Moral experiences in caring for voluntary pregnancy losses: A meta-ethnography

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Abstract

Voluntary abortions are relatively frequent and their care is complex due to the social stigma that surrounds these losses. This interpretive meta-ethnography of 11 original qualitative articles aims to synthesize the moral experiences of nurses and midwives who cared for women and couples that decided to abort or terminate the pregnancy due to foetal abnormalities. Lines of argument synthesis emerged after reciprocal and refutational translations, together with the metaphor, 'Going with the flow or swimming against the tide'. Caring in these situations was an ethical dilemma when a conflict existed between their professional duty and their moral principles. In these instances, care was associated with a significant emotional cost. They did not feel sufficiently prepared or with adequate resources, which favoured avoidance behaviours. However, the feeling of professional duty was stronger than their prejudices, and they became engaged in caring. These results could improve knowledge, clinical practice and education, being a (highly) reasonable representation of the phenomenon of interest.

Keywords: induced abortion; midwives; nurses; nursing care; qualitative research; selective abortion.

Introduction

The World Health Organization (WHO)[1] defines abortion as the termination of pregnancy of a foetus weighing less than 500 g or before the 20th week of gestational age. Advances in prenatal screening and diagnostic testing, alongside trends towards later motherhood, have increased the probability of parents receiving a diagnosis of foetal anomaly. Most pregnancy terminations due to foetal abnormalities occur during the second trimester of pregnancy, before foetal viability. First- or mid-trimester terminations are legally accepted in many countries.[2,3]

Induced legal abortion remains the main method of fertility regulation worldwide. However, there were about 25 million unsafe abortions between 2010 and 2014, accounting for 45% of all procedures. It is considered an unsafe abortion when a pregnancy is terminated by people who lack the necessary qualifications or information, or in an environment that does not meet minimum medical standards, or in both scenarios.[4] The majority of unsafe abortions (97%) have occurred within developing countries in regions of Africa, Asia and Latin America. Most often, these abortions resulted from difficultly in accessing contraceptives and safe medical care.[5] Therefore, to prevent unwanted pregnancies and unsafe abortions, countries must formulate adequate policies and allocate financial commitments in order to provide comprehensive education on sexuality and increase accessibility to safe and legal abortion.[4]

Currently, worldwide abortion legislation is very heterogeneous. The spectrum ranges from countries that guarantee access to abortion as a fundamental right of women, to others where this practice is penalized with prison for women and professionals who carry it out. According to the Centre for Reproductive Rights,[6] 59% of women within reproductive age can choose to abort more or less freely worldwide. However, 5% of women belong to countries where abortion is totally prohibited, 22% belong to countries that allow abortion only when the woman's life is at risk and 14% belong to countries that only allow abortion based on health or therapeutic grounds.[6,7]

In the last 15 years, various measures have been taken to reduce mortality and morbidity from abortion in a growing number of countries.[8] Consequently, abortion is permitted and accessible in almost the entire developed world, whereas in less developed countries, the laws tend to be more restrictive and there is less accessibility to safe abortions.[9] As a consequence, in countries with restrictive legislation, a strong incidence of maternal morbidity and mortality is observed.[9]

Nursing and midwifery are an integral part of caring for women and their families who decide to abort. However, abortion remains a morally contentious issue for health professionals. For instance, some nurses and midwives refuse to participate in this procedure on the grounds of conscience.[10] The International Confederation of Midwives' Code of Ethics establishes that '*midwives may decide not to participate in activities for which they hold deep moral opposition'*.[11] However, the means by which the necessary care can be provided is not addressed.[12] Freedom of conscience is reflected in human rights, and in Europe, it is protected in treaties such as Resolution 1763 of the Council of Europe.[13,14] The abortion laws of most European countries also support the right to object. In contrast, recent WHO abortion guidelines[1] do not mention conscientious objection.

Caring for women or couples who decide to abort requires that nurses and midwives support them in their individual situations. However, nurses and midwives may feel in conflict with their own conscience which can possibly lead to an emotional distancing from women and couples in their care.[15] Cultural and social values that frown upon abortion have a strong influence on many professionals who care for these women.[16] In the case of midwives, caring for miscarriages or abortions can be experienced as paradoxical and frustrating since it can be viewed as the opposite of midwifery, which is the care of life.[17,18] Addressing voluntary abortion care is complex due to the fact that it is socially stigmatized in many cultural contexts. This stigmatization can contribute to a moral conflict during the decision-making process and exacerbate the emotional impact experienced by women.[19]

The care experiences of nurses and midwives in involuntary pregnancy losses have already been studied.[18,20] However, overall, there is a scarcity of evidence on this topic and this meta-ethnography provides an evidence base for nursing and midwifery.

Aim

The aim of this study was to synthesize the available body of qualitative work regarding the moral experiences of nurses and midwives in caring for women and couples who decided to abort.

Methods

The meta-ethnographic approach of Noblit and Hare's[21] was utilized here, which consists of the following steps: 1) getting started, 2) deciding what is relevant to the initial interest, 3) reading the studies, 4) determining how the studies are related, 5) translating the studies into one another, 6) synthesizing translations and 7) expressing the synthesis. The aim of this approach involves the translation of individual qualitative studies into each other by reinterpreting the results, which goes beyond the sum of the parts.[22] The eMERGe Reporting Guidance[23] was followed to improve the quality, transparency and comprehensiveness of the meta-ethnography (See Supplemental File 1).

Search methods

A comprehensive systematic search strategy was carried out by SFB in PubMed, Scopus, CINAHL, PsycINFO and Web of Sciences databases in December 2020 and updated in January 2021. The search strategy was developed according to the phenomenon of interest (abortion and termination of pregnancy due to foetal anomalies), the purpose of the study or evaluation (care experiences), the sample (nurses and midwives) and the type of research (qualitative). In each, search terms and medical subject headings were included. These terms were combined using the Boolean operators OR and AND, and truncations were also employed to ensure a broad search (See Supplemental File 2).

Papers were included if they were original qualitative studies or mixed methods from which the qualitative results could be extracted. These papers had to be focused on the experience of nurses and midwives caring for women and couples who decided to abort or terminate a pregnancy due to foetal abnormalities. Grey literature, discussion or review articles and papers not in English, Portuguese or Spanish were excluded.

Search outcomes

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram[24] (Figure 1) shows the filtering process for the sample configuration of this meta-ethnography. Database searches found 672 records and supplementary searches did not provide any additional records. Following the removal of 202 duplicate results, 20 articles were selected after evaluation of the title and abstract. The final sample of 11 articles resulted after full readings. Exclusion criteria are detailed in Figure 1. The entire selection process was conducted by SFB and IBG, although meetings of all authors were held to reach consensus.

Quality appraisal

Each paper was evaluated using the Critical Appraisal Skills Programme (CASP) tool.[25] Two authors performed the evaluation independently, and the results of the evaluations were discussed in the team group. Included articles were considered to have high quality with respect to their goals, designs, analyses and results, as well as useful knowledge on the topic (See Supplemental File 3).

The steps 2 and 3 of Noblit and Hare[21] were led by IBG, although author meetings were held throughout the process to reach consensus in decision-making.

Data extraction and synthesis

The analysis was initiated with critical reading of the included studies (Table 1).

Then, first-order (participants' quotations) and second-order (authors' interpretations) concepts[26] were extracted across the full primary studies and recorded in spreadsheets (step 3), which allowed intra- and inter-study comparisons (step 4). The extraction was started with the most data-rich article[27] which was used as context for the comparisons (Table 1). In step 5, the findings were incorporated from the studies into one another by analogous (i.e. concepts in one study can incorporate those of another) and refutational (i.e. concepts in different studies contradict one another) translations, to form new third-order concepts.[26] The analysis process was iterative and involved moving back and forth in the data, comparing and contrasting the findings from the individual studies and

translating them into one another. Finally, in step 6, a storyline of the phenomenon was developed, being the basis for the line of argument synthesis.[23,28] This process culminated with the elaboration of a metaphorical phrase that captured the essence of the findings, which allows improved comprehensive understanding of the phenomenon.[29]

All the authors were involved in these synthesis steps, which were realized by meeting periodically to discuss, agree and reflect on the progress of the investigation. All authors agreed on the themes and the overarching metaphor. Finally, the obtained findings were evaluated using the Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool, which determined the degree of confidence in the review findings[30] (See Supplemental File 4).

Results

The sample consisted of 11 qualitative primary articles predominantly from Western countries that included a total of 185 nurses and midwives. These professionals worked in a hospital setting or in abortion clinics and attended abortions. Table 1 shows more details of the selected articles.

After analogous and refutational translations, the lines of argument synthesis emerged (Figure 2). The metaphor ‘Going with the flow or swimming against the tide’, and four themes that were in concurrence with the metaphor, provided explanations of the moral experiences of nurses and midwives caring for women and couples with voluntary pregnancy loss. The care entailed an emotional challenge due to the ethical conflicts that arose. Attending to these individuals could mean for nurses and midwives a provision of care contrary to what they had been trained for, and for which they lacked preparation. In addition, in many cases, they did not have the resources to deal with the emotional repercussions. Symbolically they let themselves ‘go with the flow’ when, in context to these difficulties, they focused on the physical aspects of the procedure. While ‘swimming against the tide’ represents the provision of holistic care where nurses and midwives went beyond their standard duties. CERQual assessment[30] showed high confidence on three themes and moderate confidence on 1. This implies that the results are a (highly) reasonable representation of the phenomenon of interest (See Supplemental File 4).

'The raging of the sea': Emotional difficulties of care

The 'raging of the sea' represents the ethical dilemma that may arise in the provision of voluntary abortion care. For the participants, the conflict emerged when the abortion was against their principles and personal position on the matter. Midwives were particularly affected, especially when these situations were understood as the antithesis of their profession. For this reason, some were forced to cease their work in the clinic or hospital.[31–33]

For a subgroup of women, elective abortion was the easiest response to an unintended pregnancy.[33] Given this, the ethical dilemma was based on the right of free decision of the woman or the right to life of the foetus,[33,34] as expressed by this midwife:

> 'Yes, I think first about the woman's rights because the child cannot decide for itself. So, the woman, the mother and father have to decide. And I think, once a woman has made a decision, I think I just have to support her in that decision'[34]

For midwives, this care involved a conflict with their professional identity.[34–36] Those whose role had changed from midwife to abortionist were forced to perform tasks contradictory to what they had been trained to do. This meant going from being active members in the birth of a baby to being participants in the ending of a life. The midwives found that caring for these two contradictory situations was difficult, stressful and disconcerting as they had to constantly change their behaviour and emotions. They questioned whether it was their duty to help with pregnancy terminations; however, the alternative involved not being present for women or couples.[34] The lack of training made it especially difficult for them to provide care in these situations.[35]

For nurses, on the other hand, despite the fact that they are more used to dealing with death, the care of elective abortions of healthy foetuses was emotionally hard for them.[31,32,37] Some nurses felt that they were contributing to a procedure contrary to their principles, and they would avoid working in an abortion clinic if possible. The nurses did not know how to act, especially at the moment of delivery and when handling the foetus.[31] In this context, nurses and midwives came to question the need to dedicate themselves to abortion care, considering the impact on their mental health.[27,33,37]

'We have had [our] moments where we've had lots of problems. You do question yourself – I won't say that you don't, because you do. You think, "What a horrible day, do I need to be doing this?"' Nurse/midwife[27]

Differences were perceived in the attention and care offered to women and couples according to the cause of the abortion, and consequently, the repercussions on them. Caring for women and couples after the voluntary termination of pregnancy was difficult and painful and involved emotional exhaustion. These experiences personally affected them, in some cases, lingering in their memory for years. This was exacerbated when the interruption occurred late in the pregnancy or when the nurse suffered from an infertility problem.[32,37]

> 'I had to take the specimen and put it, you know, put Formalin in it? ...and when I took the lid off, um, I could see a foot. And I just burst into tears… It just felt like somebody socked me in the gut, and I just thought, "Oh, I can't believe this!" And I just had to stop for a minute' Nurse[32]

Some nurses and midwives were upset when abortion was the result of unintended pregnancies in young and single women as they perceived it as a lack of respect for life among young people. This feeling of anger was aggravated when women repeatedly came to the clinic demanding an abortion service. This discomfort was based on concern for the health of women undergoing multiple procedures and seeing how the decision to abort was taken lightly. Furthermore, these situations caused a feeling of failure in thinking that their health education work was ineffective.[17,32,37,38]

However, in terminations of pregnancy due to foetal anomalies, the participants showed empathy for the women and became more involved with them. In some cases, they saw these experiences as positive and beneficial, being able to experience personal satisfaction and gratification. Although for some, this brought upon the generation of fear about a future similar pregnancy of their own.[31,35,37,38]

'Without protection to stay afloat': Lacking resources

This theme symbolizes the lack of resources, support, preparation and knowledge that nurses and midwives reported when it came to encountering those who decided to have an abortion.

Insufficient training

The participants reported insufficient training for these situations. They became aware of the need to have adequate training to be able to offer comprehensive care and to manage the personal repercussions on themselves.[33,35,38,39] Specifically, midwives verbalized that abortion care requires a special kind of professionalism, considering that they should be competent from both a professional and psychological perspective.[35]

A study by Andersson et al. (2014)[38] showed the importance of the training and preparation experienced by these professionals. Those who had sufficient knowledge engaged with the woman or couple emotionally and felt safe during the contact. On the contrary, less experienced nurses and midwives sometimes felt that they transferred their own anxiety when complications or unexpected events occurred.

Lack of support

The lack of emotional support and recognition of their work were aspects that distressed and upset the participants.[27,31,33,36,39] They considered the social stigma of this type of abortion as the main cause since certain social sectors or cultural contexts associated abortion with murder. Consequently, they felt socially judged and misunderstood.[27] To avoid this problem, the professionals were able to avoid discussing their profession, and if they did talk about it, they first evaluated the person, as one nurse reported:

> 'I think before I ever blurt out where I work, I try and assess the person first. We met a couple and we're having a chat, and she said, "Oh, where do you work?" and I told her, and she went, "Hah, you kill babies for a living!"' Nurse/midwife[27]

In certain situations, the misunderstanding and disagreement of radical pro-life groups reached the extreme of threatening the safety of the patients. Also, in the family environment, they found relatives unable to comprehend their work, causing them to avoid talking about their involvement with the abortion clinic.

Finally, nurses and midwives felt that the organization had a lack of interest and concern regarding their physical and psychological well-being.[33] This anger was exacerbated by the fact that other medical colleagues were practically absent at the termination of pregnancy. They perceived that they delegated the most unpleasant work to them, thus assuming tasks that were not within their competence.[31] In this context, the workload was increased, blurring the division of work, as this nurse reports: '*We are not doctors. We are nurses. We should not be expected to do a doctor's job'.*[31]

Lack of protocols, care guides and material resources

Nurses and midwives expressed that their needs in terms of resources and supplies, and the lack thereof, affected the care provided.[38] Furthermore, in many cases, the physical space was unsuitable, reinforcing the perception that little attention had been paid to their needs.[31]

'The foetal container is a peanut butter jar. Where is the dignity? Because of the shape of the container, you have to drop the foetus in – it's like a plop!' Nurse[31]

The lack of care protocols and guidelines was also a source of great concern. Consequently, they did not know how to act when faced with the choice of following unethical orders from physicians or acting on the basis of their own professional judgement. Faced with this need, they created their own protocols and guidelines. For example, nurses in the hospital context developed forms to address the level of knowledge of patients about the procedure. Likewise, they also developed a protocol for situations in which the baby was born alive.[31]

'Being rescued by a lifeboat': Dealing with the care of those who decide to abort

When the provision of care was contrary to one's principles, emotionally demanding, not supported with sufficient resources and support, and inadequately recognized, this caused

suffering to nurses and midwives. Faced with this situation, the lifeboat represents the strategies they used to avoid sinking and stay afloat.

Participants noted that their greatest support was from their colleagues.[27] Due to the lack of understanding of society, peers were the ones with whom they ventured out to speak with. In addition to providing psychological support, they also remained united to handle the heavy workload they were subjected to at the hardest moments.[27,33,38]

In addition, these moments favoured avoidance behaviours and belittling served as emotional protection. This translated into detachment and task-centred care to cope with the emotional demands put upon them. Distancing themselves from the situation and from the reality they experienced allowed nurses and midwives to continue with their task and avoid much of the suffering.[34,39]

> 'So I can't really answer that because I've always avoided thinking about the child's side of the question. And I've consciously avoided it because otherwise you just couldn't live with yourself. Because you can't carry on doing your work as a midwife like that' Midwife[9]

In certain contexts, such as in areas of Asia, the professionals also relied on faith. For example, reciting the Amitabha mantra and going to temples helped them to find spiritual comfort.[37]

'Swimming against the tide': Encountering the suffering of those who abort

Despite the aforementioned issues, nurses and midwives went beyond the standard expectation in their performance of tasks and procedures. In accordance with the metaphor, this represented the act of continuous swimming in the face of a rising tide of physical and emotional obstacles in their path of patient care.

Being involved in caring for women or couples helped nurses and midwives to consolidate an emotional bond with them and to perform care in an integral manner.[31,35] Especially for elective abortions, they began by providing information regarding the procedure and ensured that the women were confident of the decision they made. If they perceived doubts or uncertainty, they offered them full availability, information, tranquillity and space to reconsider their decision.[27,31,35,39]

When women or couples entered the institution, the nurses and midwives tried to empathize with them and to avoid judgement. Their priority was to provide them with a good environment that included the maximum possible comfort and the company of loved ones.[27,31,34–36,38,39]

> 'It's the woman's decision. I'm there to help her. And so that's what I do. . . And I do it for the woman; I'm providing a service for her. That's what I'm there for' Midwife[34]

During the procedure, they were very concerned about managing physical pain.[17,31,35] Some nurses and midwives described feelings of helplessness when they were unable to alleviate their suffering. They realized that their pain transcended physical aspects and that care must extend beyond the provision of analgesics. These situations required full presence, active listening and good communication.[38] Psychological support was essential in terminations of pregnancy due to foetal anomalies. This was administered by adapting their language to try not to hurt them, for example, using the term foetus instead of baby.[27] They also tried to get the woman to vent and express her feelings.[38]

> 'I never, ever, call it a baby in front of the client, because I think that is just…I think it's, making them change their attitudes, they would be really, if we're all calling it the baby, it's like…Oh…it puts it into that different category of a baby, something that you're going to give birth to and nurture and raise, isn't it? So I always call it a fetus' Nurse/midwife[27]

Finally, in desired pregnancy abortions, nurses and midwives were fully involved in helping the woman or couple to cope with their loss.[31,36] For example, in the study by Christensen et al. (2013),[36] they offered the possibility to see the baby, despite the harshness of this moment. They took great care in presenting the baby to the patient, making sure to emphasize human characteristics and hiding any visible abnormalities. They also facilitated for those who requested the possibility of burial and for obtaining keepsakes such as photographs or handprints.

Discussion

The metaphor 'Going with the flow or swimming against the tide' symbolizes the moral experiences of nurses and midwives in caring for women and couples who decide to terminate a pregnancy due to foetal abnormalities. Caring for these situations was an ethical dilemma since many times their moral principles and professional identity were contrary to abortion, and therefore, their professional duty. This personal conflict and its effect on care were dependent upon the cause of abortion as terminations of pregnancy due to foetal anomalies led to better engagement and less reluctance. In addition, caring often had an emotional impact. Nurses and midwives did not feel sufficiently prepared to care and handle the demands of care in these situations. They also perceived a lack of support and recognition from their organization and society and were hindered by scarce resources. In some cases, they even carried out tasks that did not correspond to them due to the reluctance of other health professionals. The support of colleagues or faith was essential. Given this, some nurses and midwives were able to detach in order to focus on carrying out tasks, while others were able to get more intimately involved in care.

Our results highlight the concepts of the *cáritas* and *ethos* of nurses and midwives in caring for these losses. The Caritative Caring Theory[40] establishes that these two components represent the fundamental motive of care and the internal force related to the mission to assist. *Cáritas* is associated with their involvement in the suffering of women despite an unfavourable context. While *ethos* is related to their sense of professional duty, for which they put aside their prejudices to take care of these women and couples. Strong values on the part of nurses and midwives promote feelings of security, trust, relief from suffering, satisfaction and gratitude in women undergoing these medical procedures.[41]

However, this care challenged their *ethos* and *cáritas*. The feeling of participating in something they felt was unworthy and against their own beliefs or social mores generated an ethical dilemma for them. Abortion is stigmatized because it can violate ideal projections of feminine social constructs and contradicts sexual and reproductive norms.[42] When this angst is directed against nurses and midwives, it can lead to compassion fatigue and exhaustion within these professionals.[43] Furthermore, the health system and its economic limitations have been pointed out as the reason why ethical values are challenged by structural issues.[44]

The complexity of this care and its prolonged emotional impact led to a personal cost for the health professionals, which was similar to the care of involuntary pregnancy losses.[20] This emotional work is a consequence of the organizational norms on emotional expression, on emotional experience, or on both, which influence the standard of care.[45] This inevitably leads to psychological wear and tear, so it is important that nurses and midwives manage their emotions properly.[46] Moral distress is the result of the emotional and psychological suffering experienced by them when they are forced to act in ways that are not consistent with their own ethical values and beliefs. This constitutes an indicator of weaknesses in the practice environment rather than weaknesses of the nurses. This moral anguish is made visible through feelings such as frustration, guilt, anger or helplessness.[47,48] Our results highlight the impact of this stress on care. Avoidance behaviours, such as detachment, task-centred care and emotional exhaustion, are some examples.

Time set aside for supervision and professional and ethical reflection is vital, but often there is a lack of accommodation.[44] In this situation, the support of colleagues to allow venting and release of emotional load was necessary, although the workload can interrupt these encounters.[47] The nurses and midwives felt pressured to act in an ethically incorrect way, which led to an elaboration of ethical strategies in the face of moral suffering.[49] In addition to meetings between colleagues, some strategies to alleviate moral suffering included modifications of protocols and routines, the search for new training materials and professional preparation.

Implications and further research

Ethical training is fundamental in the education of these professionals, which would allow them to confront these situations and develop ethical sensitivity. Ethical sensitivity provides a supportive response by enhancing the ability to identify the ethical dimensions, intuition and moral component of care. It requires exposure to suffering, vulnerability and uncertainty within relationships. Therefore, strengthening and development of personal attributes such as certainty, attention, responsiveness and courage are required.[50] Training in emotional management is also needed, as well as apportioning appropriate resources to support the integral well-being of nurses and midwives.

Looking forward, more gender-specific studies should be conducted on voluntary pregnancy losses. Research analysis in different countries would provide a more comprehensive overview of whether the different environments and policies for the care of these losses influence the experiences of women or couples, as well as the impact on nurses and midwives. Finally, it would be valuable to carry out intervention studies in healthcare settings that aim to promote comprehensive care in these situations.

Strengths and limitations

The strengths of this study are based on the methodology and the sample. This meta-ethnography has followed the original approach developed by Noblit and Hare,[21] which allows adopting an interpretive approach with an inductive process that provides the results with a new perspective.[51] The selected studies were evaluated with the CASP tool.[52] The follow-up using eMERGe Reporting Guidance,[23] and the evaluation of the results with the CERQual tool,[30] contributed to forming robust evidence as a basis for decision-making, applications in the clinical setting and future research.

The design of a comprehensive search strategy, with no time limit and open to three languages, has made it possible to include evidence from different contexts and timepoints. The inclusion of both nurses and midwives enriched the results. The inclusion of elective abortions and terminations of pregnancy due to foetal anomalies could be understood as a limitation. However, the complexity of this care goes beyond the cause of the abortion, and both experiences feed into each other. The studies included in this meta-ethnography show some limitations, since no articles within the last 4 years matched our search criteria, and the included articles focused mostly on terminations of pregnancy due to foetal anomalies.

Conclusion

The metaphor ‘Going with the flow or swimming against the tide’ informs the body of knowledge in nursing and midwifery sciences and advocates for a change in clinical practice and education. Our results describe the moral experiences of nurses and midwives in caring for women and couples who decide to abort regardless of cause. Caring for these situations was an ethical dilemma since there was a conflict between

their professional duty and their moral principles. This care required a significant emotional cost which was not socially recognized and often stigmatized. Furthermore, they did not feel sufficiently prepared or with adequate resources to provide comprehensive care. This favoured avoidance behaviours such as detachment and task-centred care. However, some of the nurses and midwives were better able to empathize with the women's and couples' suffering and became more involved in caring when they put aside their personal prejudices and followed their professional duty. These results inform nursing and midwifery sciences and should encourage change in clinical practice and education. Ethical training that allows the strengthening and development of ethical sensitivity is required. Training and support resources that provide tools for managing the emotional demands resulting from the provision of this care should also be prioritized. Future research should aim to provide an analysis of these experiences in different cultural contexts and the development of intervention studies aimed at promoting holistic care in these situations.

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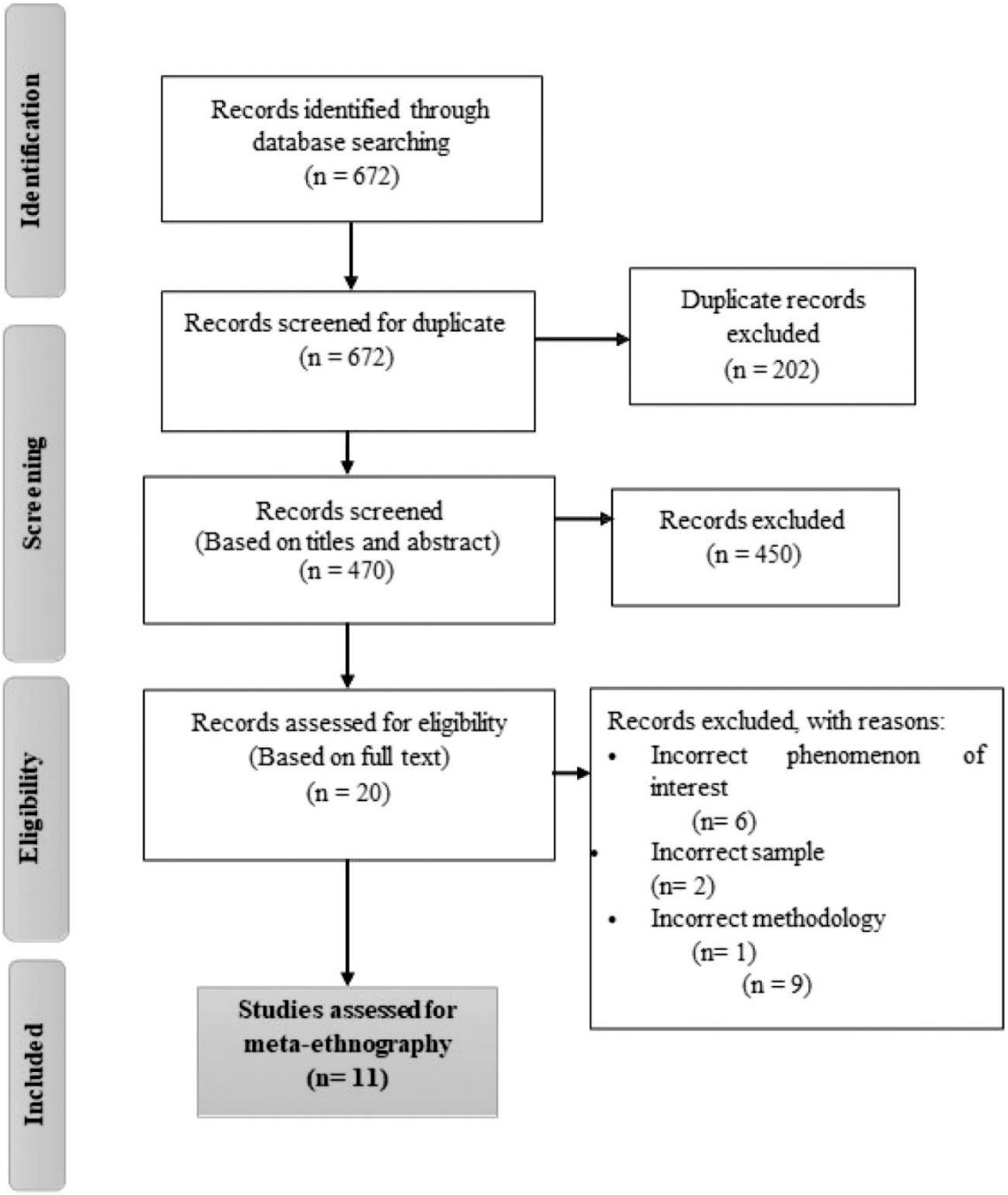

Figure 1. PRISMA flowchart.

Table 1. Characteristics of included studies.

Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
Andersson et al. (2014), Sweden	Qualitative study	To explore the experiences and perceptions of nurses/midwives caring for women undergoing second-trimester medical termination of pregnancy	17 nurses and 4 midwives	Second-trimester medical termination of pregnancy	Semi-structured interviews	The analysis revealed two themes: 'The professional self' and 'The personal self'. A conflict can be seen between the themes: what the nurses/midwives must do as part of their professional obligations and what they would like to do based on their inner feelings and thoughts. Difficult situations that arise during the process are easier to handle with increased knowledge and experience. The sense supporting women's rights bridges the difficulties nurses/midwives face in caring for women undergoing second-trimester medical termination of pregnancy
Chiappetta-Swanson (2005), Canada	Qualitative study	To examine the genetic termination nurses' experiences and the strategies they developed to respond to this dirty work	41 female registered nurses	Genetic termination	In-depth interviews	Nurses' experiences with genetic termination are viewed as unpleasant and undesirable work that others would prefer not to do or even know about. The absence of institutional support led to a number of problems for the nurses. They readily discussed situations fraught with dilemmas and frustrations, yet they

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Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
						described this work as professionally rewarding and personally gratifying. They found strategies to respond to the dirty work aspects of their job. Particularly, the quality of care they were able to provide transformed their job from dirty work and led them to find dignity and satisfaction
Christensen et al. (2013), Denmark	Qualitative study	To explore Danish midwives' experiences with and attitudes towards late termination of pregnancy (TOP). Focus was on how midwives perceive their own role in late TOP, and how their professional identity is influenced by working with late TOP in a time where prenatal screening is rapidly developing	10 midwives	Late termination of pregnancy (12th week until 24th week of pregnancy)	Semi-structured individual interviews	Current practice of late TOP resembles the practice of normal deliveries and is influenced by a growing personalization of the aborted foetus. The midwives strongly supported women's legal right to choose TOP and considerations about the foetus' right to live were suppressed. Midwives experienced a dilemma when faced with aborted foetuses that looked like new-borns and when aborted foetuses showed signs of life after a termination. Furthermore, they were critical of how physicians counsel women/couples after prenatal diagnosis

Table 1. Characteristics of included studies.

Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
Cignacco (2002), Switzerland	A qualitative and inductive research approach	To investigate how midwives view the termination of pregnancy because of a pathological foetal condition and to clarify their ethical position	13 midwives	Termination of pregnancy for foetal abnormalities	Interviews	In this situation, midwives are faced with a conflict between the woman's right to self-determination on one hand and the right to life of the child on the other. This conflict causes a high level of emotional stress and, subsequently, professional identity problems. Although questions concerning the child's right to life are generally suppressed, the ethical principle of the woman's right to self-determination is rationalized. Although this process of rationalization seems to present a false ethical decision, it enables midwives to continue with their daily professional duties. As far as orientating midwives to the value of these women's right to self-determination is concerned, it must be assumed that they have made an ethical decision to which they have given insufficient thought. This problem is exacerbated by the fact that midwives are largely excluded from the decision-making process of the parents in

Table 1. Characteristics of included studies.

Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
						question. They cannot therefore help in this process in a valuable and responsible way by providing clear information and proposing objective criteria. In relation to the tasks, they are expected to fulfil, these midwives revealed that they were in a state of professional confusion
Gallagher et al. (2010), UK	An exploratory qualitative design	To explore the perceptions of nurses who work in abortion services	9 nurses and midwives	Legal abortion (<24 weeks gestation)	Semi-structured interviews	From studying the perceptions of nurses working in abortion services, two global themes of 'Attitudes Towards' and 'Coping With' abortion were identified, comprised of six organizational themes – 'society', 'nurses' and 'reasoning' in 'Attitudes Towards' and 'role', 'clients' and 'late gestation abortion' in 'Coping With'. Nurses support a woman's decision to terminate her pregnancy and the need for women to abort in a safe environment. They build an implicit ethos of team support to enable them to tailor individual client care and their own involvement in this care which may involve limitations

Table 1. Characteristics of included studies.

Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
Hanna (2005), USA	Modified phenomenological study	To discover the essence, properties, and full content domain of the concept of moral distress so that the concept could be redefined in universally applicable terms	10 nurses	Legal, elective, surgically-induced abortions	Semi-structured interviews	Five properties of the lived experience of moral distress were identified: perception, pain, valuing, altered participation and perspective. Three types of moral distress identified in this study were shocked, muted and suppressed (persistent). Type of moral distress was related to situational conditions, recognition of moral ends, quality of coping processes and temporal breadth. Negative outcomes of moral distress, which probably exist, were undetectable with this study design. The definition has been composed in universal terms but remains tentative, since the full content domain of moral distress was largely but not definitively identified
Lindström et al. (2011), Sweden	Qualitative study	To elucidate gynaecologists' and midwives'/nurses' experiences, perceptions and interactions working in abortion services, their experiences of medical abortions and abortions performed at the	15 midwives and nurses	Elective abortion	2 homogeneous focus groups	The content analysis reflected those gynaecologists and midwives/nurses had no doubts about participating in abortions despite the fact that they had experienced complex and difficult situations, such as repeat and late-term abortions. They

Table 1. Characteristics of included studies.

Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
		woman's home. An additional aim was to illustrate gynaecologists', midwives' and nurses' visions of their future professional roles within the abortion services				experienced their work as paradoxical and frustrating but also as challenging and rewarding. However, they were rarely offered ongoing guidance and continuously professional development education. For gynaecologists, as well as midwives/nurses, their experiences and perceptions were strongly linked to the concurrent development of abortion methods. The interaction between the professions was found to be based on great trust in each other's skills
Mauri et al. (2015), Italy	Phenomenological–hermeneutic study	To explore how midwives perceive the burden of care, while assisting termination of pregnancy after 16 weeks' gestation	17 midwives	Termination of pregnancy ≥16 weeks gestation	Semi-structured interviews	Four themes emerged from the interviews: influences, supports, empathy and emotions. At the end of the study, researchers observed that midwives assert conscientious objection to the termination of pregnancy, which does not influence their experiences and memories. The midwives felt that it was important to share experiences with colleagues, discussing cases together and with the rest of the team. The midwives also

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Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
						suggested some strategies to improve this type of care: organize shifts in a way that could lead to improved and personalized care for women, continuous development, involvement of relatives and special measures for these women's rooms. Moreover, they considered help from other professionals as fundamental in order to manage the clinical and emotional complexities related to these terminations
Mauri and squillace (2017), Italy	Phenomenological approach	To provide insight into the experiences of nurses and midwives working in the Italian abortion service	22 nurses and 2 midwives	Voluntary pregnancy termination	Semi-structured interviews	Five main themes emerged from the analysis: (a) Coping with caring for women undergoing a termination of pregnancy; (b) improving professional training; (c) approaching work in a mechanistic way as a means of overcoming difficulties; (4) performing medical abortions; (d) recounting an experience
Mayers et al. (2005) South Africa	An exploratory qualitative study using a	To explore the lived experience of midwives who assist with	3 midwives and nurses	Termination of pregnancies in the second	Unstructured, in-depth interviews	Despite their support of a woman's right to make choices, the participants in this study found their work emotionally

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Authors, (year), location	Methods	Aim	Sample	Type of abortion	Data collection method	Key findings
	phenomenological approach	terminations of pregnancy in a tertiary level hospital		trimester (13–20 weeks)		draining and stressful. This was in part due to their experiences with the women who terminated their pregnancies and in part due to the structural difficulties experienced, for example, lack of support from colleagues and management
Yang et al. (2016), Taiwan	Qualitative study	To explore the experiences of nurses involved with induced abortion care in the delivery room in Taiwan	22 nurses	Induced abortion (<24 weeks of pregnancy)	Semi-structured interviews	The concealment of emotions by nurses when they encounter induced abortion care causes moral distress and creates ethical dilemmas. This study showed that social-cultural beliefs profoundly influence nurses' values and that the rights of nurses are neglected. Concealing emotions potentially affect relationships between nurses and women and the quality of nursing care

TOP: termination of pregnancy, UK: United Kingdom, USA: United States of America.

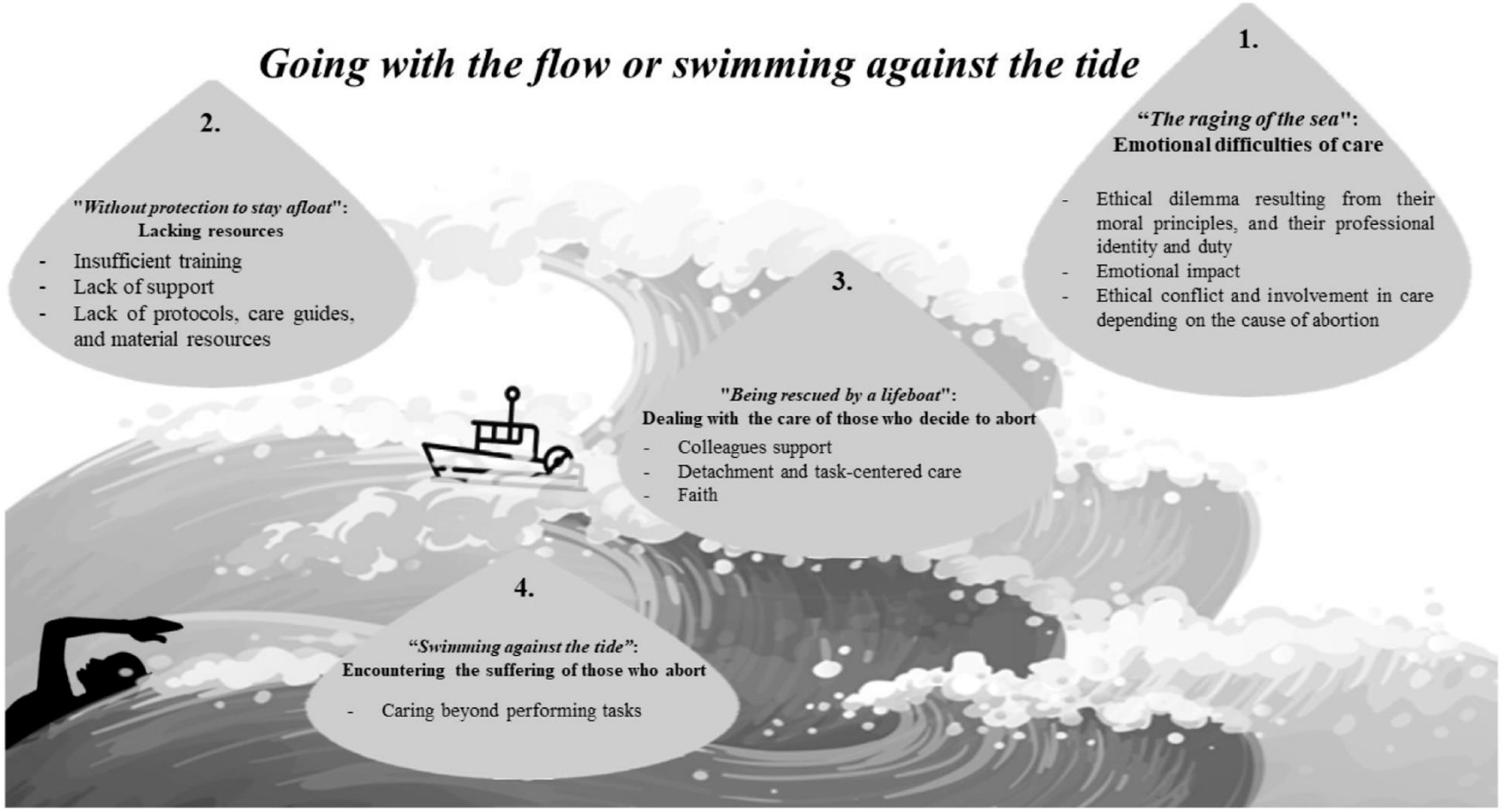

Figure 2. Lines of argument synthesis *Going with the flow or swimming against the tide*.