“IT’S BUSY .....BUT I LOVE IT”

THE EXPERIENCE OF NURSES PROVIDING ABORTION CARE IN A SPECIALIST SETTING

A thesis submitted in partial fulfilment of a Master of Nursing Science (Community Health & Primary Care)

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Contents

Declaration of originality

This work contains no material which has been accepted for the award of any other degree or diploma in any university or tertiary institution , and to the best of my knowledge and belief, contains no material previously published or written by another person except where due reference has been made in the text.

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Brigid Coombe

13/1/14

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Abstract

Aim

This is a report of a study to understand the subjective experience of nurses whose role it is to provide nursing care for women seeking abortion services in a specialist clinic.

Background

Abortion is a very commonly provided health service in Australia but remains morally and politically controversial and associated with judgment and stigma. Nurses are integral to the provision of abortion services for women. Research attention to the subjective experience of nurses providing abortion care in specialist abortion services has been limited, particularly in Australia.

Methods

A qualitative research design, informed by feminist research principles was developed to explore the experience of nurses caring for women in a gendered and marginalised area of health care. A small sample of nurses, working in a specialist clinic in SA, participated in an in depth interview with the researcher, and a workshop to validate initial thematic data analysis.

Results

Nurses choose to work in a specialist abortion clinic for a range of reasons. A commitment to self-determination in health care decision-making facilitates the nurses' work in the contested environment of abortion. Four themes emerged from the data analysis. The participants' experience was revealed, through their voices, in the themes of: *with woman*, *finding balance*, *relating with care and intention* and *silences.*

Conclusion

Providing abortion care for women in a specialist setting is a rewarding and challenging experience for nurses. Doing important work that directly helps women is rewarding for nurses who have a wide scope of practice with organisational and team supports.

This study confirms the findings of other research of the importance of supportive frameworks for nurses working in abortion care.

Future research to develop supervisory and reflective frameworks should include the development of appropriate language to discuss the difficult aspects of work in the second trimester.

Decriminalisation of abortion laws would enable nurses to provide woman centred care based on clinical guidelines, taking account of the complexities of women's lives and responsibilities.

Chapter 1 Introduction

Abortion is a very commonly provided health service in Australia (Chan & Sage 2005) but remains morally and politically controversial (Dwyer & Jackson 2008; Ripper & Ryan 1998) and associated with judgment and stigma (Ripper 2001;Rosenthal et al. 2009). Criminalised until the 1970's, legal uncertainties persist for women and providers in most states and territories (de Costa 2010; de Costa et al. 2007; de Crespigny & Savulescu 2004; Douglas 2013; Petersen 2010; Rankin 2013). The public debate is polemical and dramatic ('Abbott determined to keep ban on RU486' 2006; 'MP says he was assaulted in abortion rally' 2013), extending at times to vitriol and violence (Allanson 2006) and is arguably out of step with the 'ordinariness' of the experience for women (Smith et al. 2003).

Although surveys of social attitudes generally support women's right to choose and access professional abortion services (Betts 2009; de Crespigny et al. 2010) there are limitations to this support; such as gestation limits (Victorian Law Reform Commission 2008), and women can experience barriers and hostility when seeking information or services (Senate Standing Committee on Community Affairs 2006; Rosenthal et al. 2009; Rowe et al. 2009). It is in this complex environment that nurses provide holistic care for women requiring abortion.

My experience working in abortion care in clinical nursing and management roles highlighted that the social, moral, legal and political complexities influenced service delivery, often limiting quality care and challenging continuing improvement in service delivery. Additionally, although the work was deeply rewarding, I experienced personal and professional marginalisation, and witnessed its impact on the well-being and sustainability of this essential workforce.

Background

Legal status of abortion

Until the late 1960s, abortion was illegal in Australia and world-wide, with criminal sanctions for those found guilty of having or performing them (Baird 1990).Many abortions were performed by untrained providers, or women themselves, with unsafe equipment in unsafe environments and often without access to after care. More particularly, poor women and rural women had little access to safe services. Complications of illegal and unsafe abortion caused significant maternal morbidity and mortality (Baird 1990). Illegality was then, and remains the primary difference between safe and unsafe abortion, with unsafe abortion accounting for one of every seven or eight maternal deaths in 2008 globally (World Health Organisation 2011).

During the 1970s, campaigns for abortion law reform were successful in many countries, including Australia (Baird 1990). Since then many jurisdictions have prescribed the circumstances for legal abortion, resulting in dramatic improvements in safety and accessibility (Sedgh et al. 2011). However, only three jurisdictions in the world have completely repealed abortion law removing it entirely from criminal codes: Canada in 1988, Australian Capital Territory in 2002 and Victoria in 2008 (Sparrow 2013).

As a matter of criminal law in Australia, abortion is legislated independently by the states and territories and therefore, provisions for the conduct of lawful abortion vary across jurisdictions. These provisions include assessment and certification by a medical practitioner or medical specialist, of the risk of injury the pregnancy poses to a woman's health; serious foetal abnormality and pregnancy gestation. These legal requirements oblige abortion providers to be the gate-keepers for women's legal access and impose an unusual moral discretion on doctors or service provision (Ripper 2001).

Indicative of the controversies of women's access to legal abortion is that even where reforms or repeal have been achieved, laws have been subject to change or threat of change, perpetuating uncertainty (Douglas 2013; Rankin 2013). Where attempts by anti-abortion activists to restrict abortion by amending abortion laws have been unsuccessful, these activists have

continued to employ strategies to reduce women's access (Ryan 1992). For example: Australian women's access to the drug mifepristone, for early medical abortion, was denied for ten years when, in 1996, a political deal was made between the Liberal government and anti-abortion activist, Senator Brian Harradine, requiring Ministerial approval for the registration of mifepristone (Petersen 2010). Mifepristone is a synthetic progesterone antagonist that, when given in combination with the prostaglandin, misoprostol, causes bleeding and uterine contractions. This combination is a safe and highly effective method of pregnancy termination for pregnancies less than 63 days gestation (Kulier et al. 2011).

My experience has brought me to the view that abortion is gendered and marginalised. This is because it is only women who require or experience abortion, but provision is legislated and regulated by political, legal and medical systems where decision-making authority remains dominated by men. Additionally, although studies estimate that between one third (Chan & Keane 2004) and one quarter of Australian women will require an abortion in their reproductive lifetime (Smith et al. 2003), this gendered and regulatory framework differentiates abortion from other routine health procedures and contributes to the marginalisation of women and providers.

In 2008, the Final Report of the Victorian Law Reform Commission (VLRC) on the Law of Abortion assessed and summarised recent studies of Australian attitudes to abortion: 'A majority of Australians support a woman's right to choose whether to have an abortion.' (Victorian Law Reform Commission 2008, p.68). While this suggests support for women to have access to services to implement a decision for abortion, it does not cast light on community attitudes towards aborting women or abortion providers.

My experience has been that women and providers can experience explicit and implicit judgment and lack of understanding from those close to them and in the wider community. This may occur when the response about one's work is: *"Abortion: I HATE that word!"*, as I have experienced many times, or when politicians question the morality of women ('Abortion rate a tragedy, says Abbott', 2004).

Media reports and anti-abortion activities can affect women's attitudes to themselves or to providers. It is possibly as a result of media representations that some women seeking abortion care do at times characterise abortion as murder; and may attribute the title of murderer to themselves and on occasion to providers. I found it not uncommon for women to seek reassurance for their reproductive future, or to express surprise (and relief) at the kindness and professionalism of staff and the cleanliness of the service because they were expecting something seedy and judgmental. Marginalisation is also a consequence of anti-abortion protests outside abortion services, amplified since 2001 by the murder of a security guard employed at an abortion clinic in Melbourne (Allanson 2006).

In January 1970, South Australia (SA) enacted legislation amending the law against abortion. The reform provided amendments in Section 82A, Medical Termination of Pregnancy, of the Criminal Law Consolidation Act 1935 ('Criminal Law Consolidation Act 1935 SA' 1935) prescribing the circumstances for an abortion to be legal (Appendix 1). These extensive provisions remain unchanged, and include a clause addressing conscientious objection (Clause 7, CLCA, SA1935). Significant challenges in service delivery were encountered in the early years following the 1970 reform, as moral objection to abortion by health professionals, including nurses, was an impediment to service delivery(Cannold 1994;Fowler, Potts & Ripper 1981; Furler 1986; Ryan 1992). In 1992, the SA Health Commission established a specialist clinic, based in the community to provide comprehensive services for SA women with unplanned pregnancy including abortion. The clinic was the first, and remains the only publicly funded specialist service of its kind in Australia. Staff recruitment was specifically to work in the service, and I took up employment as a Clinical Nurse there in 1994 and was Director from 2002 until my resignation in 2012.

Approximately 5,000 South Australian women require an abortion each year; abortion the outcome for 25% of pregnancies (Scheil et al 2012), indicating that requiring an abortion as a resolution to unwanted pregnancy is common. In 2010, 78% of abortions were provided at the specialist clinic or family advisory clinics in public hospitals, and small numbers as inpatients at

metropolitan public and private hospitals and country hospitals (Scheil et al. 2012). Abortions were for maternal and foetal reasons with the majority provided by vacuum aspiration at 14 weeks gestation or less. Abortions at over 14 weeks gestation are done surgically by dilatation and evacuation at the specialist clinic or by medical induction of labour in hospitals (Scheil et al 2012). Nurses are integral to the provision of services for these women, and provide care in different settings: the specialist clinic; hospital day surgery, gynaecological or labour wards and in operating theatres.

Statement of the problem

Women's experiences of unplanned pregnancy and abortion have been a focus of inquiry in various disciplines and feminist researchers and writers have emphasised the negative impacts associated with the moral, social and legal dimensions affecting them (Cannold 2000; Kimport, Cockrill & Weitz 2012; Kirkman et al. 2010; Wainer 2007).

In exploring women's experiences, researchers have identified that the attitudes of nurses and other professionals towards the aborting woman and her reasons for abortion, contribute significantly to the woman's subjective experience (Lipp 2008a; Ryan, Ripper & Buttfield 1994). Some authors have drawn conclusions and made recommendations for how nurses should address their attitudes and for nurse education and resources to improve the abortion experience for women (Lipp 2008a; Lipp 2008b; McLemore & Levi 2011; Stalhandske, Ekstrand & Tyden 2011). Recommendations and guidelines for nursing practices that respond therapeutically in this context have been made (Lipp 2008a; Royal College of Obstetricians & Gynaecologists 2012; Rosenthal et al. 2009).

Much less attention has been given to the subjective experience of nurses providing abortion care. As a nurse and manager in an abortion clinic, I experienced first-hand the nursing and socio cultural contextual complexities of this work. I realised that, like the women in my care, I could feel intimidated by protestors, or wonder why the response I received from a hospital department was always unhelpful. What was my responsibility when conversation outside of the work environment included a discussion of the morality of abortion? Along with some of my nursing colleagues, I could be

unsure of the best way to ensure appropriate aftercare for women, for whom the secret of their unplanned pregnancy was so imperative, that they had told no one. Seeking professional support and guidance for education and resourcing for these complexities, I found little exploration of this nursing work and none from Australia. The invisibility of this work in the literature and among the nursing profession, further contributed to a sense of marginalisation for this area of women's health care.

Study purpose, aims and objectives.

The purpose of this study was to give voice to Australian nurses providing abortion care, a gendered and marginalised area of health care; using feminist research methodology to understand their experience, and to develop knowledge for the profession.

Aim

The aim of the study was to understand the subjective experience of nurses whose role is to provide nursing care for women seeking abortion services in a specialist clinic.

Objectives

The study objectives were to:

1. Explore the reasons why nurses choose to work in an abortion service
2. Illuminate the nurses' experience of nursing in an abortion service
3. Explore the personal and professional challenges the work presents.

Statement of the research question:

What is it like to work as a nurse in a specialist abortion service?

Significance of the study

Few studies report the experience of abortion service providers in Australia (Baird 1990; de Costa, Russell & Carrette 2010; Pedder 2012; Ripper 2001). However, none focuses on nurses who work in these services. This will be

the first study to provide knowledge about the experience of Australian nurses providing abortion care in a specialist clinic setting.

Terms

Abortion	the deliberate removal (from the uterus) of a pregnancy by medical or surgical means for therapeutic reasons.
Anti-abortion activist	people or organisations who take action personally or politically to reduce or restrict women's access to abortion services.
Medical abortion	abortions performed using medication rather than surgery
Pro-life organisation	Organisations with a moral position of equal rights for the foetus and the pregnant woman
Surgical abortion	abortion performed by surgical means
Termination of pregnancy	the deliberate removal (from the uterus) of a pregnancy by medical or surgical means for therapeutic reasons.

Summary of the thesis

This introductory chapter provides a background to the context and motivation for this research project. The context in which nurses provide care to women seeking abortions is outlined, and my personal experience and practice questions identified.

The literature review in chapter two identifies the directions of current knowledge development, and discusses the emerging literature on the experience of nurses in international settings.

The third chapter deals with the methodology used to inform and frame this study. My rationale for a qualitative research approach, informed by feminist principles, to the research question in a gendered and marginalised area of

women's health care is presented. My position as the researcher, with a shared, but not the same experience as the nurses is highlighted.

In the fourth chapter, the research methods and conduct for this study are detailed, incorporating my methodological and ethical reflexivity at each stage in the process. Then, my rationale for the scope of the study is explained, followed by a summary of the research design and description of the study setting and participants. My approach to ethical conduct and commitments to reflexivity are outlined. Rigour is addressed by detailed discussion of method and implementation (Liamputtong 2013).

The findings of the thematic analysis are presented in the fifth chapter. Study limitations, a discussion of the findings and recommendations for future research follow in chapter six. The thesis concludes with the nurses' voices, expressed in poetry to convey the heartfelt experience.

This introductory chapter has outlined the background and context for the study. The study purpose, aims and objectives have been identified. The next chapter will describe the review of the literature, undertaken to establish the current knowledge about the experience of nurses providing abortion care.

Chapter 2 Literature Review

Introduction

This chapter is the literature review for this study of nurses providing abortion care in a specialist setting. The first section outlines the literature search and the following sections discuss the studies identified for review. The role of the nurse in abortion care is determined by the model of service delivery; therefore this aspect of each study reviewed is included in the discussion. The chapter concludes with a summary of consistencies in the literature and the gap that this study addresses.

Literature search

To establish the current nursing knowledge of the subjective experience of nurses providing abortion care an integrated literature review was undertaken. Databases searched were Medline, the Cumulative Index of Nursing and Allied Health Literature and Scopus. Keywords for the search were nurse, midwife, induced abortion, termination of pregnancy, experience, care and exposure. Indexing language was used and limits were applied to the search for the years from 1970 and to documents in English. Articles for further review were identified by screening abstracts for relevance and additional sources identified from reference lists. Studies only investigating nurses' attitudes to abortion, or which lacked specificity to nurses, were excluded.

Abortion care as an aspect of gynaecological nursing

Research interest in gynaecological nursing revealed the role of these nurses in the care of women having abortions (Huntington 2002; McQueen 1997). Anne McQueen's qualitative study of twelve nurses working on gynaecology wards in a large teaching hospital in Scotland, identified termination of pregnancy as an aspect of gynaecological nursing that involved 'emotional labour' (McQueen1997, p. 237). This was because the caring work involved could be challenging for nurses as they had to 'suspend judgment' (McQueen 1997, p. 237) based on their own views about abortion to meet the needs of women. This study did not give any details of the methods of abortion nor of the nurses' involvement in the abortion process.

Annette Huntington (2002) also found stressful emotional impacts for gynaecological nurses, of whom she was one, caring for women having second trimester medical abortions up to 20 weeks gestation, on the gynaecology ward of a New Zealand hospital. These nurses cared for women having medical abortions and delivering the foetus on the ward. The nursing care required by the women was complex as the procedure was physiologically and psychologically stressful for the woman. The nurses provided emotional support as well as the management of labour and delivery, and were responsible for facilitating women's contact with or disposal of the foetus (Huntington 2002).

Huntington argued that an institutional oppression operated against these nurses because the needs of aborting women were prioritised over those of the nurses, also women, who agreed to provide care even though other nurses refused to do so. Although these nurses could also experience distress, there were no structures in place to acknowledge this nor to address their needs for support. The nurses found that the emotional burden of caring for the women, and managing the foetus, could impact on their own well-being.

Applying feminist principles, giving attention to both women's needs rather than prioritising one over the other, Huntington made recommendations for the development of supportive structures for the nurses (Huntington 2002).

These recommendations included debriefing opportunities, the incorporation of clinical discussions into work plans and a gradual orientation to the work ‘alongside an experienced nurse’ (Huntington 2002, p. 278). This institutional commitment to supportive strategies could provide a safe environment for both patients and nurses (Huntington 2002).

More recently, the importance of the nursing workforce in the delivery of abortion services to women has been recognised and studies undertaken specifically to investigate the perceptions and experiences of nurses doing this work (Gallagher, Porock & Edgley 2010; Lipp 2008b; Nicholson, Slade & Fletcher 2010).

A grounded theory study, using feminist methodology, sought to identify the affective attributes required of nurses providing care for women undergoing medical abortions on gynaecology wards of nine NHS trust hospital wards in Wales (Lipp 2008b). Twelve nurses and midwives, fulfilling a range of roles in the delivery of medical abortion, were interviewed for the study. Allyson Lipp discussed the nurses’ appreciation for the complexities of women’s circumstances, and the nurses’ practices to place the woman centrally to decision-making. The intense involvement with women in the process of medical abortion could have an emotional impact on the nurses. Support for formal reflection on practice is proposed to achieve organisational recognition and help nurses work through the emotions evoked. The more relaxed environment of primary care is suggested as an alternative service setting to the gynaecology ward given the emotional intensity of medical abortion for women and nurses.

Lipp used this grounded theory study (2008b) as a basis to further explore issues of stress and stigma for nurses who provide abortion care. She emphasised the importance of recognition by policy makers, health service managers and the nursing profession of the needs of nurses providing abortion care (Lipp & Fothergill 2009; Lipp 2010; Lipp 2011a; Lipp 2011b).

Specialist abortion care

The experience of nurses working in a specialist setting was investigated in a small qualitative study (n = 7) of nurses working on a public sector ward based abortion service in England (Nicholson, Slade & Fletcher 2010). The

researchers were interested in the nurses' history in abortion care and in aspects of the work that the nurses regarded as important personally.

The service, described as a nurse led unit, provided first trimester surgical abortion to 13 weeks gestation and second trimester medical abortions up to 20 weeks gestation. This study found an unconditional support and acceptance of the need for abortion supported the nurses' view that their role in provision was important. Communication, values and job satisfaction were important in coping with the "strains" (Nicholson, Slade & Fletcher 2010, p. 2253) of the work. The demands of the role such as handling the foetus; the impact when colleagues chose not to be involved; along with the work and moral complexities were identified as "strains". Contextual influences of personal experience and the service model affected these strains and coping. The authors emphasised the importance of open recognition of the challenges of the work, by the establishment of professional supervisory and reflective processes.

Attitudes to abortion and coping were the global themes identified in a small (n = 9) exploratory qualitative study of the perceptions of nurses who work in specialist abortion clinics (Gallagher, Porock & Edgley 2010). The nurses worked in three abortion clinics of the same registered public provider in the United Kingdom (UK). These services provided medical and surgical abortions up to 24 weeks gestation; the legal limit in the UK.

Societal controversy about abortion was a significant factor in the perceptions of these nurses. Although the nurses supported women's right to have an abortion, and provided care based on the woman's needs, women had expectations that the nurses would be judgmental. As well, the nurses found societal attitudes to nurses working in abortion services could be judgmental, making the nurses hesitant to discuss their work with outsiders. Late gestation abortions could be a source of difficulty, and managing the "physical being of the foetus" (Gallagher, Porock & Edgley 2010, p. 855) or being present in theatre for second trimester operations, could test nurses' support for the procedure.

One way that the nurses coped with aspects of the work they found difficult was by opting out. The authors emphasised the importance of team support

to help nurses coping with these difficulties. They also proposed developing a philosophy of nursing care in abortion services, and supporting role development through professional supervision.

Moral controversy

Debra Hanna (2005) explored the concept of moral distress through a phenomenological study of nurses (n = 10) who had assisted in surgical abortions at private clinics in the United States(US) or worked on gynaecological hospital wards. The purpose of this study was to contribute to a definition of the phenomenon of moral distress as an occupational hazard and Hanna recruited nurses who felt they had experienced moral distress.

The sample included nurses who assisted with abortions willingly and those who did not, including nurses who identified as pro-life. Witnessing second trimester surgical procedures, caring for women having medical abortions in the second trimester were identified as aspects of the work that caused moral distress. The lack of support or even criticism from management or colleagues was a significant contributor to the phenomenon. The study concluded that all these nurses assisting with abortions experienced moral distress, but found there no negative consequences of this moral distress. The most significant factor was not being able to talk about the experience.

The findings of this study should be treated cautiously for a number of reasons. Firstly, the study purpose presumes the existence of moral distress and its applicability to nursing as do the self-selected sample. There is dispute about the applicability of the theory of moral distress to nursing practice (Johnstone 2013). Another limitation in applying the findings for contemporary nursing practice is the historical and particular nurses' experiences, which included outdated clinical procedures requiring emergency hysterectomies and working in abortion care unwillingly while experiencing the personal grief of infertility.

Despite these limitations, this study contributes to an understanding that the intersection of moral controversies with nursing practice can be a source of stress for nurses if there is not safety for them in discussing or seeking support for these difficulties.

Summary

Models of service delivery and the nurses' roles varied, reflecting the differences that exist across health services. The most commonly studied setting was the gynaecology ward, where caring for women having abortions comprised only one aspect of the nurses' role (Huntington 2002; Lipp 2008b; McQueen 1997). A hospital based specialist abortion service (Nicholson, Slade & Fletcher 2010), and a free standing clinic based specialist service (Gallagher, Porock & Edgley 2010) provide a perspective from the point of view of these nurses. The emotional demands of caring for women having medical abortions, and managing the work with the foetus, were experienced more intensely for nurses who felt unsupported by their colleagues, or by the organisation. There is agreement in the literature of the importance of recognition by managers of the stresses of the work for nurses, and the potential value of structured clinical supervision or reflection to develop practice skills.

Conclusion

Research of the subjective experience of nurses providing abortion care has been limited but is emerging as an area of interest among nurse researchers. The support of the organisation, and of colleagues, is important to support nurses who can experience stress as a result of emotional labour and stigma. Representations of the diversity of this work contribute to the development of a better understanding of the experience of the nurses providing this care and assist appropriate service development. A perspective from Australia is required as the studies to date have been in settings which differ from the Australian context.

Chapter 3 Methodology

Introduction

This chapter deals with the methodology used to inform and frame this study exploring the research question “what is it like to work as a nurse in a specialist abortion service?”. The study aimed to illuminate perspectives of nurses caring for women in a gendered and marginalised area of health care. With this in mind, the rationale for a qualitative research approach informed by feminist principles is presented. My position as the researcher with a shared but not ‘the same’ experience as the nurses is discussed.

Qualitative research

Qualitative research values and is interested to develop understanding about ‘personal experience, interpretations and constructs’ (Schneider, Whitehead & Elliott 2007, p.106) and does this by exploration from the point of view of the research participant. The context of the participant’s experience is therefore central to the inquiry (Schneider, Whitehead & Elliott 2007).

Qualitative inquiry is interested in words, and the social world, and is appropriate when detailed understanding is sought through the words or stories of the participants (Liamputtong 2013). As an iterative process developing as understandings are revealed, it is appropriate for research where little is yet known. Asking beyond ‘what is it?’ (Liamputtong 2013, p xi) for explanations of how, why, by what processes and what is important, a space is made for developing knowledge where silences or marginalisation are at play (Liamputtong 2013). This concern with developing contextually specific understandings drew me to qualitative research for this small study of nurses in a single, specialist setting.

Personal experience was the starting point and motivation for this research. My nursing practice, was informed by the service philosophy of the organisation I worked for. I consider that the essence of this philosophy is to counter the negative influence of societal attitudes on women’s experience of abortion by affirming women’s, rights, experience and feelings. However, this was challenged by a lack of clarity in how best to do this given the

complexities of women's presentations for abortion. I had experienced and come to fear spoken and implicit criticisms of my work in abortion care and found little support in the nursing literature to counter this negative influence on my experience.

Feminist research methodology

Feminism is a dynamic philosophy and social movement (Oleson 2011). It has developed from the recognition of the inequality of men over women to being a movement to achieve the equal worth of women through 'transforming gender relations and gender conventions' (Freedman 2002, p.13). Feminist research contributes to this transformation by developing knowledge about women, important to women and from the point of view of women. Women are not seen as a homogenous whole, or wholes, but as diverse and complex. The existence of heirarchies and injustices between women have been revealed as problematic and socially just research processes and goals sought (Oleson 2011). Feminists have paid attention to the nature of knowledge produced and questioned the ethics and reality of the 'objective researcher' (Oakley 1981; Oleson 2011).

In response to the dominance of knowledge production by men, feminists "proposed theories of knowledge that legitimate women as knowers" (Harding 1987, p.3). Research to develop women's knowledge and knowledge about women, working to reveal difference and marginalisation, has become an enduring value of feminist research (Oleson 2011). Feminism "questions the proposition that the social world is one fixed reality that is external to individual consciousness and suggests that this world is socially constructed consisting of multiple perspectives and realities" (Hesse-Biber & Piatelli 2012, p. 560).

Exploration of the social construction of the research encounter, has led feminist qualitative researchers to continually address issues of power in research relationships prompting an evaluation of the knowledge produced. This involves reference to questions of knowledge production such as: whose knowledge, how is it collected, interpreted by whom and ultimately who decides? Feminist ethics emphasise the importance of trust and

empathy in the conduct and dissemination of research to avoid exploitation of participants (Hesse-Biber & Piatelli 2012; Oleson 2011).

Reflexivity

Reflexivity acknowledges that the researcher is integral to their own research and cannot, nor should they, be distant and objective in the process. Rather, by engaging in critical self-reflection and foregrounding their own perspectives and biases researchers can add to the credibility of the research (Liamputtong 2013). Incorporating self-awareness and critical reflection throughout the research process maintains a consciousness of the power the researcher has in design, data collection, analysis and reporting. This practice is integral to the development of supportive, respectful and collaborative processes with the research participants (Hesse-Biber & Piatelli 2012).

Ethics

Ethical principles that speak to rights, justice, consequences and duty provide a framework for the conduct of human research (Preissle & Han 2012). In challenging these 'ethics of principle' as abstract, and exclusive of women's ways of moral decision-making, feminists have proposed the addition of an 'ethics of care' to incorporate "a concern for human relationships in making moral decisions" (Preissle & Han 2012, p.584). Women's value for relationship in moral decision-making does not devalue the principles of rights, justice, consequences and duty, but builds in a caring for the other, while taking account of the contextual particularities of the situation requiring decision (Preissle & Han 2012).

This focus on relationships that are 'situation specific' expresses the step from ethics on paper to ethics in practice with all its human complexity and fluidity. Ethical research purpose, conduct and representation can be supported by strategies of collaboration, reciprocity, critical self and shared reflexivity. Self-care is an ethical stance acknowledging that undertaking research that is engaged, participatory and personal can impact on the researcher herself. In making power imbalances explicit new relationships can be fostered (Preissle & Han 2012).

Research purpose and ethical approach

The production of socially just ethical research which addresses women's diverse and complex concerns, has provided valuable evidence to transform women's lives (Reiger & Liamputtong 2010). The women's health movement rejected the dominance of male, medical knowledge as appropriate evidence for the development of women's health services and used this to successfully advocate for changes in service policy and government priorities (Oleson 2011; Reiger & Liamputtong 2010). In SA, women's health advocates recognised that the reform to the law of abortion had gone only part way in resolving the provision of safe and appropriate services for women. Anti-abortion activists and stigma residual to abortion's criminal past had resulted in uncertain and profoundly inadequate services for SA women requiring abortion (Baird 1990; Fowler, Potts & Ripper 1981). Activism to improve services was supported by feminist researchers who produced evidence specific to the needs of this group of marginalised women and from their point of view. This evidence proved critical in successful advocacy, in the face of fierce opposition, for the establishment of the specialist clinic in1992 (Ryan 1992).

This study investigates women who provide nursing services in this unique service. My literature search found nurses providing abortion care are almost exclusively women, and can experience oppression as well as, and because of, society's attitudes to aborting women (Gallagher, Porock & Edgley 2010; Huntington 2002; Lipp 2008b; Lipp 2011a; Lipp 2011b; Lipp & Fothergill 2009; McQueen 1997; Nicholson, Slade & Fletcher 2010).

Sharing this experience and a personal commitment to do research that liberated, and gave voice to, rather than further oppressed these nurses I decided that qualitative research informed by feminist principles provided an appropriate framework for this study.

These feminist principles bring me to explain my own ethical position for the research. I had worked in a nursing role and a leadership role in the clinic where the study was undertaken. I shared with the participants the contextual experience of working in this specialist abortion service. I had an

intimate knowledge of the requirements of the nursing role and eight years of personal experience of nursing in a specialist abortion clinic.

As previously described the service is a small stand-alone unit, physically separated from the hospital and proudly separate in articulating a service approach that acknowledges negative societal attitudes to abortion and privileges woman centred care. Along with this pride in approach, is recognition of the achievements of the service in developing appropriate services, especially the second trimester service. However, remaining a unique service in Australia, meant a professional isolation and an additional anxiety to not jeopardise its reputation or future. The external activities of anti abortion activists, such as the protestors at the gate of the facility or political scrutiny of the clinic's work, added a defensive element to this professional isolation and service difference.

As the clinic director, I experienced the burden of this professional isolation and these anxieties deeply, but I needed to remain aware that my colleagues experience was not mine. Undertaking this study provides an avenue for me to address this isolation in nursing experience, and likewise I wanted participation itself to contribute to each nurse's professional growth rather than just be a neutrally 'not harmful' experience as a research subject. With a feminist ethic of care, responding to the particularities of this nursing experience, I sought to provide a safe space for the nurses to explore their experience, do justice to the trust they placed in me and acknowledge their contribution.

Reflection on my recent insider status and the perspectives influencing my supportive and empathetic approach to the investigation reinforces the importance of transparency and reflexivity in the conduct of this research.

Summary

This chapter has outlined the qualitative and feminist frameworks underpinning this research and explored their appropriateness for an investigation with my motivations and perspectives. The next chapter brings these frameworks to life by describing the methods and reflexivity for the conduct of this qualitative study informed by feminist principles and ethical concerns.

Chapter 4 Methods

Introduction

This chapter details the research methods and conduct for this study and incorporates my methodological and ethical reflexivity at each stage in the process. My rationale for the scope of the study is given first, the design summarised and the study setting and participants are located. My approach to ethical conduct and commitments to reflexivity are outlined. Research rigour is addressed by detailed discussion of method and implementation.

Scope

It was a pragmatic decision to choose a single site of study. Contributing to an academic program at Masters level the entire project had a nine month time frame. The study site was accessible, personal to me and with a rich source of eligible participants. Limiting the study to a single site also limited ethics review to two ethics committees reducing the likelihood of delays to the commencement of fieldwork.

The study steps.

1. Research proposal developed in collaboration with clinic managers
2. Literature review
3. Formal ethics approval
4. Distribution of study information and invitations to participate
5. Data Collection: In-depth interviews with participants
6. Interview transcription and review
7. Closed workshop with interview participants
8. Data Analysis
9. Development of written report

Ethical considerations in study design

Reflexivity

In my role as service director, I had utilised regular external professional supervision to support reflective practice and to reduce the isolation I felt in approaching difficult and sensitive decisions or unsolvable problems. I maintained this practice with the same supervisor throughout the research process, as I valued her understanding of my approach, and her knowledge of qualitative feminist and participatory research.

I maintained a research journal for recording ideas, difficulties and dilemmas. This journal also provided a chronology of decisions for me to reflect on and make changes if possible. In the interests of self- care, I also made a point of recording successes and moments of peace in the process.

As I commenced this research, my relationship with the participants and other clinic staff changed from manager to researcher. This change was layered; insider to outsider; expert to novice; manager to professional colleague. I felt my responsibilities to recognise the different impacts that these changes could have on the study keenly.

As a strategy to reduce power imbalances between researcher and participant, feminist research promotes the value of making them explicit, enabling them to be addressed. In so doing, the risk of exploitation is reduced, the comfort of participants enhanced and the possibility for genuine collaboration enhanced (Oleson 2011).

As I have discussed my previous role as service director meant that a formal power imbalance was part of my relationship with all but two, recently employed, of the potential participants. I was aware that another element of my relationship with some of the nurses was their positive regard for me and the influence that this may have on their decision to participate and on how free they would feel to contribute if they felt that may affect my regard for them negatively.

With my external professional supervisor, I explored how these aspects of my previous responsibilities and relationship might impact on the research.

Reciprocity

Reciprocity is a gesture from the researcher to ‘give back’ to the participants for their contribution to the researcher’s goal (Polit & Beck 2004). It is a way of recognising the value of the participant’s time and expertise and of their generosity to share with the researcher. This gesture can be as simple as the sharing of personal information, as a validation of experience, or the provision of information or a perspective to add to the participants understanding or knowledge. I describe my implementation of reciprocity in the methods and analysis chapters of this thesis.

Supervision

The progress of the study was monitored and evaluated with my Academic Supervisor at meetings, or in email or phone conversations.

Autonomy

Participation in the study was voluntary and attention given to revealing all possible outcomes to achieve informed consent (Liamputtong 2009). Information sheets for participants described the research aim, objectives, what would be expected of them and potential outcomes (Appendix 2). Withdrawal at any time without consequence was emphasised and formal written consent obtained for each stage of participation (Appendices 3 & 4).

Confidentiality

The protection of participants’ confidentiality for this project was supported by the allocation of a pseudonym or code.

I recognised that in the course of the interview information may be gathered, such as years of experience at the clinic, along with a description of specific incidents, that could identify participants to colleagues or those in their close personal circle. Bosk identifies this phenomenon of ‘local confidentiality’ as an evitable feature of research ‘with highly literate subjects within one’s own culture’(Bosk 2001, p. 199). The possibility also existed that individual participant’s responses could be identified by other participants during the workshop reviewing the findings from the interviews. Therefore, full disclosure that anonymity could not to be guaranteed was included in the

consent process, and participants comfort with this, an important element of ongoing consent to participate (Stark & Hedgecoe 2010).

Demographic data collected at recruitment of nursing classification and employment status was to enable purposive sampling and not to be reported specifically.

Data was stored on a password protected USB device, and on the secure The University of Adelaide (UA) computer student drive, and individual documents password protected using Word 2010 security options. One hard copy for use during the project was stored in a locked filing cabinet in my home office during the project. All interview tapes were deleted at the completion of my analysis of the data.

At the completion of the project the data will be stored in hard copy in a locked filing cabinet in the School of Nursing, UA and in electronic format on the School's secure password protected computer drive for at least seven years. This is in accordance with the SA Health and UA research conduct policies as required by the Australian Code for the Conduct of Responsible Research (National Health & Medical Research Council 2007).

Planning for reporting and dissemination of the study findings required consideration for the protection of confidentiality given the unique service model of the clinic in Australia. Additionally, my experience of anti abortion activists using research findings to discredit abortion services and/or providers was also a source of anxiety for me in anticipating dissemination of the report. I agreed with my Academic Supervisor that a final decision, protecting the service and participant anonymity, for the appropriate dissemination of the research report could be made collaboratively with service personnel after examination of the thesis. This may mean a limited distribution as a Masters thesis, or suppression of access to the thesis without my permission for a number of years. However, as the findings of the study, have relevance to nurses working at the study setting, the report will be made available to them. In addition, findings of the study will be disseminated through selective conference presentations and a paper suitable for publication in a peer reviewed journal developed.

Benefit / Risk

On balance I considered the possibility of causing harm or discomfort to the participants unlikely, minimal and transient and benefits likely and ongoing (Polit & Beck 2008).

It is possible in the exploration of personal experience that topics are uncovered that may upset a participant. Feminist research methodology emphasises a supportive environment and recognises the expertise of participants (Liamputtong 2009). I designed the interview, workshop and education about the research process to provide participants with a supportive space for reflection and professional development. I provided my contact details to all the participants, should they wish to seek support or discuss any aspect of the research with me. The nurse manager at the clinic also made herself available for support and as staff of the hospital the Employee Assistance Program was also available to the participants. I anticipated that the participants would experience immediate and ongoing personal and professional benefit associated with their contribution to this study because of the supportive and interactive environment planned for the interviews, and the workshop.

Ethics approval

With guidance from my Academic Supervisor I prepared the research proposal for my study. A low risk submission was approved by the SA Health Human Research Ethics Committee (TQEH) (Appendix 5) and University of Adelaide Human Research Ethics Committees.

Study setting

The study setting was the specialist, publicly funded clinic service located in metropolitan Adelaide. The service provides counselling; consultations for, and provision of, early medical abortion (EMA); first and second trimester surgical abortion; follow up and contraception services for SA women. A description of the services and the nurses' role is given next to provide a background to the nurse participants' experiences.

A more detailed summary of the nurses' roles and responsibilities, prepared with assistance from the clinic nurse manager, is provided at Appendix 6.

Nurses' role

Nurses see women initially, providing assessment and consultation for their abortion and contraception needs. Nurses provide emotional and practical support, information, education and referral as necessary. This consultation takes account of women's physical, emotional, social and financial needs.

Nurses undertake all pre-operative observations (see Appendix 6) procedure planning; consulting the doctor as necessary.

Women see a doctor for their assessment for operation or prescription and administration of medications for EMA. The doctor also completes the legal requirements for certification and notification of the abortion to the Department of Health.

Early medical abortion

Early medical abortion using mifepristone and misoprostol is provided as an outpatient service. Women attend the clinic on two occasions; 36 - 48 hours apart. Women take the medications at the clinic and then go home where the abortion occurs. Nurses provide phone support and follow up.

Surgical abortion

First trimester surgical abortion by suction aspiration and second trimester surgical abortion by dilatation and evacuation (D&E) up to 17 weeks gestation are provided as day surgery procedures. Most women choose general anaesthesia, although local anaesthetic with or without any sedation is an option.

Nurses prepare women for operation and anaesthetic and support the surgeon and anaesthetist with induction and in the operating theatre.

Second trimester surgical abortion by D&E between 17 and 22 weeks is provided as a two-stage procedure over two days as day surgery. A small number of the procedures at this gestation are provided for women who require abortion because of a foetal abnormality, but do not want to undergo an induction of labour procedure as provided in hospitals.

The first part of this two stage D&E procedure involves medical dilation of the cervix by administration of an oral prostaglandin (misoprostol), followed

by surgical insertion of cervical dilators (dilapan) and feticide by ultrasound guided injection of digoxin under anaesthetic (Chambers et al. 2011).

The second stage involves further medical preparation with misoprostol over 2 – 3 hours prior to further surgical dilatation of the cervix and evacuation of the uterus. Women having this prostaglandin preparation can experience significant symptoms including pain, nausea and vomiting or diarrhoea (Chambers et al. 2011). Some women will commence labour as a result of the preparatory procedures on the second day. On occasions the foetus will be delivered unexpectedly prior to transfer to the operating theatre. Ideally, women are transferred to the operating theatre and anaesthetised prior to delivery. Women require management of pain, and other symptoms such as vomiting and diarrhoea and emotional support throughout this two stage process. Nurses provide this care in consultation with the operating doctor and anaesthetist.

Postoperative recovery and discharge is provided by nurses, following standing orders and in consultation with the doctor and the anaesthetist.

Follow up and aftercare

Aftercare includes phone or face to face follow up as necessary. Nurses and doctors share the provision of this care according to women's needs.

Collaboration with clinic managers

Aware of the work intensity of the clinic and my previous role as director I took a respectful approach to working up the study plans. I met and talked with the nurse manager early in the process to outline my objectives and hear any concerns the project raised for her. I indicated the practical assistance I anticipated that I might need from her. She helped me to work through some of the practical issues in relation to recruitment and timing for interviewing nurses. We explored the potential for workplace disharmony or destabilisation as a result of nurses' responses to theirs or others involvement in the study. She agreed that the study was worthwhile, and willingly added assisting my project to her long list of responsibilities. I was grateful indeed for her willing support of the project and after outlining my research plans with the new service director finalised the study design.

In depth interviews

Qualitative methods of inquiry include in-depth interviews that are interactive and reciprocal. This intimate, unhurried format allows for the exploration of personal experience (Liamputtong 2009) and was therefore appropriate for my study.

Sample

All nurses currently working at the specialist service who had completed orientation to the workplace (n=17) were invited to participate. A maximum of seven participants was determined as a feasible number to recruit and manage for the Masters project. This was also an adequate sample size to gain understanding by in-depth interview, as the purpose of the study was to examine the perspectives of a small defined population (Kelly 2010).

I developed a matrix to guide purposive sampling to achieve the widest range of experience (Lewis, Ritchie & Elam 2003) across nursing classification and employment status; full-time, part-time or casual (Appendix 7). To enhance the completeness of the data, by capturing early experiences of nursing in abortion care, no minimum time of employment at the service was determined for inclusion in the study.

Exclusion criteria

The majority of potential participants were previous colleagues and/or staff I had managed or been in a managerial relationship with. I had no personal relationship with nurses who commenced employment after my resignation in September 2012. Exclusion criteria addressed existing relationships that could compromise the comfort of the participant or the researcher and impact on the conduct of the research or future relationships (Polit & Beck 2008). Therefore, nurses who had direct line management to me, or had required my involvement in performance management were excluded. Nurses unavailable during the months of August and September when the interviews were scheduled were also excluded.

Recruitment and participation

With the assistance of the nurse manager, a letter introducing the research and inviting participation was sent to all nurses currently employed at the

clinic through the internal mail system via email and hard copy (Appendix 8). Volunteers could then make contact with me for further information and to arrange to meet for the interview if they so decided.

I received responses from three nurses within a week of the invitation but recruitment of a further three was slower because their busy schedules made it quite difficult for them to allocate the necessary time. In acknowledgement of their time constraints, I made myself completely available to meet the nurses at a time and place to suit them.

With only six volunteers, my plan for purposive sampling to achieve diversity in nursing classification or years of experience at the clinic, became redundant and I interviewed instead a self selected sample. I do not report this demographic data specifically as individuals from this small service could be identified by doing so. With their permission I do note however that all the participants were experienced registered nurses and had worked at the clinic for a number of years.

Interviews

I undertook in-depth interviews with all six nurses who volunteered to participate. I had worked at the clinic with all of them, enjoying respectful and productive collegial relationships with each individual. To maximise their comfort the interviews were scheduled at times and places to suit them. Two interviews were done at the clinic at the end of the working day, and one at the nurse's home. Three interviews took place in a quiet discussion room at a University library where I felt best able to make a comfortable environment and free from interruption.

The nurses expressed some nervousness as they felt unsure of what to expect and whether their contribution would be what I "would be looking for". I took time to reassure them about the semi-structured and interactive format for the interview, and to clarify my objectives, which had their experience as central.

Each of the nurses raised concern regarding the ultimate destination of the interview material. They worried that something they may say, taken out of context, could be used by anti-abortion activists, to support their opposition

and arguments for restriction of services. One nurse specifically mentioned a recent anti-abortion pamphlet that cited an SA Health site, as a reason for her hesitancy in volunteering for an interview. Another nurse informed me that her only hesitation about participating was concern about the purpose for the interview data. She added that she was only contributing because of her trust in me, feeling she would not have been able to trust a researcher she didn't know and was not completely assured of their motivations. The nurses were reassured when I explained that I shared similar concerns and that was the reason that a final decision about dissemination of the thesis report would be made in consultation between the University and the clinic. They were pleased to know this and of my commitment to present the findings to all interested nurses at the clinic and at relevant conferences. I also explained that they could then contribute to the development of an article suitable for publication, to ensure that the research findings can contribute to nursing and abortion care knowledge.

After responding to any questions and concerns, I explained the interview format. Using the participant information sheet (Appendix 2) I formally sought written consent (Appendix 3), emphasising that I did not presume their ongoing consent and would completely accept a decision to withdraw at any time. At this point, I felt assured that each nurse understood their rights in the process and the reasons why I could not guarantee their anonymity. I emphasised the importance of their comfort in the process with the statement: "It is important to me that you are comfortable and feel that you can control the process at any point – to maintain your comfort or because you may think I am on the wrong track". All of the nurses agreed to the digital recording of the interview.

I acknowledged at the beginning of each interview that my previous position as their service director may be a source of discomfort or censure if they felt unsure of my response to them. I had developed a strategy for this conversation in discussion with my external supervisor based on Bird's (Bird 2004) work with power relations in the therapeutic context. This stepped strategy (Appendix 9) enabled me to make explicit my concern but explore solutions only if the nurse was comfortable to pursue that; if she was more

comfortable to stay silent on certain thoughts I would respect that and not probe further.

A schedule of questions and prompts developed from the study objectives was used to guide the interview (Appendix 10) and pilot tested with a critical colleague. Questions were about the decision to work in abortion care; what the work was like and required; and an exploration of professional and personal challenges. This schedule of questions was not followed rigidly but acted as a guide for me for the process matters at the beginning of the interview and then to assist me to listen actively and remain with the interview focus (Kelly 2010).

With each interview my abilities as a novice researcher increased and I was better able to establish a comfortable dialogue with participants while guiding the interview flow 'with insight and tact' enriching the data (Kelly 2010, p.310).

I opened the interview with the research question itself – "Can you tell me what it is like to work as a nurse providing abortion care at the clinic?" I found this personal way of approaching the beginning of the interview allowed each nurse to start where they were most comfortable (Gubrium & Holstein 2003).

The interviews took between one and two hours and unfolded organically with my prepared questions and prompts being utilised at different points along each interview's progress. This meant that, to a large extent, the nurses' central concerns were covered with their own emphasis. I maintained a self-critical consciousness of my own experience and bias and was conscious not to identify aspects of the work as challenges aiming rather to tease these out from the nurses' point of view.

At times, I reflected on their responses by sharing my own experiences or thoughts. As I shared a workplace experience with the participants, I could engage in discussion of sensitive material without the need for them to be "self-censoring". The exchange was dialogical and reflective leading to questions of nursing beyond abortion care such as; what work are nurses doing when they are doing clinical nursing and what are they doing when they are 'just talking to people'?. As a mechanism to share control of the

interview content an invitation to talk about anything the nurse herself wished to include was made before I concluded each interview (Kelly 2010).

I had prepared a structured evaluation for the end of each interview (Appendix 11). Some nurses chose to do a verbal evaluation with me immediately after the interview, while others returned the written form to me later after time for reflection. Their reflections were self-conscious; a questioning of eloquence by one; and surprised at the enjoyment or sadness they had found unexpectedly in the experience. Others felt a renewed commitment to the work and that their frustrations about the restrictions placed on women due to abortion's legal situation were real.

As a small gesture of reciprocity, I provided each participant with a certificate, suitable for inclusion in their Continuing Professional Development (CPD) portfolio (Appendix 12).

Immediately following each interview, I made journal notes recording the experiential qualities of the interview in order to capture feelings, atmosphere and intensity. These notes informed a structured reflection of each interview (Appendix 13) and the development of improvements for subsequent interviews, preparation for the workshop and analysis of the interview data.

Transcription

Confidentiality and ethical concerns

To protect confidentiality the nurses own names were not connected with the interview transcription. Although given the option of choosing a code or pseudonym, none of the nurses wished to do this, so I allocated codes. My decision to use codes rather than pseudonyms resolved a strong discomfort I have to allocating a name to someone who already has a name and identity associated with that name. I find that a pseudonym confers an alternative identity of sorts because names can speak of age, culture and class whereas a code is just a code and suggests nothing about identity in the way that a name can. For example, a name such as Kylie might suggest a Caucasian female younger than forty.

The digital record of each interview was emailed to an external provider for transcription. To resolve my anxiety about the absolute confidential treatment of the interview content, and my ethical concerns recognising that the content, outside the usual public domain, could be disturbing for an outsider I searched for a transcriber by personal referral. A close personal referral reassured me that there was no chance of the material being used against abortion providers and enabled a personal discussion with her about the study subject. I explained the clinic services and the gestations at which procedures were provided. I talked to her about the likelihood that nurses could speak frankly about the procedures and women's experiences. We agreed on strategies to manage any difficulties she experienced, such as leaving any passages if she became uncomfortable with the content. She was welcome at any time to talk anything over with me during or after transcribing. We agreed that I would provide information in the email with the recording about any passages I thought may be problematic for her.

This provided reassurance for me and for the participants that the material would be treated completely confidentially and that I could talk over with the transcriber any issues resultant to the interview content. A formal confidentiality agreement was signed (Appendix 14).

Transcription Quality

Poland (2003) disputes that a verbatim transcription of an in-depth interview from audio tape provides a valid and reliable account for analysis. Tape quality and incorrect interpretation of language, especially technical language, can contribute to inaccurate transcription. Qualitative data, such as body language, interpersonal interactions, flow and tone are lacking from a verbatim transcription (Poland 2003).

To optimise transcription accuracy and the incorporation of qualitative data I did the following:

I discussed with the transcriber the needs of transcription pertinent to qualitative research. This was supported by the provision of an instruction sheet to guide her in recording pauses, emphasis and emotional expressions such as sighing or laughing (Poland 2003) ; (Appendix 15).

I read each transcription, while listening to the recorded interview and made corrections and filled in where the transcriber was unable to understand, or had left the passage due to the content discussed. As one of the nurses had expressed concern about what she was about to say being 'put in writing' I instructed the transcriber to leave the passage for me to complete, which I did by paraphrasing as agreed with the nurse. When another nurse expressed concern about transcription of similar issues I suggested she go ahead and talk and we could decide once the discussion had been completed. As the issues the nurse was talking about had been talked about in previous interviews, I was able to forward them on to the transcriber with advice as to the timing in the interview and to leave if she felt it best to do so.

Participant review and consent to use the transcription

I emailed the participants a password protected electronic copy of their interview transcript, asking them to make any changes such as correction, clarification or removal of text as they saw fit. They could also provide any additional or clarifying comments and confirmed their consent for the use of the data by signing and returning the transcript consent form (Appendix 16).

Workshop

To strengthen validity and to reduce the absolute power invested in the researcher as the sole interpreter and reporter of the data (Seibold 2000) the second stage of the study was a workshop with the nurses who had participated in the interviews. The workshop was to provide an opportunity for the nurses to validate my preliminary findings from the data analysis and to contribute to the decisions about reporting of the data.

Research methodology that values contributions from participants as well as informs their learning in the process of group discussions also recognises the importance of the maintenance of confidentiality by the group (Ellis & Berger 2003).

Although five of the six nurses had intended to attend the workshop, two were thwarted at the last minute leaving a group of three nurses. The workshop opened with agreements for confidentiality. After formalising their

consent to participate and for the workshop to be recorded (but not transcribed) I presented an introduction to qualitative research and feminist methodology.

I then presented the topics and themes I had found in my initial analysis and some examples of the way I intended to use quotes from the text. I was able to confirm with the nurses my intentions for the report and their comfort with the selection of quotes.

I then facilitated a discussion to verify with the nurse participants that the topics and themes I had identified reflected the experience they had conveyed and were of importance to them. The nurses assisted me to review the balance of the findings to more accurately represent the straightforward aspects of women's presentation. In the group situation of the workshop the hesitancy to discuss issues associated with foetal management was replaced with an engaged and interactive / questioning discussion.

With the feminist research ethic of reciprocity in mind, I chose a venue for the workshop that was easy to get to with a relaxed feeling about it; light and airy with a view to an expansive garden area. This venue was a quiet retreat from busy lives where we could comfortably work around a table together and talk frankly and openly. I provided lunch, refreshments and a small gift of my homemade preserves for each nurse. I also provided certificates for their CPD portfolios (Appendix 17). In evaluating the experience of the workshop the nurses agreed that it was an enjoyable opportunity to talk about work; away from work and not just about problems.

Second workshop

One of the nurses who had been unable to attend the workshop emailed me some weeks later, hopeful that another workshop could be held, as she knew that two other nurses had also been unable to attend. The timing of this request was difficult as I was already working on my discussion of the findings. However, I was very pleased that her interest and commitment was there so when the other nurses indicated enthusiasm for the idea I arranged a time.

Given limitations on time and venue, we met at the clinic at the end of their working day, and the format was an abbreviated version of the original workshop. I prepared summaries of my progress with data analysis, including the issues identified at the first workshop and we discussed some of my findings. As with the first workshop, the nurses were animated and keen to grapple with the findings contributing to my final discussion. Maintaining reciprocity I provided them with examples of my use of quotations, CPD certificates and a gift of my preserves.

Data analysis

Data analysis is the process of organising and making sense of the data collected and coding is a means to achieve this (Liamputtong 2013). To guide me in developing and analysing my data I followed the steps and strategies outlined by Liamputtong (Liamputtong 2013, p. 245) as follows:

As the nurses talked about their experience of working in an abortion service, they expressed emotions of frustration, annoyance, pride and pleasure; my notes indicate gestures such as headshaking and frowning to smiling and holding their stomach or chest with a fully open hand. At the completion of each interview, I recorded these qualitative aspects of the interview and assessed how well I had drawn out information (or data) to answer my research objectives. This was the first stage of my analysis.

The charts I had used to as a tool to support this reflection (Appendix 13) became another source of data.

I read the interview transcript for the first time while listening to the recording and corrected any transcription errors or typed any text the transcriber had not completed. This gave me an overall ‘feel’ for the interview data and I made dot point notes of my significant observations.

Rereading the transcripts I then made marginal notes and listed labels, categories or ideas in my research notebook. By using relevant quotes from the transcripts, I organised these categories again under my research objectives. Structured questions then provided a useful framework to explore the data further and develop themes (Liamputtong 2013, p.243). Additionally, I sampled literature relevant to the emerging issues.

I began coding each interview as I listened to, corrected and reread each transcript. The questions for each interview were refined using this initial analysis to follow the emergent themes at subsequent interviews. With a delay of three weeks between the first three and second three interviews, I was able to review and recode the first interviews and develop some thoughts from this initial coding. I was mindful, however in the last three interviews to remain open to the participants' emphases and direction.

At the completion of all the interviews I identified topics which were revealed for each of my study objectives. These topics are illustrated in Table 1. From these topics I developed themes for discussion at the workshop.

To explore the reasons why nurses choose to work in an abortion service.	**To illuminate the nurse's experience of working in an abortion service.**	**To explore the personal & professional challenges the work presents.**
Congruence with personal values / world view congruence with professional values area of professional expertise / interest work with heart / important work Work hours & location suited to lifestyle / family needs	Dynamic rewarding, fun, fantastic, interesting satisfying, challenging – because: variety in women, nursing & nursing skills enabling to work in a comfortable way relational – ethical, caring, multidisciplinary sensitive, transcendent, complex, contextual, collegial Frustrations: Physical environment, legal, protestors	wide scope / technical / emotional Non congruence with values: Clients, others & colleagues Legal regulatory frustrations to practice / protestors. Lack of understanding / criticism – who to tell? how to tell? Managing pregnancy / foetal tissue / visual / visceral / emotional aspects / talking about it Worries & concerns – service restriction, protestors.

Table 1. Topics by study objective.

As discussed by Seibold (2000) in her reflection on doing qualitative research from a feminist perspective I found that data analysis continued as I entered the phase of writing up my findings. Interaction with all of the textual data, in my case the interview and workshop texts and my descriptive and reflective notes, and the literature stimulated further analysis of the themes I had developed.

Summary

This chapter has described the research methods for this study, and their implementation, incorporating my reflexivity and necessary changes to the planned approach. The following chapter reports the findings and reflects the circular process of analysis while writing.

Chapter 5 Findings

Introduction

This chapter reports the findings from my analyses of the data. Congruent with my motivation to give voice to the nurse participants, protect their confidentiality and avoid representing a homogenous voice, an outline of my reporting decisions is provided first. The findings are then presented along the time line of analysis, demonstrating the iterative and collaborative elements in the process. The findings in relation to the research objective ‘to explore the reasons why nurses choose to work in a specialist abortion service’ are presented first as they provide the context for the themes which follow.

Reporting Decisions

Language

I report the findings and discussion in language that can be read easily by the nurses who participated in the study and nurses in abortion care. This study is about them and in the first instance is for them; so to recognise this contribution and promote their ownership I have aimed to write the report in language that is easy for them to read while maintaining academic standards.

Use of quotations

I have used quotes from the participants extensively in this report with two purposes in mind. The first was for the purpose of illustration of my findings and the second was to bring the nurses voices to the report. Sometimes I have used more than one quote to illustrate a finding; this demonstrates the diversity or congruence in response, or approach, and avoids sidelining a

less dominant voice or perspective. I have included complete passages where necessary so as not to reduce context or distort meaning. Therefore, some quoted passages in this report are quite long. To maintain confidentiality I have avoided using quotes or sections of quotes that could indirectly identify the nurse.

Presenting my initial findings to the participants at the workshop gave them an opportunity to see how their quotes would be incorporated in the report. Each nurse has seen the quotes included in this report and consented to its inclusion.

Poetic representation

Laurel Richardson argues that poetic representation offers a legitimate alternative to prose for some forms of knowledge because it can, among other things '... express the sense of the whole or essence of the experience as constructed by the interviewer,..'(Richardson 2003, p.193).

I found there was poetry in the nurses' expression; their speech punctuated with pauses (Richardson 2003) and the 'place holders' um and er, most notably when describing more emotional or difficult aspects their work. Their tone and emphasis within words conveyed as much meaning as the actual words they were using (Hiley 2006).

I realised that poetry could provide a method of representing the 'essence' of the nurses experience, and by blurring individual voices preserve anonymity. I experimented with the form and found that poems enabled me to fold together the different perspectives and ways of working that came through in the interviews. Diverse voices are included in the poems but I have looked to the 'sense of the whole …experience' to construct the poems (Richardson 2003, p. 193). I found poetic expression conveyed the heartfelt in the nurses experience.

Findings

Choosing to work in an abortion service

This section reports the findings about the participants' decision to commence working in an abortion service and explores their reasons for continuing to work there.

A few of the participants had known of the service and actively sought nursing employment there. However, for others it was an encouraging introduction by a colleague, or an open mind to an advertised vacancy that had led them there. The decision to seek or take up work at the clinic was informed by the following factors;

- previous professional experience and expertise; for example in women's or sexual health or day surgery
- professional interests,
- personal and professional values supporting women's autonomy in fertility control decisions
- working hours
- colleague recommendation

Common to the participants was a nursing commitment to supporting self-determination in health care decision-making. This commitment had led some of the participants to careers in women's health care whereas for others, who had worked in other general and specialist areas of nursing, the decision to work in abortion care was a change in their career direction. A number of the nurses spoke with passion about wanting to work in the area because of a consistency with their professional value of woman-centred health care including access to abortion services.

> ...maybe this is completing the circle um for me because I've done so much work in women's health....worked in this area for a long time. I have studied in this area and I have been committed. I suppose it's something you feel committed to. ...It's more than just a job. A1 p19

> ...it's about feeling like we are doing really important work.. and we're, we're doing work um which is.. directly helping women.. and is.., is directly assisting them.. to.. um move... onto the path that they want to be in in life and not to be.., um.. trapped into decisions..by ...by.. biology..
>
> B1 p5

Weekday operating hours worked well for those with children and the lifestyle benefits of these working hours was identified as contributing to the decision to choose to, and to remain working at the clinic:

> ...to get away from split nights and it suited my lifestyle and childcare arrangements. ...um and no it's a good job..it's a good rewarding job where....I would get much more out of it than I would have expected... C12 p1

As all of the nurses had worked at the clinic for some years their choice to continue working there was explored. All of them expressed the professional satisfaction of providing high quality woman centred care and of the significance of this in continuing to work at the clinic:

> ...but why I DO work in the area that I do....., the guts of it all is that I feel like women are respected... I feel like they are given their options... I feel like they're supported with their choices... . ... I want to actually work in a system where I feel supported doing what I'm doing. M12 p24

> ... I get that sense of satisfaction that I helped someone get through for some women what is really a tough decision but for other women it's a really straight forward decision but I help them get through it and get home at the end of the day and get back to the life that they want... . That they need. C12 p1

Assembling the textual and qualitative data from the interviews, my research journal and the workshop revealed a picture of work that the nurses experienced as rewarding and satisfying, albeit it challenging.

> I LOVE it, but um..it's very busy. A2 p13

> Mostly it is pretty positive. Um.. and... sometimes it's REALLY challenging. M12 p1

Satisfaction and reward were in the challenge and pleasure of working with women, in all their diversity, providing care congruent with professional values of respect and non-judgment. Witnessing women's transformation to safe discharge and receiving unsolicited but grateful thanks was gratifying and replenishing. The organisation of their work across most aspects of the women's journey, and the opportunity to develop a wide scope of nursing practice, stimulated professional growth.

This section has explored the nurse participants' choice to work in abortion care and the factors influencing their continued work there. The following section identifies and explores the four themes that developed in analysis of the interview data.

Themes

I identified three themes prior to the first workshop, after which I developed the fourth.

I named the initial themes: *With woman; finding balance & relating with care and intention*. After the workshop I decided that I needed to address *the silences* that had been uncovered in exploring these themes rather than as aspects of other themes. This was because of the emphasis that the nurses gave to discussion of the troubling aspects of the unspoken or unspeakable illuminated by the findings I presented to them under the themes. This section explores each of the four themes beginning with the theme "with woman".

With woman conveys an ethic of care based on a respect for the woman's individuality, self-determination, expertise, vulnerability, confidentiality and privacy.

Finding balance conveys the nurses' capacity to recognise personal and professional tensions in their work, the contextual influences to these, and the balancing forces contributing to their comfort and pleasure in their work enabling persistence and or acceptance.

Relating with care and intention highlights the relational requirements of the work; again personal and professional, and how the nurses approached the complexities presented.

The theme of *silences* explores the silencing effect of criticism or judgment about abortion for the nurses. They controlled information about the work to protect themselves, women or the organisation from criticism or consequences. Silences result.

With woman.

This section discusses the first theme identified in the data analysis. *With woman* conveys the nurses respect for the woman's individuality, self determination, expertise, vulnerability, confidentiality and privacy – as a midwife is "with woman" so were these nurses. As I progressed through the interviews, listening to the recordings and reading the transcripts (immersed in the interview and initial data analysis) the nurses descriptions of their experience drew me a picture of nurses walking alongside their clients, sometimes responsive and sometimes anticipative or corrective, but always focussed on the woman.

Consistently, the nurses described nursing values and practice that were aimed at ensuring each individual woman's safety – emotional, physical, social, legal and environmental. This incorporated taking account of what was known about an individual woman's circumstances, and knowledge of social inequalities such as the incidence of intimate partner violence, sexual assault and the burden of responsibility for contraception. Central to this holistic approach was individualising care informed by the woman herself:

> you know,.. you just have to be led by what they need.. if they tell you they don't need you then they don't need you... And there is nothing wrong with that. It's just being led by a person.. and going by their prompts.. and listening to them.. and doing what they tell you that they need. ...it's just trying to think of things or allowing them to express those things. You know to make.. it real.. if that's what they want
>
> C12 p3

Even in situations where the nurses felt challenged by a woman's decision(s), or what the woman needed from the nurse or the service, the primary nursing goal was to support and facilitate the woman's needs. The following quotes illustrate how the nurses translate these goals into practice:

Making a comfortable space for the woman to 'inhabit';

> When you take someone into the room I always say.. *you know I'm going to sit in this chair because we've got the leaflets.. here and things, but you sit in which ever chair you want, pull it up, move it out, you know make sure you are comfortable* ..and.. things like that so they can have it as close or as far away.. as possible....you know most people do pull it pretty closely.. and start talking.. P8 p 8

Responding when women are hostile or direct anger towards the intake nurse:

> .....do stuff unconsciously but I think... if, if I.. I really thought about it I think.. I am fairly careful about... my body language and I am very careful not to.. react to her.. [in] anger... So I try and be aware of my body language and keep.. very open..um and.. smile... and be friendly....A1 p 3

To facilitate women's self determination:

> and it's not about my set of values at the end of the day it's about HER set of values and it's about HER making a choice which is congruent with her values system. B1 p3

Sometimes this requires a nurse to extend usual' practice and her safe comfort zone even if she anticipates this may not be straightforward:

> …she did NOT have an intact delivery ...and yet she REALLY wanted to hold her pregnancy and ...this might be a bit icky.. but I don't, didn't really care and um….she actually, I...um..bagged up her products and.. wrapped it in ..a... towel and …came down stairs and you know brought her down stairs and I came down stairs ..with the ..product.. with the

> pregnancy and she held her pregnancy....and.....she ...and her husband and um you know ..they knew it wasn't intact but it didn't matter and I thought ...ooh how is she going to go so I actually had one of the social workers.. um..standing by in case she, it needed some ...more expert support but...she was so grateful..because she just really wanted to hold that ..pregnancy.. and her partner..and I just felt well.. how great is that to support that when you know really…..oooh…but "(nervous laughing)"…but..but it didn't matter to me it wasn't my.., you know that's what I was thinking it was the woman's choice it's not up to me to say..you know oooh that is not ok, like it's fine if that's what she wanted. A2 p9

Another aspect of *with woman* was the recognition the nurse may be the only person a woman had spoken to about her pregnancy and her decision for abortion. This was experienced as an intimate connection and added gravitas to the relationship as the nurses recognised that in other socially accepted health crises, this support role would be fulfilled by a partner or close friend or relative. Women trusted the nurses to respect their very private decision and / or needed their assistance to keep the secret.

The nurses all spoke of the difficulties that the legal requirements could present in individualising care for women's particular circumstances.

> It's really frustrating because …….because…of the law. "(laughing)". Because you think you have got a really good idea about what you can do ..... and then you go, actually no we can't actually do that because it would make it illegal…. You know, like there are so many road blocks because of the.. um, abortion being in the criminal code…..I find that incredibly frustrating. And you know the actual, you know women making a decision about even a… gestation 20 plus weeks….sure, you know in a perfect world…..But.. not everyone has that. A2 p17

There is also an ironical aspect to using the term with woman, as I have often heard this term used to describe the role of a midwife. As one of the

participants remarked there is much social acceptance of midwives in their work delivering babies – an area of work that is simplified as ‘good’ and ‘happy’ and certainly legitimate and good work. In contrast, as will be discussed in the theme *silences,* this social acceptance does not necessarily translate to nurses who work *with woman* in abortion care.

Finding Balance

This section explores the theme of *finding balance,* which developed as an important element in the nurses’ experience and continued work in abortion care. Finding balance is the process of steadying oneself, when faced with difficult or challenging situations. Both personal and external factors play a role in this process. The nurses identified significant personal and professional tensions in their work but were able to steady themselves sufficiently to continue working. There were organisational strengths that assisted them, and they utilised personal strategies.

My analysis of the data revealed evidence of nursing challenges that are concerns for nurses in many areas of their practice; such as managing the competing needs of women (or patients) in a busy workplace. Some of these challenges were exaggerated by the social or legal context of abortion and yet other challenges were revealed as particular to working in abortion care. The nurses in this study were experienced nurses and recognised the need to address issues of personal or professional difficulty. Managing their emotional responses to these difficulties and finding support were important strategies for finding a workable balance.

The nurses found balance in the diversity of women’s presentations. Providing individualised care required responding to the full diversity of women’s presentations. The nurses indicated that for many women the decision and process of having the abortion was straightforward. Meeting these women’s needs was ‘easy’ and immediately rewarding for these experienced nurses and provided a balance to the demands of caring for women with more complex needs. The nurses talked about coping with the emotional impact of caring for women whose lives were very difficult because of sexual or intimate partner violence, poverty or single motherhood. The nurses learned that women’s difficult lives can feel

overwhelming and recognised the importance of managing their response in these situations. This nurse illustrates how she steadies herself to focus on the immediate crisis of the abortion:

> **…**. I can help them through their abortion.. but I can't change anything else… really… And if the abortion would solve some of their issues.. then that's great, I can help them with that, but I can't.. … I think having to learn… that you can't solve everyone's problems is a big thing too…. You know, that's taken a while… You change them. You know, you can't change their circumstances… You can only help them get through… the abortion… C12 p14

The intensity of caring for women in distress, if the abortion decision was fraught with ambivalence or sadness, could also affect the nurses emotionally. Self-care was important in finding balance when nursing women with complex social and emotional needs. Some organisational structures, highlighted by these nurses, provided a place for discussing difficult aspects of the work and developing self-care skills;

> I think..you know in all the different disciplines do work together we have a lot of time, team meetings and like to discuss things and look at what we are doing, how we are going to move forward with this… I feel.. it is a very supportive environment. P8 p1

> …quite a unique workplace I feel that um there is …it often seems as though.. they seek a high.. degree of agreement.. between the staff, and a higher degree of consultation amongst the staff about what, what we could do, how we could do it, what are the options? B1 p11

However, individual nurses rather than the organisation took responsibility for reflecting on practice, debriefing or 'letting off steam' informally with trusted colleagues:

> I felt I had to look after myself.. cause for me to give.. a good service I need to look after myself… And I knew this would eventually be a strain on me.. because… it was something

> that I wasn't working through… and the environment does promote people talking and acknowledging there are times when things can be difficult… you know.. like.. we don't have to pretend that we're all fine.. with every aspect of the work that we do.. P8 p18

> From my colleagues but generally um outside.. of work hours…It [professional supervision].. doesn't really happen… I think.. it's one of those things that we think would probably be a good idea..,um but often it just doesn't.. eventuate…...., it's almost like you would need therapy yourself really isn't it, to reflect on.. what it is that.. you do and how you feel about and, and how you cope with that in your general daily life? B1 p6

> …….I often debrief with the social workers when I'm on my way out the door ….it's not formal. A1p17

Alongside these strategies for finding balance for all the nurses was the sustenance derived from supportive nursing and interdisciplinary relationships. This nurse highlights her colleague's very positive response after they had worked closely together to meet a couple's very specific (& complex) needs:

> ….we actually spoke about that later in the context of you know this worked really well. It was a great experience and actually.. um.. you know the nurse that was supporting me said you know I went home and I was just a bit high almost. M12 p22

> ... they are fantastic, supportive, caring, sharing, professional etc, etc. I'm sure they are part of the reason the job is rewarding. I always feel like I am learning something new from them. A1 p26

Requiring specialised knowledge and skills there is little change of staff. The nurses found that the importance of staff relationships was amplified by the small, closed environment of the clinic:

> There's not a lot that goes home with me… Staff issues tend to go home with me more than women.. C12 p20.

Teamwork was valued to manage the volume and demands of the work, and also an important way to find balance when collegial relationships were tested. Being part of a team of specialists and contributing to a high quality and respected service was part of this.

An organisational service principle to address both the emotional and physical needs of women was supported in routines, by the staffing plan and by the staff. This made it possible to address women's competing needs without having to compromise care:

> people do acknowledge that sometimes that you have a client that needs more time and I think people work around that. You know they might be a bit grumpy "(laughing)", but they get over it and I think people understand that happens A1 p19

> the focus is for that nurse has got to be on the women and they can support by doing the obs and things like that.. A2 p15

The nurses could prioritise a woman's needs for emotional support over time pressures or their own level of skill or capacity:

> I honestly think it is one of the best environments I have worked in for that, for the amount of overlap between the disciplines. You know, um everybody helps.. each other B1 p15

> I might say look I've got someone …I think is going to have to come into recovery for pain protocol and I need to stay with her because she's really anxious.... generally, there's enough of us around and we don't work solely, we usually have got a partner in our midst… where you have the ability to do that and I have to say most people have been really gracious.. being able to go yep I'll pick that up, I'll...I'll run

with that and do that because I can actually see you doing something really important. M12 p25

Humour and variety in the role also provided balance. A fun shift in theatre with colleagues could provide relief from the emotional work of relating to women while this relational work gave context to and relief from the visceral nature of the work in theatre.

A wide scope of practice was also source of balance. The organisation of the nursing work across most aspects of the women's journey required a wide scope of nursing practice. This breadth in work contributed helpfully to finding a balance by providing variety:

So I think we have a very wide scope of practice of nurses at [the clinic], ..it draws on different skills depending on which area you are allocated to on the day...(so it can be consultation,...., admissions, operating theatre, recovery, second stage recovery, medical abortions, follow ups). Lots of different skills. B1 p2

you know other things that we do um there... Various other things anyway,.. so... with the counselling aspect… sexual health advice, ..contraception.... all beneficial to clients. There is, there is a lot of other work involved.. within the clinic P8 p19

The challenges of protestors and legal restrictions are particular to nursing work in abortion care in this setting and could be destabilising. Located in a community setting rather than within a hospital, the clinic is easily identifiable and well known to anti-abortion protestors who can be active at the entrance to the site. Although direct (themselves) or indirect (women's) encounters with the protestors were routine these nurses described strategies, which I have named normalising, invisibilising and minimising, to steady themselves and maintain a balanced perspective:

Normalising:

Oh, I did have my picture taken one day going into the centre by the protestors out the front. I think I told you at the

time and I started parking out the back. …um and then having the photo taken of that was intimidating… you know like.. is not an uncommon strategy so.. I'm not worried um A1 p11

Invisibilising:

…the protestors you know I just have no interest in them. I don't get aggressive at them because I just don't even want them to.. enter into my sight I don't even want to give them that time to do that.. P8 p25

Minimising:

... when I first...um.. was working there I would have a bit of flush of adrenaline every time I drove past them..um and I'd... feel... reasonably anxious about the fact that they were there and then.. after a while you get used to them and they're just.., you know are part of the scenery.., but... for women.. who are coming in..[to the clinic] it probably feels like that little flush of adrenaline.. cause it's the first time they've encountered that.. as well. .., I mean.. I can I can relate to how women.. feel about the fact that they are there and I don't try to dismiss those feelings because I think it.. um... it is quite confronting for them.., but..ah I don't necessarily feel that much angst about it... um anymore.. they are almost a little bit laughable, you know.., they are just a bit ridiculous. I think...completely ineffective and I'm sure that those kind of tactics have never caused.. anybody to turn around and go home.." B1 p9

Although abortion law reform has enabled legal provision since 1970, the restrictions of the legal requirements create challenges for the provision of services to women. Nurses may need to explain the legal reasons for the organisation of services to women:

> …for the times when women feel upset about it, they say well.. you know, *"why should I need two doctors to agree that this is a good idea, why should I have to see two doctors to have a medical abortion"?*.....I say that abortion is still on the criminal code "(laughing)" in South Australia and that these are the hoops that we need to jump through in order to be able to give you a legal service. B1 p10

But feel a need to balance this information with something positive or encouraging for the woman:

> And I also do... mention that um actually... we are pretty well off in South Australia for the fact that we do have..have a free abortion service, so although it's frustrating..ah we are actually still a lot better off than a lot of other states. B1 p11

Acknowledgement that there is a lack of acceptance, criticism and judgment associated with the work is balanced by doing the work well and women's gratitude and transformation:

On overhearing a conversation in a shopping centre, this nurse took encouragement to take a normal approach to her work:

> .. and one of the girls has said to the other girl *"that girl did my abortion"*... that little bit of pride that I've made enough of an impact that they've remembered me.. out of all the people they had seen. But.. there was that little bit of embarrassment that.. maybe someone else knows.. you know,.. has heard that I do abortions and I'm like.. ok.., alright and I've just kind of.. had that moment of embarrassment and I virtually moved... you know.. then thought it was actually quite funny. C12 p6

In this theme of *finding balance* I have discussed how the nurses developed ways to find balance and prevail over some of the nursing and socio cultural challenges of nursing in abortion care. Organisational factors, including the staffing plan, staff consultation in service development and an ethos of support were built on with self-care strategies. Professional strategies for

finding and / or maintaining balance included reflecting on practice at team meetings or personal reflection, debriefing or talking with supportive colleagues. Personal strategies to steady themselves against the destabilising feelings experienced as a result of protestor activities have been highlighted.

Relating with care and intention.

This section discusses the theme *relating with care and intention* and highlights the highly relational requirements of nursing in abortion care. Relational skills are revealed along with the impact of negative or judgmental attitudes.

The nurse participants described and reflected on relating to women, to women's partners or significant others, to their clinic colleagues, to health colleagues, to family and friends and to 'dailys' such as hairdressers or children's school and child care contacts. The impact of the lack of social acceptance of women's decision for abortion extended not only to the nurses' experiences in providing nursing care for women, but also to the nurses experience of revealing their work. As this nurse commented in a workshop discussion:

> People have a problem with abortion ...

Relational encounters could be straightforward; where values and goals were consistent, yet others, where values were oppositional or unspoken and uncertain, could be fraught. Regardless, the nurses expressed thoughtful and intentional relation to care for others and themselves. The contextual environment of peoples' varied and unpredictable positions about abortion influenced the relational encounter.

Relating to women:

Relating to women involved skilled nursing by establishing a connection quickly in a busy day surgery environment. It also involved noticing and responding to non-verbal signs and providing comfort and reassurance with words and presence despite time pressures. Benner identifies these nursing practices of "being present and available to the patient" as being in "the art of nursing practice"(Benner 2004, p.346) and suggests they are endangered

as they are “invisible and rarely charted” (Benner 2004, p.346). This nurse highlights how these nursing practices are valued and supported:

> ...because we were very busy, I was in consults, but we were helping get people dressed and ready to, pre-theatre. And I said *“are you ok?”* to this young woman who burst into tears... Well I stood with her for a while… and I talked about what.., was she scared.. and did she know what was going to happen? Did she have any questions... I said *“would you like to talk to a social worker?”* and so I went and got someone to come up.. and waited with her until they got there… A1 p18

This nurse offers women an alternative view about abortion in recognition of the impact of societal attitudes:

> [women say] *“I know I’m killing the baby.. but.. you know, ..I really can’t ..”* ..so I often say at that point .... *“I acknowledge yeah.....we do hear that, that it’s a negative thing ..and it’s, it’s .you will see lots of stuff on the internet about what a bad thing abortion is but ..if we look at it you know for the reasons you are here it’s actually a loving thing to do because you are saying this is not a good situation to bring another life into”.* You know and sort of turn it around slightly so that…you can see a different view point perhaps. I just think, that women actually have said to me that was really useful like [overlapping] A2 p8

Relating to partners and significant others

The woman’s needs guided the nurses in relating to the man involved in the pregnancy or partners. Including a supportive partner was identified as an extension of the engagement in caring for the woman.

However, this nurse explains that support of significant others can be complicated:

> So she was kind of supported but I think she felt very alone.... .her mother actually had an abortion before she was

born and that she always regretted .... And so she was kind of putting that on her as well. A2 p6

In response, the nurse sensitively and creatively intervened to create a space for the woman away from her mother.

However, relating to men and/or partners who were unsupportive of the woman's decision, or exerting pressure for the termination, required a more defensive approach to keep the woman's needs central. This nurse gives an example where politics, violence and power are explicit:

... the man who.. um was involved in the pregnancy... He was a really really unpleasant man ....[.....]. he had an agenda to push about... what he thought as his rights within.. this scenario. .. he wanted some guarantee that she was going to go through with the termination because he felt that she hadn't..um he, that he hadn't consented to her becoming pregnant and that he should have some rights in regards.. to that decision.. and um, she didn't really want him there.., and... he wouldn't leave and….um and he bailed me up in the hall to um kind of push his agenda... And um, then it was a matter of.. kind of, trying to talk him down and get him out of the building. B1 p7

Relating to colleagues

I have no fear in talking to the doctors about anything.. that you know which would be very different in other areas of work because I am.. you know…, in certain places I've worked it wouldn't be a nurses decision... .... I have no fear of like speaking personally to a doctor and saying look I'd like to do this.. P8 p23

...I'm worried about a woman and I'm not sure how to talk to her about something I will engage with social workers for instance to say you know, this is what this women is saying and I'm not sure how to respond or I'm not sure if I've given her the right advice... so there's lots, because we are multi

> sort of disciplinary team, there's lots of people to go to, - to ask advice... to... I don't mind, I often do that. A2 p13

> Lots of conversations go on between different disciplines, you know, what do you think of this or have I done the right thing here, or what should I advise this person. .. Yeah.., lots of sharing of information.., helping...[and] feeling now that I can support others. B1 p16

Relating to family, friends

While the nurses had many positive experiences in relating to friends and family about working in abortion care; it was critical or dismissive responses from family, friends or colleagues that drew the most intensity in language, tone or comment in discussing this topic at the workshops. The following quotes from these nurses are illustrations of relational responses:

> And I talk, argue quite openly. I know because I don't mind having an argument with my family but I suppose it's with friends that you think, well, you know is it really worth damaging a long friendship? A1 p8

> .....you think ...crap... if I can't get the support from my mum and my best friend?? C12 p25

> ...when I first started working [at the clinic] one of the most challenging things was... um a friend who was a midwife who basically said to me:. *'that's just so left of centre for me that is something that I can't.. really understand why the service exists,.. I can't understand why on EARTH you would want to work there and for me... that's actually something I never want you to talk to me about because I can't deal with it'*…" M12 p2

This nurse expressed a particular frustration with this response because her friend, a midwife, did not have a shared professional view of the importance for midwives to respect women's right to make and implement choices in managing their reproductive role. Equally, this nurse found colleagues in another area of nursing critical:

> I did part time.. I was at both places. Um a lot of the nurses on the [....] ward.. um couldn't understand working in an environment like that?... How could you do that type of work?
>
> P8 p2

This nurse went on to explain that these colleagues viewed abortion work as incompatible with the nursing goals of preserving life and 'making things better'. She did not accept this view, recognising it was informed by misinformation and myths, and defended her choice as completely congruent with the nursing goal of making things better:

> …we DO make things better for the clients that are using our service whichever the outcome is.. you know, but they couldn't see that..
>
> P8 p2

Relating to acquaintances

As the nurses talked about the decision to tell others where they worked they revealed deliberate intention in their message. The message may be one of advocacy for their work:

> I think that I would be a really good representative, ...positive representative of the work.... And also because... I am proud of it.....so that people... DO talk about it and they are more um….sort of open to thinking about you know, it is very easy to say *"no I don't agree with that"*.... And that be the end of it because you probably don't really think about it..
>
> A2 p22

Or, as this nurse highlights, self-protective in the face of uncertain responses which could be critical:

> And I'm quite proud of what I've done.. and I don't, and I don't feel any.. need to... protect other people from that.. but sometimes I feel the need to protect myself from... the comeback. ....if I don't feel able to have that conversation then sometimes I don't. .. But that's a self-protective thing

> that's not about protecting everyone else because I would love... to be able to tell everybody M12 p7

> Um I do tend to… it depends on the group that I'm with. I have only told one of, ... now I've only told one of the[m] .. really where I work and it was only because I got caught out… C12 p23

> Oh sometimes I will say that I work in women's health... Um.. and if they ask more then I will tell them more... ...I won't volunteer the information.., but I mean.. I'm not shy to talk about what I do either.. if, if it's important to the conversation. B1 p17

This section has discussed the theme *relating with care and intention* highlighting the complexities in the relational aspects of nursing in an abortion service. Relational nursing skills are identified and an ethic of caring for self and others was expressed in the intention of relating. Criticism or the fear of criticism reveal silences leading into the final theme *silences* which is discussed in the final section of this chapter.

Silences

This section explores the theme of *silences* revealed following the exploration of the first three themes at the workshop.

Silences about abortion existed in the withholding of information by women and nurses highlighting the persistence of stigma. These silences, their elements and the reasons found for them are summarised in Table 2. This section will explore how these silences affected the nurse participants personally and professionally.

Silences	Elements of the silences	Reasons for the silences
Having an abortion Working in abortion care The work in theatre Managing the foetus and foetal tissue	What it entails How it feels Coping with how it feels Talking about how it feels Doing it well	Fear or avoidance of criticism or Judgment imposed by others' discomfort Anxiety about fuelling anti abortion arguments Lack of appropriate language – use of euphemisms
Table 2: Silences revealed in the data analysis		

I listened repeatedly to each interview and made notes capturing the essence of the message, and where there were inconsistencies. Most notable to me was the nurses' assertion of their own comfort (and pride) in working in abortion care yet, societal judgment and discomfort about abortion regulated their decisions about revealing or discussing their work. That is they could not freely translate their own normal attitude to abortion care to social interactions about the work they did. Therefore, as discussed in *relating with care and intention,* the nurses made deliberate decisions about telling others about their work (place) based on:

- The need for the other to know; this included workplace contact information for schools or childcare centre staff
- The importance of the relationship to the nurse; family and friends
- The likely or known reaction – being self-preserving as well as caring for the 'other'
- The importance of advocating for the issue

One of the nurses used the word 'disclose' when talking about sharing information about her workplace with a friend for the first time. This exemplifies this theme as for most nurses this would be an everyday act of

information exchange yet, for nurses working in a specialist abortion clinic the revelation can be heightened by a risk of rejection or criticism.

The following comment typifies how these nurses recognised that the silencing about their work was oppressive for them, but understood it in the current social context of abortion:

> ...that comes.... from somewhere much bigger than just me recognising that it's not.... relevant or not the right thing to talk about my work at that point, I think there's.. is a bigger.. societal blanket over what's palatable.. and what's acceptable.. M12 p6

> it doesn't matter theoretically, you know.. but.. they like to talk about their reasoning and I let people talk. A2 p8

> I suppose allowing them to, to not, to feel that they don't have to fit a social norm either. You know, that I should feel really sad, or why. If you don't you don't. And I think that's… .. you know people say *"I feel numb"* or *"I just feel really relieved this is over and it feels bad that I feel that, I feel happiness that it is over."* Well, why is it so wrong? C12 p3

Managing the work involving the foetus

Aspects of the work in caring for women presenting for second trimester abortions between 16 and 22 weeks gestation was identified by the nurse participants as work that could cause feelings of discomfort or distress:

> Some of it is quite unpleasant...Um... and..um....confronting. Yeah... Sometimes it's a little bit graphic... Especially second trimester..in theatre. .., I mean of course you can never talk about things which are confidential or about identifying, and that's the same in every discipline but.. you know, no one is going to go that's disgusting I can't believe you do that, or you know, faint or anything like that...

> I don't mind doing the work, it doesn't bother me to do the work and I think that.. um.. it's possibly.. better off that it's kept a little bit in-house. B1 p16

Additionally, it was difficult to talk about this work. As the nurses began to talk about their experience of the work associated with unplanned deliveries, handling foetal tissue and disposal of the foetus I noticed a reluctance to talk freely. The interview texts here are peppered with pauses and I noted their discomfort; dropping their tone, looking at the recorder or leaning to turn it off, looking back at me for guidance in whether to keep talking or not. Euphemisms such as ' icky' or 'not very pleasant' were used to explain the nature of this work or to convey the unwelcome spontaneous reactions or disturbed sensibilities that the nurses sometimes experienced when undertaking these tasks.

My reflections and discussion at the first workshop illuminated two contributors to this reticence to talk freely. Foremost, was the fear (and I use this word intentionally to convey the degree of concern I witnessed in the nurses gestures and faces; shaking the head to indicate this must not happen and even the wide open eyes of one anticipating danger) of the material getting into the hands of anti-abortionist activists. Secondly, I realised that an appropriate language to talk about this work and their feelings about it was not readily available to them.

Language I noted in relation to managing foetus / pregnancy tissue

- Intact – foetus that is delivered vaginally rather than removed in parts by surgical dilatation and evacuation procedure.
- Foetal parts or pregnancy tissue
- Responses: confronting, squeamish, distressing
- Euphemisms – Unpleasant, A little bit graphic, Visually challenging, icky
- Counter-intuitive: recognising the social construction of expectations of women, especially those who are mothers themselves, to be nurturing. Although the procedure is destructive in nature the nursing is nurturing: 'taking care of a woman's health status'.

The work involving the foetus was discussed at the first workshop. The nurses discussed the dilemma of which words to use, and whether there was a 'right' way to deal with the foetus. Some of their questions follow:

- Whilst a woman is pregnant it is easy to not talk about a foetus, however, once a 20 week foetus is in front of you, or in your hands or weighing heavily in a yellow disposal bag it makes no sense to call it anything but a foetus because that is so clearly what it is.?
- What is the difference in the experience of disposing of a fully formed 20 week foetus and a bag of pregnancy tissue including foetal parts?
- What is it about a foetus (in fully formed human shape) that 'doesn't sit right' or can cause an unwelcome emotional response for the nurse managing it?
- How should a foetus be dealt with? As any other tissue or body part removed from a person, such as a uterus or leg to which the person may well have a range of emotions depending on how the body part had served them?
- Is there something different given the potentiality of a foetus? Is it the human form?
- Is it that the nurses' response should be congruent with the woman's response? Caring and respectful if she demonstrates these attitudes and emotionally neutral and unaffected if this is what the woman demonstrates?
- Should the woman's attitude inform the nurse's response? Is the woman's attitude to the pregnancy relevant?

Is the problem really the work or that like other aspects of the 'dirty work of nursing' (Lawler 1991) it is unacceptable to talk about it. For abortion work there is an additional perceived risk that describing the work accurately could fuel arguments of immorality and restriction. This nurse's perspective from one of her colleagues is relevant:

> ….at a conference somebody said, *"just because it's icky,... doesn't make it wrong"*....you know... thinking about the work

> and all the rest of it, yeah there are parts that are... you know visually challenging and... whatever…..but.. for the purpose of the woman's safety and her reproductive future….icky is ok. A2 p27

Aware of the possibility of judgment this nurse and her colleague demonstrate a resistance to the imposition of an external verdict for the conduct of this work. Their own morality of the rightness of the work is found in the outcome for the woman.

The following quote illustrates this nurse's acceptance of the necessity for the work and articulates her nursing values enabling her to do it:

> …um my experience is not their experience so it's about having that..that boundary about..what is me..what belongs to me..they're my feelings..and what belongs to them...it's not my foetus…, it's not my.. pregnancy..that's their foetus..that's their pregnancy...um..and..marrying that up with my view..which is that...as long as that pregnancy is happening in THEIR body that they have a right to make..that decision for that pregnancy..... Somebody has to do this work...and the person that needs to do this work..is the person...that believes that this work is important..and that can do it compassionately… B1 p19

Despite the difficulties that the work involving the foetus could present, being able to achieve a level of comfort with the second trimester work in theatre or handling the foetus or pregnancy tissue enabled the nurses to provide care based on individual women's needs. This was regarded as important and an ability the nurses valued in themselves and in others. There is not a service expectation to be comfortable with the work involving the foetus but informal responsibility lies with the nurse to raise difficulties. That is the approach is one of debriefing rather than structured professional supervision.

This section has discussed the theme of *silences* in the experience of nurses working in abortion care in a specialist clinic. Silences in revealing the work and talking about the work have been discussed.

Summary

This chapter has presented the four themes identified in the analysis of the study data. *With woman* described the nurses' individualised and contextualised care of women; *finding balance* was identified as an important process in managing the personal and professional tensions in the work and *relating with care and intention* outlined the relational aspects of the work. The theme *silences* identified aspects of working in an abortion service that were not revealed or freely discussed. The final chapter will discuss the key findings and make recommendations for clinical practice.

Chapter 6 Discussion

Introduction

This chapter presents the major findings of my study asking the research question “what is it like to work as a nurse providing abortion care in a specialist setting?”. In doing this the motivation for the research and the research problem are restated. A discussion of what this study adds to the existing knowledge for nursing practice and education follows. I then make recommendations for future developments in the context of the limitations of this small study. The chapter and thesis conclude with the nurses’ voices in two poems I wrote to convey the essence of their experience of revealing their work to outsiders and of working *with woman* in abortion care.

The research problem

I was motivated to ask the research question “what is it like to work as a nurse providing abortion care in a specialist setting?” by my personal experience of nursing and managing in a specialist abortion clinic. As well as finding little representation of this type of work in the literature, I felt professionally isolated and believed that abortion care was a marginalised area of women’s health care. Searching the literature in preparation for this study, I found the emergence of an interest in other countries in the experience of nurses working in specialised abortion care.

Study summary

The purpose of this study was to add the voices of nurses doing this work in a specialist Australian setting. I used feminist research methodology, an appropriate approach, given my personal experience and abortion’s gendered and marginalised status. I undertook in depth interviews with six nurses to explore the subjective experience of nurses whose role is to

provide nursing care for women seeking abortion services in a specialist clinic. The study findings, developed by thematic data analysis, were validated in workshops with the nurse participants and reported privileging their voices.

What is it like to work as a nurse providing abortion care in a specialist setting?

The voices of the nurse participants in this study have been heard in the findings chapter of this thesis. In this next section to answer the research question, across the themes, the discussion is framed by the following categories:

The specialist setting

Commitment to women's self- determination

Working with a highly skilled and supportive team

The capacity to engage with women and the foetus

Making a difference for women

The importance of the findings and their contribution to broader understandings of this nursing work is also discussed.

The specialist setting

The findings from this study are specific to the experiences of nurses working in a specialist clinic established in SA in 1992. What is important about this clinic is that it is a centre of excellence for abortion care because of its sole focus on this speciality. Working as a nurse providing abortion care in a specialist setting has advantages and disadvantages.

Most of the literature about nurses' experiences in abortion care investigates nurses who have broader roles in gynaecology, where abortion care is only a part of the nurses' work. Whilst nurses in these non-specialist settings can feel marginalised within their hospital, as the challenges of their work doing abortions is not recognised, they are able to avoid the public stigma of abortion by only revealing a more generalist work setting.

Stigma

However, stigma and judgment about abortion were difficult for the nurses working in a specialist clinic to avoid as revealing their workplace identified their role in this contested area. This could be an area of significant personal challenge for these nurses working in a specialist clinic, as concern about potential critical reaction meant they could not talk naturally about their workplace. This made conversations about their work risky and the nurses gave many examples of controlling information about their workplace. For instance, restricting contact details for schools or childcare centres by not revealing any place of work and providing only a mobile phone contact number. Alternatively, when they actively decided to reveal their workplace, the nurses did so knowing they might have to defend themselves, or women needing abortions, against criticism or judgment.

The specialist clinic can be an easy target for anti abortion protestors. Although a health service associated with a hospital, the clinic is a stand-alone service located in the community. This makes it an easily identifiable service, which raised some personal and professional challenges for the nurses working there. In particular, the regular presence of anti-abortion protestors outside the clinic site raised questions of personal safety for the nurses in this specialist setting.

Wide scope of practice

Nurses have a wide scope of nursing practice in this specialist clinic. This wide scope of practice was an advantage because it gave the nurses the opportunity to develop a broad range of nursing skills and was professionally stimulating.

Experiencing an unplanned pregnancy and requiring an abortion can be a difficult and intensely emotional experience for women. As a specialist setting, and only seeing women with this experience, the nurses found that the work environment could also be especially emotional. They could experience personal distress or feel emotionally exhausted by the intensity of engaging with women. The wide scope of practice was important in managing this because the varied work roles provided a workload balance.

Commitment to women's self- determination

Motivation to work in abortion care

For the nurse participants in this study their commitment to women's self-determination supported their choice of workplace and was important in the conduct of their nursing work in a specialist abortion clinic. A range of motivations had led the nurses in this study to choose to work in this specialist abortion service; it was not necessarily that the nurses held strong positions about women's access to abortion, although some did.

A lack of choice in providing abortion care has been found to contribute to difficulties for gynaecological nurses (McQueen 1997) who have to put aside their own values to support a woman's abortion. It can also be a burden for nurses who find the work hard, but feel unable to opt out because no other nurses are willing to do the work (Huntington 2002; Nicholson et al 2010). However, a small study of the perceptions of nurses who had chosen to work in specialist clinics in England, found that the participants views that it was "the right of a woman to be able to choose to have an abortion if she found it necessary" (Gallagher, Porock & Edgley 2010, p.852) was important to all aspects of their experience of the work.

My study of nurses providing abortion care in a specialist setting in SA found that this political motivation of abortion access for women was not the universal motivator. Instead, the common enabler to making the choice to work in the clinic, was the ability to translate their professional nursing value for self-determination in health care decision-making to the specific context of supporting women's ability to implement a decision for abortion.

The nurses' professional value for women's self-determination was also important for managing the personally or professionally challenging aspects of the work in this specialist abortion clinic. One challenge in particular was managing the discomfort they could sometimes feel because of the sights and sounds that were aspects of working in the operating theatre for second trimester surgical procedures. By separating women's self-determined need for the abortion from the nurses' experience of the work; acknowledging that it is the woman's pregnancy and "while it is going on HER body it is for her

to decide what is right for her", the nurses were able to prevail over their own discomfort to do the work and remain compassionate towards the woman.

The nurses' ability to do this meant that women could get the service they needed. This was important to the nurses themselves and is also very important for the ongoing provision of second trimester abortion services to women.

The law

As the nurses in this study were involved at all levels of a woman's episode of care, they were very aware of the restrictions to women's self-determination caused by the regulations of the SA abortion law. As women themselves, the nurses empathised with women's indignation at the requirement for certification for the abortion by two doctors.

Additionally, it was professionally challenging for the nurses when the requirements of the legislation prevented the development of the optimum nursing care plan for a woman. A number of the nurses cited this as an issue in the provision of early medical abortion (EMA). This was because the legal requirement for women to take their medication for EMA in a prescribed hospital, prevented the nurses from developing a schedule for medication administration, that took account of a woman's family and work responsibilities. The nurses found this frustrating, because it limited their ability to provide optimal care, based on clinical guidelines for best practice. They also felt it was oppressive of women, and related to this oppression personally.

Working with a highly skilled and supportive team

There were structural and cultural factors that affected the nurses' ability to thrive in the work environment of a specialist abortion clinic despite personal and professional challenges. This was important because the clinic was busy, and work could be emotionally demanding as well as requiring a wide range of skills.

Teamwork

A collegiate culture gave the nurses the opportunity to talk to and learn from a wider team of nursing and multidisciplinary health professionals. This

informal professional development was important for developing the skills required because of women's diverse and complex presentations, and also for gaining support to manage personal challenges.

Teamwork helped the nurses manage the professional challenges of balancing women's needs in the busy and unpredictable environment of the clinic. A shared goal to provide high quality and individualised care for all women was applied to clinical practice by sharing the workload such a goal requires. The value of this team support was highlighted because it meant that the nurses could spend the time with each woman that she needed. Even though everyone was busy, other team members would 'pitch in' and look after other women so that a nurse could stay with a woman needing more time or support.

The notion of an "ethos of team support" (Gallagher, Porock & Edgley 2010, p. 853), was also identified as important to the nurses working in a specialist clinic setting in the UK.

Organisational support

The nurses in this study identified that the support of the organisation was crucial because it enabled them to manage challenges, such as working in theatre during second trimester procedures, and managing the foetus or pregnancy tissue. The nurses' identified that it was acceptable to seek help from colleagues and management. In fact, they were encouraged to seek support if the work was causing disturbance for the nurse. Examples were provided which demonstrated that some of the participants had acted on this and others, knowing they may need to in the future, expected a favourable response explaining that it's "the culture of the place that we care about each other's wellbeing".

For another nurse participant who knew she had to look after herself to "give a good service", talking over the strain of an unresolved discomfort, about the method of disposal of an intact foetus, with an experienced and trusted colleague, was helpful. Together they had worked through what was difficult and modified the method by wrapping the foetus before disposal in the yellow waste bag. This solution felt good for the nurse, lifted the strain and enabled her to continue to "give a good service".

This notion of organisational supports to actively manage difficult aspects of the work was recommended by Huntington (Huntington 2002), as a practical application of the feminist principle of equality to the clinical setting: that is not prioritising the needs of one group of women over another (Huntington 2002). Webb has criticised Huntington's recommendations arguing they are not directly applicable to clinical practice because they address nurse's needs rather than women's needs (Webb 2002). However, for the nurses providing abortion care in the specialist SA clinic, the clinic's support for their needs as women and nurses contributed to their own continuing capacity to nurse in abortion care.

This is an important consideration for the support of nurses working in abortion care generally, because a workforce of nurses willing and able to do this work is critical to the maintenance of clinical services in many settings. Therefore, not only is it ethical to care for all involved, it makes good sense for the sustainability of this workforce to care for nurses willing to work in this marginalised area of health care.

More recent studies of nurses involved in abortion care (Gallagher, Porock & Edgley 2010; Lipp 2008b; Nicholson, Slade & Fletcher 2010) have concurred with Huntington's recommendations for organisational support, but suggest formal structures for clinical supervision and reflection, to compliment informal supports, to assist the nurses to cope with the stresses of the work.

Although no formal system existed for structured supervision and reflection, the experience of the nurses working in the specialist clinic in SA was that effective support was found in sharing problems with colleagues they trusted and felt comfortable with.

However, it is worth noting that the nurse participants evaluated that contributing to my study of their experience of working in a specialist abortion clinic, was validating and affirming. This does suggest that making a space away from the busy clinic setting to reflect on personal and professional challenges can be a source of empowerment for nurses working in this marginalised area of health care.

The capacity to engage with women and the foetus

Intimate engagement

Intimate engagement with women was an important aspect of the experience of the nurses providing care for women requiring abortion care as the work required close emotional and physical contact.

Recognising women's vulnerability, the nursing care was built around permission, comfort and reassurance. Developing an expert understanding of the extent and complexities of women's reproductive responsibilities, was important knowledge for the role as it helped the nurses to relate supportively to women. A warm, friendly and nonjudgmental approach allowed women to place their trust in the nurse and confide intimate information. It also meant that a woman could ask the nurse for assistance to realise her own goals in the process of the abortion. The nurses realised that many women, expecting a judgmental response, relieved by this warmth and acceptance, were less anxious and able to focus on their own health care needs for the procedure.

The development of trust was also important because of the close physical contact required by the procedure in theatre or recovery.

Managing work with the foetus

Intimate engagement with the foetus or pregnancy tissue was required to care for women having abortions later in the second trimester, between 17 and 22 weeks gestation. Nurses worked closely with the surgeon in the operating theatre and with the woman pre and post operatively. In these roles nurses had to manage disposal of the foetus; facilitate women's needs for ritual or contact; or for pathology or forensic testing.

Although this close contact with the foetus or pregnancy tissue could be a challenging experience for the nurses, being able to achieve a level of comfort in engagement with the foetus or pregnancy tissue enabled the nurses to provide care based on individual women's needs. This was regarded as an important ability the nurses valued in themselves and in others.

However, lacking an appropriate language to discuss the challenging feelings related to the work with the foetus meant that the nurses' descriptions were limited to the use of euphemisms such a 'icky' or 'not very pleasant'.

Exploring and developing appropriate language to discuss this work and to describe their feelings would legitimise these aspects of the nursing role as a nursing skill rather than an intrinsic ability. An appropriate language would also support the orientation and experiential skill development to this work for newer staff.

Making a difference for women

The intimate emotional engagement gave the nurses a window into women's private circumstances. This meant the nurses could see that their work was 'directly helping women' and could see the difference the service made for women's lives and for individual women. This was important because it gave their work meaning and was a source of moral and professional satisfaction.

Moral and professional satisfaction

Even though the nurses in this study personally experienced, or worried about, moral judgment or criticism because of their work in a specialist abortion clinic, they derived the moral satisfaction of 'doing important work' from assisting a woman achieve her own goals based on her own morality. To do this the nurses had to resist external verdicts of the "wrongness" of their work, such as the criticisms of friends and family or the protestors' messages to women.

Professional satisfaction was derived from doing the work well and achieving optimal outcomes for women. The ability to provide clinical care that was emotionally and physically safe for the women at a time of crisis, meant that what I term 'holistic homeostasis' could often be achieved by the time women were discharged. This idea of holistic homeostasis describes the outcome for women whereby the pregnancy is safely removed, physical homeostasis restored and women are emotionally 'settled' enough to 'go home happy'.

The nurses stressed the importance of the rich moral and professional reward they gained by contributing to, and witnessing, women's transformation to holistic homeostasis despite the negative societal attitudes towards their work. Women's grateful thanks were a bonus. Nurses looking for rewarding work with women can be encouraged to consider working in abortion care.

Summary

A range of motivations led the nurse participants to take up employment at the specialist clinic. Common to the participants was a nursing commitment to supporting self- determination in health care decision-making. This commitment was integral to the nurses' ability to facilitate women's decision for abortion because aspects of the work were difficult.

There are challenging and rewarding experiences for nurses providing abortion care in a specialist clinic.

External factors associated with abortion stigma such as protestors, and criticism and judgment, can challenge nurses' feelings of personal safety and emotional comfort in revealing their work. This limits exploration and discussion of challenging aspects of the work. Legal restrictions frustrate their nursing goals of best practice.

Internal factors such as organisational and team support, and a wide scope of nursing practice caring for women throughout their abortion process are professionally satisfying and personally rewarding. Nurses use a range of personal strategies to resist criticism and sustain their important work directly helping women.

The personal journey of the research

Conducting this research has been a challenging personal journey for me, deeply influenced by my eighteen years of work in the clinic setting for the study.

I first recognised the need for research in this area ten years ago because of the personal experience of finding little of relevance to our struggles and challenges in the nursing literature or professional nursing forums. My solution at that time was to attempt to get some academic interest in the

question of “what it is like to work as a nurse in a specialist abortion clinic?”. Had this plan been successful I would have been a contributor to the research.

However, I was not successful, so decided to attempt the project myself. I was aware that my many years experience of working in the clinic meant that I was very close to the research topic and that this could present challenges for me. Maintaining a relationship with a trusted external supervisor was important to care for myself as well as to support reflexivity.

I expected that many of the nurses’ experiences would resonate for me; I found I missed the intimate engagement with women, but not the protestors. I felt sad to hear my colleagues talk of the rejection of family as I too, had experienced.

What I did not expect was the extent to which I had taken on the silences because of my own experience of the criticism and stigma of working in abortion care. This has made it difficult for me to find a strong voice in the development of this discussion of the study. I have learned how much I had internalised strategies of minimising the personal difficulties of feeling marginalised and realise even now that this is reflected in this report.

I missed the collegial support I had enjoyed as a member of a team of committed and supportive workers. Their strength in sustaining me in my work in abortion care had been crucial in my time at the clinic. Without their support, I have drawn deeply on the generous and grounded encouragement of my academic and external supervisors throughout this project. Though I feel my voice in this report is somewhat muted, that it is revealed at all is liberating.

Study Limitations

This small qualitative study sought access to the knowledge and perspectives of the nurse participants in one particular setting. As such, the aim was to develop understanding from the perspective of the participants rather than to make findings for generalisation to other populations.

There were demographic similarities among the participants who were all well experienced registered nurses, mature in their careers and with some

years of experience at the clinic. As ‘local confidentiality’ (Bosk 2001) was a concern for this small sample group, detailed demographics have not been reported limiting description of participant diversity by employment status, personal experience or role definition in this report.

Perspectives from enrolled nurses, new graduates or nurses who had worked at the clinic for only a short time (less than a year) are not reflected in this study. Voluntary participation and inquiry by face-to-face in-depth interview are unlikely to recruit participants to share their experiences with a researcher with whom they do not feel comfortable. My previous position as service director may have discouraged participation by newer or less confident nurses.

For the participants in this study their view of me as a ‘trusted insider’ contributed to their decision to volunteer to participate. This self-selected sample came to the study with a positive view of their work and it is possible that nurses with a more problematic experience chose not to volunteer.

Recommendations for further investigation

In future research, an analysis of the Australian nursing workforce involved in the provision of abortion care would provide information about the range of settings in which nurses do this work. This would determine appropriate sites for further multi-centre investigations to build on the findings from this study, and recognise the contribution of nurses in other settings providing abortion services to women.

Specific research conducted using a critical reflective framework to develop language for discussing the experience of the work associated with the pregnancy tissue or foetus has the potential to build knowledge for this area of practice. Language to talk about difficulties would further validate this aspect of the work and help nurses in debriefing and supporting others. Additionally, appropriate language would assist in legitimising the challenging aspects of work with the foetus and pregnancy tissue for nurses.

Conclusion

This small study has explored the subjective experience of nurses who provide nursing care for women seeking abortion services in a specialist

clinic. Motivated by personal experience in abortion care and taking account of the gendered, controversial and stigmatised context of abortion, feminist research principles and methods provided a supportive framework for this exploration of personal perspectives. In-depth interviews were interactive and reflective and the workshops with the interview participants validated the initial data analysis. The nurse participants evaluated their experience of contributing to the research as validating and affirming of their experience, and of the importance of their work.

Commitment to the nursing value for self- determination in health care decision-making is crucial for nurses to provide woman centred care in this controversial and stigmatised area of women's health.

Organisational recognition of the requirements of the nursing role, and structural support of these requirements in the staffing plan and culture, has a beneficial impact on nurses' well-being, job satisfaction and ability to withstand the challenges of the work. Maintaining the well-being of nurses, essential to the provision of this important women's health service, contributes to the continuation of services for women.

Commencing a dialogue about the silences surrounding the difficult or 'icky' aspects of the second trimester work involving the foetus, has highlighted the importance of developing a language to develop and validate this aspect of the work.

Decriminalisation of abortion laws would enable nurses to provide woman centred care based on clinical guidelines, taking account of the complexities of women's lives and responsibilities.

This research provides a contemporary Australian perspective of the experience of nurses working in abortion care; revealing the voices of nurses working in a specialist clinic setting, it builds understanding of this area of nursing work. This understanding, and the research recommendations, contributes to an emerging international literature exploring the perspectives of nurses providing abortion care in hospitals and specialist clinics.

Nurses providing abortion care in a range of different service settings may find validation of their experience in the rich data this study contributes.

Service providers can gain an understanding of the complexities of the nurses' role, the effect of stigma and the importance of organisational support to recognise and assist nurses with the difficult aspects of the work.

This study using feminist research methodology, has given voice to a small group of nurses persisting and finding satisfaction in abortion care. Future research to develop supervisory or reflective frameworks should include nurses in different practice settings to develop knowledge and support for nursing practice in abortion care.

My thesis concludes with two free form poems. The nurses' voices convey the essence of *what it is like work as a nurse in a specialist abortion service.*

Gambling

What will you say

if I tell you

What will you do

if I tell you

...what I do?

(Will you) criticise me

Will you turn away from me?

Maybe it will upset you to remember?

Could you take it out on my little one?

Could you take it out on my career?

What will *happen* if I tell you what I do?

I worry you might...

Not give me that job

I worry our friendship will change

So I tread with care and precision.

I don't mind defending

I don't mind explaining

I even don't mind that no-one will call me an angel

I mind that

you can't be proud of my work

I mind that

you can't be proud of me

I mind that

You say I wouldn't do it if I didn't

have to!

I mind being dismissed as pro-abortion – whatever that means

rest assured never fear – I won't tell you all –

You don't need to know it all

What language do we have to talk about it anyway?

with woman

I sit with you…in silence… or in conversation

making space...room for you.

For your expectations

your urgency

your practicality

your shock

your anger

your sadness

your fear

your hurt

understanding...you are not a failure

bearing witness to your decision

tell me all, tell me nought – you know best.

what might you be thinking but cannot, dare not ask?

sensing what you need...responding where you are at....

a different way of thinking?

Walking quickly slowly

slowly so you can cope...quickly so that you don't run out of time

there is room for your laughter

and questions are fine

what do you need to hear?

injections we can do

sleep if you want

wake as you are

keep you safe then send you on your way

we're just a phone call away.

Sometimes

I shed a tear with you

feel you lingering with me til evening…I might refill that glass of wine.

How much a smile can mean

a friendly gesture

a hug of thanks

when you go home happy my job is done.

Work with heart

why I came…why I stay.

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Appendices

NOTE:
This appendix is included on pages 96-98 of the print copy of the thesis held in the University of Adelaide Library.

Appendix 2 Participant Information Sheet

Government of South Australia
SA Health

PARTICIPANT INFORMATION SHEET
PART ONE
PROJECT SUMMARY AND INTERVIEW

Title: The experience of nurses providing abortion care in a specialist clinic setting

Protocol Number: HREC/13/TQEHLMH/120

Researchers: Dr Lynette Cusack — Coordinating Principal Investigator
Senior Lecturer — Student Supervisor
School of Nursing
The University of Adelaide

Brigid Coombe — Site Principal Investigator
Postgraduate Student — Student in Master of Nursing Science '
School of Nursing — (Community Health)
The University of Adelaide

INVITATION TO PARTICIPATE

We invite you to participate in a research project which we believe is of importance. However, before you decide whether or not you wish to participate, we need to be sure that you understand

why we are doing it, and
what it would involve if you agreed.

We are therefore providing you with the following information.
Please read it carefully and be sure to ask any questions you have.
Brigid Coombe, who is the Principal Site Researcher, be will be happy to discuss it with you and answer any questions that you may have.
You are also free to direct questions to Dr Lynette Cusack, who is coordinating and supervising the research or to discuss it with outsiders or other colleagues if you wish.

You do not have to make an immediate decision.

PARTICIPATION IS VOLUNTARY

Participation in any research project is voluntary. If you do not wish to take part, you are not obliged to. If you decide to contribute and later change your mind, you are free to withdraw from the project at any stage without providing a reason.

Your decision to take part, not to take part or to withdraw will not affect your employment or work conditions at all.

BACKGROUND TO THE STUDY

What is the research about?
The research is a small qualitative study to understand the experience of nurses providing abortion care in the specialised setting of the Pregnancy Advisory Centre (PAC).

Why is the research being done?
Research about women's experiences of unplanned pregnancy and abortion has highlighted the negative effects of societal attitudes of judgment and shame for them.
Nursing care of women seeking abortion responds therapeutically in this stigmatised environment by ensuring a supportive and non-judgmental approach that meets women's needs.
Very little attention has been given to the experience of nurses who, like the women they care for, can also feel the effects of this criticism. The effect of stigma on nurses is now developing as an area of professional interest by nurse researchers.
To address this gap in professional nursing knowledge the proposed research intends to give voice and acknowledgement to the experience of nurses who provide abortion care in a specialist setting in Australia, to provide a representation of this work in the literature and contribute to developing international understandings.

Who is sponsoring it?
The research is being done as a project towards a Master of Nursing Science (Community Health and Primary Care) at The University of Adelaide and does not attract any financial sponsorship.

How and why have I been chosen as a possible participant in the research?
You have been invited because you work as a nurse at the PAC and it is this experience which is to be studied.

How many other people have been asked to consider participating?
All current nurses at the PAC who have completed their orientation to the nursing role are being invited to participate.

WHAT WILL THE RESEARCH INVOLVE?

There are two separate stages to the research.
The first is participation in a face-to-face, in-depth interview with Brigid (the researcher).
The second is the opportunity to meet with the researcher and other participants in a closed, interactive workshop to discuss the findings from the interviews.

What will I have to do?
You will participate in a face-to-face interview with the researcher and later have the opportunity to contribute to the findings from the interviews in a closed, inter-active workshop with the researcher and other participants.

The interview would take place at a time and place of your choosing.
The questions will be about

- your decision to work at the PAC,
- what your role entails and

- what it is like to work as a nurse providing abortion care from professional and personal points of view.

You may use examples from personal experience to illustrate your answers and the researcher may also share examples from her experience to discuss or clarify your answers.

If you are agreeable the interview will be recorded on an audio recorder. The interview will be transcribed verbatim from this tape and stored as a secure computer file. The tape will then be erased. You will be offered a copy of the transcript to check and correct or change anything you are not comfortable about.

With your consent the researcher will contact you again to make arrangements for the time and place of the closed workshop with the researcher and other participants.
At this workshop the researcher will present her findings from the interviews to the group.
With the other participants you will be invited to provide comment on the findings and discuss them as a group with the researcher.
Following this input from the interview participants the researcher will complete the written report of the project.
The workshop will be recorded on an audio recorder and transcribed to provide a written record of the workshop for the researcher.

How long will my participation in the study last?
Your time commitment is likely to be about 3 hours. The interview would take about an hour and a half and the workshop would be scheduled for one and a half hours.
In addition to this would be the time you take to read the transcript of your interview and undertake any discussions with the researcher should you choose to do this.

DISCOMFORTS, RISKS OR SIDE EFFECTS

Will there be any discomforts?
This is considered to be unlikely but it is always possible in an interview about personal experience that topics are uncovered that can cause you to be upset.
The interview is proposed as a supportive place and if you were to become upset this would be worked through as part of the interview. If you determined it best to not continue the interview would be stopped. It would then be up to you to decide if you wished to complete the interview at another time.

Are there likely to be side effects from the research procedures, and if so what are they?
This is also considered to be unlikely.
If you feel upset at some time after the interview you are welcome to contact the researcher directly for support or feedback.
If you felt it more appropriate your supervisor will be available for support or one of the SA Health Employee Assistance Programs could be used.

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED?

How will my confidentiality be protected – will the information and results be de-identified?
Your participation in the research is confidential.
Demographic data - nursing classification and employment status (full/part-time or casual) will be de-identified.

Your confidentiality will be protected by the use of a pseudonym.

It is recognised that the PAC is a small workplace and has a service model that is unique in Australia. This presents a challenge in the preservation of participant's anonymity.

The intention of the research is to build information and understanding of the range of experiences of nurses rather than to build a story of individual nurses' experiences.

However, it is recognised that in the course of the interview information may be gathered, such as the time you have worked at the PAC along with your description of experiences that could identify you to a small number of your colleagues.
This could occur at the workshop or be revealed in the final written report of the project.

The research design aims to minimise this possibility in the following ways:

- confidential participation
- limiting the demographic data collected about participants to nursing classification and employment status
- de-identification of this demographic data
- the workshop will be closed and with the requirement for confidentiality
- the preparation of the report of the project will prioritise a format where the information is reported in general terms - for example direct quotations used in the report of the research will be used to illustrate examples or themes rather than connecting an individual story
- dissemination of the final report of the project may be limited

However, it may still be possible that you or your contribution could be identified by a colleague who is very familiar with your involvement and experiences at the PAC.

Your decision to participate in the research therefore rests on your comfort with this possibility.

All data collected will be stored securely on password protected computers at the University of Adelaide and the researcher's personal laptop and hard copies locked in a filing cabinet in the researcher's home office.

How long will my information be stored for?
In accordance with the National Health & Medical Research Council Guidelines your information will be stored securely at The University of Adelaide for at least seven years.

Will I be informed about the results of the study?
Yes.
A copy of the complete project report will be available for you should you wish for this.
A summary of the results will be emailed to all participants in the study.

WHAT ARE MY RIGHTS?

If you become injured during this study, and your injury is a direct result of the effects of study procedures, SA Health will provide reasonable medical treatment. Your participation in this study shall not affect any other right to compensation you may have under common law.

PAYMENT FOR PARTICIPATION

Will I be paid for my participation?
No.

The interview and reflection and the workshop discussion of the analysis of the interview data is suitable for inclusion in your Continuing Professional Development Portfolio.

BENEFITS OF THE RESEARCH

Is there any chance that the proposed research will be of benefit to me personally, or to future patients with the same condition?
Interview methods that value your time and contribution and give you a space to explore your work can be experienced very positively as participants feel validated and listened to. This is especially important when those being interviewed are in some way marginalised or their experience not well understood.

It is possible that you will find the interview and the workshop valuable opportunities for reflection and professional development.
Your contribution to the study of nursing knowledge has the potential to benefit other nurses working in this area of nursing by informing the development of professional practice in abortion care and inspiring further exploration.

WHAT IF I HAVE A QUESTION ABOUT THE STUDY?

For more information or for questions about this study, please contact:

Brigid Coombe	0409 711203 or	brigid.coombe@student.adelaide.edu.au
Dr Lynette Cusack	8313 3593	lynette.cusack@adelaide.edu.au

The Human Research Ethics Committee (TQEH/LMH/MH) has approved this study.

Should you wish to speak to a person not directly involved in the study in relation to:

- *matters concerning policies,*
- *information about the conduct of the study*
- *your rights as a participant, or*
- *Should you wish to make a confidential complaint*

you may contact The Executive Officer of this Committee, on (08) 8222 6841.

Thank you for taking the time to read this information.

Brigid Coombe
Postgraduate Nursing Student
School of Nursing
The University of Adelaide.

Appendix 3 Consent to Interview

THE QUEEN ELIZABETH HOSPITAL
CONSENT FORM 1
INTERVIEW

Title: The experience of nurses providing abortion care in a specialist clinic setting

Protocol Number: HREC/13/TQEHLMH/120

I, the undersigned .....

hereby consent to my involvement in the research project explained above.

- I have read and kept a copy of the information sheet, and I understand the reasons for this study. The researcher has explained the format for the interview and workshop and research report. My questions have been answered to my satisfaction.
- My consent is given voluntarily.
- I understand that the purpose of this research project is to improve the *experience of nurses providing abortion care* but my involvement may not be of benefit to me.
- The details of the research project have been explained to me, including:
  - The expected time it will take
  - What my contribution will be
  - Any discomfort which I may experience
  - Information management
- I understand that the interview will be recorded and that I can ask for that to be stopped at any time.
- I understand that my individual information will be kept confidential but that anonymity cannot be completely assured as my identity may be apparent to colleagues who have shared experiences with me.
- My involvement in the study will not affect my relationship with my supervisor.
- I understand that I am able to withdraw from the study at any stage without having to give a reason, and that by withdrawing it will not affect my employment at the Pregnancy Advisory Centre.
- I give my consent to being contacted to receive a copy of the interview transcript / recording **YES / NO** (please circle)

PARTICIPANT SIGNATURE ..... **DATE** ...../...../.....

WITNESS: ..... **DATE** ...../...../.....
(only to be completed when the investigator is not present)

I certify that I have explained the study to the participant and consider that she understands and freely consents to participation

INVESTIGATOR:..... **DATE** ...../...../.....

INVESTIGATOR NAME.....

NB 2 SIGNED COPIES TO BE OBTAINED.

Government of South Australia
SA Health

PARTICIPANT INFORMATION SHEET

PART 2
CLOSED INTERACTIVE WORKSHOP

Title: The subjective experience of nurses providing abortion care in a specialist clinic setting

Protocol Number: HREC/13/TQEHLMH/120

Researchers: Dr Lynette Cusack — Coordinating Principal Investigator
Senior Lecturer — Student Supervisor
School of Nursing
The University of Adelaide

Brigid Coombe — Principal Site Investigator
Postgraduate Student — Student in Master of Nursing Science '
School of Nursing — (Community Health & Primary Care)
The University of Adelaide

INVITATION TO PARTICIPATE

Thank you for participating in an interview and contributing to the first stage of this research project about the experience of nurses providing abortion care in a specialist setting.
You are now invited to participate in the second stage of this research project which is a closed, interactive workshop with the Principal Site Investigator (the researcher), Brigid Coombe and other nurses from the PAC who also participated in an interview for the first stage of this project.

However, before you decide whether or not you wish to participate, the following information is provided to ensure that you understand

why the workshop is to be held, and
what it would involve if you agree to participate.

Please read this information carefully and be sure to ask any questions you have.
Brigid Coombe, who is the Principal Site Investigator (the researcher), will be happy to discuss it with you and answer any questions that you may have.
You are also free to direct questions to Dr Lynette Cusack, who is supervising the research or to discuss it with outsiders or other colleagues if you wish.

You do not have to make an immediate decision.

PARTICIPATION IS VOLUNTARY

Your participation in the second stage of this research project is voluntary. If you do not wish to take part, you are not obliged to. If you decide to contribute and later change your mind, you are free to withdraw at any stage without providing a reason.

Your decision to take part, not to take part or to withdraw will not affect your employment or work conditions at all.

BACKGROUND TO THE WORKSHOP

What is the workshop about?
The workshop is about the findings the researcher has made from the interview data collected in the first stage of the research.
All the people who participated in these interviews will be invited to attend the workshop.

Why is the workshop being held?
The workshop is being held to:

- Provide the findings from the interviews to the participants
- Provide an opportunity for a discussion of the findings between the researcher and the participants
- Give the participants the opportunity to advise the researcher on the priorities for reporting the findings from the data drawn from the interviews
- Give participants the opportunity to increase their knowledge about qualitative research

Why have I been chosen as a possible participant in the workshop?
You have been invited because you participated in an interview for this research project.

How many other people are being asked to consider participating in the workshop?
All the nurses who participated in an interview for this research project are being invited to participate.

WHAT WILL THE WORKSHOP INVOLVE

The workshop will commence with a review of the requirement for confidentiality and the development of a group agreement to the extent of this confidentiality.
The researcher will give a short presentation about her research and the method used to collect her data and make her findings.
This first part of the workshop will be educational and increase participant's knowledge about qualitative and feminist research.
For the second part of the workshop the researcher will present her findings from the interviews, seek participant's responses to these findings and facilitate a discussion by the group of these findings and their importance for the report of the research.
It is anticipated that this interactive discussion will provide an exciting opportunity for participants to learn together in a supportive and exploratory environment.
The workshop will be recorded on an audio recorder and transcribed to provide a record of the workshop for the researcher.

What will I have to do?
You will participate in the closed, interactive workshop with the researcher and other participants.
All participants will be required to agree to maintain confidentiality of the workshop participants and discussions.
You will be invited to contribute to the discussions of the research findings in this workshop.
The workshop would take place at a time and place suitable to the participants.

How long will my participation in the workshop last?
The workshop will be scheduled for one and a half hours.

Will I be paid for my participation in the workshop?
No. Participation in the workshop and reflection on your learning is suitable for inclusion in your Continuing Professional Development Portfolio.

DISCOMFORTS

Will there be any discomforts?
This is considered to be unlikely but it is always possible in a discussion about personal experience that topics are uncovered that can cause you to be upset.
The workshop is proposed as a supportive place and if you were to become upset this would be worked through as part of the workshop.
If you determined it best to not continue in the workshop you will be able to withdraw without any consequences.

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED?

How will my confidentiality be protected – will the information and results be de-identified?

Your participation in the workshop is confidential.

Confidentiality of other participation and content will be a requirement of all participants in the workshop.

Interview data will be reported anonymously using participants pseudonyms.
Demographic data (such as your nursing classification and employment status) will be de-identified.

However, it may still be possible that you or your contribution could be identified by another participant in the workshop who is very familiar with your experiences at the PAC.
Your decision to participate in the research therefore rests on your comfort with this possibility.

It is possible that you will experience this recognition and sharing of experience with other research participants as a positive and validating experience.

WHAT IF I HAVE A QUESTION ABOUT THE WORKSHOP?

For more information or for questions about the workshop, please contact:

Brigid Coombe	0409 711203 or	brigid.coombe@student.adelaide.edu.au
Dr Lynette Cusack	8313 3594	lynette.cusack@adelaide.edu.au

The Human Research Ethics Committee (TQEH/LMH/MH) has approved this study.

Should you wish to speak to a person not directly involved in the study in relation to:

- *matters concerning policies,*
- *information about the conduct of the study*
- *your rights as a participant, or*
- *Should you wish to make a confidential complaint*

you may contact The Executive Officer of this Committee, on (08) 8222 6841.

Thank you for taking the time to read this information.

Brigid Coombe
Postgraduate Student
Master of Nursing Science (Community Health & Primary Care)
School of Nursing
The University of Adelaide

Government of South Australia
SA Health

THE QUEEN ELIZABETH HOSPITAL

CONSENT FORM 3
CLOSED INTER-ACTIVE WORKSHOP

Title: The experience of nurses providing abortion care in a specialist clinic setting

Protocol Number: HREC/13/TQEHLMH/120

I, the undersigned .....

hereby consent to my involvement in the workshop explained above.

- I have read and kept a copy of the information sheet, and I understand the reasons for the workshop. The researcher has explained the format for the workshop. My questions have been answered to my satisfaction. My consent is given voluntarily.
- I understand that the workshop will be recorded.
- I understand that my individual information will be kept confidential but that anonymity cannot be completely assured as my identity may be apparent to colleagues who have shared experiences with me.
- My involvement in the workshop will not affect my relationship with my supervisor.
- I understand that I am able to withdraw from the workshop at any stage without having to give a reason, and that by withdrawing it will not affect my employment at the Pregnancy Advisory Centre.

PARTICIPANT SIGNATURE ..... **DATE** ...../...../.....

WITNESS: ..... **DATE** ...../...../.....
(only to be completed when the investigator is not present)

I certify that I have explained the workshop to the participant and consider that she understands and freely consents to participation

INVESTIGATOR:..... **DATE** ...../...../.....

INVESTIGATOR NAME.....

**NB 2 SIGNED COPIES TO BE OBTAINED.*

Appendix 5 TQEH/LMH HREC Approval

Government of South Australia
SA Health

Human Research Governance Office (TQEH/LMH/MH)
Basil Hetzel Institute
DX465101
The Queen Elizabeth Hospital
28 Woodville Road
Woodville South SA 5011
Telephone: 08 8222 6910

31 July 2013

Ms Brigid Coombe
School of Nursing
University of Adelaide

Dear Ms Coombe

HREC reference number: HREC/13/TQEHLMH/120
SSA reference number: SSA/13/TQEHLMH/121
Project title: The subjective experience of nurses providing abortion care in a specialist clinic setting.

RE: Site Specific Assessment Review

Thank you for submitting an application for authorisation of the above project. I am pleased to inform you that authorisation has been granted for this study to commence at the following site:

- **The Queen Elizabeth Hospital (TQEH)**

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Notification of extensions to ethics approval granted by the lead HREC are to be provided to the Research Governance Officer.
2. Notification of completion of the study at TQEH is to be provided to the Research Governance Officer.
3. Confidentiality of the research subjects shall be maintained at all times as required by law.
4. Researchers are required to immediately report to the Research Governance Officer anything which might warrant review of site approval of the protocol including serious or unexpected adverse effects on TQEH participants;

Should you have any queries about the consideration of your Site Specific Assessment form, please contact me on 08 8222 8019 or geh.ethics@health.sa.gov.au
The SSA reference number should be quoted in any correspondence about this matter.

Yours sincerely

ALISON BARR
A/Research Governance Officer (TQEH/LMH/MH)

Appendix 6 Summary of nurse roles and responsibilities at clinic

Summary of Nursing Roles and Responsibilities

Role	Responsibilities
Consultations for surgical TOP to 15 weeks gestation	First assessment for women. History and provision of information, support or referral as required. Contraceptive and STI education and information. Chlamydia testing as required or opportunistic. Pre- operative observations BP, BMI and collection of blood for Rh D & other specimens as required.
Consultations for surgical TOP 16 to 22 weeks gestation	First assessment for women. History and provision of information, support or referral as required. Contraceptive and STI education and information. Chlamydia testing as required or opportunistic Pre- operative observations BP, BMI and collection of blood for Rh D & other specimens as required.
Medical Abortion 1st visit Consultations for outpatient early medical abortion (EMA)to 63 days gestation.	First assessment for women. History and provision of information, support or referral as required. Observations BP, BMI and collection of blood for Rh D Qβhcg Hb & other specimens as required Contraceptive and STI education and information. Chlamydia testing as required or opportunistic (Medical officer provides mifepristone tablet to commence abortion)
Medical Abortion Results	Collection of all pathology results for women undergoing Medical Abortion from Oacis and transcribe results into clients' case notes. Arrange for prescriptions and invoices to/from pharmacy.
Medical Abortion 2nd visit	Assessment and history since mifepristone administration. Information and method instructions. Provision of misoprostol tablets. Administration of Anti D when prescribed. Administration of contraception (Implanon Contraceptive Implant/Depo Provera)
Medical Abortion Follow Up	Confirmation of effective EMA by assessment of quantitative βhcg results at 2 weeks post EMA. Follow up of women if Qβhcg not available or test indicates EMA failure.
Admission (for theatre)	Client identification. Preparation for anaesthetic and surgery. History, assessment, pre op medication as ordered, peripheral IV cannulation and initiation of IV fluids
Nurse 1. Operating Theatre for first and second trimester surgical abortion	Assist anaesthetist for induction of GA Ultra sound guidance for surgeon Assist surgeon with vacuum aspiration Preparation of theatre for next client (not sure if you want to go this far?)
Nurse 2. Operating Theatre for first and second trimester surgical abortion	Scout nurse duties Assistance for surgeon if required Insertion of Implanon (NXT) contraceptive implant Identification of client and documentation in case notes

Recovery –1st Stage	Receive patient from theatre (clinical handover as per NSQHS standards) Monitor vital signs, respond to changes. Support as necessary if upset, in pain, bleeding

Role	Responsibilities
2nd Stage Recovery & Discharge	Receive patient from 1st stage recovery (Clinical Handover) Monitor vital signs, respond to changes. Provide light snack and fluids Support as necessary if upset, in pain, bleeding Discharge assessment and preparation. Information, contraception, support and referral as required Hand over to support person or support with departure if required.
Response to telephone inquiries Nurses rostered to consultations and second stage recovery as required	Response to phone contacts from women undergoing abortions. History & assessment, reassurance, information to assist with symptom management or referral as necessary.
Back – up nurse	Management of women undergoing treatment to prepare the cervix for safe dilatation for second trimester procedures over 15 weeks gestation. Monitor and support, pain and symptom management,emotional support Monitor and manage if labour commences, liaise with surgeon and anaesthetist Sensitive support for contact with foetus as woman needs
Coordinator of the day	Co ordinate staffing, client flow. Liaison for medical officers and reception Organise appointments for women with complex needs Complete all documentation/pathology results in case notes for women attending next day for surgery
After hours phone	Response to phone contacts from women undergoing abortions. History & assessment, reassurance, information to assist with symptom management or referral

Appendix 6 Summary of nurses role and responsibilities.

Appendix 7 Sampling Matrix

Appendix 5

Nurses in abortion care

Sampling Matrix

Numbers of Nurses at PAC by classification and employment status

Black = Potential for inclusion

Red= Interviewed

Employment Status	RN 2	Interviewed	RN 1	Interviewed	RN RM	Interviewed	EN	Interviewed	TOTAL	TOTAL
Full time										
Part time	2		4		3		4			
Casual			4							
TOTAL	2		8		3		4		17	
QUOTA	1		3		1		2		7	
TOTAL										

Nurses in abortion care

Appendix 6 Sampling Matrix 12 May

Appendix 8 Letter of introduction to the research

THE UNIVERSITY of ADELAIDE

SCHOOL OF NURSING
FACULTY OF HEALTH SCIENCES

THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA
TELEPHONE +61 8 8313 0511
FACSIMILE +61 8 8313 3594
nursing@adelaide.edu.au
CRICOS Provider Number 00123M

Nursing Staff Member
Pregnancy Advisory Centre
PO Box 21
WOODVILLE SA 5011

Dear Nurse,

I am undertaking a research project as part of study towards a Master of Nursing Science (Community Health & Primary Care) at The University of Adelaide. The research project will be undertaken under the supervision of Dr Lynette Cusack, Senior Lecturer, School of Nursing, The University of Adelaide.

The aim of the research project is to understand the experience of nurses who provide nursing care for women seeking abortion services in a specialist clinic service in Australia.

This study is important because very little has been published about the experiences of nurses providing abortion care and there is currently no Australian perspective in the literature to inform the nursing profession.

There are two separate stages to the research.
The first is participation in a face-to-face, in depth interview.
The second is the opportunity to meet with me in a closed, inter-active workshop with other participants to discuss the interview findings.

If you would like to participate in this study, by consenting to participate in an interview and then having the opportunity to contribute in the interactive workshop to a discussion of the interview findings, your total time commitment is likely to be about 3 hours. I anticipate that the interview will take about one and a half hours and the workshop later in the year would be scheduled for an hour and a half.

Should you wish to contribute to this study or to find out more about it please contact me at the email address below and I will send you an Information Sheet.

A Consent Form to participate in the study will be provided before the interview takes place. You will be able to decline to answer any particular questions and to withdraw from the process at any time during the interview or workshop without any detriment to your role at the Pregnancy Advisory Centre.

Your participation is entirely voluntary.

If you are interested in participating or would like more information please email brigid.coombe@student.adelaide.edu.au

Thank you for your consideration of this project.

For any concerns in relation to the research please contact:-

Research Supervisor Dr Lynette Cusack at 83133593 (The University of Adelaide) or Human Research Ethics Committees as outlined below.

Best regards,

Brigid Coombe RN, GradDip(CommHlth & Prim Care)
School of Nursing Masters Student
The University of Adelaide

2/8/13

This research project has been approved by the Human Research Ethics Committee (TQEH/LMH/MH) and the Adelaide University Human Research Ethics Committee (Project Number HREC/13/TQEHLMH/120).

For more information regarding ethical approval of the project or any ethical concerns you can contact Melissa Kluge, Executive Officer Human Research Ethics Committee (TQEH/LMH/MH) on (08) 8133 4018

Or

The Research Branch of The University of Adelaide on 8313 5137, or by email rb@adelaide.edu.au

Stepped strategy

In qualitative research what we are after is data about people's experience.

Therefore it is important before starting to address anything that might prevent a participant being comfortable and frank in their answers.

As the researcher it is not my place to make any judgments about the anything you tell me but I also want to be real and recognise that as when we worked together I was the service Director this may mean that you might not feel free to be completely frank with me.

That may be because you feel concerned about 'measuring up' to my expectations or that you have a criticism of my approach / work as part of discussing your experience.

I do want your experience of the interview to be a comfortable one and even a positive learning opportunity so I want to be transparent about that possibility and explore what is possible.

Can I ask you if you were feeling uncertain about what I might be thinking given what you are saying and that were making you uncomfortable or preventing you from answering a question would you be prepared to tell me that?

IF yes – that is great and I want to acknowledge your trust in me to do that

IF unsure – is there something I could do or say that would enable you to tell me?

IF – No – thanks for your honesty and that is fine.

Appendix 10 Schedule of Questions

Interview Schedule

Experiences of nurses who provide nursing care for women seeking abortion services in a specialist clinic setting

Guidelines

The following presents the intended order of the interview, questions and prompts.

Remember signposting

Introduction (Issues to cover)

Thank and acknowledge time and contribution

Info about project

Participation is confidential –pseudonym – choose or be allocated

Review title and aim / objectives of the research project & why interviews

Interview format – Questions or concerns about the interview process or research

Questions / Themes

General introductory question – Can you tell me what it is like to work as a nurse at [ ]? feel free to start anywhere - prompt can be the question about metaphor, symbol or it might be a colour or an emotion / feeling?

Can you tell me about how you came to be working as a nurse at [ ]?

What were your reasons for choosing to work at **[ ]**?

What was your journey to working in this area of practice?

Did you answer an advertisement or did you contact the Centre looking for vacancies?

What are you required to do in your job?

What do you do - tasks are you required to do?

Qualifications

What do you need to know?

What skills are required?

Has that changed over time?

What is it like for you professionally (working in this area of nursing practice?)

Environment / the clinic

Structures and professional expectations

Opportunities

Role development

Supervision -"Professional supervision – what does that mean to you?"

"If you did have structured professional supervision what themes/aspects of practice would be important for you to explore? - caring; ethical; legal, stressors, strategies for managing (eg: women's anger??")

Multi disciplines / professional / collegial relationships - *" Can you tell me about team work?"*

If your professional experience could be communicated in a way other than by literal description for example as a colour, emotion, musical instrument, animal or song can you tell me what it would be?

What are the challenges for you professionally in this role?

ethical

nursing practice

professional

How have you managed these challenges? Illustration with real examples

"in your work do you come across women who are angry?; anxious?, quiet & 'going thru the motions'? - "What is about how you engage with these women that addresses their emotional/spiritual needs?"

What is that like for you?

What is it like for you personally (working in this area of nursing practice ?)

Environment / the clinic

Impact on your personal time

Impact on personal relationships *(BC eg is finding people confiding secrets to me)*

Self

If your personal experience could be communicated in a way other than words for example as a colour, musical instrument, animal or song can you tell me what it would be?

What challenges have you experienced personally in this role?

How have you managed these challenges? Illustration with real examples

Is there anything else you think is important to tell me about your experience that has not already been covered?

Appendix 11 Participant Interview Reflection

REFLECTION for xxxx xx/x/13

We have completed an hour and a half of interview about your experience as a nurse working in abortion care. This guided reflection is designed to facilitate evaluation of the interview. It is an exercise in self-reflection and the last question is a format for providing me with feedback arising from your reflections.

Could you say there is anything you have learned?

.....

What has it felt like thinking and talking about your experiences?

.....

Was the experience what you were expecting? If so - in what ways? If not – in what ways?

.....

Do you have any feedback you wish to give me or suggestions for me to consider for future interviews?

.....

Thank you for your time and contribution and for returning your feedback to me in the stamped addressed envelope or via email.

Brigid Coombe

16/8/13

Appendix 12 CPD Certificate for Interview Participation

Appendix 10

Nurses in abortion care

Certificate of Participation in Research Interview

This is to certify the participation of :....., RN

in an in-depth, interactive interview with me for the first stage of a research project about the experience of nurses providing abortion care.

The interview format included open ended questions and discussion about the nurses professional and personal experiences of working as nurse providing abortion care. The interview concluded with reflection & evaluation.

This interview was conducted on .....September 2013.

.....

Brigid Coombe,

RN, GradDip NSc

/9/13

Cert Interview Participation

Appendix 13 Interview Reflection

Chart to map KPIs for interview effectiveness

explore the reasons why nu choose to work in an abortio service *(travel around, discover, walk aro look at, search, investigate, go int the sights, survey, open up, delve Oxford (Verb) Inquire into, investi examine.*	**illuminate** the nurses' expe of nursing in an abortion ser light up, light, illumine, shed light floodlight) – Oxford (Verb) Light u make bright,Give spiritual or intell light to; help to explain;shed light Decorate with lights(buildings) de (initial letter in a manuscript) with (silver & brilliant colours)	**explore** the personal and professional challenges the wo presents. *(travel around, discover, walk aroun at, search, investigate, go into, s sights, survey, open up, delve into) (Verb) Inquire into, investigate, exami*
Work focus in reprod & sexual health/ abortion advocacy Community, primary health care principles Counselling quals and work.	Rewarding Women readily express thanks. Also witness a change as woman feels less anxious. And home safe.	Sisters. Doesn't expect her nun sisters to understand but does expect other sisters to & so frustrated when they dont'"get it'
Circle – way of describing her work at the clinic – as in full circle " where it was all leading me"	Privileged because able to work in her preferred way – 'just talking to women' "Non traditional" nursing "what is nursing?" – conversation started.	Friend – 'not cos u want to – just cos the hours suits' Compromise – not only my friend – friend of the family – hard to make an issue of her attitude to my work. Women keeping the peace!
Inspired by doctor colleagues who had worked with women before law reform and been active in law reform and improving women's access (including Stefania)	Comfort in face of anxiety / anger of women. " we are here to alleviate their anxiety as best we can – kindness and information. Working out what is the problem? What is she feeling anxious about – it may not be the abortion.	Work meeting – change in attitude – worry about how that is going to affect her ability to achieve goals in this aspect of her work
	Essential skills of observing, assessing, getting to what is really going on.	Photographed by protestor leading to changed approach to work car park
	Importance of team work in particular needing to understand that a woman may require longer attention at some point along her journey.	Busy / balance women's needs for emotional support with staff availability - -getting social work to assist if nursing demands pressing.
Saw the sights, opened up and walked around	Lit up – need to use reflection, including intellectual reflection to 'make bright' work harder to "help to explain"	Opened up and walked around – ? did I examine, delve into enough??

Appendix 14 Confidentiality Agreement for Transcription of Interviews

Appendix 12

Interview Transcription

CONFIDENTIALITY AGREEMENT Between BRIGID COOMBE & KELLY BROADBENT

I understand that the audio taped interviews I am transcribing are undertaken as part of a research project and that in accordance with The National Statement on Ethical Conduct in Human Research the interviewees and organisation they work for have been guaranteed privacy and confidentiality.

I agree to maintain the confidentiality and privacy of the transcribed material and delete all files from my computer when the transcription has been returned to the researcher.

.....

KELLY BROADBENT

Date: .....

.....

BRIGID COOMBE

Date: .....

.....

Witness Signature & Date

.....

Witness Name (please print)

NOTE:
This appendix is included on page 123 of the print copy
of the thesis held in the University of Adelaide Library.

THE QUEEN ELIZABETH HOSPITAL

CONSENT FORM 2
INTERVIEW TRANSCRIPT & WORKSHOP CONTACT

Title: The subjective experience of nurses providing abortion care in a specialist clinic setting

Protocol Number: HREC/13/TQEHLMH/120

INTERVIEW TRANSCRIPT

I have read the transcript of my interview and agree to its use

with no changes / the changes as marked **(please circle)**

PARTICIPANT SIGNATURE: ..... **DATE** ...../...../.....

Print Name.....

WORKSHOP

I understand that there is a workshop planned later in this research project and I agree to the researcher contacting me with specific information about the format and details for the workshop closer to the time.

I prefer to receive the information by email / letter **(please circle)**

PARTICIPANT SIGNATURE: ..... **DATE** ...../...../.....

**NB 2 SIGNED COPIES TO BE OBTAINED.*

The participant should keep one copy of the consent form and forward the other copy to the researcher with any changes to be made to the interview transcript.

Appendix 17 Workshop CPD certificate

Nurses in abortion care

Certificate of Workshop Participation

This is to certify the participation of :....., RN

in the second stage of the research project about the experience of nurses providing abortion care.

This second stage of the project was conducted as a 2 hour workshop on Friday 27th September 2013.

The workshop introduced participants to the theoretical and methodological aspects of qualitative and feminist research.

Using this background the participants contributed to an interactive and reflexive discussion of the findings I had drawn from the interview data.

The participants input from this workshop will inform the report of the study findings.

.....

Brigid Coombe,

RN, GradDip NSc

27/9/13

Cert Workshop Participation