EXPLORING ABORTION EDUCATION IN UNDERGRADUATE NURSING PROGRAMS IN GEORGIA

by

KIM HUDSON-GALLOGLY

(Under the Direction of Lorilee Sandmann)

ABSTRACT

According to the National Right to Life (NRL), the pro-life organization, and National Abortion Federation (NAF), the pro-choice organization, there were 1.2 million abortions in the United States in 2009. Shotorbani, Zimmerman, Bell, Ward, and Assefi (2004) contend that surgical abortion remains one of the most common surgical procedure for women of reproductive age. Further, Guttmacher Institute (2011) estimated 1.21 million was performed in the United States in 2009. According to the Centers for Disease Control (CDC) there were 28,440 residents of Georgia who obtained a legal abortion (2008). Considering the numbers of abortions performed in the United States and Georgia, nurses need to be educated about caring for women who seek abortion.

Little is known about instruction related to abortion in nursing curricula. This quantitative study investigated educational practices and factors that may impact the inclusion of abortion content. A 32-item questionnaire was developed to measure three foci: *Program Practices, Accommodations,* and *Contextual Factors* related to nursing education about abortion. The survey was administered online and via telephone to the

women's health educator from each accredited pre-licensure nursing program in Georgia. Of the 34 such schools, 22 schools (64.7%) participated in the study.

Data analysis showed that 77.3 % of Georgia nursing educators provide content about surgical abortion in the classroom; 61.9% % did not provide an alternate assignment (accommodation) for the content. "Time to teach" was identified by 70 % of faculty respondents as the primary factor impacting inclusion of abortion- related content in the curriculum.

INDEX WORDS: abortion, abortion education, nursing education, nursing curriculum, adult education

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DEDICATION

This dissertation is dedicated

to my

loving husband

Paul Gallogly

who has supported me

through *the process*.

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I owe this accomplishment to many individuals' support, encouragement, and knowledge. A special thanks to Dr. Lorilee Sandmann, my advisor and committee chair, for her guidance and *patience* throughout this journey – better known as a *process*. She kept me focused when I found it difficult to focus.

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CHAPTER 1

INTRODUCTION

Background of the Problem

As the direct result of the Supreme Court decision on abortion and increasing acceptance of this procedure, abortion instruction in the classroom has become more significant. In 1973, the *Roe v. Wade* decision established a constitutional right of all women to an abortion during most of the pregnancy (Colin, 2003). Before 1970, most states enacted laws prohibiting abortions. Since that time, movement to reform or repeal statues began in the 1950s, with advances slowing through the 1960s, and then finally *Roe v. Wade* in 1973 (Jost, 2003). Abortion has been practiced in every society throughout history (Ehrlich & Ehrlich, 1972; MacLauren, 1990; Riddle, 1992). There has always been a tendency to influence fertility practices by either increasing or decreasing conceptions and births (McLauren, 1990). To comprehend the relevance of abortion education, we must first understand the significance of the data reported by governmental agencies and the implications for nursing education and practice.

Abortion is one the most common surgical procedures in the United States (Tausig, 1939; Shotorbani, Zimmerman, Bell, Ward, & Assefi, 2004). In 1939, one in every five pregnancies terminated in voluntary abortion, with a total of 700,000 interruptions of pregnancy annually in the United States (Taussig, 1939). The National Abortion Federation (NAF) found that in 2006 in the United States, one of three women will have an abortion by age 45 (National Abortion Federation, 2009). According to the

National Right to Life (NRL), there were 1.2 million abortions in the United States in 2008 (National Right to Life, 2010; Guttmacher, 2011)). The Guttmacher Institute (2011) found that nearly half of all pregnancies among American women are unintended, and four in 10 of these are terminated by abortion. Further, about half of American women will have experienced an unintended pregnancy by age 45 - and at current rates, more than one third will have had an abortion (Guttmacher, 2011). Research has also validated that it is not a one-time event. About half of all U.S. women having abortions today have had one previously (Cohen, 2007, Guttmacher, 2011). The preponderance of evidence validates that abortion is and has been practiced in every society of recorded time.

The numbers are overwhelming, yet there is limited research on abortion and nursing education. Foster, Polis, Allee, Simmonds, Zurek, and Brown (2006) conducted a national survey of abortion education in nurse practitioner, physician assistant, and certified midwifery programs. The study was undertaken to examine abortion education in accredited programs of advanced practice. These researchers found a deficiency in abortion instruction in advanced practice education. With abortions provided so frequently, it is critical to examine what professionals are teaching about abortion. Also, it is equally important to determine the factors that may impact the inclusion of abortion as part of the reproductive curriculum.

The impetus of this research is my personal experience, both as a nurse and as a nurse educator. As a registered nurse who pledged to deliver care without bias or judgments, I have witnessed refusal of care and failure to provide reproductive options. As a nurse educator, I have participated in the removal of abortion content from the curriculum.

In 1993, I was working in the labor and delivery unit of an urban hospital in central Georgia. A patient admitted to the unit had chosen to terminate her pregnancy because it was medically determined that the fetus had multiple anomalies incompatible with life. In this hospital, the patient is given the option of terminating the pregnancy at that time or carrying the fetus to full term. The decision was not an easy one to make, but based on the prognosis of the pregnancy, the patient chose termination. Several nurses refused to care for the patient due to their attitudes regarding abortion. As a result, the woman lay quietly in a recovery room alone while nurses argued in the hallway about who was going to care for her.

In another situation, a patient presented to the health care clinic with an unintended pregnancy. I was a nurse practitioner student, and my preceptor was a women's health nurse practitioner with 10 years of experience. As she advised the patient of her options, she did not present information on abortion. The patient was visibly upset with the news of an unintended pregnancy. She had two children at home and was still breastfeeding her nine-month-old daughter. We left the room to locate pregnancy information. I chose this time to discuss with my preceptor the lack of choices she proposed to the patient, specifically information on abortion. She stated it was against her religious beliefs to discuss this option. Further, she stated that her contract did not oblige her to provide such information. However, she did allow me to discuss the option with the patient, but she chose to remain outside the room while I discussed all options with the patient including: (a) parenting, (b) adoption, and (c) abortion. I taught in the family nurse practitioner program at a university in north Georgia. As a faculty member and women's health nurse practitioner, I was allowed to develop the syllabus and adjust the

content as warranted by both current literature and scope of practice. The women's health component of the family nurse practitioner program included several content areas for the student to research; for example, domestic violence, lesbian care, and care of a woman undergoing an abortion.

The care of the client undergoing an abortion was an option for students to choose and present. A faculty member felt the content was too controversial and should not be included in the curriculum. Removing the content removed the discourse and the opportunity to provide detailed information on the care of a client who undergoes a therapeutic abortion while taking away my academic freedom as an educator to teach content that I felt was essential for the nurse practitioner student and a violation of academic freedom. Students lost a learning opportunity, and my voice was silenced.

Education is the key to positive discourse within the profession. As noted in the American Nurses Association (2001) code of ethics nurses are expected to "practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems "(p. 4). Without instruction on abortion, nursing students will be ill prepared to care for the thousands of women who seek an abortion each year in the United States.

Statement of the Problem

Abortion in all societies lies at the crossroads where political, social, and religious forces interact and intersect. The values of the individuals occupying positions of power (for example, nursing educators) would apparently color the abortion issue (Price-Bonham, Santee, & Bonham, 1975). Allowing attitudes, politics, and religion to influence

decisions regarding what is and is not taught in the classroom presents a social problem nurse educators should recognize. Adult education has long been the foundation for shaping attitudes, spreading knowledge, developing skills, and increasing information literacy. As adult educators, nursing faculty are charged with ensuring that nursing students are knowledgeable, experienced, and have had opportunities reflecting on informed professional practice. The language that we use in the classroom can impact the validity of the content.

Westen, Greenberg, Bocian, and Shreffler (2008) suggest that we need to change the way we talk about abortion, creating a menu of well-tested, principled strands - strands that can withstand the scrutiny of politicians and educators and used in different situations. These authors provide many examples of developed principles strands on the topic of abortion, dependant on individual values. Their research indicates that the language used to discuss this volatile topic can impact the outcome of the educational experience. Faculty members are challenged to ensure that the content is introduced in a manner that allows for a full and informed examination of the issue.

The literature is not extensive in regard to undergraduate nursing education and abortion. A study by Olson (1982) revealed a lack of an abortion curriculum in undergraduate programs. AbortionAccess and Association of Reproductive Health Professionals (ARHP) have developed scientifically sound curricula for use in both undergraduate and graduate programs. Foster (2006) determined that the curricula is not being utilized in advanced-practice programs (Foster et al., 2006); therefore, it is important to understand why it is not being utilized. This study seeks to address the gaps in abortion education, determine the level of instruction nursing students receive in their

undergraduate educations in Georgia, and provide understanding of the contextual factors that impact abortion instruction.

Three million women each year have unintended pregnancies, and 40 percent elect to have a therapeutic abortion. Foster et al, (2006) further determined in her research that advanced practiced professionals were not being taught the abortion content. As already discussed, three million women each year have unintended pregnancies, with 40 percent electing to terminate, Identified barriers include: (a) lack of faculty qualified to teach reproductive options, (b) fear of anti-choice backlash, (c) the absence of appropriate curriculum, and (d) attitudes of nursing faculty. It is important to understand whether these barriers are influential in undergraduate nursing education programs, as well.

The Reproductive Options Education (ROE) consortium and Massachusetts General Hospital Institute of Health Professions (MGHIHP) are presently working to address the gaps in reproductive options curricula in nursing programs across the country. Developing and designing standardized curricula based on research will provide nursing students with the grounded research knowledge base to adequately address the physical and psychological needs of the patient who undergoes an induced abortion. This research will provide a foundation for curricula development while understanding the contextual factors that influence instruction, creating an opportunity for discourse within the profession as well as the tools to develop scientific-based curricula.

Purpose and Research Questions

The purpose of this study is to better understand the extent and nature of abortion education experienced by undergraduate nursing education students in the state of

Georgia. In order to understand what nursing education students in Georgia experience, three central questions guide the study

1. What is the current status of abortion instruction in undergraduate nursing education programs in Georgia?
2. To what extent do nurse education programs make accommodations for students who have a moral or religious objection to instruction on abortion in Georgia?
3. To what extent do contextual factors explain the level of abortion instruction in undergraduate nursing education programs in Georgia?

This study examined these questions through a survey of nursing educators in Georgia.

Significance of the Study

Nurses potentially encounter patients in a variety of settings who have an unintended pregnancy, have a history of an unintended pregnancy on their health record, or are seeking advice for reproductive options. It is not only the nurse who is working in a practice setting where abortions are performed who needs knowledge, a value set, and skill related to abortion and its implications in a woman's life. For this reason, instruction on abortion is relevant for all students of nursing.

There is limited research related to instruction about abortion in nursing curriculum in this country, particularly as it relates to the pre-licensure nursing student. Since the current incidence of abortion is 1.2 million yearly in the United States (Guttmacher, 2011), a dearth of research is concerning. The current study proposes to investigate the extent to which instruction on abortion is included in pre-licensure nursing

education. This information will show how nurses are being educated on content relevant to many areas of practice.

Any empirical study of education demands a theory base. For this study, critical theory was used as the theoretical framework.

Significance for Theory

Adult education has long been a forum for social reform change. According to Darkenwald and Merriam (1982), adult education "is a process whereby persons whose major social roles are characteristic of adult status undertake systematic and sustained learning activities for the purpose of bringing about changes in knowledge, attitudes, values, or skills" (p. 9). As a result, a referendum for change in the way nursing education operates is validated by several key factors. Critical pedagogy serves as the framework to bring about the needed changes in knowledge, attitudes, values, and skills.

In nursing education, critical pedagogy can facilitate freedom for individuals and allow us to define what knowledge is, how we know, and who provides the evidence. Critical social theory can assist nursing education by promoting a caring and humanistic approach to research and practice. If nurse educators begin the analysis of how and why certain assumptions guide their actions in theory and practice, they can begin to describe and explain oppressive effects on society and their role in that oppression. Critical theory uses oppression as a springboard or tool to transform the individual or the society. It is an approach in which knowledge is valued, and that value is derived from dialogue. It allows rational discourse to transform educational practices.

The concept of critical theory refers to the nature of a self conscious critique and to the need to develop a discourse of social transformation and emancipation with a

willingness to change (Giroux, 2003). Merriam and Brockett (1997) consider the critical viewpoint to be one that sees capitalistic and democratic perspective as flawed. Further, a critical theorist "holds that change can best occur when the existing system is abandoned and replaced with a different perspective" (p. 43).

The most notable proponent of this radical position was Paulo Freire who maintained education can be used to effect radical change in society leading to empowerment and action. Critical theory has challenged our thinking and forced us to consider the effects of thoughtful dialogue and the ability to raise our consciousness.

Critical theory recognizes the implications of reflection and action. Mezirow (1981) and Brookfield (1987) propose that adult learning should be about the development of critical thinkers who examine the assumptions of this world, and then set out to empower and transform that world.

Significance for Profession

The National League for Nursing Priorities for Nursing Education Research challenges educators to (1) increase their pedagogical literacy to meet the challenges of a changing world and (2) to develop research-based pedagogies for nursing (2001). These challenges are a result of a renewed interest among nurse educators in developing pedagogical strategies that reflect the changing world. Pre-service nursing education does not offer courses on how to teach - only how to practice. For the most part, nurses are recruited as educators solely based on their clinical expertise rather than on their ability to teach in the classroom. If you are recruited to teach, you tend to mimic the pedagogical process you were exposed to - without regard to the numerous theories. As a result, nurse

educators rarely are compelled to reflect on various pedagogic practices. This deficiency results in a gap in knowledge and practice.

As a profession, the American Nurses Association (ANA) code of ethics provides the framework for ensuring patients are recognized for their worth and uniqueness. Nursing has a long history of caring for the sick, injured, and the vulnerable - effecting social change. It is expected that independent and individual nurses will act to change social structures that detract from health and well-being (ANA, 2001).

The code of ethics provides direction for many provisions within the broad topic of ethics, but two provisions are distinctly related to abortion. First, nurses should practice with compassion and respect for the inherent dignity and worth of the individual, independent of their social or economic status, personal attributes, or nature of health problems. Second, the nursing profession is responsible for articulating values inherent in nursing and shaping social policy through political action, constituting a referendum for change within nursing education.

Significance for Nursing Education and Nursing Practice

There is limited research on abortion instruction in undergraduate nursing education. It is essential to determine the practice of the nursing educator with regard to providing abortion instruction. Further, do nurse educators in Georgia provide accommodations for students when this topic is addressed in the nursing programs, and lastly, it is important to determine what factors influence the lack of instruction? This research will also be useful to initiate dialogue within the profession. Nursing professionals who are inadequately prepared to care for patients who undergo an abortion put patients at risk. Educating the nursing student on the care of a woman undergoing an

abortion, therefore, should be an essential component of classroom instruction. Data from this research can contribute to positive discourse between the faculty and the student. Lastly, this research has implications for practice in the form of pre-professional preparation, continuing professional education, and curriculum development.

Curriculum demands by the educational program and the accrediting organizations place tremendous pressure on nursing education programs to provide comprehensive didactic content to the students. The demands of the accrediting organizations challenge nurse educators to cover the mandated content, but nurse educators are also daunted by the controversial nature of this subject matter. There is anecdotal evidence through personal experiences and observations that suggest abortion instruction is not provided in Georgia nursing education programs. The question becomes, "Why not?" With more than a million abortions yearly, the profession should focus on providing nursing education students in Georgia with reproductive curriculum that mirrors the expectations of the professional nurse.

As providers of care to women of reproductive age, nurses are very likely to encounter patients who have elected to terminate their pregnancy. All physical assessments include a woman's reproductive history as part of the annual physical examination. As such, nurses will be in contact with women who have had or may be planning an abortion. Failure to deliver accurate, scientifically based information to the patient can impede the nurses' ability to provide high-quality health services that meet the reproductive health care needs of the patient.

In more recent years there has been an attempt for health care professionals, primarily pharmacists, to deny health care services and prescribed pharmaceuticals,

specifically emergency contraception and birth control pills (Beal & Cappiello, 2008). This has become known as the professional right of conscience. When Roe vs. Wade was enacted in 1973 a limited version of the right of providers was established to protect the rights of physicians who chose not to perform abortions and sterilizations. This trend has been expanded from its original intent. The original intent was to protect pharmacists who did not want to dispense hormonal pharmaceuticals incongruent with their values or religious beliefs. Now the movement has extended to protect all health care professionals, no matter their position.

Beal and Cappiello (2008) determined data are lacking as to the extent at which advanced practitioners choose to limit contraception information, and or services based on personal, religious or ethical beliefs through use of the professional right of conscience clause. Expansion of this trend does not exempt educational settings. While its original intent was to protect professionals from being required to perform abortions, it is my fear that nursing educators may extend this clause to include the teaching of controversial reproductive content, producing a nursing professional who will perpetuate this social and political negligence in their perspective practice.

The ethical principles of respect for autonomy, beneficence, and fairness are integral to nursing education and the provision of nursing care (McCrink, 2010;Ulrich, et al. 2010; Vanlaere & Gastmans, 2007). In the recent book, Educating Nurses, A Radical Transformation (Benner, Sutphen,Leonard, & Day, 2010), the authors highlight the work of Sarah Shannon, an exemplary nurse ethicist and nurse educator. To meet the goal of preparing students to apply ethics in the provision of care, regardless of the dilemma, Shannon advises students to separate their personal feelings from their professional

responsibilities to the patient. Her advice" It is not about you, it's about the patient and the family. What you personally think doesn't matter, It's how you act professionally as a nurse that matters" (p. 174). This advice is given for all aspects of health care, including respect for women's decision making regarding unintended pregnancy.

Significance for Future Research

The research supports the incidence of abortion, and the lack of abortion research in nursing education mandates the importance of exploring the level of abortion instruction nursing students receive in their undergraduate education and understanding the contextual factors that influence abortion instruction. The review of literature demonstrates a potential gap in abortion instruction in nursing education with limited contributions from medicine and graduate nursing education. It is expected this study will be the impetus for future research at a national level.

Summary

While times have changed, the abortion controversy remains alive and permeates every sector of our society. Abortion is legal, but some women do not report abortion for fear of retribution. Most religious affiliations still denounce its place in health care and choice, but some religious women continue to seek abortion services. Professional programs remain restrictive in providing abortion curricula, yet it continues to be the most common medical procedure performed in the world. Educators must respond to this emotionally charged subject warranting self-evaluation and reflection.

Definition of Key Terms

Abortion : a medical term that describes the therapeutic or spontaneous expulsion of the embryo or fetus (Youngkin, 2004; Webster, 2011).

Undergraduate nursing education: comprises all pre-licensure nursing education that prepares the student to practice as a registered nurse.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study is to determine whether abortion instruction is provided in nursing education programs and to determine the factors that influence abortion instruction in undergraduate nursing education programs in Georgia. This chapter is divided into three sections to provide an overview of this topic.

The first and major section of this chapter will examine the historical perspective on abortion, violence surrounding abortion, and research on abortion - providing the reader with background information on this volatile topic. Then, the second section will explore attitudes toward abortion. Finally, the third section will provide an overview of current abortion curriculums and discuss factors that influence abortion instruction. Understanding the history of abortion practices in the United States will provide the backdrop for understanding the development of attitudes and personal beliefs which have influenced the educational practices in nursing education.

Abortion

To provide a conceptual map of the topic, the following review will be organized into five subsections including: (a) an historical perspective on abortion, (b) a definition of abortion, (c) the demographics of abortion, (d) abortion and legislation, (e) abortion and social injustice, (f) the violence of abortion, and (g) abortion research.

Historical Perspective of Abortion

Abortion was one of the most common surgical procedures performed in the United States in 1939 and continues to be in 2006 (Shotorbani et al., 2004). In 1939, one

in every five pregnancies terminated in abortion, with a total of 700,000 interruptions of pregnancy annually in the United States (Taussig, 1939). In 2009 in the United States, one of three women had an abortion by age 45 (NAF, 2009; Guttmacher, 2011). According to the National Right to Life web site, there were 1.2 million abortions in the United States in 2004, or 50 million since 1973. (National Right to Life, 2011). Abortion has a long and turbulent history in the United States, and the right to a safe and legal abortion is still being battled today.

Abortion has been performed for thousands of years, in virtually every society that has been studied (NAF, 2009). It was legal in the United States from the time of the earliest settlers. In the mid-to-late 1800s, states began passing laws that made abortion illegal. Motivations behind the strict laws varied from state to state. One reason why anti-abortion laws were enacted was fear – fear that the population would be dominated by the children of newly arriving immigrants, whose birth rates were higher than those of Native American women (NAF, 2009).

By 1859, abortion had become so prevalent that the American Medical Association (AMA) felt compelled to issue a position statement discouraging its use. The laws restricting its practice began to appear during this time, but prior to this period it was not illegal – and abortifacients were advertised in newspapers.

The single strongest force behind the drive to criminalize abortion was the attempt by physicians to establish for themselves exclusive rights to practice medicine. The physicians wanted to prevent untrained practitioners, including midwives, apothecaries and homeopaths, from competing with them for patients and income. The newly formed AMA felt that the best way to accomplish this goal – while remaining moral and ethical –

was to argue that abortion was both immoral and dangerous. By 1910, all but one state had criminalized abortion except where necessary – in a doctor's judgment to save the woman's life. As a result, legal abortion was successfully transformed into a physician-only practice (NAF, 2006; Regan, 1997).

As the decade closed, federal, state, and local government had abandoned its laissez-faire attitude toward women's reproductive rights. For the first time in American history, abortion and birth control were deemed criminal. Both supporters and practitioners were labeled as criminals. The AMA was lobbying to control and restrict the procedure, having a therapeutic clause added to the law that permitted physicians to perform the procedure to save the life of the mother. The law made legal access to abortion the physician's right, not the woman's right.

In 1973, the *Roe v. Wade* decision established a constitutional right of all women to an abortion during most of their pregnancies (Colin, 2003). Before 1970, most states enacted laws prohibiting abortions. Since that time, movement to reform or repeal statues began in the 1950s with advances slowing through the 1960s and then finally *Roe v. Wade* in 1973 (Jost, 2003). Public opinion usually sides with the mother's right to choose; however, violence sometimes erupts when a mother acts upon her rights as an individual and as a woman. Therein lays the division of a nation.

Abortion restrictions continue to gain legislative support, resulting in a variety of restrictions. Initially, *Roe. v. Wade* was the basis by which the constitutionality of state abortion laws was determined. However, recently the U.S. Supreme Court has begun to allow more restrictions on abortion.

On March 6, 2006, Governor Mike Rounds of South Dakota signed into law a ban on nearly all abortions in his state. The voters of South Dakota rejected the ban on two different occasions – first in 2006 and again on November 4, 2008. The ban would have prohibited nearly all abortions in South Dakota and threatened the lives and health of the women of South Dakota (Guttmacher, 2008). If the vote had carried in South Dakota, it could have set a potentially dangerous precedent for women across the world. Several states, including Georgia, have introduced similar bans, but they have been defeated in the legislature.

Planned Parenthood v. Casey (1992) established that states can restrict pre-viability abortions. Restrictions can be placed on first trimester abortions in ways that are not medically necessary as long as the restrictions do not place undue burden on women seeking abortion services. Now, the trend continues with many states having restrictions in place such as parental involvement, mandatory waiting periods, and biased counseling (NAF, 2009).

A federal law published by the George W. Bush administration vastly expands the rights of individuals and institutions to refuse to provide or assist in providing health care services, including abortion and birth control that is offensive to the individual's religious beliefs or moral convictions (Guttmacher, 2008). The legislation was expanded to allow health care providers the right to refuse information on topics and treatments that they may find offensive – including abortion and birth control but also services such as vaccination and blood transfusion. Lastly, this legislation would expand the definition of health care provider to include office assistants who may file insurance claims, draw blood, or schedule appointments.

State legislation since *Roe v. Wade* and *Doe v. Bolton* has sought to regulate and limit when and under what circumstances a woman may obtain an abortion. Current highlights of abortion regulation reveal: (a) 38 states require an abortion to be performed by a licensed physician, (b) 19 states require an abortion to be performed in a hospital or after a certain time in the pregnancy, (c) 18 states require the involvement of a second physician after a specified point in the pregnancy, (d) 36 states have gestational limits on abortion, (e) 14 states prohibit partial-birth abortion, (f) 17 states use their own funds for all or most medically necessary abortions and 32 states plus the District of Columbia prohibit the use of state funds except in the case of rape or when a woman's life is in danger, (g) 46 states allow for individual health care providers to refuse to participate in an abortion with 43 states allowing institutions the right to refuse to perform abortions, 16 of which limit refusal to private or religious institutions, (h) 17 states mandate counseling that may include the purported link between breast cancer and abortion or the fetus's ability to feel pain, (i) 24 states require a woman seeking an abortion to wait a specified time – usually 24 hours, and (j) 35 states require parental involvement in some form, ranging from two-parent consent to parental notification (Guttmacher, 2011).

While the Bush administration has diminished the rights of women across the United States, the Obama administration opposes this regulation and is currently in discussions to overturn the regulation (Guttmacher, 2008).

Definition

Webster (2011) defines abortion as the termination of a pregnancy after, accompanied by, resulting in, or closely followed by the death of the embryo or fetus. It is the spontaneous expulsion of a human fetus during the first 12 weeks of gestation

(Webster, 2011). By definition, abortion includes both the spontaneous loss as well as the therapeutic or induced loss of a pregnancy. According to Youngkin (2004), editor of current protocols for advanced practice in women's health, induced or therapeutic abortion involves the expulsion or extraction of the products of conception from the uterus by either medical or surgical intervention before the fetus or embryo is capable of living outside the uterine environment. Presently, there are two recognized types of voluntary abortion; surgical and medical.

Vacuum aspiration or suction curettage, also known as a dilatation and curettage (D&C), is the most commonly used surgical abortion method in the United States for pregnancies of 14 weeks gestation or less (Youngkin, 2004). It is done in an ambulatory setting such as a physician's office or clinic. The procedure is performed under local anesthesia or a para-cervical block, based on the physician's and patient's preference. Prior to surgery, the cervix is dilated by graduated instruments or by osmotic dilators (for example, laminaria). The products of conception are removed by suction evacuation. Curretage, or scraping of the uterine lining, is then performed to ensure the complete removal. Diagnostic ultrasound is then used to confirm that the uterus is empty. The procedure usually takes 10 minutes or less.

For pregnancies further along than 14 weeks, the procedure is referred to as dilatation and extraction (D&E) and is commonly used for second trimester pregnancies (Youngkin, 2004). Again, the procedure involves dilatation of the cervix with dilators or laminaria and the products of conception removed with specially designed forceps, followed by curettage, then suction. The procedure is carried out under local anesthesia.

In September 2000, the U.S Food and Drug Administration approved mifepristone to be marketed in the U.S., as an alternative for surgical abortion. Today medication abortion is provided by over 1,066 facilities, or 59% of abortion providers. Approximately 9% of these providers only offer medication abortion (Guttmacher, 2011).

Medication abortion requires the use of a substance such as prostaglandin E2 suppositories, 12-methylprostaglandin F2 intramuscular injection, hypertonic saline intra-amniotic infusion, intra-amniotic prostaglandin infusion, or hypertonic urea intra-amniotic infusion. These methods are generally referred to as instillation methods. Medication abortion, with the use of Mifeprex and Cytotec account for 17% of all nonhospital abortions (Guttmacher, 2011).

A common method of induced medication abortion involves the use of mifepristone or Mifeprex, also known as RU-486, followed by the administration of another prostaglandin (misoprostol or Cytotec). Mifiprex was approved for use by the Food and Drug Administration (FDA) in 2000. Mifeprex is an extremely potent oral antiprogestin. It blocks the action of the natural hormone progesterone, which prepares the lining of the uterus for the fertilized egg – maintaining the pregnancy. Without progesterone, the lining of the uterus will soften, break down, and bleeding will begin. Along with the Cytotec, which causes contractions of the uterus, the two agents interrupt the pregnancy at its earliest stage – which results in expulsion of the pregnancy (Youngkin, 2004).

Van de Walle (1999) studied the different practices associated with century-old practices of induced termination. In early Roman times, abortion was more frequently referred to as contraception than infanticide. In medical or pharmacological works,

abortifacients were often classified alongside love potions and treatments for the plague or syphilis. Products extracted from plants, such as rue, savin, and ergot, were administered orally or as pessaries – inducing menstruation or delivery. Savin, an extract of juniper, was used as an oral abortificent. Potts et al. (1972) states:

> Perhaps all that can be said of it is that no other therapeutic agent has been so widely used, for so specific a therapeutic purpose, and yet so little studied in animals and never once scientifically investigated in man or woman. (p. XX)

Abortion Demographics

The Centers for Disease Control and Prevention (CDC) is the national system for collecting data on induced termination. States have moved to adopt federal standards that aim to make data complete and comparable across state lines. However, even today there remains considerable variability among state laws, policies, forms, and systems, and this variability inevitably affects the CDC's capability to determine accurately the total number of abortions performed each year. This inability leaves the CDC with unanswered questions. Each state independently prepares a state reporting form that is sent to the CDC for monitoring. However, most states report inaccurately or provide incomplete information (Saul, 1998). While some data limitations may be intrinsic to abortion, the CDC's information is primarily compromised of the inequities of reporting in the states. For more accurate representation of the frequency and distribution of the incidences of abortion, standardized abortion reporting policies are needed.

Underreporting of past abortion experience is an issue today. A study conducted by *Family Planning Perspectives* (2006) found that the best way to obtain information about past experiences with legal abortion was via phone interviews. Some other

interesting findings included the following: (a) at a minimum, four million U.S. women have had illegal abortions, (b) U.S. Catholic women are as likely as Protestant women to obtain abortions, despite the strong opposition of the church, (c) women who attend church at least once per month are less likely to obtain an abortion, (d) higher socioeconomic status is associated with lower abortion rates among women younger than 35, (e) separated or divorced women are more likely that other women to have had abortions, (f) Democrats or liberals younger than 35 are more likely to have had an abortion than Republicans in the same age category, and (g) relatively few women who have had an abortion believe that they made a mistake.

Guttmacher Institute (2011) reported each year, two percent of women aged 15-44 have an abortion; half have had a least one previous abortion. Forty percent of pregnancies among white women, 69% among blacks, and 54% among Hispanics are unintended. Guttmacher (2011) also reported in their latest publication, *In Brief,* that 18% of U.S. women obtaining abortions are teenagers; those aged 15-17 obtain 6% of all abortions, teens aged 18-19 obtain 11%, and teens under the age of 15 obtain 0.4% of all the abortions. Women in their twenties account for more than half of all abortions performed, and women aged 20-24 obtain 33% of all abortions with women aged 25-29 accounting for 24% of all abortions performed. Further, 37% of women obtaining an abortion identify as Protestant and 28% identify as Catholic.

In Brief also stated that women who have never married and are not cohabitating account for 45% of all abortions, while 61% of abortions are obtained by women who have one or more children. In addition, 42% of women obtaining abortion have incomes below 100% of the federal poverty level which is currently $10,830 for a single woman

with no children. Additionally, 27% of women obtaining abortions have incomes between 100-199% of the federal poverty level.

Women give many reasons for undergoing an abortion underscoring their level of understanding of the responsibilities of parenting. Many of women cite concern for or responsibility to another individual while others cite they cannot afford a child. Others state that having a baby would interfere with work or school, and others state they do not to be a single parent or they are having trouble with their husband or spouse.

In Georgia the abortion rates have increased since 2003 from approximately 35,000 per year to 40,000 per year. Georgia has remained below the national trend with approximately 17 abortions per 1000 women aged 15-44. The national level is approximately 20 abortions per 1000 women aged 15-44.

In Georgia, the number of abortion providers has dropped since 2005 from 35 to 31. The national trend remains stable. Between 2005 and 2008 the number of providers was reported at 1,787-1,793 nationally. Eight-seven percent of all U. S. counties lacked an abortion provider in 2008 and 35% of the women live in those counties. Providers vary in what services they provide early termination vs. late term termination. Forty-two percent of providers offer very early abortions and 95% offer abortion at eight weeks from the last menstrual cycle. Sixty-four percent of providers offer at least some second-trimester abortion (13 weeks or later) and 23% offer abortion after 20 weeks. Of all providers who offer abortions, only 11% offer abortions at 24 weeks (Guttmacher, 2011).

Abortion and Legislation

On January 22, 1973, the U.S. Supreme Court legalized abortion in the infamous *Roe v. Wade* decision. Since that time, numerous issues have been raised to disrupt the

decision. In 1976, Congress adopted the first Hyde Amendment barring the use of federal Medicaid funds to provide abortions to low-income women. Legislatively, it was relatively quiet in the 1980s; nevertheless, violence erupted and the United States was faced with chaos and violence.

The 1990s brought about several legislative issues. In 1991, *Rust v. Sullivan* upheld the constitutionality of the 1988 gag rule that prohibited physicians and counselors in clinics that received federal funding from providing patients with information about and referrals for abortion. In 1992, *Planned Parenthood of Southeastern Pennsylvania v. Casey* (NAF) reaffirmed the core principles of *Roe v. Wade* that "women have a right to abortion before fetal viability, but allows states to restrict abortion access so long as these restrictions do not impose an 'undue burden' on women seeking abortions" (p. 3).

According to NAF (2006), the Freedom of Access to Clinic Entrances (FACE) Act, passed by Congress in 1994 with a large majority, was in response to the murder of Dr. David Gunn. Dr. Gunn was a physician who provided abortion services. He was the first to be gunned down in protest against abortion. The FACE Act forbids the use of "force, threat of force, or physical obstruction" (p. 3) to prevent someone from providing or receiving reproductive health services. The law also imposes penalties for criminal and civil acts of violence.

Stenberg v. Carhart ushered in the twenty-first century. This case ruled that the Nebraska statute banning so-called partial-birth abortions is unconstitutional for two reasons: the statute lacks the necessary exception for preserving the life of the mother; and the definition of the targeted procedures is so broad as to prohibit abortions in the

second trimester, thereby being an "undue burden" on women. This invalidated 29 of 31 similar statewide bans (NAF, 2006).

In 2003, Congress passed and President Bush signed into law a federal ban on abortion. However, NAF immediately challenged the law in court and was successful in blocking enforcement of the law for its members.

Social Justice

Nursing has a distinguished history of concern for the welfare of the ill, injured, vulnerable and for social justice (ANA, 2001). Nursing encompasses the prevention of illness, and the alleviation of suffering of all individuals, groups or communities. The profession of nursing acts to change those aspects of social structures that detract from health and well-being, protecting the social justice of all individuals, groups or communities.

In 1939, Taussig wrote that cases of voluntary abortion are understandable when the "forceful interruption" of pregnancy is justified when the continuance of the pregnancy will bring harm to the mother (p. 859). Taussig continued, "On the other hand. it happens only too often that instruments and drugs are employed without medical reasons of this kind. In the unmarried, it may be done to conceal the fact of illicit sexual relations; in married, poverty, unhappy family relations, or too many children are some of the reasons that incite the pregnant mother to resort to abortion. Usually, a physician or midwife is employed for this purpose, but occasionally, among the poorer classes; the woman herself employs some instrument to attain this end" (p. 859). At this time in the United States, voluntary abortion was illegal except under special circumstances (when the life of the mother was threatened either medically or psychologically).

According to Belsky (1992), in the years before *Roe v. Wade*, most states had laws prohibiting abortion unless a pregnancy was life threatening – and a mother's potential for suicide was considered a life-threatening situation in which it was legal to obtain an abortion. However, if the woman did not have insurance, she was not eligible to seek this option. Belsky's study revealed that between 1940 and 1954, there were more than 7,000 incomplete abortions treated at Bellevue gynecology in New York City. Of the reported cases, 2,500 had signs of infection, with 22 cases resulting in death of the mother. Several cases were examined in detail: two women admitted using a catheter to induce an abortion; three attributed the abortion to a fall; and one to a child jumping on her abdomen. It was also reported that ingesting quinine and other unidentified medications was also used to induce abortion (Belsky, 1992).

Other methods employed to induce abortion included ineffective folk remedies and the insertion of foreign bodies and/or instruments or irritating solutions into the uterus or vagina. Roemer (1998) looks at abortion through the accounts of Leslie Reagan, who wrote *When Abortion Was A Crime* – reviewing the history of abortion from 1867 to 1973 – and Cynthia Gorney, who wrote *Articles of Faith* (reviewing the history of abortion from 1968 to 1998). According to Roemer (1998), Regan described how the criminal abortion system worked in 1867 to 1973:

> Every city had one or more abortionists, who were physicians, midwives, or completely untrained persons. Most women were referred to these practitioners by a physician who received a payment, usually about $15, from the abortion provider, one-third of which was paid for protection from the police (p. 502).

Although there were 14 states that enacted reformed abortion laws permitting abortion on specific grounds, most women who found themselves in this situation did not meet the criteria. As a result, the desperate women confronted with an unintended pregnancy resorted to knitting needles, crochet and button hooks, hairpins, scissors, and even a bone stay from a corset to induce a pregnancy loss. Socioeconomic reasons such as poverty, the inability to care for children, a husband's illness, and unemployment also led women to resort to unsafe methods (Roemer, 1998). These accounts offer a glimpse into how women of this time chose to end their pregnancies: clandestinely and violently.

Some women sought abortions not because they were raped or poor but because they feared they would be beaten by their husbands who reacted with rage when they learned they were pregnant. Regan (1970) wrote about one woman who wrote a letter seeking help from Margaret Sanger, begging her to help her obtain an abortion: " I am a poor married woman in great trouble … having another baby, he will beat the life out of me" (p. 41). She promised to pay for the help received, inferring she would rather starve a couple weeks to save money for the abortion. The literature reveals hundreds, if not thousands, of stories such as this one – stories of desperation.

Abortion rights advocates praise the landmark guarantee of what they call a "woman's right to choose." Anti-abortion groups bitterly protest *Roe v. Wade* and defend what they call the "right to life of the unborn child" (Jost, 2003). Proponents of the two sides feel they protect the rights of the individual, whether the individual is the mother or the fetus.

The current debate about abortion rights is not without historical significance. History indicates that states have exerted varying degrees of control over the supply of

abortion services. The *Roe v. Wade* decision in 1973 *momentarily* evened that control by rendering states powerless to regulate access to an abortion (Gober, 1994). A study by Gober (1994) demonstrates the importance of supply factors as determinants of abortion rates in the 1980s. The variables studied included: (a) funding, (b) laws, (c) metro, (d) Jewish descent, (e) persistence, and (f) African Americans. The paper attempted to show that abortion rates of the 1980s can be enlightened by a geographic perspective. The likelihood that women will obtain an abortion varies across the country, state to state. If abortion and reproductive freedom offer new opportunities for women, this study suggested that the opportunities vary enormously from place to place, dependent on the variables studied (Gobel, 1994).

According to Davis (1985):

> … abortion is a world-shattering event in the sense that it arouses the best and worst in the human responses. It simultaneously offers a collective trigger for generating a new, more positive place for women in society, as well as allowing for absolute political control over entire populations (as cited in Gobel, 1994, p.230).

Violence of Abortion

On December 30, 1994, two abortion clinics in Massachusetts were raked with gunfire from a .22 caliber semiautomatic rifle, killing two employees and wounding five other employees. A 22-year-old male hairdresser was charged with the murders and assaults. On June 4, 1994, three men and two women methodically set about creating havoc and fear at a Milwaukee abortion clinic. They used elaborate constructions of chains, concrete blocks, and iron pipes to secure themselves to two cars blocking the

clinic entrance (Clark, 1995). In Atlanta in 1997, there was a bombing at a suburban family planning clinic. Six people were injured in the second explosion at the clinic where abortions were performed (CNN, 1997).

There have been more than 2,000 acts of violence against abortion clinics, including bombings and arson. Some clinics are built with bullet-resistant windows and 600-pound steel doors. Physicians wear bulletproof vests. These incidents are only a small sampling of the crimes that have occurred since *Roe v. Wade* gave women the right to choose. Every January 22nd, the two sides – pro-choice and pro-life – converge on the sidewalks of many clinics to protest. Sometimes the two engage in shoving matches, creating a war zone (Jost, 1995). The war is fought in the heartland of America with guns, bombs, words, and hostility toward one another.

According to Nice (1988), the controversy over abortion has produced political violence in the United States. The Federal Bureau of Alcohol, Tobacco, and Firearms, which has been the primary agency investigating abortion clinic bombings, reported that 30 bombings occurred between May 1982 and January 1985. This research article analyzed why political violence occurs. Nice (1988) asserts that when individuals are involved in a stable environment with strong group affiliations, such as church, clubs, neighborhood friendship groups, and so on, they tend to be less politically violent. When individuals do not have this strong affiliation, they tend to migrate toward violent behavior. He continued, "Abortion clinic bombings are heavily concentrated in states which have conditions associated with weaker social controls, higher abortion rates, and greater acceptance of violence toward women" (p. 178). Eight states were studied,

including Georgia. From this research, one must surmise that Georgia has weaker social controls, higher abortion rates, and a greater acceptance of violence toward women.

In 1994, Clark recounts several aspects of violence – and the chain of violence prompted U.S. Attorney General Janet Reno to assemble a task force to determine whether there is a criminal conspiracy among anti-abortion activists. Only a fraction of anti-abortion activists defend the extremist doctrine of "justifiable homicide," yet many protesters have intensified their disruption tactics in recent years – and it continues. Techniques used by anti-abortion protestors include: (a) clinic blockades, (b) flooding clinics with foul-smelling butyric acid, (c) putting glue in the locks of clinic doors, and (d) picketing abortion doctors' homes and harassing their children on the way to school. The most common of all occurrences at abortion clinics is protestors chanting on the sidewalks, offering impromptu counseling services, or rescuing the patient.

As a result of the protests, both peaceful and violent, the Planned Parenthood Federation of America (PPFA) – which operates nearly 1,000 abortion clinics – provides pregnancy services under armed guard in some areas of the country. Other clinics have metal detectors, bullet-proof glass, and 24-hour surveillance systems (Clark, 1996).

Research

Research on the physical and psychological aspects of abortion is extensive. In 1978, the *Digest* reported five studies that looked at the effects of abortion on subsequent pregnancies. The conclusion was as follows: "Legal abortion does not appear to have any deleterious effect on subsequent pregnancies, although dilatation and curettage (D& C) may be associated with several problems in later pregnancy (*Digest*, 1978, p. 34).

Another study authored by Udry, Gaughan, Schwingi, & van den Berg (1996) reviewed the inaccuracy in women's reports of their abortion histories. The study looked at 104 American women aged 27 to 30 in 1990 and 1991, and their self-reported abortion histories revealed that 19 percent of them failed to report one or more abortions (Udry, Gaughan, Schingi, et al., 1996). To provide quality health care for patients, reproductive health professionals need a complete medical history.

One of the most contested research areas in the abortion field is the study of abortion linked to the occurrence of breast cancer. A study conducted by Calle, Mervis, Wingo, Thun, Rodriguez, and Heath (1995) looked at an association between breast cancer and induced or spontaneous abortion. A large prospective study of United States adult women was studied. The study examined 579,274 women who were cancer-free at the time of the interview in 1982. After seven years of follow-up, 1,247 cases of fatal breast cancer were observed in the population studied – and no association or relationship was found between breast cancer and abortion (Calle, Mervis, Wingo, et al., 1995).

Another study by Wingo, Newsome, Marks, Calle, and Parker (1997) conducted a detailed review of 32 epidemiological studies that provided data by type of abortion and by various measures of exposure to abortion defined as the number of abortions, timing of abortion in relation to the first full-term pregnancy, length of gestation, and age at first abortion. This study concluded that breast cancer risk did not appear to be associated with an increasing number of spontaneous or induced abortions.

Abortion has long been associated with long-term mental health outcomes; however, a literature review article looking at 21 studies found that a clear trend emerged from the systematic review of the highest-quality studies. The findings were mostly

neutral, suggesting few – if any – differences between women who had abortions and their respective comparison group in terms of mental health sequelae. The studies with the most flawed methodology found negative mental health sequelae (Charles, Polis, Srinivas, Sridhara, & Blum, 2008).

Abortion is violent. The very word stirs emotions that most do not want to acknowledge or defend. If you are pro-choice, then you are perceived as a radical non-Christian, with no conscience. If you are pro-life you are perceived as a fundamental Christian, who owns the moral high ground on this issue. No one admits they are moderate on this issue, because the very name invokes hostility. It is customary to choose a side, but remain silent. The violent history has evoked silence and creates attitudes.

The violence of abortion is indisputable, influencing the lives, policy and health of women globally. According to Center for Reproductive Rights (2011), the health of women is in jeopardy. The international community has recognized that liberalizing restrictive abortion and investing in abortion safety, governments can save lives of tens of thousands of women each year. Violence is not the key to this dispute. Women will seek abortions, regardless of the consequences associated with the procedure, and if it is illegal, they will seek out practitioners who are not qualified and in doing so women can die from complications such as sepsis, hemorrhage, uterine perforation, infertility and reproductive tract infections.

Attitudes on Abortion

According to Chaplin (1968), attitudes are assumed to derive from "propaganda, suggestion, authority, business, religious, and educational institutions and other agencies

which seek to influence conduct" (as cited in Price-Bonham, Santee, & Bonham, p. 16). The following discusses attitudinal influence and the healthcare professional.

Rosen, Werley, Ager, and Shea (1974) conducted a nationwide survey on nursing, medical, and social work faculty and students' attitudes toward abortion. Nurses and nursing faculty were expected to be conservative. Many who worked with abortion clients in states where abortion laws were liberal often had negative attitudes toward abortion. Many disapproved of their patients' sexual behaviors and their failure to avoid an unintended pregnancy. Nursing faculty were most like society as a whole, although they had a considerably less-favorable attitude toward freely accessible abortion than did the general population.

Shotorbani et al. (2004) examines abortion-related attitudes of future health care providers attending a university and their intentions to provide abortion services in their practices. The conclusion of the study suggested it may not be possible to require abortion training for every future health care provider and that making abortion a standard part of clinical training would provide opportunities for future physicians and nurse practitioners and would ameliorate the abortion provider shortage.

Lawson & Miller (1996) investigated the influence of information from others on the correspondence bias in the attribution of attitudes. The participants were presented with an essay either for or against the legalization of abortion. They were divided into three groups: (a) received no information, (b) received an argument mentioning the target person's constraint, and (c) received behavior-inconsistent, prior information about the target from a "fellow classmate." The participants were then asked to estimate the constrained target person's actual attitude.

The results indicated that the correspondence bias was substantially attenuated by the constraint argument and was reversed by the prior information. In summary, the findings demonstrate that arguments from others may prompt perceivers to make an inferential adjustment to take into account the target's situational constraint – and that behavior-inconsistent, prior information from others may lead perceivers to assign greater inferential weight to that information relative to the behavior (Lawson & Miller, 1996).

Price-Bonham, Santee, & Bonham (1975) conducted a survey to investigate the relationship between clergyman's' demographic variables, socio-cultural attitudes, and their attitudes toward induced abortion. Analysis of the data indicated that the demographic variables were only slightly related to the attitudes toward induced abortion. In contrast, strong relationships were found to exist between the socio-cultural attitudinal variables and clergymen toward women and induced abortion. This study concluded that a prejudice or bias toward women or sex "could be expressed in a negative attitude which, in turn, could affect the clergy's attitude toward induced abortion" (p. 15).

Another study conducted by Rosenblatt, Robinson, Larson, and Dobie (1999) explored the attitudes toward abortion in first- and second-year medical students at The University of Washington. The study surveyed 286 first- and second-year medical students. The response rate was 76.6 percent. Women were slightly overrepresented among the respondents. A majority of the students supported the broad provision of reproductive health services, 58.1 percent felt that first-trimester abortions should be available, and 43.3 percent anticipated providing abortion services in their practice. The study concluded that despite continuing pressure on abortion providers, most of the students surveyed intended to incorporate this procedure into their practices.

Werley, Ager, Rosen, and Shea (1973) conducted a study evaluating health care professionals (student and faculty) and their attitudes toward birth control. The attitudes of health professionals regarding family planning must, at least partially, reflect what they have learned in the classroom. Therefore, the participants were chosen from professional schools in nursing, medicine, and social work. Across the groups surveyed, 85 to 94 percent agreed that abortion should be performed to terminate a pregnancy if the mother's life is in danger. Nursing respondents (both students and faculty) held that abortion should not be performed under any circumstances.

However, public opinion and attitudes have not changed significantly since legalization in 1973. Public opinion usually sides with the woman's right to choose an abortion but also supports restrictions on that right (Jost, 2003). According to Elizabeth Cavendish of the National Abortion Rights Action League Pro-Choice America (NARAL), "Abortion rights are in great peril" (as cited in Jost, 2003). When asking the public, "Would you describe yourself as being more pro-choice – supporting a woman's right to have an abortion – or more pro-life – protecting the right of the unborn children?" The results: 45 percent are pro-life, and 49 percent are pro-choice (Jost, 2003). More than 300 anti-abortion laws have been enacted since 1995, all in an effort to reduce the reproductive rights of women (Jost, 2003).

The silence has resulted in deeply seeded emotions that have resulted in attitudinal changes that have penetrated each sector of our society, creating a social injustice that has affected the very individuals who are charged with caring for the patient who undergoes an abortion, the professional nurse.

Abortion Instruction in Professional Health Care Curriculum

The majority of research on abortion instruction has been generated from medical education, but little from nursing education. The following literature review spans 20-plus years and provides an overview of the research that has emerged both from nursing and from medicine.

Medical School Curriculum

A study on abortion training of gynecology medical residents in the United States reveals similar findings as the previous study. In 1998, the National Abortion Federation (NAF) surveyed 261 accredited U.S. residency programs. Of the 179 programs responding to the survey, 81 percent reported that they offer first-trimester training –46 percent as core curriculum components and 34 percent as an elective. Respondents stated that while 26 percent of their programs indicated that all residents in their programs were trained, 40 percent said that half were not trained. Fifty-nine percent of the respondents reported that the operating room was the most common site for the abortion training (Almeling, Tews, & Dudley, 2000)

Castle and Fisher (1997) implemented abortion training programs in three free-standing clinics of a women's health care agency in a large U.S. city. The program was designed to address the growing shortage of health care providers trained and willing to perform abortions. The shortage of these trained providers has restricted a woman's access to an abortion. Since *Roe v. Wade*, abortion services have been found in free-standing ambulatory clinics outside the normal periphery of women's health (in other words, hospitals). As a result of this trend, abortion providers have been stigmatized or ignored by mainstream hospital-based or traditional academic obstetrician-gynecologists.

Abortion violence has caused physicians to be reluctant to train in this field. Against all odds, this project managed to train 60 physicians and two physician-assistants who were trained to perform first trimester abortions. This training was necessary to fill the gap in medical education.

Medical and nursing schools are faced with the challenge of presenting an enormous amount of material to their perspective student bodies. As a result, there are gaps in the curriculum –most often related to abortion education. Medical students from Brown Medical School organized a collaborative, multidisciplinary elective course to address the gaps found in their curriculum (Caro-Bruce, Schoenfeld, Nothnagle, & Taylor, 2006).

Medical students at the school identified curricular gaps in the areas of abortion, sexual assault, lesbian/gay/bisexual/transgender health, and HIV counseling. Clinical educators and community-based professionals provided guest lectures on these topics. The course included a half-day experience shadowing at a local abortion facility. Of the first- and second-year students, 37 percent enrolled in the elective and received credit for the course. Evaluations were positive toward the guest lecturers and resulted in a permanent change in the standards of the medical curriculum (Caro-Bruce, Schoenfeld, Nothnagel, et al., 2006).

Espey, Ogburn, Leeman, Nguyen, and Gil (2008) conducted a national survey to evaluate medical students' attitudes toward the inclusion of abortion education in preclinical and clinical medical school curriculums. The study included all students completing the OB/GYN rotation from May 2004 through January 2005 (a total of 118 students participated). The students were asked to complete a questionnaire of 21 items.

These questions focused on attitudes about the appropriateness of abortion education, reasons for participation or nonparticipation in abortion care, and the value of abortion education. Of the 118 who were asked to complete the questionnaire, 100 completed the survey. The results were as follows: (a) nearly all participants indicated that abortion education was appropriate in the curriculum, (b) 53 percent participated in a clinical abortion experience, (c) of those that participated, 84 percent felt it was valuable, (d) 73 percent would recommend the clinical to a friend, and (e) 74 percent of the students who planned a career in family practice and obstetrics/gynecology preferred the integration of the content into the curriculum.

A study by O'Connell, Jones, Simon, Saporta, Paul and Lichenberg (2009) discusses the aging of skilled practitioners which raises concerns about the future availability of surgical abortion. This study surveyed 289 facilities and found similar practices amongst their practitioners indicating similar education; however, they found that the respondents are aging and that there are inadequate practitioners to continue this service, which could lead to a public health crisis. The authors also reported that surgical abortion is one of the most common procedures performed in the United States, again bringing to question, if it is the most common surgical procedure, why is there a lack in both medical and nursing education?

Nursing Education Abortion Curricula

Abortion education is not traditionally a standard part of a nursing education program. This subject matter typically has been overlooked or inadequately covered in many health care professional programs, including nursing education (Beatty, 2000;

Foster et al., 2006; Ameling, Tews, & Dudley, 2000; Espey, Ogburn, Chavez, Qualls, & Leyba, 2005; and Simmonds, Foster, & Zurek, 2009).

Olson (1982) determined the essential components on abortion care. Essential components include: (a) legislation and impact, (b) describing and explaining types of abortion services, (c) identifying stressors and psychological needs of women seeking abortion services, (d) characterizing abortion attitudes, (e) developing care plans for the abortion method of choice, (f) discussing the positive role and conflicts of the health care team, (g) discussing current trends in contraception, and (h) demonstrating professional nursing care for women having abortions. An exhaustive literature review revealed little regarding undergraduate nursing and gaps in undergraduate nursing curricula on the subject of abortion.

Wong, Hockenberry, Wilson, Perry, and Lowdermilk (2006) discuss abortion in the chapter addressing infertility, contraception, and abortion. Four pages are dedicated to this topic. The authors include: (a) legal tips regarding the importance of understanding the laws of your state, (b) a nurse alert that states a nurse whose religious or moral beliefs do not support abortion has the right to refuse the assignment or request reassignment, (c) content-specific information regarding types of abortion, (d) nursing considerations that address the consequences of a woman's decision to herself and to others, (e) the importance of providing support to the woman, and (f) post-abortion grief counseling. All essential components identified by Olson (1982) were included. An important component of this chapter discussed an evidence-based practice research project that addressed differences between surgical versus medical methods of abortion in regard to pre- and post-operative pain, bleeding, and infection (Say, Kullier, Gulmezoglu, and Campana,

2002). Wong et al. (2007) provides the best overview for teaching abortion in the classroom, integrating basic concepts and evidence-based practice.

London, Ladewig, Ball, and Bindler (2007) discuss abortion in the chapter addressing pregnancy at risk. Four pages are dedicated to the care of the woman who undergoes a spontaneous abortion. The chapter does not address abortion as an induced or therapeutic option. In fact, abortion is only described as threatened, imminent, complete, incomplete, missed, recurrent, and septic. In medicine and nursing, these terms are primarily used to describe a spontaneous abortion or miscarriage.

Pillitteri (2007) discusses abortion in the chapter dedicated to reproductive life planning. Six pages are dedicated to the care of the woman who undergoes an induced abortion. Diagrams and charts highlight the surgical procedures. There are discussions of saline-induced abortions and partial-birth abortions, carefully explaining that partial-birth abortions are no longer legal in the United States. Pilliatari lists several key points for the learner. The first key states, "Reproductive life planning involves personal decisions based on each individual's background, experiences, and sociocultural beliefs" (p. 130). Wong et al. (2006) strength is the inclusion of evidenced-based research, but Pilliatari integrates the content in a chapter dedicated to reproductive life planning (which is the most appropriate place for this content)**.**

Orshan (2008) was recruited by Lippincott, Williams, & Wilkins to provide an outline of her fantasy textbook incorporating her experiences as an academic in maternity, newborn, and women's health nursing. The collective efforts to produce a book that provided an "innovative approach to nursing care of women and their families" (p. v) failed miserably in achieving its goal. Like London et al. (2007), Orshan addressed

abortion only in the "spontaneous" context. The author did not address the political, social, or cultural dimensions associated with an induced or spontaneous abortion.

Kish (1996) used additional handouts to provide didactic content on abortion. Olds was the author of the textbook used at that time, but it appears there was inadequate content on the subject of abortion; therefore, the professor used additional handouts to provide students with a comprehensive outline and curriculum on the subject. Kish (1996) defined abortion as the "purposeful interruption of pre-viable pregnancy" (p. 173). In the lecture notes, Kish considers the nurses' rights with respect to abortion to refuse if they have moral and religious beliefs that interfere with providing patient care. She also notes a woman's right to receive "non-judgmental supportive care that includes information on which she can make an informed decision" (p. 173). Also, an algorithm is included that illustrates the decision points in the abortion procedure process, demonstrating the different types of abortion procedures available.

The ethical principles are an integral part of nursing preparation and provision of nursing care. In Patricia Benner's recent book, *Educating Nurses, A Radical Transformation* (Benner, Sutphen, Leonard, Day 2010) the authors highlight the work of a exemplary nurse ethicist and nurse educator. To meet the goal of students to think ethically about taking care of patients, Shannon, the nurse ethicist, advises students to separate their personal feelings about patients from their professional responsibilities to them. "It is not about you, it's about the patient and the family. What you personally think doesn't matter. It's how you act professionally as a nurse that matters" (Benner et al, 2010, p 174). Shannon's sound advice applies to all aspects of health care, including how nursing students are educated, regardless of the instructional content.

Youngkin and Davis (2004), editors of an advanced-practice textbook, include the content of abortion in the chapter addressing control of fertility. All birth control methods are included in this chapter. Four pages are dedicated to the topic, with three additional pages dedicated to the discussion of abortion rights, emotional issues, and the challenges associated with the procedure – specifically, addressing reproductive freedom.

Simmonds, Foster, and Zurek (2009) found that the introduction of new content into a nursing curriculum can present significant challenges for nursing faculty. Abortion content is a subject of deep ethical, religious, and political controversy that warrants inclusion in the curriculum. Generally, education reform comes from a public health mandate, accreditation bodies, or from the insightful efforts of courageous individuals within the discipline. The Reproductive Options Education Consortium for Nursing (ROE) is a committee of individuals who work to improve abortion instruction in the nursing curriculum. The authors seek to highlight the challenges of abortion instruction in nursing education.

While this study is focused on undergraduate nursing education, the most current curriculum reform is taking place in graduate nursing education. Foster et al. (2006) conducted a national survey of abortion education in nurse practitioner, physician assistant, and certified midwifery programs. The study examines the inclusion of abortion education in accredited programs of advanced practice. The results are significant. Of 486 surveys mailed, 200 were returned. Overall, 53 percent of programs reported didactic instruction in the clinical curriculum on surgical abortion, manual vacuum aspiration, or medication abortion (Foster et al, 2006). Of those responding, 21 percent reported including at least one of three procedures in their curriculum (Foster et al, 2006).

Foster et al. (2006) states, “Of the approximately three million women who have unintended pregnancies each year, 60 percent continue the pregnancy, and the rest elect to have an abortion. In spite of the frequency of unintended pregnancy and abortion, many advanced practiced nursing programs do not adequately prepare students to care for these women. Factors such as unqualified faculty, fear of anti-choice backlash, and absence of appropriate didactic content have been identified as barriers to teaching this subject matter” (Foster et al., 2006). As integral components of women’s health care, abortion, pregnancy options counseling, and family planning merit incorporation into routine didactic and clinical education (Foster et al., 2006).

Another study initiated by Foster, A. Simmons, K. Jackson, and Martin (2008) looked at 67 accredited nursing programs in Massachusetts. This Web-based survey examined reproductive curricular adequacy and found that 48 percent of the programs responding provide instruction in abortion. The response rate for this study was 60 percent. The authors have a network within the Massachusetts College and university settings which has contributed significantly to the high response rate. This study, as well as others, has found that networking in the professional community has a significant impact in response rate.

Factors Which Influence Abortion Curricula

Two studies previously discussed in the literature review also studied the factors that have the potential to influence whether abortion instruction is included in the curriculum. The first study is by Foster et al. (2006) and evaluates the incidence of abortion instruction in advanced-practice settings. The factors studied included: not a particular curricular priority, religious restrictions prohibit instruction, no facility for

clinical experience, no faculty qualified to teach the content, administration of institution does not approve of the topic, and funding restrictions prohibiting instruction. The second study was by Espy et al. (2008) and surveyed physicians only. This study looked at which factors influence why the physician would not have offered patients elective surgical abortion. The factors studied included: (a) personal, religious, or moral beliefs against abortion, (b) a lack of training, (c) community and/or office attitudes against abortion, (d) concern for safety, and (e) no perceived need.

Summary

Abortion education is not a new phenomenon. Sauer (1974) reported that as early as 1839, Professor Hodge of the University of Pennsylvania saw it necessary to lecture on abortion because he felt it necessary to prepare the students for the "numerous requests they would receive" (p. 54).

It is now 2011, and according to this review of literature, there is no apparent consistency in curricula in U.S. nursing professional schools. As noted in this review, two textbooks do not acknowledge personal choice as it relates to abortion. A national survey concluded that 53 percent of advanced-practice programs do not provide abortion instruction. Furthermore, a review found that there is no research that provides information on undergraduate nursing education. This study serves to fill the gap in this area of research.

This review has found that of the research that has been conducted on abortion, its instruction has not been researched exhaustively. Rather, the research is focused on medical education, primarily addressing the lack of trained providers and the impact on public health.

Nursing education has chosen to remain almost silent on this topic, with very little scientifically based research in this area. There are numerous organizations, specifically ROE and the Association of Reproductive Health Professionals (ARHP), who are partnering to develop reproductive health competencies. Both these organizations have been tireless in their attempt to inform educators of current trends in abortion education. These competencies will then be presented to the accrediting bodies to ensure that the graduating nurse is competent in the area of reproductive health. This research has the potential to be useful in this effort by providing increased knowledge about current educational practices which will serve to guide the development of the competencies.

Through global discourse and research, educators across the globe understand the historical perspective of abortion, the legislation and policies that have shaped the legalization of abortion, and a respectful acknowledgement of the violence that continues to threaten legalization. Without the violence, the legislation, and the discourse abortion would eventually resort back to its earlier history of clandestine events threatening the health of women globally and impacting public health across the globe.

CHAPTER 3

THE METHODOLOGY

The purpose of this study is to better understand the extent and nature of abortion education experienced by undergraduate nursing education students in the state of Georgia. In order to understand what nursing education students in Georgia experience, three central questions guided the study:

1. What is the current status of abortion instruction in undergraduate nursing education programs in Georgia?
2. To what extent do nurse education programs make accommodations for students who have a moral or religious objection to instruction on abortion in Georgia?
3. To what extent do contextual factors explain the level of abortion instruction in undergraduate nursing education programs in Georgia?

The methodology study is organized into six sections: (a) measurement framework, (b) instrumentation, (c) study population and sample, (d) data collection, (e) data analysis, and (f) limitations.

Measurement Framework

While reviewing the literature on abortion education, very few studies were discovered describing the extent to which students in undergraduate nursing education received abortion instruction. Graduate nursing education has examined this topic, but it is limited. Medical literature reveals extensive writings on the subject of abortion

education. Current medical literature expresses the importance of training providers and exposing all medical students to the care of the woman undergoing an abortion. However, the review of the literature on abortion education in undergraduate nursing education is limited.

According to The Guttmacher Institute (2011), there are 1.2 million abortions in the United States yearly. Shotorbani, Zimmerman, Bell, Ward, and Assefi (2004) reported that surgical abortion remains one of the most common surgical procedures for women of reproductive age. Therefore, women who have abortions constitute a significant trend in medical care and warrant pre-service education as well as continuing professional education for health care professionals. However, evidence suggests abortion instruction is not included in the curriculum of many educational institutions.

While abortion remains a heavily debated topic in political arenas, it is in many ways an unknown terrain in nursing education. Over the many months of writing, reading, thinking, listening, and discussing, I experimented with different aspects of this politically charged subject to determine which themes would surface that would ultimately provide a foundation for questionnaire development. Three major foci surfaced as worthy of investigation: the educational practice of the nursing education programs in providing instruction on abortion and the contextual factors that influence the instruction of abortion in the classroom. Table 1 provides definitions of the three foci. For the purpose of this study, abortion education is defined as both the physical and psychological care of the woman undergoing an abortion.

Table 1

Definition of Foci for Measures

Name	Definition
Program Practices	Specific practices of undergraduate nursing education programs in providing instruction on abortion
Accommodations	Specific practices for students who have religious or moral objections to instruction on abortion
Contextual Factors	Factors that impact the inclusion of abortion education in nursing education programs

Instrumentation

In order to accomplish the purpose of the research study, a multi-faceted instrument was developed. This development involved 14 steps that allowed the development of instrument to measure the 3 foci.

With the 3 foci identified through a careful and methodical process of deliberation, it was time to use the concepts to develop items for the instrument. Over the course of this study, several variations of the instrument were developed to accommodate the research methodology. The final version of the survey instrument is available in Appendix A.

A variety of researcher-designed survey instruments were evaluated for use in the national survey. Espey, Ogburn, Leeman, Nguyen, and Gil (2008) and Foster, Polis, Allee, Simmonds, Surek, and Brown (2006) produced quality questionnaires that looked at similar Foci. Ultimately, the questionnaire developed by Foster et al. (2006) was modified for the purpose of measuring the three distinct foci: Program Practices, Accommodations, and Contextual Factors.

The Foster et al. (2006) instrument was an online, self-completion, confidential survey. It was designed to be completed by active undergraduate nursing educators employed by either public or private institutions in the United States. The nursing educators reported on their programs' practices regarding abortion instruction and the factors (personal and institutional) that influence instruction on abortion. Additionally, this study sought to evaluate the reproductive curriculum as a whole, rather than teasing out abortion instruction alone.

The following sections describe the multi-step instrumentation process including (a) development of the item pool for each foci (b) refinement of the item pools for each foci (c) selection of the response scale for each of the foci, (d) addition of background items, and (e) expert critique of the questionnaire.

Abortion in and of itself is a topic that is discussed extensively in literature, but abortion within nursing education is limited. It is very important in a dissertation to fully explore all research that would be beneficial in developing items to be used in construction development. Consequently, I sought to reach saturation by reviewing the literature on abortion in both medical and nursing education until I reached a point of repetitiveness of themes. I relied on the literature related to abortion, nursing education, and all related health professions that discussed abortion. I depended on experts from the Reproduction Education Options consortium to discuss their experiences on teaching abortion education, my own personal experiences, undergraduate nursing curriculum experts, nurse educators, nursing education students, and the drive to break the silence on this topic.

After completion of the literature review and interview/brainstorming sessions, the researcher collapsed the construct indicators into categories to assist in the identification of redundant and inappropriate items (Appendix B). Using the literature review, Foster et al. (2006) questionnaire, the Espey et al. (2008) questionnaire, and data collected from the expert panel, I eliminated semantic equivalents, retained the most appropriate inclusive items, and standardized the grammar of the survey. In addition, after each meeting with the methodologist and dissertation chair, I eliminated items from the item pool that were inappropriate for the study.

Over a six month period, the researcher developed and refined item pools for the separate measures of *Program Practices, Accommodations*, and *Contextual Factors*. I ensured content validity for all foci through a methodical and rigorous process of item generation described in detail in the following section. In addition, items generated were compared to the Foster et al. and Espey, et al. (2008) questionnaires for validity of themes and saturation on the topic.

Through each phase of the refinement process, I worked with her dissertation advisor, methodologist, nursing educators, and expert panel to refine the *Program Practices* pool from 61 to 12 items, *Accommodations* from 11 to 8, and the *Contextual Factors* collapsed from 161 to 14. The researcher continued to review the literature for additional foci, but none emerged. As a result, the researcher concluded that she had reached saturation on this topic. Table 2 outlines the steps in item pool development and refinement process for all foci. The development, refinement and response selection scale for each of the 3 foci follows Table 2.

Table 2

Steps for Item Pool Development and Refinement for Study Foci

Steps for Instrument Development	Principal Activities
Item Pool Development	Literature review
	Interviews/brainstorming with nursing
	Interviews/brainstorming with expert panel
	Interviews/brainstorming with students
Item Pool Refinement	Review for redundancy
	Review for inappropriate items
	Revision of wording
	Review by consortium
	Review by tenured nursing faculty
	Review by methodologist
Expert Critique	Revision of items
	Revision of scale
	Re-wording of directions
	Elimination of inappropriate items

Program Practices Development

Development of the Program Practices Items: I began the process by developing and refining the item pool for measuring Program Practices as summarized in Table 3. I generated the item pool for the measure of Program Practices through a methodical review of the literature that included relevant questionnaires, through interviews with

practitioners and through a brainstorming session with an expert panel of nursing educators. During the literature review and interview sessions, the researcher generated a list of 61 construct indicators in no particular order (Appendix C). The researcher was not concerned with the revision of items or deletion of redundant items during the initial compilation of construct indicators.

Refinement of the Program Practices Items: Through each phase of the refinement process, the researcher worked with her dissertation advisor, methodologist, nursing educators, and expert panel to refine the Program Practices measurement.

The next step in development and refinement of the measure Program Practices was an interview/brainstorming session with nursing educators who are experts in reproduction options education and who are all members of a national consortium concerned with reproductive education. The researcher gave these experts the task of conducting an open discussion on reproductive education issues in nursing education, with special emphasis on abortion instruction in nursing education.

The discussion emphasized the lack of competencies in the care of the woman undergoing an abortion and how important this research is in order to address the gaps and develop competencies that will strengthen abortion education. While there have been localized studies in abortion education (in Massachusetts, for example), there has not been a regional survey aimed at this topic.

As a result of the refinement process, 12 topics collapsed from the 61 topics and were chosen to represent the program practices foci for this study. Other research studies have had respondents calculate the actual amount of content in each area. This study will not require the respondent will to calculate the didactic or clinical components.

Selection of the Response Scale for Program Practices: For the measure Program Practices, I developed a response scale that measured the respondent's opinion of the relative frequency ranging from "classroom and clinical instruction" to "no instruction." For the Program Practices, the researcher used a five-point scale including, "no instruction", "classroom instruction and clinical experiences," "classroom instruction but not clinical experiences," "clinical experiences but no classroom instruction," and "reading assignments outside of class." After the question, a text box was provided to allow for the participant to enter "no assignments" for each area. An expert nurse educator suggested adding the option of "reading assignments outside of class". As a result of the recommendation, this was added to the questionnaire to capture this type of response.

Accommodations Development

Development of the Accommodations Items: As I developed the item pool for the first foci, I worked to develop and refine the item pool for the measure of accommodations as summarized in Table 3. As an experienced educator, I recognize the various methods of instruction. The investigator methodically reviewed the literature and generated 12 potential indicators of accommodations. In generating the items, it was apparent that many of the items overlapped, but several themes emerged as broad topics in the refinement process. The accommodations measure was less difficult to develop, as the measures were derived from program practices item pool. During a period of three months, the items were sorted and refined using six common themes.

Refinement of the Accommodations Items: Through each phase of the refinement process, the researcher worked with her dissertation advisor, methodologist, nursing

educators, and expert panel to refine the Accommodations measurement. Accommodations item refinement resulted in the collapsing of items from 11 to 8. The researcher continued to review the literature for additional foci, but none emerged. The refinement process resulted in the measurement of 8 potential indicators for accommodations.

Selection of Response Scale for Accommodations: The selection of the response scale for the accommodations measure was developed by the researcher based on response scales used in previous studies such as Foster, et al (2006), expert nurse educators and recommendations of methodologist. The response scale selected to measure the amount of accommodations were: (a) no instructors make accommodations, (b) some instructors make accommodations, and (c) all instructors make accommodations.

Contextual Factors Development

Development of the Contextual Factors Items: The item pool for this focus was developed from the item pool of the other two measures. The themes that emerged from the data were religious, attitudes, safety, institution, law, resources (lack of curriculum and/or faculty), and violence (Appendix D). During this grouping sequence, the researcher did not revise or eliminate items. Subcategories of fear, morality, and ethics were subsumed into the broader categories of safety and religion. All items were compared to three previous questionnaires as well as themes found during the review of the literature for construct development. The only item that was found on the Foster et al. questionnaire but not found in the review of the literature was the inclusion of funding restrictions that may prohibit the instruction of abortion. As a result, the researcher

included this item on the questionnaire – although the researcher did not find this theme in the review of the literature.

Refinement of the Contextual Factors Items: Through each phase of the refinement process, the researcher worked with her dissertation advisor, methodologist, nursing educators, and expert panel to refine the Contextual Factors measurement. Contextual factors item refinement resulted in the collapsing of items from 161 to 14. The researcher continued to review the literature for additional foci, but none emerged.

Response Scale Selection for Contextual Factor Items: For the measure Contextual Factors, I developed a response scale that measured the respondent's opinion to what extent do the contextual factors affect the program's decision about offering abortion instruction. Initially, the response scale was based on a 5 point scale ranging from "not at all" to "I don't know". Based on the suggestion of nurse experts, the response scale was modified to collapse the two options of "to a small extent" and "to some extent ", into one option, "to some extent". It was decided by the panel of experts that it was difficult to quantify differences between the two options, and I chose "to some extent" to include as the response scale for Contextual Factors. "I don't know" was later removed also and a text box provided to provide the respondent with the option of writing "I don't know".

Addition of Background Items

The final instrument contained an additional five items for the purpose of collecting demographic information on the participants. These questions included geographic location of the nursing program, the type of institution, the participant's title,

the type of program, and gender. These variables were chosen to describe the survey participants.

Expert Critique of Study Documents and Questionnaire

The final draft of the questionnaire, used for expert review and pilot, included an introduction, screener questions, and brief instructions for the 37 items presented in draft form on the SurveyMonkey Web site. The first question addressed 12 topics covered in the curriculum using the scale ranging from "both classroom and clinical instruction" to "reading assignments only." To accommodate the instructor who offered no instruction in the area, a text box was provided for the interviewer to write or the respondent to type "no instruction". The second topic identified six abortion content areas, i.e. lectures in discussing surgical techniques, using a scale ranging from "all instructors make accommodations" to "no instructors make accommodations." The third topic measured was factors impacting abortion education, with 14 items using a response scale ranging from "not at all" to "a great extent."

The researcher asked five experts in nursing education to participate in a final critique of the items and structure of the online questionnaire and to test administration of the procedures. The participants included two faculty members who teach women's health in an undergraduate program, two faculty members who are program administrators, and one faculty member who is a women's health advocate. The participants collectively demonstrated more than 40 years as nurse educators, with two faculty members having administration responsibility over a program. In past drafts, the expert panel educators were not able to return to the survey once they had exited. To

ensure the panel member was able to provide a thorough critique, I provided the survey via e-mail (sent electronically as an attachment).

Following completion of the survey, an interview was conducted with experts using a standard set of questions to guide the discussions (Appendix E). As a result, minor revisions were incorporated into the instrument.

Pilot Study

The population for the initial study was undergraduate nursing educators in accredited nursing education programs in the United States. Ultimately, the results of the pilot study affected a significant change in the study and methodology.

The pilot study consisted of 188 participants. Of the 188 participants, 23 were undeliverable, 9 opted out of SurveyMonkey permanently, 3 needed IRB approvals from their institution to participate, 19 had out-of-office replies and 19 responded to the survey, three partially and 16 completely. The researcher sent out the initial email to request participation and one reminder letter over a period of two weeks. The response rate was 14%. The committee anticipated a 45-50% response rate based considering we had a well-defined group. Several issues were identified during the pilot that may have impacted the results. They include:

- Filters on the various email systems may actually "junk mail" the survey
- Summer provided numerous out of office replies
- Several email addresses were returned(faculty have changed jobs, retired
- Sensitive topic
- No pre-notification letter was sent

To address the non-response issue I used additional methods of data collection. A sample of 60 non respondent participants was selected from the 168 non-respondents. Thirty respondents were contacted through the US postal mail. Thirty respondents were

contacted by telephone. A telephone script was developed and amended with IRB approval. The measures undertaken to increase the response rate of the study did not produce a sufficient return. Appendix F provides an overview of the results of the pilot study.

The results of the pilot study did not produce the results I desired. A memorandum was composed and sent to the committee informing them of the outcome of the pilot study. The committee reviewed the findings and permitted me to reduce the scope of the study in an effort to increase my response rate. This study was unfunded and I asked permission to reduce the scope as the cost of multiple studies was becoming a financial burden.

Research Study of Largest 100 Nursing Education Programs in the U.S.

With permission from the committee, I reduced the scope of the study. Consequently, I made the decision to aggressively collect data on the top100 largest nursing schools. While I understand the importance of randomization, I decided a random sample of 100 from a population of 1,155 would introduce an unacceptable sampling error, again challenging the value of our study.

Consequently, we decided to use the identified nursing educator from the 100 largest schools in the US. In choosing the largest, I could say this is what is going on in the largest nursing programs in the country. The 100 largest schools accounts for 19.8% of nursing students who are educated in our country. In an effort to increase the response rate, it was decided to change the methodology of the study from the online survey to a telephone survey. According to Babbie (1990) interview surveys typically attain higher response rates than do mail and generally decreases the number of "don't knows" and "no

answers" allowing for the interviewer to probe for answers if indicated. Musselwhite, Cuff, McGregor, and King (2006) conclude that telephone interviews for data collection use economic and human resources efficiently, minimizing disadvantages associated with in-person interviewing, develop positive relationships between researchers and participants, and improve quality of data collected.

Questionnaire Modification for Telephone: I modified the questionnaire for a telephone interviewer to use to collect data responses. The integrity of the original questionnaire did not change; we developed a script around the questionnaire. See Appendix J to review the telephone script. In an effort to ensure the survey was modified for timely administration, a nursing education faculty member was asked to assist. I read her the survey in the manner it would be delivered providing opportunities for her to answer the questions, pausing when appropriate, repeating the items when necessary. The entire telephone interview took 14 minutes to administer. It was determined the questionnaire length was appropriate for the intent of our research.

To assist with the administration of the questionnaire, assistance was sought from a nurse educator who would help with data collection through administration of the questionnaire. I solicited recommendations from a graduate nursing education program hoping for someone who would like to complete their research requirements assisting me in the data collection process. Three candidates contacted me for the opportunity. I interviewed each participant advising them of the research questions and asking would they have moral or ethical dilemmas in collecting the data. One person withdrew her name for consideration after the interview process. Of the two candidates remaining, one

showed great organization and communication skills. She was hired to assist in data collection.

The original survey was submitted to the IRB with the following changes: (a) the methodology was changed from complete web-based to telephone data collection, (b) dates of data collection changed (c) survey was modified for telephone data collection. The integrity of the original questions was not changed, only slightly modified for ease with telephone collection. The IRB approved the changes and data collection began in April 2010 and continued over the next 5 weeks.

To further track the study, a spread sheet was created with each of the participants identified. Each time the participant was contacted via email or telephone, it was recorded to ensure that we had an accurate account of the efforts of myself and research assistant.

Pre-notification letters explaining the research were sent to each participant. A web-based link was not included in the original pre-notification letters. Each participant was advised in the pre-notification email that he would be receiving a call from me or my representative during the week of April 1-7, 2010.

Again, the person most likely to teach the content was identified and this person was called 5 times over the 6 weeks of data collection. Of the initial calls made, only 2 participants answered the phone. Two participants returned the call and asked for a web based link to complete the survey. We placed over 500 phone calls over the course of five weeks, but our response rate remained low. Midway in the research, in an effort to increase response rate, I resubmitted the IRB asking for permission to include the web-based link in our email notifications. The approval to include the web-based link was

expeditious, but I still did not acquire the response rate we desired in the period of time we were collecting the data. Data collection ended May 14, 2010 with the end of the semester upon us and summer looming. My response rate was a dismal 16%, demanding a revisit of the methodology.

The chair and methodologist met with me to discuss implications of low response rate and problem solve for solutions to complete this study. After a thoughtful exchange of ideas and considerations, it was decided to recruit our participants from Georgia. As a result, the scope of the research was further reduced to Georgia nursing education faculty. In reducing our scope I was still studying a population and the contextual practices of the population, now defined as Georgia, so it was determined to go forward with these changes. All members of the committee were notified of the reduction in the scope of the study and all were in agreement for me to go forward with the study focused in Georgia.

Study Population and Sample

As a result of an unsuccessful pilot and study of the 100 largest programs, the scope of the study was further reduced to nursing programs in Georgia. The population for this study was undergraduate nursing educators in fully accredited nursing education programs in Georgia. A complete list of fully accredited undergraduate nursing programs in Georgia was found on the Georgia Board of Nursing (GBON) website. GBON provides a current data list that includes all fully accredited/approved nursing programs in the Georgia. This data set includes the name of the educational institution, contact information, and the state of approval rendered by the GBON. For the purpose of this study, fully approved/accredited nursing program is defined as a program that has had the opportunity to teach reproductive content. Nursing programs that are in the initial stage

of approval typically have not had the opportunity to teach this content, as reproductive health is typically in the second year of nursing instruction.

Based on information obtained from the GBON, there are 34 fully approved undergraduate nursing programs. Only fully approved programs were selected. Programs identified as being in developmental stages or approved initially have not taught this content in their respective programs, therefore only programs fully approved were sought. As a result, coverage error is eliminated from this study.

The second step in the process was identifying the actual participant from each nursing program. Selection criteria were developed to select the informant. It was determined that the best informant for the survey would be the faculty member who has the responsibility to teach reproductive content. Efforts were focused on identifying the faculty member who taught this content.

The tool was further refined for ease of data analysis and collection. Several items were standardized for accuracy. Questions 1-12 were coded "0" to "4". If items were reported as reading assignments and clinical instruction this was interpreted as both classroom and clinical. Questions 13-18 were coded "1" –"3". If items were reported as no accommodations this was coded as no instructors make accommodations. Questions 19-32 were coded "1" –"3". If items were reported as don't know then these responses were recorded as missing data. A survey key was developed to assist in the statistical analysis and coding

In June 2010, I attended a leadership workshop where 75% of the deans and directors of Georgia nursing colleges and universities were in attendance. I printed the copy of the latest GBON nursing programs in the state. During the conference, I was

provided an opportunity to speak to the deans and directors about my research requesting their cooperation in providing the name of the person responsible for teaching the reproductive content. Each dean/director identified the faculty member who was most likely responsible for teaching the content identified for the study. If the dean/director did not attend the meeting or provide the contact information, I browsed the website of each school and chose the person I considered to be responsible to teach the content. For this study, we selected the entire population of fully approved undergraduate nursing education programs in Georgia.

Of the 42 plus programs in Georgia, 34 were fully accredited by the Georgia Board of Nursing. For the purpose of this study, I did not research whether the program was accredited by national accreditation bodies, such as National League for Nursing Accrediting Commission, only whether they had full approval by the Georgia Board of Nursing.

Data Collection

The data collection process was a confidential telephone questionnaire with anonymous web based support. Each participant was initially contacted by email pre-notification which included the web-based link. The web-based link was unique to this study, but not to each individual respondent. It was determined that allowing SurveyMonkey the ability to provide unique web based links through bulk mailings may have caused emails to go to junk mail in both the previous two studies. To reduce this occurrence, I sent the email notifications each week individually from my personal UGA email account. In using the UGA email account, I was unable to track the participants, providing complete anonymity for the participant, but did not allow for tracking

responses. Without the ability to track respondents, I was required to call each respondent up to 5 times in order to collect responses. If I had collected the response by phone, I had the respondent tracked, but otherwise I did not know who had responded by web-based link. One week following the email pre-notification, telephone contact was attempted. This was continued until the study time frame was completed.

According to Dillman (2000), web based surveys have many advantages such as easy Internet access, tailored design, and dynamic interaction. Tracking is a highly valuable tool for this research to ensure an adequate response rate from the participants. I chose the survey development and administration website at SurveyMonkey (www.surveymoneky.com) for the secure online questionnaire for several reasons, but primarily for its ease of administration and ability to creatively design my specific survey. The features of SurveyMonkey allowed multiple access, design, administration and collection features that were appropriate for this study. Additionally, these features included the ability to provide a unique collection link allowing only those recruited to participate in the study. In addition, results could be downloaded and translated in compatible SPSS formatting for ease of statistical analysis. Coupled with the personal telephone calls, I was confident of a high response rate.

The online questionnaire was presented in a series of pages that were easily viewed in their entirety on the majority of computer monitors used in educational facilities. The pages were categorized for ease of data analysis. Instructions and information was provided on the welcome page, advising each participant number of questions in the entire questionnaire and I also provided directions on how to request a copy of results in this section. The respondent was allowed to answer the questions they

determined and no blocks were imposed to keep them from moving forward in the questionnaire. Once the participant exited the survey, their responses were tabulated and included in the statistics. When respondents submitted their survey, a thank you page was displayed.

The original survey was modified for use in telephone survey research. It included the opening statements by the researcher advising the participant of the reason for the research, the number of questions in the questionnaire, and the opportunity to opt out of the survey was provided to the participant at the beginning of each section of the telephone survey, as well as the number of questions in each section. Additionally, each participant could opt out of answering any question in the survey at any time. At the end of the telephone contact, the participant was thanked for their participation in the survey. Each question was asked and repeated, if needed, allowing sufficient time to respond.

As suggested by Dillman (2000), a multiple contact strategy was used for this study. The first communication the participant received was a pre-notification email advising them of my intent to collect data by phone or secure unique web based link at www.surveymonkey.com. Follow- up communication, such as email reminder letters, followed weekly in addition to weekly phone calls. After the pre-notification email was sent out, the telephone calls began and continued weekly until the study ended. Table 3 provides the timeline for data collection.

Table 3

Timeline for Data Collection for Georgia

Steps for Data Collection	Dates
Pre-Notification Letter	July 23-July 30, 2010
Telephone Call # 1/#2	August 1-7, 2010
Telephone Call #2/#3	August 8-15, 2010
Telephone Call #3/#4/#5	August 15-22, 2010

Response Rate

GBON's list of fully approved programs provided the foundation to secure individual contact information. Deans and directors provided the email addresses and phone numbers of faculty members who were the most likely to teach the abortion content. Faculty members were contacted via telephone and email. Tracking was not utilized in this study, as it was in the initial pilot study. Because tracking was not used, it was not possible to know who had responded via the secure web based internet study, but we did have record of the ones who had responded via telephone solicitation. When I sent out reminders, I did exclude the ones who had already responded via telephone or mail, but otherwise all other non-respondents were sent follow-up email reminders and phone calls were completed each week. Table 4 provides an overview of the responses per contact type.

Table 4

Reponses Rates for Each Method of Collection

Responses	Total by each category	%
Response by telephone communication	5	22.7
Response by secure web based link	16	72.7
Response by US postal mail	1	4.5
Total Responses by all methods of contact	22	

Respondent characteristics

An assumption of this research is that only one person for each nursing education program responded to this questionnaire, either by telephone or web-based survey. The respondent provided data from their perspective as faculty member who taught this content in the classroom. All the respondents were female and held a master or doctorate degree. Table 5 provides an overview of the respondents.

Table 5

Description of Study Respondents

Variables	n	Value %
Educational Preparation		
Masters	13	61.9
Doctorate	8	38.1
Current Title		
Administration	3	13.6
Faculty	17	77.3
Gender		
Female	22	100

The organizations represented in this study are described in Table 5. As reported by the respondents, 81% worked in a publicly funded college or university not affiliated with the armed services, 9.5% worked in a publicly funded college or university affiliated with the armed services, and 9.5% worked in a private college or university with a religious affiliation. Of the 34 colleges and universities in Georgia, we received 22 responses to the survey either by interview/phone or web-based survey, a 64.7% response rate.

The response rate was 64.7% for this study, representative of the undergraduate nursing programs in Georgia. The respondent organizations resembled the approved programs in the state of Georgia, with the majority of programs public without religious or armed services affiliation (Table 6). The majority of the respondents, 77.3% reported

their position as faculty and 13.6% reported to themselves as administration, a dean, director or coordinator.

Table 6

Description of Program Respondents Affiliation

Type of College or University	n	%
Publicly Funded (no armed services affiliation)	17	77.2
Private (no religious affiliation)	2	9.0
Private (religious affiliation)	2	9.0
Missing Data	1	4.5

Data Preparation

The surveys received via mail or telephone was entered individually to the web-based online survey. The raw responses for all the instances of the data collection were then downloaded into Excel spreadsheets. The data was cleaned and uploaded for statistical analysis by SPSS 17.0. The text-based responses were exported to a Microsoft word document for further analysis.

The first step in the data cleaning was to standardize each item in the questionnaire. The items were standardized for accuracy. The second step in the process required coding of the items so that we could perform statistical analysis. Questions 1-12 were coded “0” to “4”. If items were reported as reading assignments and clinical instruction this was interpreted as both classroom and clinical. Questions 13-18 were

coded “1” –“3”. If items were reported as no accommodations this was coded as no instructors make accommodations. Questions 19-32 were coded “1” –“3”. If items were reported as don’t know then these responses were recorded as missing data. A survey key was developed to assist in the statistical analysis and coding. Questions 1-12 revealed no missing items. Questions 13-18 had 8 missing responses collectively. Questions 19-32 had multiple missing items.

The format that was used for the study was a checklist. In using a checklist I could not differentiate missing data from no response. A coding rule was established to help understand the data. All missing data were coded as no response in order to help interpret the data.

I reviewed the submissions to determine if all were complete and appropriate to include in the study. After review, all questionnaires were determined to be eligible for use in the research study. The data cleaning process resulted in 22 useable surveys which I saved as new and cleaned SPSS file.

Data Analysis

Data analysis was conducted using SPSS 17 statistical software package. Appropriate statistical analysis was selected to answer the two research questions. For research question one, frequency tables were performed on each of the items. Additionally, each response was converted to a numerical code (i.e., none-0 reading assignments only-1, classroom instruction only-2, clinical experiences only-3, both classroom and clinical-4,) calculating the frequencies of each item.

For research question two, the researcher completed frequency tables for each item. For questions 13-18 she calculated only frequency tables. Each response for

questions 13-18 was converted to a numerical code (i.e., no instructors make accommodations-1, some instructors make accommodations-2, all instructors make accommodations-3). In addition to the calculation of frequencies, she calculated means for questions 19-32. Each response was converted to a numerical code (i.e., not at all-1, to some extent-2, to a great extent-3).

Assessing the External Validity of Sample

Because the intent of this study was to discover the type of instruction students were receiving, drawing a representative sample was extremely important. It was exactly the results of the national study that was the impetus for using Georgia programs, because I feared not getting the required response rate would make the estimation of parameters an exercise in futility. Once the committee provided approval to administer the study in Georgia, I worked aggressively. Although our goal was 100% participation using multiple methods, the response rate resulted in 64.7% of nursing program respondents reported on the instruction in their programs. There was no missing data on key questions, further supporting the importance of the study findings.

The key question of external validity is to ask if the results of the study can be applied to the population. The single and best answer to this question: With caution I can apply the results to the population, with the population defined as undergraduate nursing programs in the state of Georgia.

Bias Statement

I am women's health nurse practitioner and have spent over twenty years caring for women in reproductive health, including abortion services. Additionally, I am a nursing educator who has taught women's health instructional content in all levels of

nursing for over twenty years. Further, I believe all women are entitled to non-judgmental quality care from their health care providers. While I respect the individual instructor and their personal or religious views, I also believe it is the responsibility of the instructor in women's health courses to provide instructional content in the area of abortion. If they cannot teach the content, then it is their responsibility to find an instructor who will teach the content to ensure students receive the instruction.

Experiences have shaped my desire to bring this topic to forefront to ensure that nursing students receive instructional content on abortion to ensure the patient receives quality, non-judgmental, and safe nursing care.

Because of this bias I asked all committee members review all documents prior to mass distribution to ensure the documents were neutral in tone and verbiage. I did not ask any committee member their personal views on this topic, the committee members were only asked if they would participate as committee members. All committee members accepted the invitation for committee membership. Each committee member directed and guided the research to the best of their ability to ensure bias was not evident in the research.

Other Limitations

This study employed a purposive population study, with all nursing educators in Georgia approached to complete the study either through web-based internet survey or telephone contact. Of the 34 approved programs in Georgia 22 of the program contacts responded to the survey either through the web-based link or telephone contacts. With caution, it can be surmised that 22 (64.7%) responses are representative of educational

practices in Georgia. Table 7 provides an overview of the number and type of pre-licensure nursing education programs in Georgia.

Other limitations of this study include the omission of data. Some of the questions on the survey were not answered, omitting data. It is unclear if the omissions were a result of bias, or if the faculty who answered did not know the answers to the questions. So rather than answer incorrectly, she did not answer.

Tracking was not initiated in the third study due to the problems encountered in the previous studies. Because we did not track we were not able to identify certain characteristics on our informants, limiting the analysis.

Table 7

Pre-Licensure Programs in Georgia

Type of College or University	n=34	%
Publicly Funded (no armed services affiliation)	29	85.0
Private (no religious affiliation)	3	9.0
Private (religious affiliation)	2	6.0

CHAPTER 4

RESEARCH FINDINGS

The purpose of this study is to better understand the extent and nature of abortion education experienced by undergraduate nursing education students in the state of Georgia. In order to understand what nursing education students in Georgia experience, three central questions guided the study:

1. What is the current status of abortion instruction in undergraduate nursing education programs in Georgia?
2. To what extent do nursing education programs provide accommodations for nursing students who have a moral or religious objection to instruction on abortion in Georgia?
3. To what extent do contextual factors explain the level of abortion instruction in undergraduate nursing education programs in Georgia?

All data analysis was completed using SPSS 17. Data preparation was completed in order to set the stage for statistical analysis to answer the three research questions. Findings will be presented in the following sections dedicated to the analysis of the individual research questions. Simple frequency statistics were used for descriptive statistical analysis.

Research Question 1

To answer research question #1 "What is the current status of abortion instruction in undergraduate nursing education in Georgia", simple frequency statistics were utilized.

Twelve items on abortion and abortion related topics were included in the questionnaire selected by experts as essential components in abortion instruction. The study sought to understand to what extent students in undergraduate nursing programs in Georgia were receiving direct instruction.

To do this the researcher re-tabulated the data to indicate no instruction, reading assignments only and direct instruction. In order to gain clarity on the amount of direct instruction to students, classroom instruction, classroom and clinical instruction and clinical experiences were grouped together for statistical analysis as noted as direct instruction. The following table provides an overview of the 12 questions. The data is reported in valid percent. Table 8 provides the data as reported by the respondents followed by the collapsed data analysis in Table 9.

According to the data analysis, 77.3% of programs in Georgia provide undergraduate nursing students with instruction on surgical abortion, followed by nursing care of the woman undergoing an abortion, abortion and public policy, abortion and the law, and abortion and ethical and religious instruction all at 68.2% respectively.

Review of the analysis reveals that 54.5% of students in Georgia nursing education programs receive instruction in abortion and public policy and 54.5% for abortion and the law. Public policy and law can be interpreted as one theme, as the majority of the data in this line item of results were similar in response rate. Similarly, the analysis of the theme post abortion counseling resulted in most respondents providing classroom instruction only at 40.9% with pregnancy options counseling at 36.4%. Pre-abortion counseling resulted in 36.4% of the respondents offered no instruction, and the same 36.4 % of the respondents provided classroom instruction only.

Medication abortion and care of a woman receiving a medical abortion received classroom instruction 45.5% of the time. Surgical abortion and care of a woman undergoing a surgical abortion received classroom instruction 54.5% and 50%, respectively.

The woman undergoing pre-abortion counseling received a 50% response rate. For the item, abortion and public health, classroom instruction yielded a response rate of 31.8% and 36.4% for no instruction, indicating approximately one third of nursing students in Georgia receive instruction.

According to the respondents in Georgia, the majority of students do receive classroom instruction (59.1%) on the ethical and religious dilemmas of abortion. The researcher is uncertain if this content is taught in an ethics course or if it is taught in a maternal child nursing course, but it does indicate most students in Georgia are provided classroom instruction in this area.

In summary, 77.3% of the students in undergraduate nursing programs in Georgia receive instruction on surgical abortion, an essential topic in abortion instruction. In contrast, only 40.9% of the students in undergraduate programs in Georgia receive instruction in pregnancy options counseling and abortion and public health.

Table 8

Instructional Practices as Reported

Instructional Items	No Instruction	Reading Assignments Only	Classroom Instruction Only	Clinical Experiences Only	Both Classroom and Clinical Instruction
1.Abortion and Public Policy	n=3 13.6%	*n=4* *18.2%*	*n=12* *54.5%*	*n=1* *4.5%*	*n=2* *9.1%*
2.Abortion and the Law	*n=1* *4.5%*	*n=6* *27.3%*	*n=12* *54.5%*	*n=1* *4.5%*	*n=2* *9.1%*
3.Post Abortion Counseling	*n=8* *36.4%*	*n=4* *18.2%*	*n=9* *40.9%*	*n=0* *0%*	*n=1* *4.5%*
4.Pregnancy Options Counseling	*n=8* *36.4%*	*n=5* *22.7%*	*n=6* *27.3%*	*n=1* *4.5%*	*n=2* *9.1%*
5.Pre-abortion Counseling	*n=8* *36.4%*	*n=3* *13.6%*	*n=8* *36.4%*	*n=0* *0%*	*n=3* *13.6%*
6.Medication abortion	*n=7* *31.8%*	*n=3* *13.6%*	*n=10* *45.5%*	*n=0* *0%*	*n=2* *9.1%*
7.Nursing Care of Woman Undergoing Medication Abortion	*n=4* *18.2%*	*n=4* *18.2%*	*n=10* *45.5%*	*n=0* *0%*	*n=4* *18.2%*
8.Surgical Abortion	*n=1* *4.5%*	*n=4* *18.2%*	*n=12* *54.5%*	*n=1* *4.5%*	*n=4* *18.2%*
9..Nursing Care of Woman Undergoing Surgical Abortion	*n=2* *9.1%*	*n=5* *22.7%*	*n=11* *50.0%*	*n=0* *0%*	*n=4* *18.2%*
10.Pre-abortion Counseling	*n=4* *18.2%*	*n=4* *18.2%*	*n=11* *50%*	*n=0* *0%*	*n=3* *13.6%*
11.Abortion and Public Health	*n=8* *36.4%*	*n=5* *22.7%*	*n=7* *31.8%*	*n=0* *0%*	*n=2* *9.1%*
12.Ethical and Religious Dilemmas of Abortion	*n=4* *18.2%*	*n=3* *13.6%*	*n=13* *59.1%*	*n=0* *0%*	n=2 9.1%

Table 9

Instructional Practices Collapsed and Ranked

Topics	No Instruction		Reading Assignments Only		Direct Instruction	
	n	%	n	%	n	%
8.Surgical Abortion	1	4.5	4	18.2	17	77.3
9.Nursing Care and Surgical Abortion	2	9.1	5	22.7	15	68.2
1..Abortion/Public Policy	3	13.6	4	18.2	15	68.2
2.Abortion and Law	1	4.5	6	27.3	15	68.2
12.Ethical/Religious	4	18.2	3	13.6	15	68.2
10.Post AB Care	4	18.2	4	18.2	14	63.6
7.Nursing Care Medication AB	4	18.2	4	18.2	14	63.6
6.Medication AB	7	31.8	3	13.6	12	54.5
5.Pre AB Counseling	8	36.4	3	13.6	11	54.5
3.Post AB Counseling	8	36.4	4	18.2	10	45.5
4.Pregnancy Options Counsel	8	36.4	5	22.7	9	40.9
11.AB/Public Health	8	36.4	5	22.7	9	40.9

Research Question 2

To answer research question #2, "Do nursing education faculty provide accommodations for students who have religious objection to instruction on abortion in

Georgia" participants were given six items on abortion related topics and asked if they provided accommodations. Table 10 and 11 provides an overview of the responses.

A simple frequency table reveals between 60% and 70% of programs do not make accommodations for students who have moral or religious objection to instruction on abortion. While 25%-20% of programs make accommodations for their students, and 5-15% of programs make some accommodations, resulting in 40% that make accommodations of some type and 60% or more make no accommodations of any type.

To summarize the findings for accommodation practices, 60-70% of faculty do not provide accommodations on any of the content abortion topics surveyed and 30-40 % do provide accommodations on the abortion topics surveyed.

Table 10

Accommodation Practices as Reported

Topics	No Instructors Make Accommodations (1)		Some Instructors Make Accommodations(2)		All Instructors Make Accommodations(3)	
	n	%	n	%	n	%
13.Public Health and Abortion	12	60.0	3	15.0	5	25.0
14.Surgical Techniques and Abortion	13	61.9	2	9.5	6	28.6
15.Complications of Abortion	13	61.9	2	9.5	6	28.6
16.Pre and Post Counseling	13	61.9	2	9.5	6	28.6
17.Reproductive options	13	61.9	1	5.0	6	30.0
18.Ethical Issues Related to Abortion	14	70.0	1	5.0	5	25.0

Table 11

Accommodation Practices Collapsed and Ranked

Topics	No Instructors Make Accommodations		Instructors Make Accommodations	
	n	%	n	%
18.Ethical Issues Related to Abortion	14	70.0	6	30.0%
14.Surgical Techniques and Abortion	13	61.9	8	38.1%
15.Complications of Abortion	13	61.9	8	38.1%
16.Pre and Post Counseling	13	61.9	8	38.1%
17.Reproductive options	13	61.9	7	35.0%
13.Public Health and Abortion	12	60.0	8	40.0%

Research Question 3

To answer research question #3, "to what extent do contextual factors explain the level of abortion instruction in undergraduate nursing programs", we identified several factors that may explain levels of abortion instruction in undergraduate programs. In order to clarify the significance of the contextual factors, the individual contextual factors were categorized. The categories were public entities, curriculum concerns, personal and moral issues, and external constraints. Public entities is noted as "P", curricular concerns is noted as "C", personal and moral issues is noted as "M", and external constraints is noted as "E". Table 12 provides an overview of collapsed findings identifying the categorized contextual factors and whether there is or is not an impact on instruction. The findings presented in Table 12 and Table 13 provide an overview of the factors ranked categorized contextual factors.

The categorized contextual factors illuminate the areas that impact abortion instruction in Georgia. In Georgia, of the 14 contextual factors, 9 are related to curricular concerns and personal and moral issues, at 5 and 4 respectively. External constraints such as funding or public figures are 2 each.

In Georgia 70% of nursing educators have identified "time to teach" as the primary factor determining the level of abortion instruction in Georgia (50% to some extent, and 20% to a great extent). Other significant contextual factors that determine the level of abortion instruction include the student's religious beliefs or the psychological impact for the student was significant at 44.4% and 33.3% respectively. Lastly, the expertise to teach the content (36.9%) was reported as a primary factor in determining the level of abortion instruction in Georgia.

It is logical to assume that expertise and time to teach can be viewed as a theme. If a faculty responded they lacked expertise, then it is likely they would also indicate time to teach as a factor that impacts abortion instruction. In summary, time to teach was indicated as the primary contextual factor that impacts instruction of abortion, followed by student's religious beliefs and the psychological impact for students round out the top three contextual factors impacting instruction of abortion content. Conversely, the impact of the state legislator, funding and personal safely is ranked low.

Table 12

Contextual Factors and Impact on Instruction as Reported

Contextual Factors	Percent Frequencies					
	Not At All		To Some Extent		To Great Extent	
	n	%	n	%	n	%
19.State Legislator	15	88.2	0	0.0	2	11.8
20.College Administrator	14	77.8	3	16.7	1	4.5
21.Community Physicians	16	94.1	0	0.0	1	5.9
22.High Priority for Curriculum	14	70.0	4	20.0	2	10.0
23.Time to Teach	6	30.0	10	50.0	4	20.0
24.Expertise to Teach	12	63.2	6	31.6	1	5.3
25.Student's Religious Beliefs	10	55.6	0	0.0	8	44.4
26.Faculty's Religious Beliefs	13	68.4	5	26.3	1	5.3
27.Community Attitudes	15	88.2	2	11.8	0	0.0
28.Text Books	15	71.4	4	19.0	2	9.5
29.Lack of Scientific Curriculum	14	70.0	5	25.0	1	5.0
30.Personal Safety	17	89.5	1	5.3	1	5.3
31.Psychological Impact for Students	11	61.1	6	33.3	1	5.6
32.Funding Restricts	15	83.3	2	11.1	1	5.6

Table 13

Contextual Factors Collapsed and Ranked

Contextual Factors	Percent Frequencies				Category
	Not At All		To Some / Great Extent		
	n	%	n	%	
23.Time to Teach	6	30	14	70.0	C
25.Student's Religious Beliefs	10	55.6	8	44.4	M
31.Psychological Impact for Students	11	61.1	7	38.9	M
32.Expertise to Teach	12	63.2	7	36.9	C
26.Faculty's Religious Beliefs	13	68.4	6	31.6	M
22.High Priority for Curriculum	14	70.0	6	30.0	C
29.Lack of Scientific Curriculum	14	70.0	6	30.0	C
28.Text Books	15	71.4	6	28.5	C
20.College Administrator	14	77.8	4	21.2	P
32.Funding Restricts	15	83.3	3	16.7	E
21.Community Attitudes	15	88.2	2	11.8	M
19.State Legislator	15	88.2	2	11.8	P
30.Personal Safety	17	89.5	2	10.6	E
Community Physicians	16	94.1	1	5.9	P

P=Public Entities, C=Curricular Concerns, P=Personal and Moral Issues,
E= External Constraints.

Summary of Findings

This study found that 77% of nursing programs in Georgia provide direct instruction on surgical abortion, followed by 68.2% provide direct instruction on nursing

care of the woman undergoing an abortion. Additionally, 61.9% do not provide accommodations for students who have religious or moral objections to the instruction of surgical abortion, with 70% providing no accommodations for instruction regarding ethical issues related to abortion. Lastly, faculty identified "time to teach", as the primary contextual factor that impacts instruction on abortion related topics.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS

This chapter presents a summary of the study conclusions and implications which are significant for research and educational practices of Georgia nursing programs. This study is guided by the researcher's critical theory perspective, which was informed by the work of critical theorists Freire (1921) Habermas (1973) and Giroux (1983). The critical theory standpoint required that the interview subject matter, resulting data and findings be analyzed by considering the issues of power, franchisement/disfranchisement, and the societal position/place of the participant or program would affect the research.

Overview of the Study

This study gathered data from GBON approved nursing programs in the State of Georgia. The purpose of this study was to understand the educational practices of nursing programs in the state of Georgia related to abortion education. The research questions guiding this study were: (1) what is the current status of abortion instruction in undergraduate nursing education programs in Georgia, (2) to what extent do nursing education programs make accommodations for students who have moral or religious objection to instruction on abortion, and (3) to what extent do contextual factors explain the level of abortion instruction in undergraduate nursing education programs in Georgia?

A survey instrument was developed to address these three research questions; it was used to collect data via the web-based link and telephone collection. The item pool for the survey was generated directly from relevant literature and directed discussions and

review of items with key stakeholders, nursing educators who have an expertise in reproductive education. The instrument included 12 items designed to measure the frequency of specific educational practices in reproductive nursing education categorized as *Program Practices*. The instrument contained six items to measure the extent to which programs made accommodations for students who had religious or moral objection to instruction on abortion categorized as *Accommodations*. The instrument contained 14 items to measure the extent to which contextual factors impacted the instruction of abortion categorized as *Contextual Factors.* Additionally, the instrument contained five demographic related questions and an open ended question at the end of the survey for additional comments.

The questionnaire was administered online and by telephone to the contact person of record for the 34 GBON approved nursing programs in the State of Georgia, generating a 64.7% response rate. With caution, the researcher can determine statistical inference for the nursing programs in the State of Georgia.

To answer each of the research questions, simple frequency statistics were utilized. The items were then evaluated based on the three foci: (1) *Program Practices*, (2) *Accommodations*, and (3) *Contextual Factors*. Each focus was analyzed independent of each other and rank ordered by percentiles. A summary of the findings follows.

Three significant findings were determined through this study. The first finding was that 70% or more of the students in Georgia nursing programs receive some form of instruction in abortion. Secondly, accommodations are not made for students who have religious or moral objection to the content, indicating that students who receive classroom instruction are not provided an alternative assignment. Lastly, the faculty have

overwhelmingly identified "time to teach" as the primary reason abortion content is not taught in the classroom.

Discussion of Principle Findings

Of the 34 GBON approved schools of nursing, 22 or 64.7% responded to the survey either by web-based internet link or through confidential telephone contact. Seventy-seven percent of Georgia educators reported providing direct instruction of abortion instruction to their respective students. In review of the literature and studies that are similar in context, results are higher than reported in those studies.

In the national study by Foster et al. (2006), 53% of the advanced nursing education programs reported providing abortion education to their students. Georgia reported a similar finding indicating 54.5% of the nursing programs in Georgia provide classroom instruction on surgical abortion, and 50% provide instruction on the care of the woman undergoing an abortion. However, when the themes are collapsed and grouped according to direct instruction, 77.3% receive instruction on surgical abortion and 68.2% receive direct classroom instruction on nursing care of the woman undergoing a surgical abortion.

Another study by Foster et al. (2008) reviewed the curricular adequacy for nursing programs in Massachusetts and found similar results, with 48% of the nursing programs in Massachusetts providing instruction in abortion. Of note, this study had similar response rate at 64.7% primarily due to the collegial network created by the researcher.

Findings for Research Question 1: Of the 12 items designed to measure the *Program Practices* foci, all items were considered acceptable, with little missing data. Of the

acceptable program practices, the highest ranking items were: (1) abortion and public policy at 54.5%, (2) abortion and the law at 54.5%, (3) surgical abortion at 54.5%, and (4) the care of the woman undergoing a surgical abortion at 50.0%. However, when collapsing the categories of classroom instruction and clinical instruction as direct instruction, the items rated higher. The highest ranked items in the study are surgical abortion and nursing care of the woman undergoing a surgical abortion at 77.3% and 68.2% respectively. Conversely, pregnancy options counseling and abortion and public health ranked last each at 40.9% receiving direct instruction.

From this study, we can determine that 77.3% of the students in nursing programs in Georgia receive direct instruction on surgical abortion. However, the extent or quality of the instruction cannot be assessed because of the survey questioned existence of content and did not allow for ascertaining the type/format or scope of the abortion education. This study did not institute tracking to allow for greater confidentiality, so therefore, we cannot identify the programs that do offer classroom instruction and those that do not offer classroom instruction. These results are higher compared to other research studies that have been conducted in the past in both advanced nursing education and medical education. The two highest ranked items, surgical abortion and care of the woman undergoing a surgical abortion, are typically presented together in classroom discussion.

It is significant to note that when discussing the care of the woman undergoing a surgical abortion it is common to discuss the right of the woman to choose an abortion. Based on my own personal experiences in the classroom, often times the political position of the nursing educator does surface within the classroom. Nursing educators

are to provide scientific based education, but this topic often times leads into a debate scenario, regardless of the intent of the instructor. Critical theory points educators toward a mode of comprehension and analysis that considers the tensions in history, the rational and irrational discourse, all of which become invaluable in the struggle to understand the gap between society as it currently exists and society as it might be (Giroux, 2003). As educators it is important to recognize that abortion is a legal means of pregnancy termination and consider the needs of the patient, rather the opinions of those in opposition.

Approximately two-thirds of nurse educators in Georgia offer direct instruction on abortion and public health and abortion and the law. Nurse educators may not see counseling as part of the responsibility of the professional nurse. This may explain the low percentage of 54.5% of direct instruction in this area. However, the Center for Reproductive Rights (2008) has determined that lack of providers as a result of the restrictive laws may impede the delivery of safe abortions, resulting in a public health imperative, thus the need to improve direction instruction in this area.

This study reveals limited clinical instruction in all areas of abortion instruction. Unlike medical doctors who receive their training or education in the operating room, clinical opportunities in abortion for nursing are limited and difficult to access if you are not familiar with abortion facilities. Additionally, there are only 31 facilities or practitioners in the state of Georgia that offer abortion services, and most are located in the metropolitan Atlanta area (Guttmacher, 2011). Therefore, clinical facilities in areas outside of Atlanta are rare. For a student to travel to the Atlanta area may present a hardship. Additionally, clinical facilities that provide abortion services require an

extensive criminal background check in an effort to protect their employees and patients. Current research on abortion and abortion activities reveal violence continues to be a threat (Jost, 2003; Guttmacher 2011) and requires its proponents to be cautious in and outside of the clinic. Clinics will not allow significant others to accompany them beyond the waiting room. All patients must leave all personal belongings outside the building, in an effort to reduce the threat of bombing, or knife/gunshot attack to patients or staff of the abortion clinic. Additionally, abortion funding is currently under debate in our congressional system, as our legislators determine amount of funding for Planned Parenthood of America.

Medication abortion has been used in the United States since 2000 (Guttmacher, 2011), while surgical abortion has been around for centuries. As a result, many nurse educators may be unfamiliar with this type of non-surgical abortion. The survey reveals that only 54.5%% of the nursing programs offer direct instruction in medication abortion.

Many nurses work in ambulatory settings, such as OB-GYN offices, family practice clinics, and outpatient centers. In these settings, the professional nurse will encounter patients who have a positive pregnancy test and require counseling as to their options for the pregnancy. Interestingly, this study revealed only 40.9% of nursing programs provides direct instruction in this area. This specialty area in reproductive health is not an invasive procedure, it does not demand clinical expertise or skills, it only requires the nurse to provide written or spoken information on pregnancy options, but very few programs offer counseling in pregnancy options. It is unknown why programs in Georgia only taught pregnancy options counseling 27.3% of the time, but could be

related to a knowledge deficit in this area of instruction. As a result, the professional nurse may not be prepared to provide the patient with pregnancy options.

In summary, over 70 % of the nursing programs in Georgia provide nursing students with direct instruction in surgical abortion and the nursing care of the woman undergoing an abortion (77.3% and 68.2%, respectively). Abortion and the law, abortion and public policy, and the ethical and religious issues of abortion are presented through direct instruction in 68.2% of the Georgia programs. Medication abortion and nursing care of the woman undergoing a medication abortion are presently directly in nursing programs in Georgia, 63.6% and 54.5%, respectively. Pre and post counseling of the patient undergoing an abortion is presented through direct instruction only 54.5% and 45.5%, respectively. Pregnancy options counseling and abortion and public health is provided through direct instruction 40.9% each.

Providing instruction on nursing care of the woman receiving an abortion remains a primary referendum for nursing education. Efforts from women's health organizations should recommend a review of women's health curriculum in public and private nursing programs addressing this pressing issue. With over 1.2 million abortions performed yearly in the United States, it seems apparent, based on a needs assessment, that information on abortion would be a beneficial addition for nursing programs. Each year educators address curriculum demands by providing the students with instruction they are most likely to see in hospital and ambulatory settings. Maybe this explains why abortion instruction is not viewed as a high priority and time to teach is not provided in the curriculum. For the most part, abortions are performed in ambulatory settings, rather than hospitals.

The finding from this study can serve to inform educators in the United States on abortion instruction in Georgia, creating an impetus for change and curricular reform. Each year in the U. S. 250,000 appendectomies are performed (Cuschieri, Florence, Flum, Jurkovich, Lin, Steele, Symons and Thirlby, 2008) compared to the 1.2 million abortions that are performed each year in the U. S. (Guttmacher, 2011). Consideration of the implications for incomplete or inadequate instruction on abortion is warranted. My experiences as a professional nurse and educator know that women do feel devalued or disenfranchised as both a patient and as a woman. Further, society continues to debate this topic in the news almost daily and the women are constantly reminded of the volatile nature of the topic.

While the findings are significant, it is important to recognize that 12 (35.3%) programs did not complete the survey either by phone or internet. The researcher is unsure if the participation of all 34 programs would have changed the results significantly.

Findings for Research Question 2: Seventy percent of programs do not make accommodations for students who have religious or moral objection to instruction on abortion. The survey asked the respondent to reply based on if they offer an alternate assignment based on religious or moral conviction for a variety of instructional methods regarding abortion. Anecdotal comments collected identified that most students do not ask for accommodations or faculty do not breech this subject with them. Again, these mirror the results in research question 1; over 70% of programs in Georgia provide direct instruction on abortion.

Based on the finding when the content is presented in the classroom, most instructors do not make accommodations, requiring the student to be present for the instruction. Also, the data mirrors the finding in relation to direct instruction on surgical abortion, as 77% of instructors provide this in their programs, and 61.9% instructors do not make accommodations, requiring all students to attend. One anecdotal response "no one has asked for accommodations" suggests that most faculty treat this topic as they do all other content areas, not providing the student with the option or idea to opt out of the classroom exercise. However, in regards to public health and abortion, 25% of nursing program faculty provides accommodations for students. The researcher is unsure why instructors would make accommodations for abortion and public health, or what content they consider offensive to warrant the need for accommodation, warranting further research in this area.

Critical theory provides the framework to enact social change. In nursing education, critical pedagogy can facilitate freedom for individuals and allow us to define what knowledge is, how we know, and who provides the evidence. Critical social theory can assist nursing education by promoting a caring and humanistic approach to research and practice. If nurse educators begin the analysis of how and why certain assumptions guide their actions in theory and practice, they can begin to describe and explain oppressive effects on society and their role in that oppression. Critical theory uses oppression as a springboard or tool to transform the individual or the society. It is an approach in which knowledge is valued, and that value is derived from dialogue. It allows rational discourse to transform educational practices.

Findings for Research Question 3: Seventy percent of nursing educators have identified "time to teach" as the primary factor determining the level of abortion instruction in Georgia. Further, 44.4% report the student's religious beliefs impact the level of instruction of abortion instruction in Georgia. Only 31.6% of faculty reported that faculty's religious beliefs impact instruction of abortion. One anecdotal response stated "I'm the primary faculty and I don't agree w/abortion".

Nursing educators in Georgia have indicated that "time to teach" factor has impacted instruction in abortion. The subject matter is often overlooked or inadequately covered in many professional education programs, including nursing (Beatty, 2000; Foster et al., 2006; Ameling, Tews, & Dudley, 2000; Espey, Ogburn, Chavez, Qualls, & Leyba, 2005; and Simmonds, Foster, & Zurek, 2009). Further, 30% indicate that scientific based curriculum has increased the amount of abortion instruction in the classroom, but this research did not ask programs to identify if they had noted an increase in scientific based curriculum. One faculty member in this student stated, "I've only been here a year. Maternity will be taught in the fall quarter for only the second time since my arrival. In looking at last year's PPT, there were 3 slides on abortion. I will probably teach it this year and though I will mention it and briefly discuss it, I will stress that is an emotion laden topic and try to avoid a debate in the classroom. Any student or nurse who is opposed to abortion needn't fear being forced to participate in the procedure". While another states, "information is not provided in depth. We usually have case studies or debates on this type of topic. Another comment" education regarding abortion is included in lecture plans. We as nurses must respect a woman's legislative right to have an abortion and we should be prepared to care for her in this

context. If there were a law against abortion, I would not integrate it into my lesson plan. I am pro-life."

Another anecdotal comment, "I teach it in high risk OB and discuss abortion r/t fetal demise, including pre-post op care. We briefly discuss all methods to induce abortion, but I do not allow discussion of personal beliefs or views. Topic in the past experiences is still hot! And the class loses the bigger focus of the lecture.

Other anecdotal comments reveal that some faculty feel the content is important. One faculty member stated, "I feel it is extremely important for student's to hear abortion is not illegal!! I am very careful to present the material in a nonthreatening way and to talk about the fact that is ok that not everyone has the same opinion. I have never had a student ask to be excused from a class or had one offer any negative comments after the class. I talk about the fact that if you have strong feeling about this subject, it is important to examine those feelings before you encounter your first patient that may need counseling on the subject. I also talk about the legal writes [sic] of nurses, physicians and pharmacists."

Another anecdotal comment by a faculty member again emphasized the importance of the content as she wrote, "Student's in women's health and maternity nursing will encounter EAB, no matter what. I feel it would be irresponsible of me as an instructor not to present this material in class. I also teach pharmacology and it is difficult not to discuss such mediation as the "abortion pill" and Plan B". Many of the anecdotal comments support the teaching of the content, with each faculty member who provided a comment reflecting the views of the society as a whole.

Faculty in Georgia are not concerned with safety related issues, community physicians, administration, funding restrictions, state legislation, or community attitudes. These themes have been identified in the literature as possible reasons why abortion curriculum is not taught, but in Georgia it does not significantly impact instruction. Time to teach, student religious beliefs/psychological impact, expertise to teach and curriculum priority outweigh many of the other factors that have been identified in the literature as possible reasons why abortion content is not taught. With abortion recognized as the most common surgical procedure in the U.S. (Shortobani, et al.2004; O'Connell, et al. 2009), it is important for the nursing education programs in Georgia to reevaluate the significance of this instruction.

Conclusions and Discussions

The conclusions of this study are a result of a thorough review of the relevant literature, dialogue with other nursing educators, pilot study, and results of both a national study and the study in Georgia. The following are conclusions rendered from this study.

Conclusion 1-Most Georgia Educators Teach Surgical Abortion. Currently, over 77% of nursing programs in Georgia provide direct instruction on surgical abortion through classroom or clinical experiences. Public attitudes on abortion have not changed over the decades of legalization (Jost, 2003). As described by Jost (2003), 45% are pro-life and 49% are pro-choice. The pro-choice movement is organized and with each political administration seeks to gain power. As a women's health practitioner, the researcher has witnessed protests at abortion facilities or facilities that may not perform abortion, but are known as supporters of women's rights.

Georgia nursing educators indicate through the research that abortion instruction is provided in either the classroom or clinical 77% of the time. This is higher than studies conducted in advanced practice nursing education programs. Even at 77%, there are still 23% of students in Georgia who do not receive instruction on surgical abortion, while other topics such as public health and abortion are taught less frequently. Up to 40% of unintended pregnancies result in abortion (Guttmacher, 2011), but surgical abortion instruction is provided in 77% of the nursing programs in Georgia.

The researcher supports both the woman's right to choose, but also the instructor's right to not teach the content, as long as there is a qualified instructor to teach the content. With over 1.2 million abortions yearly in the U.S. it is unconscionable to allow political or religious views to determine what is taught about subject areas. It is just as it is unconscionable that a registered professional nurse would deny care to a patient who engages in activities incongruent with our personal or religious opinions. Both incidences have been witnessed by the researcher and has shaped her personal and social views. As educators we impart knowledge to our students, not our bias. Critical theory provides the framework to bring the discussion to the forefront for rational discourse.

Westen, et al. (2008) suggests that we need to rethink the way we talk about abortion, creating a language that can withstand the scrutiny of the politicians and educators. Allowing for a full and informed examination of the issue can impact the outcomes of the educational experience. The Center for Reproductive Rights (2008) has recognized that unsafe abortion is a major threat to women's health. By liberalizing restrictive abortion laws and investing in safe abortions, governments can save lives of

tens of thousands of woman each year. History has shown that women, when faced with unwanted pregnancy, seek abortions regardless of the legality of the procedure. Many women have no choice but to undergo abortions performed by unqualified practitioners in unhygienic settings or by health care providers who lack the skills or knowledge to perform the procedure. Many women will experience complications of unsafe abortion, such as sepsis, hemorrhage, infertility, reproductive tract infections, and death.

According to the World Health Organization (2008), at least 78,000 women die each year from complications of unsafe abortion, and hundreds suffer from long or short term disability. It is estimated that over 20 million unsafe abortions are performed in the world, 95% of those are performed in low socioeconomic countries. Over 200 women die each day as a result of unsafe abortions in low income countries, and unsafe abortion is responsible for 13% of all maternal deaths globally.

In the 1980's, ten or more years after Roe vs. Wade a young woman, age 16, sought an abortion from a physician who performed abortions in his office, directly across the street from an large urban hospital in the state of Georgia. During the procedure the physician's surgical instrument penetrated the uterine cavity and the inferior vena cava. Emergency services, located directly across the street from the physician's office, was alerted and responded appropriately. The young girl died from a hemorrhage. I do not know why the young girl sought abortion, only that she sought them from a local physician in the area. I know this story because I was a labor and delivery scrub technician at the time of this incident. I witnessed the death of young woman in a society where abortion had been legalized. We must learn to talk about this

topic and find language that does not inflame or retard the discussion. Without talk there can be no action.

Conclusion 2-Georgia Educators Do Not Provide Accommodations. The results of the study indicate that the majority of Georgia nursing educators (70%) does Not provide accommodations for students who have a religious or moral objection to the abortion instruction.

Conclusion 3-Time to Teach Impacts Abortion Instruction in Georgia .Greater than two-thirds(70%) of the faculty has identified that time to teach as the primary factor in determining that impacts abortion instruction in Georgia. Time to teach is subjective and not appropriate given the purpose of nursing education. The review of the literature has shown that curriculum that is scientific based is available for use to instruct students, but this study revealed that 77% of students receive direct instruction on abortion. Breast cancer life time risk is 12% which translates to 1:8 women will receive a diagnosis of breast cancer. In comparison, 1.2 million abortions are performed annually in the United States or 1:3-4 women will undergo an abortion. I have been affiliated with 3 nursing education programs in Georgia and all 3 have included breast cancer instruction in the curriculum, compared to 2 programs that have included abortion instruction.

Conclusion 4-Networking is Essential in Enabling Research Methodology. The researcher conducted a pilot study, a national study, and a Georgia study in an effort to generate a response rate worthy of graduate education. In both cases, contacts were made via email and telephone contact, with limited responses. Numerous phone calls were made, and virtually no one returned the call. In the national study, primarily conducted through a telephone solicitation, the researcher made numerous phone calls, but the effort

did not yield significant results. At each turn, the committee reviewed collection techniques in an effort to produce a significant response rate. The response rates were unacceptable and required additional multiple collection methods to improve response rate.

The final study of Georgia did yield results and made for an adequate response rate. The researcher has been an educator in Georgia for over 20 years and she has many colleagues both in reproductive education and administration. The Georgia educators did provide data, data that as a whole is higher compared to data collected on advanced nursing education and medical education. Networking was essential in completing this study. The completion of this study was due to the willingness of nursing educators in Georgia to participate in this study.

Nursing education is on the forefront of transformation in the way it views education and the way it educates the professional nurse. In nursing education, critical pedagogy can facilitate freedom for individuals and allow us to define and reshape what knowledge is, how we know and come to understand, and who provides the evidence. Critical social theory can guide nursing education by promoting a caring and humanistic approach to research and practice. If we begin to understand why and how certain assumptions guide our actions, we can begin to describe and explain the oppressive effects of those actions on society. Nursing education can use the oppression to facilitate a transformation, much like Benner et al. (2010) describes in their research. In this approach knowledge is valued and as a result rational discourse evolves and transforms the way and what we teach.

Implications for Practice

On a national scale, this study has important implications for the profession of nursing. It is our responsibility as nursing educators to provide relevant education to our consumers: the students. With 40% of unintended pregnancies, ending in abortion, the topic is significant in nursing education and supports "time to teach" the content in the classroom.

Consider that approximately one-third to one-half of nursing education students in Georgia are not receiving any instruction on abortion and the other half is only receiving pieces of information. Students of Georgia undergraduate programs are not adequately educated to care for the patient who is contemplating abortion, or even pregnancy options. Nursing students in Georgia are inadequately prepared to care for many of the patients who present in reproductive health care centers. Research suggests that Georgia mirrors other states, but again, is still inadequately prepared to care for patients in the multiple practice settings. This study indicates pieces of instruction are being provided across the curriculum, but without consistency.

Other studies suggests only about half of all nursing students receive instruction in the area of abortion. It is unknown exactly what content is sufficiently taught, but based on this study and previous studies, it can be surmised that there is limited research related to abortion instruction. Knowledge is essential to understanding the complexities that surround this emotional and volatile subject, but without the positive discourse, curricular transformation cannot take place.

As educators have indicated, time to teach is identified as the primary reason abortion instruction is not provided. Of the top ten contextual factors that impact

instruction, five factors were related to curricular factors. Education is the key to contributing to this body of knowledge. In order to fill this gap in knowledge, programs should consider offering electives in reproductive education allowing those students that desire additional instruction in this area the option to obtain this knowledge, and encourage educators to become more knowledgeable in this area of content. The more nurses who are educated in reproductive content, the more professional nurses that will be experts in this field, leading the way toward a more open discourse.

As a nurse, I have had the opportunity to work in a variety of settings, both ambulatory and acute care settings. Based on my personal experiences a nurse will have 20-30 encounters with patients in any given setting, which are 100-150 encounters per week and over 5,000 patient encounters over a course of a year. Consider during this year the nurse will direct the care of 5,000 patients or more who will seek information and care from her. Many of the topics discussed in this research are public health topics, such as pregnancy options counseling and abortion and public health, all of which were areas nurse educators ranked low as instructional practices, 27.3%, 31.8%, respectively. Nurses are on the forefront of patient care and knowledge is essential to ensure patients receive quality care and complete information.

Implications for Research

As this was the first empirical study on the level of abortion education in the state of Georgia, further studies are needed to expand this research. This research started as a national study, but ended as a state study because response rates across the county were substantially low. Several suggestions for further research are as follows:

1. Faculty networking should be integral to any study on abortion or reproductive concept to ensure response rates are adequate.
2. Gather more descriptive data: demographics, type of accommodations, educational experiences of respondents, amount of didactic content
3. Data collection: Institute tracking in the web-based survey design, choosing best web-based platform to support the study, anecdotal comments.

As part of a consortium working to develop reproductive competencies, the researcher should have utilized the Reproductive Options Education colleagues early in the process to help secure response rates. The colleagues were very supportive in the research. There were efforts made on the behalf of the researcher by colleagues in other states, but it was noted too late to be of any use.

When the analysis piece of the research was reviewed, it became clear that limited demographic data was collected. This was intentional on the part of the researcher as it was felt asking additional demographic data of the respondent may make them feel anonymity was threatened and they would not complete the questionnaire. However, next time, additional demographic data would be requested so that a broader analysis might be attempted providing a clearer understanding of the findings.

Tracking was initiated on the first pilot study and as a result data were tracked easier. The ability to track responses made non-response follow up on the pilot study much easier. However, because tracking was utilized through SurveyMonkey.com, I determined many emails were sent to the junk mail boxes and were never actually read by the selected respondents.

The establishment of a network of professional educators who can assist in the identification and selection of appropriate individuals in reproductive education will increase response rates and contribute significantly to the body of knowledge. This individual can be the promoter within the state and the facilitator of the network to ensure data are collected.

SurveyMonkey was the platform used to gather data for this study. No other platforms were reviewed. At the time of the study initiative, there were not many platforms available that could accomplish the goals of this research. Since that time, the platforms are more sophisticated and can provide the researcher with a variety of options that can assist in data collection and analysis resulting in increased response rates.

While it is known and recognized globally that abortion is a complex subject, data were not collected to support that assumption. In future research, anecdotal or qualitative data should be collected more rigorously to better understand the enigma surrounding this controversial subject.

The study investigated if nursing educators provided accommodations for students related to a variety of types of abortion related content areas. While it was that determined most instructors do not provide accommodations, others did, but what type accommodations educators provided was not asked. The study assumed by the use of accommodation that the student is given an alternate assignment, but there were no data to identify this assignment.

Further, the critical educator is one who is committed to transform the classroom from its current pedagogy to one that incorporates dialogue and critique to empower its students, whether they are in the classroom or the community. Further, critical

educational theory combines the ability to critique and the ability to empower to develop effective change agents (Ironside, 2011).

Concluding Statement

In Georgia, 77% of students in nursing education programs receive direct instruction on abortion or related reproductive issues. Based on the findings, Georgia does not mirror other states and health professional programs, most indicating that about half of their students receive instruction in abortion related topics.

It is the hope that this study and its findings will contribute to the dialogue. One of the central tenets of the critical educational theory is the ability to create a dialogical practice. According to Freire (2007) dialogue is a way of knowing and should never be viewed as a task, but rather a way to engage the other person, an indispensable component of both leaning and knowing.

To bridge the gap between theory, research, and practice, there must be radical critical reflection about abortion curriculum and the factors that impact delivery of the instruction. Educators must be engaged in facilitating empowerment of students and willing to dismiss themselves from the classroom if they are not wholly prepared to facilitate the learning. The educator must pass the torch to those who are prepared to engage in the dialogue and transform the classroom facilitating change and eliminating oppression.

Educators identified “time to teach” as the primary factor that impacts this instruction. It is the goal of this researcher to further the dialogue within professional groups to emphasize the incidence of abortion and the need to educate students in this

specialty area. This allows the student to reach his full potential delivering quality nursing care in a nonjudgmental and nonbiased manner.

Further, I hope that this research will serve as the impetus for further research, not only in Georgia, but across the nation. Recognition that a problem exists is the first step in making the change with eventual acceptance. As educators we must ask ourselves, " Is it morally acceptable to not include this topic in our classroom, and is it ok to allow students to "opt out" of the classroom when it is evident from the research that 1.2 million abortions are performed in the United States yearly". The recognition and acceptance can create an opportunity for change, without resistance. In the words of Shannon (Benner, et al., p.174) "It is not about you, it's about the patient and the family. What you personally think doesn't matter. It's how you act professionally as a nurse that matters".

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APPENDIX A

FINAL QUESTIONNAIRE WITH SUPPORT DOCUMENTS

Participant #_____

Telephone Questionnaire
Study Title: Exploring Abortion Education in Undergraduate Nursing Programs

Participant Phone Number_____

Call #1 Date_____ Return Call_____

Call #2 Date_____ Return Call_____

Call #3 Date_____ Return Call_____

Call#4 Date_____ Return Call_____

Call #5 Date_____ Return Call_____

Script for Telephone Interviews (**Bold** identifies the actual script for the telephone survey).

Identify 100 faculty members for participation in a telephone survey. Determine their phone number either through a direct line found on the website or call the administration assistance and asked to be forwarded to the person responsible for teaching in family nursing or obstetrics.

A. **Hello, my name is Kim Hudson-Gallogly from the University of Georgia. I would like to talk to the person on your faculty who is responsible for teaching obstetrics, family nursing.**

B. **Hello, my name is Kim Hudson-Gallogly (or I am representing the researcher Kim Hudson-Gallogly). Doctoral Candidate Hudson- Gallogly is from the University of Georgia and currently we are conducting a research study looking at instruction on abortion in undergraduate nursing education.**

C. **We hope you can give us a few minutes of your time to answer some questions about instruction of abortion in your nursing program. Are you the best person to answer questions on instruction on abortion?**

   If the response is yes**: Could you can give us a few minutes of your time, it should not take more than 10-15 minutes?**

If the response is no**: Could you provide the name and phone number of the best person to answer these questions?** Yes:_____, No, **Thank you**. Return to website to locate contact information for the appropriate faculty member to respond to the survey.

D. Would it be a good time to talk or would it be better for me to call back at another time? Yes _____ No_____(If yes, proceed to the next paragraph, if no, **ask the participant when is a better time to call back_____).**

E. Before we can go any further, you should know that everything you say will be strictly confidential. Your involvement is the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. The researcher guarantees that neither your name nor the name of your institution will ever be used in any report produced from this study. There are no known risks or discomforts associated with this research. Can you help us by giving us some of your time and knowledge regarding your nursing program? In doing so you are implying consent to proceed. If at any time you would like to stop the telephone survey, you may do so. Please state that you would like to end the survey at any point and I will stop the survey.

F. **Are you willing to proceed with the survey?** Yes____ (proceed to G section)

No____ (**Thank you for your time)**.

G. I am going to give you several statements regarding instruction on abortion. You are to reply based on the practice in your institution. You will respond using the response scale provided. I will repeat the question/statement and the response scale each time. Do you understand?

H. Any questions?
If the participant asks if this is the same survey she received a few months ago, advise **yes it is, and in order to improve the validity of the study, we are contacting all participants again).**

(Again, ask):
Are you willing to proceed? (Yes____, proceed or

No_____. (**Thank you for your time)**

A. The first group of questions deals with the type of instruction on abortion offered in your program. **You will be asked to describe the type of instruction students in your program receive on 12 topics. I will read the response scale**

at the end of each question. The response scale is: reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical (The researcher will highlight the response of the participant on each question.)

1. **Do students in your program receive instruction on abortion and public policy?** If no, move to the next question. If yes, **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

2. **Do students in your program receive instruction on abortion and the law?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

3. **Do students in your program receive instruction on post abortion counseling?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

4. **Do students in your program receive instruction on pregnancy options counseling?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

5. **Do students in your program receive instruction on pre-abortion counseling?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

6. **Do students in your program receive instruction on medication abortion?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

7. **Do students in your program receive instruction on the nursing care of the woman undergoing a medical abortion?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

8. **Do students in your program receive instruction on surgical abortion?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

9. **Do students in your program receive instruction on the nursing care of the woman undergoing a surgical abortion?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

10. **Do students in your program receive instruction on post abortion care?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

11. **Do students in your program receive instruction on abortion and its impact on public health?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

12. **Do students in your program receive instruction on the ethical and religious dilemmas of abortion?** If no, move to the next question. If yes, , **(a) reading assignments only, (b)classroom instruction only, (c) clinical experiences only, or (d) classroom and clinical? I repeat, reading assignments only, classroom instruction only, clinical experiences only, or classroom and clinical?**

B. **Thank you for your responses, we will now move to the next group of questions. The following 6 questions are focused on accommodations that your program may offer to a student who has a moral or religious objection**

to instruction on abortion. For the purpose of this study, accommodation is defined as providing the student with an excused absence or alternative assignment in lieu of instruction about abortion. I will ask the question and provide you with the response scale to describe level of accommodation at the end of each question. The response scale is: no instructors make accommodations, some instructors make accommodations, or all instructors make accommodations Do you understand? Yes____ No_____. If yes, proceed to the questions. If no, repeat the above paragraph in its entirety. The researcher will highlight the response of each participant.

1. **Do instructors in your program offer accommodations to students for lectures discussing the impact of abortion on public health. (a) No instructors make accommodations, (b)Some instructors make accommodations, (c) All instructors make accommodations.** Repeat statement and options if pause is noted.

2. **Do instructors in your program offer accommodations to students for lectures discussing the medical or surgical techniques of abortion. (a) No instructors make accommodations, (b) Some instructors make accommodations, (c) All instructors make accommodations.** Repeat statement and options if pause is noted.

3. **Do instructors in your program offer accommodations to students for lectures discussing the complications of abortion. (a) No instructors make accommodations, (b) Some instructors make accommodations, (c) All instructors make accommodations.** Repeat statement and options if pause is noted.

4. **Do instructors in your program offer accommodations to students for lectures discussing the pre and post counseling of the woman undergoing an abortion. (a) No instructors make accommodations, (b) Some instructors make accommodations, (c) All instructors make accommodations.** Repeat statement and options if pause is noted.

5. **Do instructors in your program allow the student to refuse to participate in small group activities/discussion on how to counsel a woman on reproductive options. (a) No instructors make accommodations, (b) Some instructors make accommodations, (c) All instructors make accommodations.** Repeat statement and options if pause is noted.

6. **Do instructors in your program allow the student to refuse to participate in small group activities/discussions on the ethical issues of abortion? (a) No instructors make accommodations, (b) Some instructors make**

accommodations, (c) All instructors make accommodations. Repeat statement and options if pause is noted.

C. **Thank you for your responses, we will now move to the next group of questions. The following 14 statements are focused on the factors that may impact the decision to offer instruction on abortion in your program? I will provide you with a factor and you will be given the response scale to describe the level of impact. The response scale is: not at all, to some extent, and to a great extent. Let me repeat those options once again: not at all, to some extent, and to a great extent. Do you understand?** Yes_____, No_____. If yes, proceed to the factors. If no, repeat the paragraph again. (The researcher will circle the participants response).

1. **To what extent do your state legislators affect your program's decision to offer instruction on abortion? (a)Not at all, (b) To some Extent, (c)To a great extent.** Repeat statement and options if pause is noted**.**

2. **To what extent does the college administration affect your program's decision to offer instruction on abortion? (a) Not at all, (b) To some extent, (c)To a great extent.** Repeat statement and options if pause is noted

3. **To what extent do the community physicians affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

4. **To what extent does the opinion that abortion is not viewed by the faculty as a high priority affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

5. **To what extent does the lack of time in the curriculum to teach abortion content affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

6. **To what extent does the lack of faculty expertise in providing abortion related nursing care affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

7. **To what extent do the student's religious or moral beliefs about abortion affect your program's decision to offer instruction on abortion? (a) Not at**

all, (b)To some extent, (c)To a great extent Repeat statement and options if pause is noted

8. **To what extent do the faculty's religious or moral beliefs about abortion affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

9. **To what extent do the attitudes of the community about abortion affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

10. **To what extent does the lack of quality text books and materials affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

11. **To what extent does the perceived lack of scientific-based curriculum on abortion affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

12. **To what extent does personal safety of faculty affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

13. **To what extent does the perceived psychological impact of instruction on abortion on students affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

14. **To what extent does the funding for the nursing program restrict instruction of abortion in the classroom affect your program's decision to offer instruction on abortion? (a) Not at all, (b)To some extent, (c)To a great extent** Repeat statement and options if pause is noted

D. **Thank you for your responses. We are nearing the end of the survey. I will now ask you some basic demographic questions and you may select the best response for you and your program. Do you understand?** Yes___ No____. If yes, proceed to demographics. If not, repeat the paragraph.

1. **In what state do you practice?**_____

2. **Which of the following statements best describes your institution?(**The researcher will circle the participants answer)
    a. **A publicly funded college or university (not affiliated with armed services) or**
    b. **A publicly funded college or university(affiliated with the armed services)**
    c. **A private college or university(not religiously affiliated)**
    d. **A private college or university (with a religious affiliation)**
    e. **A regional health center**
    f. **Other –please specify_____**

3. **What is your title at your present position?**
    a. **Administration which includes a Dean, or program director/coordinator**
    b. **Faculty**

4. **What type program do you teach in?**
    a. **Diploma**
    b. **Associate**
    c. **Baccalaureate**

5. **What is your gender?**
    a. **Male**
    b. **Female**

6. **What is the highest degree you have earned?**
    a. **Associate**
    b. **Baccalaureate**
    c. **Master**
    d. **Doctorate**

Do you have additional comments or personal experiences you would like to share with me regarding instruction on abortion at this time. Yes_____ No_____

_____
_____
_____
_____
_____
_____

If you would like to share your comments/experiences via email you may send them to khg@uga.edu

Thank you for participating in this survey research. Your feedback is essential in determining if abortion is provided in undergraduate nursing education programs in the United States. Additionally, you have helped to identify factors which may

influence instruction on abortion. This information will be useful in understanding the social, cultural, and political impact of this subject matter.

Your decision to participate in this study is valued.

Informed Consent:
This is notification of implied consent for the research titled Exploring Abortion Instruction in Undergraduate Nursing Education. The purpose of this research is two fold. First, we want to determine if abortion instruction is included in the reproductive curriculums of undergraduate nursing programs. Secondly, we want to investigate the factors that may impact the instruction of abortion in the classroom. Please know that the research is being conducted by the below individuals with intent to publish. It is expected this research will provide the researchers with insight on classroom and clinical management of this sensitive topic.

Lorilee Sandmann, PhD
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*Kim Hudson-Gallogly is the program director for an undergraduate nursing program at Gwinnett Technical College. All work on this research study is in her capacity as doctoral candidate at the UGA Department of Adult Education.

Your participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty or loss of benefits to which you are otherwise entitled, or skip any questions that you feel uncomfortable answering. We do not foresee any psychological, social, legal, economic, or physical discomfort, stress or harm that might occur as a result of participation in this research because the participant may refuse to participate or withdraw at any time. It should take approximately 10-15 minutes to complete the questionnaire. All of your responses will be confidential and will not be associated with your name, email address or any other individually identifying information.

Please note the following: Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the survey is received by the researchers, standard confidentiality procedures will be followed. In addition, only summary data will be reported.

Given that communication via the Internet is more risky in regards to privacy, if you prefer, you can open a PDF version of the survey instrument, complete by hand, and then submit via FAX or U.S. Postal Services.

Exploring Abortion Instruction in Undergraduate Nursing Education: A National Study (pdf)
UGA Department of Adult Education
c/o Dr. Lorilee Sandmann and Kim Hudson-Gallogly
River's Crossing, 4th floor
Athens, Georgia 30602
FAX: 706.542.4024

If you have any questions, feel free to contact us at any time for any questions you may have. You may contact Kim Hudson-Gallogly, Co-Investigator (404)376-5205 or khg@uga.edu.

Additional questions or problems regarding your rights as a research participant should be addressed to IRB chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411, Telephone 706.542.3199, email address irb@uga.edu.

Distribution Date:

PRE-NOTIFICATION OF RESEARCH STUDY
Exploring Abortion Instruction in Undergraduate Nursing Education
Kim Hudson-Gallogly and Dr. Lorilee Sandmann
University of Georgia, Department of Lifelong Education, Administration, & Policy
Program in Adult Education

Dear Nursing Educator,

I am a nursing educator currently fulfilling requirements for a doctorate in adult education. We are currently conducting a research study to determine if abortion instruction is provided in undergraduate nursing programs and what factors may influence such instruction. This past year has been spent investigating abortion instruction in the classroom. Based on our research, we have developed a questionnaire that will help us better understand the influence of social, cultural, and religious beliefs on abortion instruction in the undergraduate nursing curriculum

We need your help to successfully complete an IRB-approved study of this important issue. You will receive a request to participate email during the week of August 1-7, 2010. The questionnaire will be attached to this email. We are sending the questionnaire prior to the telephone call to allow you time to review the questions. The questionnaire will ask you to report on your knowledge of abortion instruction in your curriculum as a member of your college/university faculty. We would greatly appreciate if you would take 10-15 minutes of your time to complete the questionnaire by telephone. We will call between the hours of 8-5 on Monday-Friday of each week. If you have a preferred time, please notify us and we will accommodate your schedule. Additionally, if you would like to mail or fax your questionnaire responses, please do so at the address provided in the informed consent attached to this email.

All your responses will be confidential and will not be associated with your name or your institution. Only summary data will be reported.

Please send an email to the study director if you would like to be removed from this study group email list at this time.

Thanks in advance for your help in completing our research study. We will provide any participant with a summary of the study. Please contact me at khg@uga.edu if you would like a summary.

Kim Hudson-Gallogly*, MS, RN, WHNP-BC
Co-Investigator & Doctoral Candidate
Adult Education, University of Georgia
khg@uga.edu

Lorilee Sandmann, Ph.D.

Associate Professor
Adult Education, University of Georgia

**Kim Hudson-Gallogly is the program director for an undergraduate nursing program at Gwinnett Technical College. All work on this research study is in her capacity as doctoral candidate at the UGA Department of Adult Education.*

Informed Consent:
This is notification of implied consent for the research titled Exploring Abortion Instruction in Undergraduate Nursing Education in Georgia. The purpose of this research is two fold. First, we want to determine if abortion instruction is included in the reproductive curriculum of undergraduate nursing programs. Secondly, we want to investigate the factors that may impact the instruction of abortion in the classroom. Please know that the research is being conducted by the below individuals with intent to publish. It is expected this research will provide the researchers with insight on classroom and clinical management of this sensitive topic.

Lorilee Sandmann, PhD
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Your participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty or loss of benefits to which you are otherwise entitled, or skip any questions that you feel uncomfortable answering. We do not foresee any psychological, social, legal, economic, or physical discomfort, stress or harm that might occur as a result of participation in this research because the participant may refuse to participate or withdraw at any time. It should take approximately 10-15 minutes to complete the questionnaire by telephone, email or web-based. All of your responses will be confidential and will not be associated with your name, email address or any other individually identifying information.

Please note the following: If you choose to return your survey via fax, email, or web-based, please remember phone lines and internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the survey is received by the researchers, standard confidentiality procedures will be followed. In addition, only summary data will be reported.

Given that communication via the Internet or fax is more risky in regards to privacy, if you prefer, you can return the PDF version of the survey instrument provided in the pre notification email, complete by hand, and then submit via U.S.

Postal Services.

Exploring Abortion Instruction in
Undergraduate Nursing Education in
Georgia UGA Department of Adult
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If you have any questions, feel free to contact us at any time for any questions you may have. You may contact Kim Hudson-Gallogly, Co-Investigator (404)376-5205 or khg@uga.edu.

Additional questions or problems regarding your rights as a research participant should be addressed to IRB chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411, Telephone 706.542.3199, email address irb@uga.edu.

1. The following questions focus on the type of instruction on abortion offered in your program, accommodations offered in your program for students who have religious or moral objection, and identification of factors that may impact the decision to offer abortion instruction. For the purpose of this study accommodation is defined as providing the student with an excused absence or alternative assignment in lieu of instruction about abortion.

Do students in your program receive instruction on abortion and public policy?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

2. Do students in your program receive instruction on abortion and the law?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

3. Do students in your program receive instruction on post abortion counseling?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

4. Do students in your program receive instruction on pregnancy options counseling?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

5. Do students in your program receive instruction on pre-abortion counseling?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

6. Do students in your program receive instruction on medication abortion?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

7. Do students in your program receive instruction on the nursing care of the woman undergoing a medical abortion?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

8. Do students in your program receive instruction on surgical abortion?

◯ a. Reading assignments only

◯ b. Classroom instruction only

◯ c. Clinical experiences only

◯ d. Both classroom and clinical

Other (please specify)

9. Do students in your program receive instruction on the nursing care of the woman undergoing a surgical abortion?

◯ a. Reading assignments only

◯ b. Classroom instruction only

◯ c. Clinical experiences only

◯ d. Both classroom and clinical

Other (please specify)

10. Do students in your program receive instruction on post-abortion care?

◯ a. Reading assignments only

◯ b. Classroom instruction only

◯ c. Clinical experiences only

◯ d. Both classroom and clinical

Other (please specify)

11. Do students in your program receive instruction on abortion and its impact on public health?

◯ a. Reading assignments only

◯ b. Classroom instruction only

◯ c. Clinical experiences only

◯ d. Both classroom and clinical

Other (please specify)

12. Do students in your program receive instruction on the ethical and religious dilemmas of abortion?

- a. Reading assignments only
- b. Classroom instruction only
- c. Clinical experiences only
- d. Both classroom and clinical

Other (please specify)

13. Do instructors in your program make accommodations to students for lectures discussing the impact of abortion on public health?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

14. Do instructors in your program offer accommodations to students for lectures discussing the medical and surgical techniques of abortion?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

15. Do instructors in your program offer accommodations to students for lectures discussing the complications of abortion?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

16. Do instructors in your program offer accommodations to students for lectures discussing the pre and post counseling of the woman undergoing an abortion?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

17. Do instructors in your program allow the student to refuse to participate in small group activities/discussions on how to counsel a woman on reproductive options?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

18. Do instructors in your program allow the students to refuse to participate in small group activities/discussions on the ethical issues of abortion?

- a. No instructors make accommodations
- b. Some instructors make accommodations
- c. All instructors make accommodations

Other (please specify)

19. To what extent do your state legislators affect your program's decision to offer instruction on abortion?

- a. Not at all
- b. To some extent
- c. To a great extent

Other (please specify)

20. To what extent does the college administration affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

21. To what extent do the community physicians affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

22. To what extent does the opinion that abortion is not viewed by faculty as a high priority affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

23. To what extent does the lack of time in the curriculum to teach abortion content affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

24. To what extent does the lack of faculty expertise in providing abortion related nursing care affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

25. To what extent do the student's religious or moral beliefs about abortion affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

26. To what extent do the faculty's religious or moral beliefs about abortion affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

27. To what extent do the attitudes of the community about abortion affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

28. To what extent does the lack of quality text books and materials affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

29. To what extent does the perceived lack of scientific-based curriculum on abortion affect your program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

30. To what extent does personal safety of faculty affect the program's decision to offer instruction on abortion?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

31. To what extent does the perceived psychological impact of abortion instruction on students affect your program's decision to offer abortion instruction?

◯ a. Not at all

◯ b. To some extent

◯ c. To a great extent

Other (please specify)

32. To what extent does the funding for nursing program restrict instruction of abortion in the classroom affect your program's decision to offer instruction on abortion?

- ◯ a. Not at all
- ◯ b. To some extent
- ◯ c. To a great extent

Other (please specify)

Please provide the following information about your program and yourself. All information will be treated with complete confidentiality. No data will be reported about individual schools or respondents.

33. Which of the following best describes your institution?

- ◯ A publicly funded college or university (not affiliated with the armed services)
- ◯ A publicly funded college or university (affiliated with the armed services)
- ◯ A private college or university (not religiously-affiliated)
- ◯ A private college or university (with a religious affiliation)
- ◯ A regional health science center
- ◯ Other (please specify)

34. Please provide information regarding yourself and institution. What is your title at your present position?

- ☐ Administration: Program Dean, Director, or Coordinator
- ☐ Faculty

35. Program type:

- ◯ Diploma
- ◯ ASN/ADN
- ◯ BSN

36. What is your gender?

- ◯ Male
- ◯ Female

37. What is the highest degree you have earned?

- [ ] Associate
- [ ] Baccalaureate
- [ ] Master
- [ ] Doctorate

38. We appreciate any additional comments you would like to share. If you have personal experiences that you would like to share with us regarding abortion instruction and practices please feel free to use the space below to do so.

We would like to thank you for participating in this survey research. Your feedback is essential in determining if abortion instruction is provided in undergraduate nursing programs in the United States and identifying factors which may influence abortion instruction. This information will be useful in understanding the the social, cultural and political impact of this subject matter.

If you would like to share your comments/experiences via email, please send them to khg@uga.edu

Your decision to participate in this study is valued.
Again, thank you for your input.

APPENDIX B

CONSTRUCT INDICATORS

Collapsing of Themes into categories for questionnaire inclusion: Conceptual Map

Contextual Factors that influence →	**Program Practices**
Institutional/Community • Public/private institution • Religious/moral	*Topics:* ***Law/Politics*** *Abortion and public policy* *Abortion and the law* ***Religious/Ethical Dilemmas:*** *Abortion related to* ***Public Health:*** *Abortion and* ***Care of the Woman Undergoing an Abortion:*** Post abortion counseling Pregnancy options counseling Medication abortion Nursing care of the woman undergoing a medical abortion Surgical abortion Nursing care of the woman undergoing a surgical abortion Post abortion care ***Types of instruction:*** Classroom only Classroom and Clinical Classroom and no clinical No instruction ***Accommodations:*** Lectures Small group activities Small group discussions
Personal Characteristics/Views • Where you teach • Gender • Personal Experiences* • MD views opposes abortion • Legislator opposes abortion	
Desire for efficiency • Teach what's on the test* • Time constraints	
Concern for Safety • Public reaction • Workplace consequences • Violence and harassment	
Belief in Importance • Abortion as common procedure • Professional preparedness	
Respect for Individual Beliefs • Student reaction • Faculty reaction	

APPENDIX C

PROGRAM PRACTICES ITEM REFINEMENT

Abortion is recognized by professional organizations as an important topic for inclusion in school curricula	Espy, Ogburn, Leeman, Ngymen, Gill 2008 Abortion Education in the medical curriculum
Abortion is an appropriate topic for education	"
Students with moral objections should be excused from lectures about ph impact on abortion and	"
Lectures about the techniques of abortion and	"
Clinical experiences regarding abortion	"
Against Personal Values	"
I may be ostracized by my colleague	"
Discriminated against in my profession	"
I fear that either I or my family will be harassed or threatened	"
When an educational component is not integrated into curriculum , fewer students participate	"
Lack of text books that adequately address subject	Foster, et al.
Abortion issues are not viewed as curriculum priority	"
Abortion provider shortage constitutes a considerable institutional barrier to incorporation of abortion into routine APC curriculum	"
Lack of clinical sites	"
Lack of qualified faculty	"
Lack of support in the provider/MD community	"
Migration of abortion services into specialty clinics have exacerbated this barrier to training	"
Religiously affiliated health care system	"
Inclusion of abortion is incompatible with religious sponsored health care systems	"
Religious refusal extends throughout a health care system	"
I am open to hearing how I can incorporate this topic without insulting a student's belief system	"

Politically charged topic	“
Disapproval of administration	“
Uncertainty s to the role of abortion in advanced practice	“
Response bias to questionnaire as many of the respondents hold strong opinions about the moral and religious permissibility of abortion in general and inclusion in the APC curricula	“
Course title was misleading as “sexual health elective”	Caro-Bruce et al.
Medical school survey found less than 30 minutes of abortion curriculum	“
Ethics forum on abortion that was ultimately incorporated into the preclinical ethics curriculum	“
Limitations in teaching sexual health in general and abortion in particular	“
Professors encourage development of elective, but were overextended and unable to sponsor project	“
Students desired less abortion content	“
Pro life attendees attended the abortion clinic and had a positive educational experience	
Correlation between age of student and propensity to feel that abortions should be broadly available,	Rosenblatt et al.
Shortage of providers	Wear et al.
Bottom feeders- an antiabortion flyer sent to US medical students	“
Paucity of abortion education and training options in US medical school	“
It is a medical procedure	“
Abortion should not be provided	National Abortion Federation questionnaire
Extends beyond the scope of practice for the NP/PA	Foster, et al.
Exempt from abortion clinic clinicals	“
Exempt from lectures on abortion	“
Exempt from small group activities	“
Exempt from observations or in hospital based experience	“

APPENDIX D

CONTEXTUAL FACTORS ITEM POOL

Abortion is deemed a problem	Josten, Wilcox 2003
Wording of abortion does not matter	“
Of all social predictors, abortion attitudes, religion is generally considered tobe the strongest	“
Research has shown that frequent church attendenance is associated with greater oppositions to abortion	“
Opinions have been stable on abortion	“
Abortion has been and important and divisive issue in American politics	“
Abortion has become a political issue	“
Added abortion emphasizing counseling and contraceptive education	Early ab in a family planning clinic, 2006, Goldsmith,
Those with reservations about AB selected other work such as desk work	“
Manslaughter conviction of abortionist which rules manslaughter only if the baby is definitely alive	NRL, 2006 History of AB
No constitutional right for women to receive abortions at public expense	“
US Congress approves the amendment barring the use of federal employee’s health benefits to pay for AB, except in the life of the mother.	“
A right to an abortion is not secured by the constitution rejected in 1983	“
Regan, counseling must be included in order to get funds	“
Definitive account of the illegal, clandestine, and often unsafe abortions practiced from 1867-1960’s	When AB was a crime, wmen, medicine, Roemer, 1998
Raids of abortionists offices by police led to enforcement of criminal abortion laws that punished women by subjecting them to intrusive questioning.	“
Historians provide a refreshing shake up to the stultifield debate over the moral interpretation no fetal status	Webster, Heatlh and History, Chavkin, 1990
Physician opposition to abortion in the mid nineteenth century stemmed largely from a desire to establish professional sovereignty and to stake out a moral high ground in order to distinguish themselves from the irregular healers.	“

Negative impact of restricted abortion	“
State imposed restriction on abortion will sabotage medcine’s proclaimed goal of furthering patient health	“
Perceive moral quandaries are limited in time and place and thus underscore the social and political nature of the argument	“
The chance of dying as a result of a legal abortion in the US is far lower than the change of dying during childbirth.	Abortion, artificially induced abortion around the world, wwwdeathreference.com/A-BI/Abortion.html
State laws forbidding abortion unless a pregnancy was life threatening	Belsky 1992 Medically indigent women seeking AB
Abortions were done for ward patients later than for private patients and commented on the increasing number of abortions done for psychiatric reasons.	“
Four women tried to self abort, one subsequently hospitalized for treatment of septic abortion caused by a Lysol douche.	“
McCains Anti Choice appeal scarred by old battle	3/08 Cooper WeNews correspondent
Plenty of anti choice activists have given McCain a nod	“
NARAL Pro Choice has given McCain a 0 out of 100 –he took anti choice 123 of 128 votes	“
NE said there was an enormous amount of misinformation in the area of FP	Education on Abortion, urged, Australian Nursing Journal, 1995 Sam Prenesti
A study found that there was no uniformity in the information and education for nurses on TOP	“
I don’t know what nurses can do in that situation but I guess if nurses have the information then they can perhaps start to be involved in policy and play a far greater role in ensuring women have choices when they are faced with unplanned pregnancy	“
Many medical educators, even legislators have come to recognize the importance of teaching about abortion.	Abortion: Teaching why as well as how. 2003 Stewart, Darney
The exclusion of abortion from the services provided to women in teaching hospitals has meant that many students complete their training with little or no experience in providing abortion care	“

PH framework may not be helpful to the student who encounters challenging moral or religious questions about abortion.	“
Women are just as likely to get an AB in countries where it is illegal as they are in countries where it is legal.	The Times, Gainesville,October 2007
Prejudice or bias toward women or sex could be expressed in a negative attitude which, in turn could effect the clergy’s attitude toward induced AB	Price-Bonham, Santee, Bonham, 1975 An analysis of clergymen’s attitude toward AB
Does the fetus have a soul?	“
Three religions do not agree on the subject	“
No systematic way to attempt to trace how Americans historically have felt toward abortion	Attitudes to Abortion in American 1800-1973 Sauer 1975
Abortion and infanticide	“
Abortion a rather common phenomenon 1839	“
The moral and policy debate over AB in the US has become so intransigent and polarizing that comparison to the nation’s divisive experience with slavery and civil war are commonly drawn	Abortion in America: A Consumer Behavior Patterson, Hill,Maloy, 1995
Birth or abortion decision have emotional moral and practical components	“
Abortion is one of the most controversial social issues of our time	Attitude strength and social action in the abortion dispute, Scott, Schuman, 1988
There has been some concern that it has become an overriding issue in elections.	“
Anti abortion respondents who are affiliated with religious organizations opposes abortion, Catholic Church, Fundamentalist—strong condemnation of abortion stems from religious commitments and defense of traditional morality	“
Blacks will regard the abortion issue less than whites	“
Political activism	The Abortion Controversy: Conflicting beliefs and values
No differences among democrats, independents and republicans in how they responded to abortion, it could have been related to religious affiliation influence	“
Abortion wasn’t talked about in the late 1950’s-1960’s	Reflections of a Provider before and since Roe vs Wade from the voices of choice archive, Pelletreau, 2003
The MD dilemma: Abortion was absolutely	“

not a part of the practice of medicine, and avoiding ties to illegal providers, did not want to taint myself.	
In the 1960's we did legal abortions, we went through the sterilization committee as a threat to the life of the woman…it was a big charade	"
Frustrations with the law—it just didn't make sense	"
We must educate people that abortion is an important part of medical care.	"
The attitudes and beliefs of potential clients are known to play a critical role in whether or not a woman will choose medical vs surgical abortion.	Knowledge and perceptions of medical abortion among potential users, Harvey, Beckman, 1995
Clinics that continue to provide abortions have been threatened, bombed and burned	"
National information on the characteristics of women who have abortions come from the CDC, however, notably lacking has been any national information on her religion, income, or political attitudes	Women who have had abortions, family planning perspectives, 1982
Women will conceal their abortion history	"
US Catholic women are as likely to have abortions as Protestant women	"
Church's strong opposition to AB	"
When life begins vs unborn is a person	Abortion and public opinion in the US, Blake 1977
Human person vs human life	Solinger, A complete disaster: AB 1950-1970 1993
Unborn child	
They adapted a legalistic. Tribunal method which tightened the association between two powerful professions—legalizing medicine and medicalizing the law	"
A health care provider's moral or religious beliefs cannot justify attempts to override a patient's autonomy	Rights vs Responsibilities, Sonfield, 2005 Guttmacher
New refusal clauses shatter balance between provider conscience patient needs allowing health care providers, institutions and payors to refuse to participate in sexual and reproductive health service by claiming moral or religious objections	New refusal clauses shatter…Sonflied, 2004 Guttmacher

Supreme Court uphold federal abortion ban, opens door for further restrictions by state	Guttmacher, 2007 Policy Review
The federal partial birth abortion ban act is the first federal law aimed at ciminalizing an abortion procedure since Roe v wade	Guttmacher, 2004 Dallard
To understand the changes in the international environment on the abortion issue for the last two decades, analysis must begin with the single most influential factor—the government of the US	The transnational politics of abortion, Crane, 1994
Botched abortions	The politics and practice of abortion, 1987
Hyde amendment—forbids the use of federal funds for abortions except….	State policies, 2007 Guttmacher
Faith in hiding, are there secular grounds for banning AB	Thomas Clark, same title, 2007 The Humanist
Life always trumps liberty--- (declaration of independence asserts rights to life, liberty and pursit… Woman's right of liberty vs fetus life..	"
The faith based claim that God endows a newly formed embryo with an immortal soul is sectarian and it invokes a religious worldview that might not hold true for the whole world.	"
Creating havoc at a Milwaukee abortion clinic	Abortion clinic protests, CQ Researcher 1995
1, 712 acts of violence since 1977-1995	"
1,500 clinics experience death threats, stalking, bombing,	"
Any antiabortion amendment to the Constitution would undermine the first, ninth, and fourteenth amendment.	US Civil Rights Commission, 1975, Family Planning Perspectives
When does life begin	"
Is a matter of religious controversy	"
Murdering a baby	Privacy Rights and AB outing: A proposal for using common law torts…1994, Chapman
Abortion MD are target of intentional exposure, picket outside MD's homes, photograph them, videotape them, and observe thru binoculars	"
Abortion clinic bombings as political violence	Same title, Nice, 1988, American Journal of Political Science
Reports on abortion clinic bombings indicate that a small minority of people believe that	"

bombings may indeed help the antiabortion cause	
Strength of the antiabortion movement is the relative prominence of religions that are generally opposed to AB	
Is it ethical to tamper with the reproductive process	Phillips, 1994
Battle lines drawn on the AB issue remain clearly drawn 30 years after R vs W	CQ Researcher, 2003, Jost, Abortion Debates
Anti abortion militant faces life in prison after being found guilty of second degree murder in the shooting of MD	"
Number of protestors and clinics escorts grow	"
S.D. has become the latest battlefield in the abortion wars, a referendum will let voters approve or reject a new law aimed at banning virtually all abortions in the states.	Abortion Showdowns, CQ Researcher, 2006
Protect the woman's life	"
Face it Abortion kills, (sign is over a baby's face)	
Most Americans are against most abortions	"
A woman's right to choose	"
In spite of frequency of unintended pregnancy and abortion, many nurse practitioner etc do not adequately prepare	ROE, Foster, et al. 2006
Resource poor women face greater maternal mortality and morbidity due to lack of access to services	Samora. Leslie, 2007 AWHONN, The Role of Advanced practice clinicians in AB services…
Increased experience or the potential for experience with abortion patients tended to increase the favorableness of attitudes toward the issue	Allen, Reichelt, Shea, 1977 Two measures of nurses attitudes toward abortion
Many nurses opposed to AB from both professional and personal viewpoints	"
Exposure of nurses to AB activities frequently resulted in negative affect	"
One might infer that AB services could be seriously curtailed by the reluctance of nurses to participate voluntarily.	"
Right to life protestors seen as the forces of narrow-minded intolerance who would deny women access to a choice that is seen as fundamental to women's freedom and ability to overcome sexual discrimination	Procreation Stories—Faye Ginsburg 1987 American Ethnologist
Narcissistic attitudes toward sexuality	"

Isaia44 I knew you before you were formed in your mother's womb, fear not, for you are my witness	"
Abortion is of crucial importance because it negates the one irrefutable difference between man and women, it symbolically destroys the precious essence of womanliness-nurturance and pro AB women open themselves up to hypocrisy by indulging in unethical use of power to usurp the rights of the less powerful	"
Became acutely aware of how little physicians knew about women's bodies	"
Judeo Christian principles Family with a strong sense of ethics Difficulty stomaching what goes on in churches in the name of Christianity, those opposed to abortion will attempt to say their moral beliefs are the only correct ones	"
Abortion mortality constitutes at least 13% of maternal mortality	Making Abortion Safe Marge Berer 2000
Unsafe and clandestine abortion	"
To make abortion safe restrictive abortion laws (traditional and religious) need to be amended or replaced	
Fear of imprisonment and other punitive measures for women and providers	
Abortion rates are equal in rich and poor countries, and half of all abortion are unsafe	Gainesville Times October 2007
Improving women's health means improving access to safe abortion, some experts criticize the restrictions that often come with donor money---funds from US governments cannot be used in health services associated with abortion	"
For thirty years the issue of abortion has grown increasingly difficulty, few issues have more thoroughly fragmented contemporary American	The Ethics of Abortion Baird, Rosenbaum 2001
Thousands of actions against clinics that perform or refer for abortions, against physicians who perform AB and against organizations even indirectly supportive of abortion	Barid/Rosenbaum a collection of essays
Successive acts of violence against abortion providers	"
Moral and religious integrity, the Bible as the	"

legal cornerstone to condone murder	
Millions of babies abortion providers kill every year in America	“
Abortion is straightforwardly murder	“
Comparison of Nuremburg files that those who killed the Jews were brought to justice and so to will the abortion providers as their crimes are similar	“
The Handmaid’s Tale- antiabortion activist would fee comfortable in this setting as it enslaves women for the purpose of pleasure and reproduction an abortion I forbidden on penalty of death (futurist in nature)	“
Communist China is antichoice, but women can have no more than one child and it will face mandatory abortion if they become pregnant (incongruent)	“
Compare this to the increasingly new occurrence of abandonment of infants –this could possibly be a natural extension of the culture of convenience expressed in Roe vs Wade (or it could be they could not find an abortion provider due to the decrease)	“
In India abortion in commonly practiced in order to avoid female children.	“
Divisive and disheartening	“
How will women exercise their constitutional right of AB when all the providers are retired or death	“
A tiny naked body, its arms and legs flung apart, its head thrown back, it mouth agape. Its face serious, tiny carcasses on the street.	“
Fetuses accidentally got mixed up with the garbage and fell off the truck	“
In 1963, a woman had an abortion, saline induced abortion that failed at first and then I began to hurt and I was alone in my dormitory room.	“
Clandestine abortion, more blood than I had ever seen, I filled up a metal wastebasket with blood and a fetus. I was ill and sought help from a fellow college student who called his rector who called a MD in congregation and he performed a D/C to stop the bleeding. I remember feeling so grateful to the Rector	“
I did not feel guilty	“

There was a doctor who did abortions in 1950 in Virginia, he as ultimately arrested and sent to prison	“
Cut of the money	“
I felt a little mixed then because it seemed like I should have done something at that moment (after passing the fetus)	“
December 1972-patient becomes pregnant and desires abortion – the MD wanted one thousand dollars to pay off the hospital board	“
She became so desperate that she jumped in front of a subway train	“
I thought is a woman was willing to go to that extent to avoid pregnancy she did not want, then something really ought to be done, and I became a active advocate of abortion form that time on	“
She used a knitting needle, she had 5 children	“
Cause of death –abortion	“
A judge ruled that the risk of suicide is much less and of a differ order of magnitude than the certainty that the life of the unborn will be terminated (a ruling after a 14/y0 girl was raped by a playmates father)	“
Some kind of douche, some kind of drug, some kind of tubing, women do it themselves and they always have. They become desperate for reasons we know nothing of	“
Abortion Orphans (children whose mother died during an abortion attempt)	“
It is a great mistake to think that if abortion is illegal that it will be nonexistent.	“
GUILTY of Crimes Against Humanity	Nuremburg Files web 2008

APPENDIX E

SURVEY CRITIQUE OF QUESTIONNAIRE

Survey Critique

Name_____ **Date:**_____

Overall, what did you think about the survey (in general sense)?

Would you have completed the survey?

Did you understand the instructions for each section?

Did the item and response format make sense for each section?

Any typographical errors noted?

Page 1, any problems noted?

Page 2, any problems noted?

Page 3, any problems noted?

Was there something missing that you thought I should have covered?

Do all items belong in the survey?

Do I need to measure any other demographic data?

APPENDIX F

OVERVIEW OF THE PILOT STUDY

Pilot Study Results: Response Rate

Participants	Responded Complete	Responded Partial	Undeliverable/ Unable to Contact	Out of Office	Opted Out	Adjusted Participants	Response Rate
188(SM)	16	3**	23	19	9	156*	10.2 %
30(US Mail)	6	0	3	-	-		20%
30 (Telephone Email)	5	0	2	-	-		16.7%
							17.3 adjusted for all methods of collection.

Pilot Study Results: Program Practices Foci

What type instruction do nursing students in your program receive on the following topics? Results are displayed in percentages of respondents.

Topics	No Instruction	Reading Assignments only	Both Classroom and Clinical	Classroom/no clinical	Clinical only
Abortion and Public Policy (20)	15%/33.3%	20%	5%	60%	0%
Abortion and the law(19)	10.5%	21.1%	5.3%/	63.2%/	0%/
Post AB Counseling(19)	42.1%	10.5%	5.3%	42.1%	0%
Pregnancy Options(19)	36.8%	5.3%	21.1%	36.8%	0%
Pre AB Counseling(19)	57.9%	5.3%	15.8%	21.1%	0%
Medication AB(19)	36.8%	5.3%	5.3%	52.6%	0%
Nursing care of the woman undergoing Medical AB(19)	47.4%	0%	5.3%	47.4%	0%
Surgical AB	31.6%	5.3%	5.3%	57.9%	0%
Nursing Care of the woman undergoing Surgical AB(19)	42.1%	5.3%	5.3%	57.9%	0%
Post AB care(19)	47.4%	0%	10.5%	42.1%	0%
Abortion: public health(19)	57.9%	0%	5.3%	36.8%	0%
Abortion: ethical and religious(19)	31.6%	0%	5.3%	63.2%	0%

Pilot Study Results: Accommodations
Do instructors in your program make the following accommodations?

Instructional Methods	No instructors make accommodations	Some instructors make accommodations	All instructors make accommodations
Lectures discussing the impact of abortion on public health(16)	50.%	18.8%	31.3%
Lectures discussing the medical or surgical techniques of abortion(16)	43.8%	18.8%	37.5%
Lectures discussing the complications of abortion(16)	37.5%	25.0%	37.5%
Lectures discussing the pre and post counseling of the woman undergoing an abortion(16)	37.5%	25.0%	37.5%
Small group activities/discussions on how to counsel a woman on reproductive options(16)	50%	18.8%	31.3
Small group activities/discussions regarding ethical issues of abortion(16)	50%	18.8	31.3

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Pilot Study Results: Contextual Factors Foci

To what extent do the following factors affect your program's decision about offering abortion instruction?

Factors	Not al all	To a small extent	To some extent	To a great extent	I do not know
State legislature holds strong views on AB(15)	46.7%	0%	33.3%	13.3%	6.7%
College Administration holds strong views on AB(14)	78.6%	0%	14.3%	0%	7.1%
Community MD's hold strong views on AB(14)	78.6	0%	7.1%	7.1%	7.1%
Abortion is not viewed as high(14)	21.4%	14.3%	35.7%	14.3%	14.3%
Not enough time to teach(14)	35.7%	14.3%	28.6%	7.1%	14.3%
Faculty lack experience to teach topic(14)	42.9%	35.7	7.1%	14.3%	0%
Student's religious/moral Beliefs(14)	57.1%	14.3%	21.4%	7.1%	0%
Faculty's religious/moral beliefs(14)	64.3%	14.3%	14.3%	7.1%	0%
Faculty are concerned with community attitudes(14)	50%	14.3%	14.3%	21.4%	0%
Lack of quality text books(14)	57.1%	21.4%	21.4%	0%	0%
Lack of scientific-based curriculum(14)	64.3%	21.4%	7.1%	7.1%	0%
Concerned with personal safety(14)	85.7%	14.3%	0%	0%	0%
Faculty concerned with psychological impact on students	64.3%	21.4%	7.1%	7.1&	0%
Funding is restricts instruction	85.7%	0%	7.1%	0%	7.1%