessarily indicative of their behavior and may be evidence of internalized abortion stigma (Coleman-Minahan et al., 2019). Thus, categorizing abortion attitudes with greater nuance will require more examination in future work.

The potential for belief systems and attitudes toward abortion to influence patient care has implications for how both nurses and patients experience the processes of abortion provision. Although there are very limited data on the association between abortion attitudes and practices among nurses, a recent study found advanced practice nurses with more supportive abortion attitudes were more likely to provide pregnancy options counseling and abortion referrals to their patients (Coleman-Minahan, 2021). In addition to abortion attitudes potentially limiting specific care that some nurses are willing to provide, attitudes may also shape nurse–patient interactions. For example, in a study of five countries (not including the United States or Canada) where providers such as RNs and midwives are able to provide abortion care, results indicated that patients were less concerned with the type of provider and more with feelings of trust in the provider, sense of kindness and caring from the provider, belief in confidentiality, and cost/accessibility of the procedure (Glenton et al., 2017). This study also found that a willingness to engage in abortion care was, in part, influenced by individual moral and religious views on abortion. Together, these findings suggest that the interaction between patient and provider is a critical aspect of abortion care, and that individual attitudes or beliefs may be a barrier to the expansion of the abortion care workforce. In our study, these influences may be reflected by the geographical location of respondents—regions known for having historically elected more moderate and liberal-minded officials were more likely to hold proabortion attitudes.

Interestingly, however, our study found the majority of those who identified as having Christian beliefs—often associated with antichoice attitudes in U.S. mainstream media—were actually more likely to fall under the category of unsure. This insight is important, because many large health care systems are religiously affiliated and may have antiabortion policies that restrict the provision of care; however, our findings suggest that these policies may not reflect the views of nurses working in those systems. In addition to the prohibition of most abortions at Catholic hospitals, patients may encounter barriers and fewer option for reproductive health care at some Protestant-affiliated institutions (Hasselbacher, Hebert, Liu, & Stulberg, 2020).

Another structural way in which nurses' attitudes about abortion can manifest in patient care is conscientious objection, the process of opting out of providing care that conflicts with one's own personal, moral, and religious beliefs (Lamb, 2016). Hospital nurses who invoke a conscientious objection to participating in abortion must assess whether they are not only denying a patient's autonomy and human dignity, but whether they are also contributing to the mental and/or physical harm of the patient by delaying or eliminating their access to care. Conscientious objection, as it currently exists in health care setting in the United States, cannot truly balance the affirmative right to justice, autonomy, and self-determination of the individual in need of abortion services (Eagen-Torkko & Levi, 2020). Additionally, there is an institutional moral obligation on the part of hospitals, clinics, insurers, and other health administration to ensure timely care is provided without added burden when providers object to assisting with health care such as abortion.

There are some limitations to this study. First, the sample represents a low response rate (9%). This rate is typical for surveys of RNs, and there may be reasons for nonresponse that would influence findings. Those who did take the survey, however, represented a broad range of demographic characteristics and beliefs related to abortion care. A limitation of the design is the use of a convenience sample, which limits its generalizability. Another limitation of this study is the cross-sectional design, which limits its interpretation and applicability if attitudes about abortion change over time. Finally, attitudes are only one dimension to how nurses engage with ethically challenging care provision, particularly in a health care system increasingly dominated by Catholic-affiliated hospital systems (Uttley & Khaikin, 2016). Few studies have explored the context of if and how attitudes influence behavior and future studies should focus attention on those relationships.

Implications for Practice and/or Policy

Given that a substantial proportion of nurses express uncertainty about abortion or antiabortion attitudes, individual nurses and institutions must take steps to ensure that nurses who do not hold proabortion beliefs support pregnant people who are seeking abortion care as part of comprehensive reproductive health care delivery (Harris, Cooper, Rasinski, Curlin, & Lyerly, 2011). To facilitate this care, values clarification exercises should be part of new-hire training for any health care providers who may come into contact with a person in need of options counseling. Nurses and all health care providers should be made aware of how their own personal experiences and opinions may affect their approach to abortion care, and health care organizations should be attuned to the nuanced, complex, and sometimes contradictory ways in which people understand abortion. Health care settings must ensure that training and evaluation of options counseling is ongoing. Stigma around abortion in the United States is common and deeply rooted, so researchers and providers alike need to be clear about the role of abortion as part of comprehensive reproductive health care delivery.

Conclusions

Understanding the attitudes of health care providers who counsel about and provide abortion care is critical to ensure that unbiased and complete patient information is provided. Nurses in the United States are not often included in abortion research, leaving a gap in our understanding of how a critical part of the health care workforce views abortion. These findings demonstrate the complexity of abortion attitudes among obstetric nurses, suggesting we should move away from divisive proabortion/

antiabortion dichotomies. This complexity, particularly that almost one-third of participants fell into the unsure attitude category, suggests the need for values clarification training regarding willingness to participate in abortion care and provide options counseling. Future research should explore nurses' ethical duty to provide abortion counseling and care and how nurses negotiate their personal beliefs and respect for patient autonomy.

Supplementary Data

Supplementary data related to this article can be found at doi:10.1016/j.whi.2021.10.011.

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