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Calculus Formation: Nurses' Decision-Making in Abortion-Related Care

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Abstract: Nurses routinely provide care to patients in ethically challenging situations. To explore the continuum between conscientious objectors and designated staff in the provision of care to women seeking abortions, the aim of this study was to thickly describe decision-making, using abortion as the clinical context to elucidate how nurses approach ethically challenging work. A purposive sample of 25 nurses who worked in abortion clinics, emergency departments, intensive care units, labor, and delivery, operating rooms, and post anesthesia care units were interviewed. Qualitative description and thematic analysis were used to identify the cognitive, emotional, and behavioral processes in nurses' decisions to care for women needing abortions. Nurses developed and used multifaceted, real-time calculi when making decisions about their participation in emergent or routine abortion care. Nurses tacked back and forth between the personal and professional and/or held multiple contradictory positions simultaneously. Nurses weighed the role and opinion of others to determine if they *know how* to or *know why* they would provide abortion care to women, particularly in the elective abortion context. The parameters of the nurse–patient relationship were complex and specific to the experiences of both the nurse and patient. Findings from this study further develop the science of ethically challenging decision-making and expand our understanding of factors that influence how nurses develop relationships to ethically challenging work. © 2015 Wiley Periodicals, Inc.

Keywords: abortion; decision-making; nursing care; nursing ethics; qualitative research

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Registered Nurses (RNs) routinely provide care to patients in ethically challenging situations, and clinical decision-making and nursing judgment have been the subjects of much inquiry (Benner, 1984; Benner, Sutphen, Leonard & Day, 2010). Enabling RNs to make real-time clinically appropriate decisions leads to better patient outcomes and experiences and reduces errors (IOM, 2010). Researchers have depicted how expert RNs develop clinical skills, critical reasoning, and an understanding of patient care over time (Benner, 1984), but past models have failed to elucidate differences in decision-making in urgent, emergent, and elective ethically challenging situations.

Abortion care is a rich context to study how RNs participate in decision-making in this work. Abortion is a common procedure; it is estimated that one in three women in the United States who experience an unintended pregnancy will have an abortion before the age of 45

(Guttmacher, 2014). Although complications are rare (Weitz, Taylor, Upadhyay, Desai & Battistelli, 2014), when they occur, skilled RNs in critical care settings and other areas may need to provide acute and comprehensive care, even if those nurses are not familiar with or expert in abortion. In addition to nurses' possible decisional conflict regarding the ethics of abortion, situational conflicts can arise due to patients' decisional conflict, abortion-related stigma, and conflict of values between RNs and others (McLemore & Levi, 2011).

One aspect of ethically challenging work may be moral distress. Jameton (1984) first described moral distress as arising when one knows the right thing to do but institutional constraints make it nearly impossible to pursue that of action. Wilkinson (1987, p. 16) expanded the definition to “the psychological disequilibrium and negative feeling state experienced when a person makes a moral

decision but does not follow through by performing the moral behavior indicated by that decision." Moral distress has been described in psychological, emotional, and physiological terms, but there is lack of consensus on its definition, operationalization, and parameters (McCarthy & Gastmans, 2015). In the single study to date of nurses' moral distress in abortion care (Hanna, 2005), moral distress was an inclusion criterion, so the prevalence of moral distress among nurses in abortion care was not determined.

Because some RNs conscientiously object to caring for women seeking abortions, and others do provide abortion care as designated abortion service staff, the decision to provide this care may be seen as a simple dichotomy, in which nurses either participate in abortion care or do not. However, a complex continuum (Harris, 2012; Steinauer et al., 2014) may exist between conscientious provision of abortion care and conscientious objection to participation in such care. A continuum of participation was found in physicians' provision of abortion care (Steinauer et al., 2014). The purpose of this study was to explore a continuum of RNs' decision-making between the two extremes of conscientious objectors and designated abortion care staff. Using abortion as a case in point, we sought to gain a deeper understanding of the processes, and factors that influence RNs when making decisions in ethically challenging situations, including how RNs make sense of conflicting perspectives and values in their work and how they explain, reason through, and/or rationalize difficult decisions.

Methods

Setting and Sample

RNs from the San Francisco Bay area were invited to participate in the study after Institutional Review Board approval was obtained from the University of California, San Francisco. Flyers were sent to nurses from their managers and were posted in staff-only areas in 14 Bay area sites. Given the sensitive nature of abortion and decision-making, volunteers could then contact the study team independent of their employers' knowledge. Demographic data were collected to describe the sample, but no identifying information was collected other than the participant's signature on the consent form. RNs were given gift cards in appreciation of their participation.

RNs in all job titles were eligible to participate. The only exclusion criterion was not working in the clinical areas of interest. In hope of capturing conscientious objectors or nurses with complex views on abortion, we sought RNs who could have encountered women needing abortions but for whom abortion was not the primary area of clinical expertise or practice. A purposive sample of RNs from emergency departments (ED), intensive care units (ICU), labor and delivery (L&D), post anesthesia care units (PACU), and operating rooms (OR) was recruited. Based

on a review of the literature, these diverse practice settings were tapped to garner detailed experiences of women seeking emergent, urgent, or elective care for miscarriage, abnormal pregnancy, and abortion complications such as respiratory events or severe bleeding. This ensured a range of variation in setting and nature of abortion care experiences.

We assumed that RNs primarily working in abortion care provision (i.e., designated staff) would have a narrower range of objection, but our first three participants, ED, L&D, and PACU RNs, all reflected on caring for women who had come directly from abortion clinics and described tensions in information transfer and handoffs. Our assumption that abortion clinic RNs would have fewer objections to abortion was not entirely accurate, from the urgent care RNs' perspective. Developing themes (e.g., weighing the role and opinions of others, separating self from patient and environment of care) also supported theoretical sampling of designated abortion care staff.

In all, a sample of 25 RNs was recruited. The RNs providing urgent/emergent clinical care provided a broad range of data and quickly identified tensions within care provision, and the designated abortion staff RNs provided rich descriptions of their nursing work and identified new tensions that RNs working in urgent/emergent care provision did not experience or discuss. Taken together, the data depicted wide variations in how RNs determined their participation in abortion care provision and developed relationships to ethically challenging work.

The mean age of this sample ($N=25$) was 42.5 years (range 31–66 years); all were women, and 64% ($n=16$) reported no religious affiliation. All had at least a bachelor's degree and 63% ($n=15$) had master's degrees, consistent with employment demographics of the San Francisco Bay area. The mean time in nursing was 13 years, and there were 18 children among 16 participants. Consistent with US population reports, 32% ($n=8$) voluntarily disclosed a personal history of at least one abortion.

Data Collection

Semi-structured interviews (25–90 minutes) were conducted in person or by telephone between November 2012 and August 2013 and recorded by the lead author, a clinician scholar with expertise in women's reproductive health, including abortion care. The interview guide included several broad questions on the RNs' careers in nursing and work experiences. They then were asked to think of a time when a woman needing an abortion was admitted to their unit and to recount that day. We included several probing questions on any interactions they had or observed regarding the woman's care or any interactions with the patient. We also asked the nurses to describe the unit that day and any interactions they had with others in the context of this patient's care. Interviews were transcribed verbatim by an

outside agency and read by the lead author for accuracy and re-familiarization.

Data Analysis

Qualitative description (Sandelowski, 2000) and thematic analysis (Braun & Clarke, 2006) were used to characterize the process of clinical decision-making of nurses in relation to the ethically challenging context of abortion care. Initially, the entire dataset was coded line by line; then, themes were identified by categorizing the codes. Next, transcripts were re-read to examine themes by urgency of abortion (i.e., emergent, routine, urgent) to determine if additional categories could be developed. An additional layer of analysis focused on the clinical area of work (i.e., abortion clinic, ED, ICU, L&D, PACU, OR).

Conceptual memos were written along the way to provide definition and illustration of developing themes. Reflexive memos were written to explore potential areas of researcher influence on the analytic process and bias. To ensure rigor and credibility of the findings, we engaged in the iterative process of coding and reviewed all products of analysis as a team (second author- clinician scholar with abortion care expertise, third author- expert in qualitative methods). Atlas-ti software was used to aid data management and analysis. To maintain anonymity in presentation of results, nurses were identified only by their clinical areas.

Results

Calculus Formation

RNs made clinical decisions related to participation in abortion care using a variety of perspectives with a multitude of influencing factors. Calculus formation was defined as an iterative process of assessing and weighing relevant variables (i.e., person or thing) in a situation to determine a decision and set of associated actions. The development of calculi was a complex, iterative, ongoing process for RNs, regardless of their status as novice or expert.

Although calculus formation was a component of the process of developing a relationship to their ethically challenging work, it did not completely describe this process. How RNs created staffing assignments, documented their care, and the extent to which they shared work with other RNs also were components of the process they used to develop relationships with this work.

Urgency of the abortion and workplace of the RNs shaped four sub-themes of calculus formation: (a) tacking back and forth between personal and professional perspectives; (b) considering the opinions, perceptions, and roles of others; (c) making a clear distinction between *knowing how* to provide abortion care and *knowing why* they should or would do so; and (d) attempting to delineate the

parameters of the nurse–patient relationship (NPR). Calculus formation included the option of *not* making a decision, and perpetually tacking back and forth between these actions. This process was not linear. We provide exemplars of each action to highlight this complexity.

Tacking Between Personal and Professional Perspectives

Participants described tacking back and forth between their personal attitudes, beliefs, and feelings and their professional obligations as nurses. Tacking involved wrestling with oneself, which included separating self from patients; becoming self-aware; preparing oneself; and sitting with discomfort in real time. Additionally, many participants described the tension of holding two contradictory positions simultaneously as they tacked between perspectives.

A psychiatry/ED RN who moonlighted as designated staff eloquently illustrated the complexity of tacking back and forth:

I think working at an abortion clinic is hard as a nurse. I think that there are times that you're dealing with things as a woman, as a mother, as a non-mother, as a wife or a partner that come up, because your patients are emotional and it's our nature as human beings, as nurses, as people to share that through our therapeutic communication, through our social support for our patients, your personal stuff comes up.

Tacking was also described by RNs in more concrete terms specific to their professional obligations. An L&D RN stated:

I can't speak for everybody, but I think most of us are trying to deal with like, "I don't want to bring my personal feelings into here, or my personal upbringing into my professional life." I'm sure at some point it can have influence, like for me, maybe years ago, I would be "No way." But at the point when I'm a nurse, I'm like, "Okay, I need to be – I need to learn, okay, what is it that I need in order to be able to provide professional care for these patients and without bringing my own background?"

Wrestling with oneself. RNs spoke frankly about wrestling with themselves around their beliefs in bodily autonomy, comparing themselves and their pregnancy experiences to other women, judgment of women seeking abortions, and conflicting views about self-determination. An L&D RN stated,

I think for some nurses, if they feel that the client had nothing to do with the issue or had no control over it, such as an anomaly, they tend to be more empathetic. Psychiatric illness, people are much more judgmental. I think people feel like a patient should be able to deal with that or something.

A designated abortion staff RN described her personal journey to heal her own wounds around her abortion:

You know, there are just so many things that make you who you are. I kind of did it for selfish reasons (taking a job at an abortion clinic), well, I did it for several reasons. Selfish reasons in the fact that I thought it would help heal some old wounds around abortion. That was one of the reasons I was seeking it out.

An oncology RN who also moonlighted as designated abortion care staff described using her own pregnancy loss experiences to support other women and develop empathy:

I mean, of course, my experiences shape my emotions and my work ethic and my thoughts, and of course, yes, when I meet a woman who was in the same spot as me two different times is losing a child – losing, well, losing an embryo specifically, of course, I have much more empathy for her and I understand it and I want to say, “I know how you feel,” and I think I've said it a couple of times, but yet, you really just want to sit there and say, “Believe me, like I don't just know, like *I know*,” and so, of course, I feel more empathetic to those people...But I do get sad when I think about those babies and I don't share with all of my patients that I've experienced that loss.

Separating self from patients. Many RNs described the impact of their own parenting decisions, their thoughts about death and dying, and ultimately their own ethical, moral, personal, and spiritual conflict about abortion care provision:

I'm not going to go in and have the experience of remembering what it was like to have a child or making that choice, because I made a different choice. So, I do not think that for me, those feelings are not going to come up. So, yes, I think there is a different emotional component. (L&D RN)

But people also ask me, who knew I was trying to get pregnant and it was not

happening, they say, “How can you work there? How can you do that?” And I'm like, “What are you talking about? Their fertility has nothing to do with my fertility.” These people asking me these questions could not separate my situation from other people's situations, and I think that that—that's a problem. (designated abortion staff RN)

Comments about death and/or dying in the abortion provision context were made by most of the RNs. Many who worked on L&D units viewed abortion as a “death process” and described how it complicated their expectations of the care their units usually provided. One RN stated:

When fetuses have feticidal agents, the procedure is over, so they (the other RNs) think some people need to feel more comfortable, ethically, taking care of those patients, because they do not have to participate, even though, theoretically, the termination is over, too. It just feels different to people, I think.

Many of the nurses noted that women needing abortions were “unique” compared to patients having other surgical procedures. This unique status included not only the emotionally charged and unexamined feelings it brought up for the nurses in real time, but also the politics and stigma associated with abortion care provision. The burden of paperwork reflected the uniqueness of abortion care provision, as in these two examples: (a) I will “dot my i's” and “cross my t's” because abortion is a contentious clinical service, and participation could be a legal liability for the RN and (b) Paperwork allows me to distance myself from the patient and to be able to do what I need to do for them, but not seriously engage in or participate fully in the NPR.

An L&D RN summarized this point in this way:

Then, sometimes the concern is, “Is this body going to have a heartbeat?” If it has a heartbeat, we have to call pediatrics. And so, it becomes like a grey area. If there was a heartbeat, then the paperwork was different. If there was not a heartbeat, a death certificate has to be used. Then, pediatrics will have to produce it, I believe. Then, they don't want to have anything to do with it. So, it's really difficult. So, they are like, I” don't want to have anything to do with it either.” So, it's kind of like that. Nobody wants to have anything to do with it, the legalities of signing a death certificate, or finding the heartbeat or no heartbeat and then discussing this with the parents.

Self-awareness and self-preparation. RNs who were more likely to provide care for women needing or seeking abortions spoke at length about needing to have real-time self-awareness and preparation. Several RNs commented about the need to be “flexible” with one’s emotional spectrum and to be constantly monitoring one’s own judgments:

I just think that if you are going to work in abortion care, that you have to be somebody who is extremely flexible with your emotions, that you can deal with the angry patient, you can deal with the extremely sad patient, you can deal with the patient who has a flat affect to know when to use humor and not use it and be more empathetic.

Weighing the opinions and role of others.

In addition to identifying and confronting their own personal thoughts and opinions, RNs integrated the comments or opinions of others into their calculus formation. This theme was informed by perceptions of nursing as shared work, lack of support from others, and poor communication. Interestingly, RNs did not directly discuss patients as others but made clear distinctions among other RNs, physicians, and other healthcare providers and family members.

Nursing as shared work. RNs in all job categories perceived nursing as shared work:

So, there is people who you work with and you make tacit agreements with them. I take care of babies. I like babies, babies do not scare me, I will take care of all the babies and some people say, “I hate babies, their airways close up so quickly and it looks like my kid and I don’t” so, you say, “I’ll do that.” (PACU RN)

However, nursing as shared work also had negative connotations, and several RNs talked about retaliation or threat of retaliation from colleagues who did not agree with their decision to participate in abortion care:

Nurses can leave you alone if they object, one case took an hour to get in an IV and she had to call anesthesia (and it is frustrating to not be able to control her pain). Nurses will demonize you for caring for those patients and it is hard to find coverage like when you want a lunch or to go to the bathroom if you are on with nurses who won’t do these cases. (PACU RN)

RNs spoke frankly about how their colleagues’ perceptions of them mattered both positively and negatively,

and most acknowledged that avoidance of conflict was their primary goal.

Lack of support from others (non-RNs).

Almost every RN spoke of their lack of support from friends, their own family members, and other acquaintances, such as teachers or parents at their children’s schools. RNs said they could not freely talk about their work in abortion care, out of respect for other people with differing opinions or to avoid conflict; designated abortion staff RNs specifically discussed their need for discretion when discussing their work:

It would be nice to—sometimes I wish my friends would ask, “How’s work? How’s it going, you know, like working in abortion?” Or just acknowledging my career. They know I’m a nurse. They know that I work at a hospital, but ... they don’t know—they don’t ever ask, and I do not ever say, unless people ask. But if somebody has sat down with me, I will tell them, and I have, “Yeah, this is what we do,” you know, but people never really ask me. (PACU RN)

Poor communication and inter-professional conflict.

All of the RNs discussed episodes of poor communication or inter-professional conflict. RNs in many settings expressed dissatisfaction in the care provided to women seeking or needing abortions. Surprisingly, many of the RNs expressed positive feelings about their work despite these conflicts, including a clash with a physician colleague, and member of administration:

I have always been very proud of the work that I do and there has been some times that I have had conversations that I did not want to have from not necessarily coworkers, but from just small-minded, narrow-minded people and wanted to chastise me for my work and, you know, I will defend it to death, but I—sometimes it is better just to avoid it and situations just because I’m not going to back down. (designated abortion staff RN)

Interdisciplinary differences in care approaches also frequently were discussed:

The only problem I have, and it is not just in terms of abortions, I feel like physicians generally have one idea in their head about what’s going to make somebody comfortable, and I don’t feel like they personalize as much as I do as a nurse. So, that same—for instance, an assumption that somebody is going to want an epidural and not feel any pain, and in a sense not be very involved, a

lot of women want that, but there are some that do not, and I do not always feel like the physicians are trying to tune in to what somebody really wants. (L&D RN)

Knowing How Versus Knowing Why

RNs required more than the technical skills and tasks (knowing how) to participate in abortion care. They integrated their awareness of self and others into their calculation of whether they had the basic knowledge or skill set to care for women needing or seeking abortions, but more importantly, they considered whether that care needed to be provided, as well as whether they were able to provide it. They needed to understand why they should and would participate in care provision. In models of how novice RNs become expert (Benner et al., 2010), knowing how (i.e., practical knowledge) has been distinguished from knowing why (i.e., theoretical knowledge).

RNs clearly could distinguish the technical skills required to care for patients. For example, an L&D RN described having the skills required for abortion using induction termination methods:

I mean I think it is all childbirth, even if it is not a child. You know what I mean? I think that the pure physiology of what is happening is consistent if it is a desired, healthy fetus or an abortion. It is all physiologically giving birth. The work is the same. I mean I would say every aspect of it is the same because you are—okay, there is one little piece that is different in that you do not have a fetal monitoring strip. So, you are not monitoring a fetus intrapartum, you are not listening to a baby's heart tones as you do in labor. A huge piece of labor and monitoring is around monitoring the contraction pattern and how the fetus is tolerating it, but there are so many other elements of birth, which is emotional support, physiological support, pain management, that are exactly the same.

Knowing why included knowing the reason for the abortion. Many RNs were able to empathize with women when they knew that woman's story, and those with less positive attitudes toward abortion could use this information to tune their calculus formation toward provision of care. This phenomenon was particularly pronounced among the L&D RNs.

However, the most poignant and important exemplar of knowing how versus knowing why came from a PACU RN who described how patients were assigned as they came out of surgery. In that hospital, RNs were able to negotiate with their colleagues over which patients they would care for and in what order:

Yeah, we had a big fight about that with one nurse and myself. It was like, "Gee, you can take care of the murderer, the rapist, the bank executive, but you can't take care of the 21 year old, you don't know how she got pregnant, if she's got five kids at home and what her life is like...Why do you get to pick that little girl and tell her that you're not taking care of her, but your moral boundaries accept every other creep that comes in here?" We do not make those moral distinctions. We deal with people and we say, "You're my patient. I'm going to do the best I possibly can for you."

Knowing how and knowing why were influenced by fear, the perceived failure or inability to translate a skill set, and silos in care across the reproductive spectrum.

Fear. The technical work of nursing in abortion care provision was no different than the work RNs routinely provided to patients, yet there were major differences. A lack of time for calculus formation, time to consider the issues in providing care, impeded the decision to provide care. A small number of RNs, none of whom were designated abortion care staff, feared being labeled by their colleagues as abortion-friendly nurses or as the nurse who would take care of abortion patients in their clinical area, thereby becoming the designated abortion staff within a team. Others were fearful due to their lack of familiarity with abortion care (i.e., procedure, instruments, medications administered) or feeling unprepared in other ways (i.e., not knowing patients' expected emotional spectrum, not having clarified their personal values, or not knowing the clinical distinctions between medication and aspiration abortion).

My colleagues have a —I do not know if stigma is the word. Fear? When there is someone who needs care, not only psychiatrically, but also gynecologically, it is panic-inducing in my colleagues. It is. Whether it is like, "Oh my gosh, she's post-op, she's bleeding. Are there sutures? Are there —?" And you're like, "No, there's no sutures. She just had an abortion. There's no cutting. There's no stitching." You know. (ED RN who moonlighted as designated abortion staff)

Perceived failure or inability to translate a skill set. Most of the RNs talked about their own inability to translate their skills to abortion care without time to consider it, or perceived that others were unable to do so. One RN who moonlighted at several hospitals as an L&D and designated abortion care RN said,

Well, in one sense, I think there is a huge difference because taking care of people in Labor and Delivery as opposed to the rest of the hospital, it is usually a happy occasion, somebody is having a baby, and so, I know that I'm going in to support a positive experience. If I'm going in to support somebody with an abortion, I know it may be a positive experience for that person in terms of a choice they really want to make, but it is much more mixed and I know the experience they are going to be going through will bring up possibly very different feelings—definitely different feelings than having a baby.

Several RNs talked about their colleagues' inability to translate their skill sets due to fear of retaliation. A designated staff RN recounted this experience from her student preceptorship:

I did not feel safe talking to the nurses that I was working with there about all of my experience in abortion care. One time it came up because somebody—normally Rhogam is given in post-partum, and for some reason, they had a postpartum patient waiting in L&D even though she had already delivered, she needed Rhogam. None of the nurses there had any experience with it. None of them wanted to give the shot. I said, "I'll do it, I've given a million of them." And one of them, who was younger, and I thought she'd be kind of cool, looked at me and said, "How do you" – because I was a nursing student, she said, "How do you know how to give Rhogam?" And, I said, "Because I worked in abortion clinics for 13 years." And, she goes, "Eew."

Silos in services across the reproductive spectrum. Many RNs spoke about the silos of care and how the infrequency of abortion care provision in their setting made them uncomfortable with participation. Many saw abortion care as solely within the purview of designated abortion staff RNs, regardless of the level of care required by the patients. ED, ICU, L&D, OR, and PACU nurses said they did not understand why the designated abortion staff RNs could not provide round-the-clock care for their patients, even when those patients were critically ill as a result of the pregnancy or some other condition. One ICU RN related a story about caring for a woman who needed an abortion before starting chemotherapy for breast cancer:

I would probably feel more comfortable than most, just based on my experience working

on the surgical oncology floor, it being with a lot of gynecological cancers. So, I know pad checks, I know—but when we do have like anything with a fundus, then, I'm definitely out of my comfort zone. So, I would say, I'm probably more comfortable than most of my colleagues and my comfort level is not amazing.

Delineating the Parameters of the Nurse-Patient Relationship (NPR)

RNs spent significant time discussing several challenges to delineating the parameters of NPRs in abortion-related situations: (a) establishing what was meant by nursing work in the abortion context, (b) making clear distinctions between women and patients, and (c) discussing the impact of the environment of care and its role in abortion care provision.

Meaning of nursing work in the abortion context. RNs described the appropriate development of their NPR as their primary motivation to determine and/or facilitate care provision that would ultimately meet the needs of the patient. Both positive and negative aspects of nursing work in abortion care affected their calculus formation, including how their own abortion experiences influenced how they enacted that NPR.

An RN who moonlighted in abortion clinics reinforced the nature and spectrum of the NPR in abortion care provision:

I spend most of my time in the recovery room. And that is a really different—it is a different pace, but it is still essential. You are the last person, often, that the patient sees before they go home. You have to make sure that they understand their self-care—That is important and prevents numerous complications and that education piece is huge. I think pain management is so crucial and I'm so happy to do anything I can to listen to what our women are experiencing and try to make them more comfortable, if that is pain, if that is bleeding and cramping, if that is emotional, and then, that is when the emotional piece comes in. All these things that come up, you are there to mediate that with them—not just for them, with them. And I think provide whatever you can to make the experience a more positive one. And that sounds crazy, but I really believe that is part of your job is to be there for them so that when they walk out the door, they are not wanting for anything. It is not an easy day. So, let us try to make it as smooth and as comfortable as we can do.

Distinguishing women and patients. RNs made a clear distinction between women and patients, which was reflected in their language (not using the words women and patients interchangeably), and conceptually (not immediately identifying a role for themselves in the care of women with unintended pregnancies). The label of patient was a legitimizing status, and the RN's role for patients was clear, but not all RNs identified women considering abortions as their patients. Several ED and L&D RNs remarked: "Until she makes a decision, she's not my patient yet," and an L&D RN said,

I think that for me, I used to think that women who had abortions were all these kind of strange women (laughs). Strange women who had abortions. But actually when sitting down and thinking about it, it can happen to any woman who may need the care. And I feel really bad for the woman who is trying to have a termination and then she ends up in an ICU and then the whole family, the whole world will find out about her and all that.

Impact of the environment of care on abortion care provision. Many RNs remarked that the environments of care on their clinical units were not ideal for abortion care. Not only did some RNs feel unprepared for post-abortion care, but the actual physical space was problematic. Many RNs, including designated abortion staff RNs, commented about the lack of privacy, the varied circumstances surrounding the need for abortion, and the conflicting care provision models of group care:

We are just—we are not—we are kind of not set up to be an all-encompassing kind of women's health place. Women come in for really contradictory reasons who will be interacting in the waiting room and kind of upsetting to each other, right? Someone's there for their, whatever, 20th abortion, and someone there is having a problem and needing to have an abortion that they do not want. They are not the same group of people. (L&D RN)

Discussion

This study provides a thick qualitative description of RNs' relationships with ethically challenging work, specifically, abortion care, and the influences on the decision-making processes (calculus formation) to determine their level of participation. The initial expectation of the study was to describe a continuum of perspectives between

conscientious objectors and designated abortion staff, but we discovered instead that RNs used complex processes to determine their relationship to ethically challenging work, and those processes were influenced by diverse factors. The complex interactions of personal and professional roles and of the perspectives of RNs and their patients challenge what is generally described as a dichotomy of beliefs between those who provide abortion care and those who do not.

Our findings are consistent with and add to those of other studies of RNs' abortion care provision. First, several researchers have described how the reasons for the abortion affect the willingness of RNs to participate in abortion care provision at various gestational ages, including whether the abortion is for contraceptive failure, fetal indications, health of the mother, income status, rape, or incest (McLemore & Levi, 2011). Previous studies also revealed that RNs do and do not participate for a spectrum of reasons that relate to perceived legitimacy of the reason for abortion. Others (Mizuno, Kinefuchi, Kimura & Tsuda, 2013) have shown that burnout and perceived stigma affect RNs' willingness to participate in abortion care provision. Ours is the first report that RNs can concurrently hold two conflicting views and/or tack back and forth between their personal attitudes and beliefs and professional beliefs and obligations.

Second, several teams have shown that RNs and other staff who object to abortion care pose a major barrier to its provision (Guiahi, Lim, Westover, Gold & Westhoff, 2013; Turk, Steinauer, Landy & Kerns, 2013), and our data show several reasons for this, particularly, the degree to which RNs weigh the role and opinion of others, in addition to their own attitudes, beliefs and knowledge, when determining if they will provide care to women needing abortions. Perceived or real retaliation from colleagues, physicians and other staff influences how RNs tune their calculi. We believe a structured team approach to abortion care (Levi, Burdette, Hill-Besinque & Murphy, 2013) may ameliorate some of these perceptions and provide the necessary supports needed to ensure consistent care provision.

Third, our results indicated that RNs' decisions to participate in abortion care were not only about having the technical skill set but also about understanding why a woman came to decide to seek an abortion. Before providing abortion care, many RNs needed to know why (background and contextualized reasons for the abortion), and not all RNs felt capable and/or had the resources to provide this care (knowing how). The designated abortion staff model is a double-edged sword, contributing to other nurses' barriers to knowing how and knowing why, and intensifying the internal conflict those nurses face in establishing the NPR. RNs who routinely worked in abortion care found it frustrating to provide basic information about the context of the abortion to other RNs when an escalation of care was needed. In the abortion staff RNs' minds, the

abortion was over, and nurses who had the expertise to care for abortion-related complications had no need to know the original reasons for the abortion. In contrast, ED, ICU, L&D, and PACU RNs needed that information as part of their calculus formation to understand how to establish an NPR. They needed to know why, in order to do what they knew how to do.

Finally, establishing the parameters of the NPR was a complex, but crucial component of calculus formation and care provision. Many RNs commented on the difficulties of this task when managing their own values (wrestling with oneself) or when there was a conflict in values between the RN and the patient. RNs also identified others as facilitators or barriers to NPR development, particularly when their views or the views of co-workers or the patient's family members were in conflict.

The previous study of moral distress of nurses in the context of abortion care provision (Hanna, 2005) had a similar qualitative design to the present study but was different in two ways. First, Hanna assumed that legal, elective abortion was an issue with moral implications, and that moral distress could occur for both "pro-choice" and "pro-life" nurses, albeit for different reasons. The sample in the present study included RNs in emergent/urgent situations and included both abortions that were elective and those that were performed due to medical conditions and may or may not have begun as elective procedures. We posit that urgent/emergent abortion care is different than care for elective abortion, and designated abortion care staff may or may not view abortion as an issue with moral implications. The studies also had different goals. Hanna included only RNs who self-reported moral distress in regard to their work in abortion care provision, with the goal of describing that concept. We did not use language of moral distress, conscientious objection, or provision in our inclusion/exclusion criteria or recruitment materials and allowed RNs to freely describe their experiences. Our goal was to capture the complexities of abortion care provision and to describe the alignment (or lack thereof) of abortion care provision with RNs' own personal and professional values.

The findings of this study should be interpreted cautiously in the context of clinical decision-making and how nurses transition from novice to expert. The RNs in this study described their perspectives and pre-existing values regarding abortion care provision, but it is possible that some had never encountered women in need of abortion care in their clinical areas. Therefore, it is unclear whether any conflict they experienced was a product of their clinical experience or preceded it.

The study was limited by the geographic location of the study participants. RNs were interviewed from the San Francisco Bay area, and many participants lived and worked elsewhere in California. Objection to abortion care and abortion care provision may be subject to sociopolitical and environmental factors where care is occurring. More hostile environments may contribute to different ways that

calculus formation occurs. Second, although many of the nurses self-identified as objectors to abortion, many of those objections were grounded in elective abortions, and no extreme objectors were interviewed. Finally, given the precautions we took to maintain participant anonymity, it would have been inappropriate to attempt to re-contact our participants, and therefore we used constant comparison of codes and themes rather than member checking.

Conclusion

A multitude of factors influence RNs' clinical decision-making and their relationships to ethically challenging work. Findings from this study can be used to develop reflexive exercises and simulations, such as values clarification workshops, to provide neutral space for nurses to consider and explore ethically challenging parts of their work. In particular, it is important to create opportunities for nurses to explore together their shared work in situations characterized by competing and conflicting views and beliefs, including those held within the individual. Future researchers may further elucidate the mechanisms of calculus formation (i.e., tacking back and forth, weighing the role of others, knowing how versus know why and delineating the parameters of the NPR) and identify other factors RNs consider when making sense of conflicting perspectives and values in their work.

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