

NURSING IDENTITY AND ABORTION WORK:
INTERRUPTING 50 YEARS OF PROFESSIONAL DISCOURSE

by

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Abstract

In this inquiry, I investigate the discursive processes of professional identity construction and acquisition in the context of nurses' participation in abortion work. Guided by social linguistic theory, I have conducted an historical discourse analysis of the abortion-related articles, advertisements, editorials, and letters to the editor published in the national professional journal, *The Canadian Nurse*, from 1950 to 2000. I have determined that multiple abortion care identities—or the specific ideologies and practices that are normalized as legitimate nursing values and work—have been constructed for nurses through a variety of discursive moves, including didactic messaging and implicit comparison with and in contrast to other social actors and the procedure itself.

Ultimately, the availability of professional identities that support abortion as legitimate nursing work enable nurses to provide and promote the physically and psychologically safe abortion services that are essential to the health and well-being of women and communities worldwide. Recommendations and strategies for evaluating and operating professional abortion discourses in practice, research, education, and policy arenas to improve women's access to safe care are included. Additionally, the findings of this investigation are discussed within the context of professional identity nursing scholarship in general.

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Chapter 1: Introduction and Background

Unsafe abortion is a preventable and avoidable phenomenon that generates myriad actual and potential negative health outcomes for women, children, families, and communities in Canada (Erdman, 2007; Kaposy, 2010) and worldwide (Berer, 2004; Grimes et al., 2006; Henshaw & Finer, 2003; Singh, 2006; World Health Organization (WHO), 2003, 2011). As members of a skilled profession increasingly involved with the provision of abortion services (Kane, 2009; Lipp, 2008a) and ethically required to promote safety, health, and well-being in general (Canadian Nurses' Association, 2008), Canadian nurses are obligated to work toward improving women's access to safe abortion care and eradicating unsafe abortion. Nursing care, a fundamental component of abortion services, has been shown to affect the safety and accessibility of the procedure for women (Ferris, McMain-Klein, & Iron, 1998; Kade et al., 2004). However, belying the necessity of accessible and safe abortion services to women's health and well-being, abortion nursing and nurses' impacts on the quality of abortion services have not yet been studied in the Canadian context.

This work investigates Canadian abortion nursing within the broad framework of professional identity as constructed through professional discourse. Specifically, guided by a constructivist social linguistic approach, I focus on historical discursive constructions of abortion-related professional identities and the subsequent abortion ideologies and practices that have been, and continue to be, permitted and expected of nurses. Generating an understanding of the historical relationships between discourse, identity, and practice provides a foundation for devising and enacting effective discursive strategies that can improve the provision of abortion care in the future. Drawing data from the pages of the national professional journal—and major distributor of professional discourse—*The Canadian Nurse*,¹ I have conducted a discourse analysis of public professional texts to investigate how discursive constructions of nurses' identities shaped abortion practice. I examined the professional discourses in *The Canadian Nurse*

¹ The journal is titled both *The Canadian Nurse* and, more recently, *Canadian Nurse*. For consistency, I use *The Canadian Nurse* throughout this paper.

focusing on the following research questions: (a) what professional identities have been discursively created and made available to nurses who provide abortion care—what have nurses historically been permitted to do, say, or be regarding abortion; (b) how have specific constructions of professional identity enabled or discouraged nurses to provide or promote safe abortion care; and, (c) how can professional identities that permit and support safe and accessible abortion services be discursively created and enacted by and for nurses practicing today?

In this chapter, I provide contextualizing background information on abortion safety and abortion access in Canada. First, I review the definition of safe abortion for this inquiry and then I describe the legal history of abortion in Canada, the range of abortion methods available to women, and nurses' clinical duties and responsibilities in providing abortion services. I present a review of the current literature that addresses obstacles to safe abortion access to identify and describe tangible and intangible barriers to safe care including obstacles related to healthcare providers in general, and nurses specifically. Finally, I focus the literature review on abortion nursing, which includes nurses' attitudes toward abortion, their experiences of providing care, the emotional impact of abortion work, and nursing care from patients' perspectives. Turning to the processes of the inquiry, I review the concepts of professional identity and discourse and explain the methodology associated with historical discourse analysis. Finally, I describe what data collection and data analysis strategies I have employed in the investigation.

The remainder of this paper is devoted to a discussion of the key findings, conclusions, and recommendations stimulated by this investigation. In Chapters 2, 3, and 4, I reconstruct the multiple abortion-related professional identities discursively created and maintained for and by nurses in the past. I describe the specific permitted abortion practices and ideologies embedded in those identities and their impacts on nurses' abilities to provide safe abortion care in both clinical and non-clinical contexts. In Chapter 5, I summarize my conclusions and situate my findings within more recent climates of nursing practice, education, and administration. Furthermore, I provide

reflections on the processes of this investigation and make recommendations for future research.

Background

Defining abortion safety.

Unsafe abortion is defined by the World Health Organization (WHO) as: “a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both” (WHO, 2011, p. 2). This definition seemingly confines “unsafe abortion” to developing countries, where “trained health care providers with proper equipment, correct technique, and sanitary standards” (WHO, 2003, p. 14) are lacking. Indeed, the WHO (2003) reports that of the estimated 20 million unsafe abortions performed annually, “ninety-five percent of these occur in developing countries” (p. 12). Additionally, the WHO (2011) correlates the safety of abortion to the degree of legal restriction placed on the procedure, such that, “where abortion laws are the least restrictive there is no or very little evidence of unsafe abortion, while legal restrictions increase the percentage of unlawful and unsafe procedures” (WHO, 2011, p. 6). Following these estimations, women in Canada—a highly developed country where abortion has been legally unrestricted since 1988 (*R v. Morgentaler*, 1988)—should theoretically be able to obtain safe abortion services at their discretion. However, despite the greater numbers of skilled professionals and sanitary medical facilities in Canada, safe abortion care remains unattainable for many women (Erdman, 2007; Kaposy, 2010). Therefore, the safety of abortion is more complicated than mere access to a technically skilled operator and a sanitary environment (Erdman, 2007; Kaposy, 2010).

For the purposes of this study, abortion safety includes not only the physical safety of women, as promoted by access to competent operators and appropriate facilities (WHO, 2011), but must also protect the psychological safety of women undergoing the procedure, as promoted by respectful and humane abortion care attitudes and practices of professional caregivers (Huntington, 2002; Slade, Heke, Fletcher, & Stewart, 2001). Psychological safety in abortion care is less dependent on what technical care is delivered

than on “the *way* [emphasis added] care should be delivered” (Slade et al., 2001, p. 72) and “the *quality* [emphasis added] of care received from staff” (Slade et al., 2001, p. 72). Thus, although their physical safety may be protected, women who access technically appropriate abortion services but receive them in dehumanizing or demeaning ways do not access safe abortion services as their psychological safety remains at risk. In this inquiry, safe abortion care refers to both physically and psychologically appropriate abortion services.

To further explore the current state of abortion safety in Canada, I will provide a brief review of the Canadian legal history of abortion, current methods of abortion that are available to women, nurses’ clinical roles in abortion provision and the documented obstacles to safe abortion care.

Legal history of abortion in Canada.

Between 1869 and 1969, abortion was an indictable offence under the Offences against the Persons Act of the Canadian Criminal Code; abortionists could be punished with life imprisonment and women aiming to abort themselves could be sentenced to seven years imprisonment (Backhouse, 1983; Dunsmir, 1998, Erdman, 2007; McLaren & McLaren, 1996). There were no formal statutory provisions or exceptions to the Canadian abortion law although in Britain, a common law “defense of necessity” could make abortion “lawful when performed in good faith to preserve a pregnant woman’s life or physical or mental health” (Erdman, 2007, p. 1138). This common law defense was never invoked in Canadian court and therefore was never tested or upheld as Canadian law (Dunsmir, 1998). In 1969, the abortion section (Section 251) of the Criminal Code was amended: abortions remained illegal in Canada but Section 237 allowed that a physician could lawfully perform an abortion if certain conditions were met (Committee On The Operation of the Abortion Law, 1977; Dunsmir, 1998; Jenson, 1992; McLaren & McLaren, 1986; Pelrine, 1971). The lawful-abortion requirements included: (a) the abortion must be authorized by a three-physician abortion committee; (b) the operating physician must not sit on any therapeutic abortion committees in any hospital; (c) the

abortion must be performed in an accredited hospital; and (d) continuing the pregnancy must endanger the life or health of the pregnant woman (Committee On The Operation of the Abortion Law, 1977; Dunsmir, 1998; Jenson, 1992; McLaren & McLaren, 1986; Pelrine, 1971).

Responding to accusations that women's access to lawful abortion services after the 1969 Criminal Code amendments was inequitable, the Privy Council of the Government of Canada created a special committee to study abortion services across the country (Committee On The Operation of the Abortion Law, 1977). The committee's aim was to "conduct a study to determine whether the procedure provided in the Criminal Code of obtaining therapeutic abortions was operating equitably across Canada" (Committee On The Operation of the Abortion Law, 1977, p. 3). The committee found "sharp disparities in the distribution and the accessibility of therapeutic abortion services; a continuous exodus of Canadian women to the United States to obtain this operation; and delays in women obtaining induced abortions in Canada" (Committee On the Operation of the Abortion Law, 1977, p. 17). Although these findings were published in 1977, the 1969 amendments to the Criminal Code were upheld until 1988 (Dunsmir, 1998).

In 1988, the Supreme Court of Canada struck down Section 251 of the Criminal Code (*R v. Morgentaler*, 1988), ruling that it violated the Canadian Charter of Rights and Freedoms, enacted in 1982, by restricting "women's right to security of the person" (Dunsmir, 1998, p. 4). Thus, abortion became regulated as a medical procedure rather than a criminal act. In 1991, the Canadian Senate, by way of a tie vote, defeated Bill C-43—a proposed abortion law meant to replace Section 251 (Brodie, 1992). As a result, abortion in all cases remains decriminalized in Canada today.

Methods of abortion in Canada.

Currently women in Canada can lawfully obtain abortion services in physicians' offices, clinics, and hospitals (Davies, 2006). An abortion is either initiated medically

using abortifacient pharmaceuticals prescribed by the physician and taken by a woman at home or performed surgically by an operator, with nursing assistance, who manually removes the products of conception (Davies, 2006). Where a woman can go for services and by what method she can attempt abortion largely depends on the gestational age (or the length) of her pregnancy. Medical abortions are reserved for early gestations of less than eight weeks (Davies, 2006). Pregnancies of less than 16 weeks can be terminated in clinics or hospitals using manual and machine assisted vacuum aspiration (Davies, 2006). Pregnancies over 16 weeks must be terminated in hospital facilities using surgical techniques or chemical labor induction (Davies, 2006). Regardless of the method used, the Society of Obstetricians and Gynaecologists of Canada maintain that, “all patients choosing abortion are entitled to quality care by practitioners who are qualified to perform procedures and to identify and manage complications” (Davies, 2006, p. 1015). Although this claim is made by a professional association of physicians presumably referring only to physicians, nurses are necessarily implicated as additional practitioners from whom women are entitled to receive quality abortion care.

Clinical duties and responsibilities of abortion nurses.

Throughout this paper, I refer to nurses as abortion care providers, providers of abortion services, and participants in abortion care. These terms are not meant to indicate that nurses in Canada prescribe abortion medications or perform abortion procedures; they do not. However, nurses are fundamentally involved in many aspects of caring for women seeking, undergoing, and recovering from abortions. In those capacities, nurses act as abortion care providers. The specific clinical duties and responsibilities currently assigned to nurses participating in abortion care in Canada are difficult to determine from public documents. Although detailed best practice guidelines for abortion providers—in which nursing interventions are embedded, but not specifically identified as such—have been published online (British Columbia Women's Hospital & Health Centre, 2004; Davies, 2006), there are no readily available public descriptions of what Canadian

abortion nurses actually do (or should do) in clinical practice.² Although the nursing interventions required by abortion patients differ depending on the method of abortion, the facility available and the individual needs of the woman herself, I will nevertheless outline what nursing duties have emerged as common practices from the international abortion nursing literature.

Abortion nurses, in conjunction with other health care professionals such as social workers, may participate in pre-abortion processes including general health screenings, counseling or educating women on pregnancy options and abortion procedures, facilitating decision making, and processing paper work such as consent forms (Kane, 2009; Lipp & Fothergill, 2009; Wolkomir & Powers, 2007). For medical abortions, nurses do not prescribe, but may administer physician-prescribed abortifacient pharmaceuticals to women and provide them with appropriate medication education (Lipp, 2008a). During surgical abortion procedures or medically induced labors, abortion nurses must “attend to [patients’] medical needs and be on guard for potential problems” (Wolkomir & Powers, 2007, p. 156). In other words, nurses must: (a) monitor and manage patients’ vital signs, bleeding, pain, reactions to and side effects of medications; (b) assist the physician with the processes of the procedure and the necessary equipment; and (c) anticipate and manage potential emergencies (Al x & Hammarstr m, 2004; Huntington, 2002; Nicholson, Slade, & Fletcher, 2010). After the abortion, nurses are responsible for “the management and appropriate disposal of the fetus” (Huntington, 2002, p. 275). In fulfilling this responsibility, especially after therapeutic abortions performed at later gestational ages, “nurses are frequently required to clean and dress the fetus, ensure transfer to an appropriate receptacle” (Huntington, 2002, p. 275) and support the mother in viewing or photographing the fetus, if she so chooses (Huntington, 2002). Nurses are also responsible for monitoring the physical and psychological health of women after the procedure (Al x & Hammarstr m, 2004; Huntington, 2002). In addition to developing supportive and empowering relationships with their own patients (Al x & Hammarstr m, 2004), abortion nurses frequently manage relationships between

² Such as in the extensive best practice guidelines provided by the Registered Nurses Association of Ontario; see www.rnao.org/bestpractices/

women and their support people or significant others, women and other professionals such as physicians and social workers; and liaise with multiple colleagues themselves (Lipp 2008a, 2008b).

Ultimately, abortion nurses are responsible for providing complex physical and psychological care to abortion patients. They require comprehensive and specialized knowledge of anatomy and physiology, abortifacient and analgesic pharmacology, surgical procedures, and psychological care processes. However, even though women seeking abortions are certainly entitled to this high quality, multifaceted nursing care, many women in Canada face multiple barriers that prevent them from accessing abortion services or encountering an abortion nurse at all. Moreover, additional obstacles exist that prevent nurses who are providing abortion services to women from consistently caring for their patients in physically and psychologically safe ways. The next section of this paper constitutes a review of the abortion-access literature and the abortion nursing care literature. It provides an overview of the multiple barriers women and nurses face in attempting to access and provide safe abortion care.

Literature Review

Obstacles to accessing safe abortion services.

Current research exposes the numerous obstacles encountered by women in their attempts to obtain safe abortion care in North America. Henshaw & Finer (2003) use the terminology “tangible and intangible barriers” (p. 16) to describe and differentiate what prevents women from acquiring appropriate abortion care. Many of the barriers, tangible and intangible, however, are inseparable; rarely does just one factor impede a woman’s ability to procure a safe abortion. Furthermore, women are not equally challenged by these barriers to safe care. In general, some women, such as those of lower socio-economic status or those living in rural areas, are more vulnerable to abortion access challenges than are other women. Moreover, those who are vulnerable to one prohibition are also commonly susceptible to a combination of many others (Kaposy, 2010).

Tangible barriers to safe-abortion access are largely related to the intersecting difficulties associated with geography and lack of abortion facilities. Women who must travel away from home to obtain their abortions in physically safe conditions may be prohibited by the cost of doing so. In addition to potentially paying for her own procedure and medication, as required in a few Canadian provinces (Kaposy, 2010) and in many American States (Henshaw & Finer, 2003), women who have to travel to an abortion facility face additional costs associated with transportation, lodging, food, and missed income (Ferris et al., 1998; Henshaw & Finer, 2003; Jones & Kooistra, 2011; Kaposy, 2010). Moreover, even where abortion clinics or hospitals do exist, lack of equipment (such as operating or recovery beds) additionally limits women's abilities to access safe abortion services (Ferris et al., 1998; Henshaw & Finer, 2003; Jones & Kooistra, 2011; Kaposy, 2010).

Intangible barriers to safe-abortion access include deliberate misinformation by governmental or independent agencies about, "the legality of abortion and about where and how to obtain abortion care" (Henshaw & Finer, 2003, p. 16). However, where accurate abortion information is made available, some women remain unable to access or understand it (Kaposy, 2010). Mandatory wait times, which necessarily increase gestational age, not only decrease the medical safety associated with the procedure (Bartlett et al., 2004; Stubblefield, Carr-Ellis, & Borgatta, 2004), they also limit where and from whom a woman can obtain a later abortion (Henshaw & Finer, 2003; Kaposy, 2010). Compulsory counseling, which may be delayed, similarly results in increased gestational age and may be purposefully dissuasive (Henshaw & Finer, 2003). The fear of poor opinion or lack of support from friends and family, especially when confidentiality is impossible, and harassment or intimidation of women seeking abortions, whether occurring in the media or at abortion facilities, similarly discourages and prohibits them from obtaining safe care (Eggertson, 2001; Henshaw & Finer, 2003; Jones & Kooistra, 2011; Kaposy, 2010).

Additional intangible barriers to safe abortion care are related to restrictive laws and regulations that operate outside of federal legislation (Eggertson, 2001; Erdman,

2007; Kaposy, 2010). In Canada, contrary to the Canada Health Act, prohibitive laws and regulations include variable provincial legislation of abortion providers and facilities, and inconsistent availability of public funding nationwide (Erdman, 2007). Kaposy (2010) describes restrictive provincial regulations: “The province of New Brunswick, for instance, requires the approval of two doctors in order to have an abortion in a hospital. New Brunswick also refuses to pay for abortions performed in the province’s single private clinic” (p. 20); similarly, in Nova Scotia, a woman is required to secure “the approval of two doctors who must agree that the procedure is medically necessary” (p. 20) before she can obtain an abortion. Comparable access-limiting, state specific regulations are reported in the United States (Guttmacher Institute, 2011).

Women seeking safe abortions also face tangible and intangible obstacles that are directly related to the actions and attitudes of their would-be professional care providers. Safe care is increasingly difficult to obtain due to: (a) a shrinking number of physicians who are trained and willing to perform abortions at all, and (b) the small number of practitioners who can (and are willing) to provide the full scope of abortion care—from initiating early-gestation medical abortions to performing surgical operations at later gestations (Coeytaux, Moore, & Gelberg, 2003; Eggertson, 2001; Ferris et al., 1998; Henshaw & Finer, 2003; Jones & Kooistra, 2011; Kade et al., 2004). Furthermore, physicians motivated by their personal anti-abortion ideals or fear of harassment from colleagues and public protestors reportedly misinform their patients about abortion options or refuse to refer them to willing abortion providers (Eggertson, 2001; Kade et al., 2004; Kaposy, 2010). Decreased numbers of trained physicians coupled with inappropriate physician attitudes certainly limit women’s access to physically and psychologically safe abortion services.

Unlike physicians, the roles and attitudes of nurses, as they directly affect abortion access and safety, have been minimally addressed in the interdisciplinary abortion access literature. In their study of Ontario hospitals Ferris, McMMain-Klein, & Iron (1998) reported that 3% of hospitals had “problems recruiting nurses to work in this area” (p. 137). Additionally, they reported that 25% of the hospitals employed nurses

who “refused to be present [let alone provide direct care to the woman] during the procedure” (Ferris et al., 1998, p. 137). The authors did not elaborate on the implied connection between difficulties recruiting and retaining nurses and women’s limited access to abortion, nor did they discuss the needs of nurses working in abortion care areas. However, they did explicitly address the needs of abortion-providing physicians, concluding, “physicians willing to perform the procedure need to have improved working conditions” (p. 138); “physicians need to be able to provide care in an environment that does not allow them to be harassed for providing a legal medical procedure” (p. 138); and, “physicians need to be provided with appropriate training opportunities...” (p. 138). Ferris et al., while implicating nurses as limiting women’s access to abortion, explicitly focused on the roles and needs of physicians instead.

Perhaps recognizing the potential influence of under-examined nurse actions and attitudes on abortion access, Kade, Kumar, Polis, & Schaffer (2004) focused their research specifically on nurses, setting out to explore “a largely unacknowledged obstacle to abortion access in Massachusetts: the unwillingness of nurses to staff abortion procedures” (p. 59). To achieve their goal, they collected “qualitative information from [20] physicians and nurse managers [but no practicing nurses] about how nurses’ attitudes affect hospital-based abortion services” (p. 60). They concluded that “many Massachusetts physicians working in hospitals that provide accessible abortion services believe that nurses’ unwillingness to participate in abortion services poses at least somewhat of a barrier to abortion access” (p. 61). Kade et al. reported that physicians perceived nurses as specifically hindering the range of options that could otherwise be made available to women seeking abortions, stating, “particularly compelling are the statements from physicians that indicate that their desire to offer a wider variety of services to patients is stifled by nurse unavailability” (p. 61). Kade et al. do not speculate on how or why nurses developed their negative attitudes or why nurses may be unwilling to perform abortion care. Nor do they suggest ways for nurses to change their attitudes or alter their care-giving behaviors so that women’s access to safe abortion may be improved. Ultimately, Kade et al. neglect to consider the questions of abortion access and nursing care from the perspectives of nurses at all. Fortunately, nurses’ abortion attitudes

and care-giving practices have been examined, both from their own and their patients' perspectives, in other, largely nurse-led, investigations. The next section of this paper reviews those investigations.

Abortion nursing.

Nurses' perspectives of their roles in abortion services in developed countries have been addressed by a number of studies. Researchers have mainly investigated: (a) nurses' attitudes towards abortion and women undergoing abortion, both in general and in the context of doing abortion work (Marek, 2006; Marshall, Gould, & Roberts, 1994; Natan & Melitz, 2010); (b) the ways nurses experience providing abortion care (Gallagher, Porock, & Edgley, 2009; Huntington, 2002; Lipp, 2008b, 2009, 2011a, 2011b; Nicholson et al., 2010); and, (c) the emotional impact of abortion work on nurses (Lipp & Fothergill, 2009; Hanna, 2005; Huntington, 2002). The fundamental suggestion made by these authors is that factors directly related to nurses and nursing care—the ways nurses perceive and understand their work, the ways their work impacts them, and the ways they are able to enact their care roles—affect the delivery and quality of abortion care. In other words, nursing care has been shown to affect women's access to physically and psychologically safe abortion services.

Nurses' attitudes toward abortion.

Nurses' attitudes toward abortion and the women who seek abortions varied depending on the conditions of the pregnancy and factors related to the nurse. Nurses' attitudes were found to be generally supportive in cases of confirmed fetal demise, severe fetal anomaly, life or health endangerment of the pregnant woman, and instances of conception resulting from rape or incest (Marek, 2004; Marshall et al., 1994; Natan & Melitz, 2010). Supportive attitudes towards abortion and nurses' subsequent willingness to participate in abortion care decreased as gestational age increased, and when abortion was performed for non-lethal fetal anomaly and sex selection (Marek, 2004; Marshall et al., 1994; Natan & Melitz, 2010). Common personal attributes of nurses that influenced their perspectives were cited as: moral/ethical beliefs, religious affiliation or level of religious observance, previous experience with abortion work, and previous experience

with grief and loss (Marek, 2004; Marshall et al., 1994; Natan & Melitz, 2010). These attitudes were shown to affect the degree to which nurses willingly participate in abortion work and further, for those who do participate in abortion work, their attitudes are “reflected in the subsequent standard of care they provide” (Marshall et al., 1994, p. 568).

Nurses’ experiences of providing abortion care.

Nurses’ experiences of providing abortion services were generally focused on abortion care as particularly demanding work, requiring complex physical and psychological nursing skills, provided in challenging (and sometimes hostile) care environments (Gallagher et al., 2009; Huntington, 2002; Lipp, 2008, 2009, 2011; Nicholson et al., 2010). Nicholson, Slade, & Fletcher (2010) found that abortion work could be understood “in terms of a balance between strains, coping, and contextual influences” (p. 2245). Strains of abortion work included handling the fetus, nursing repeat patients, nursing a range of patients, and heavy workloads. Coping strategies included attempting to control emotions and debriefing with colleagues. Contextual influences were related to nurses’ personal experiences and degree of professional autonomy. Nicholson et al. noted that, “how [nurses] experience their roles has implications at different levels for individual staff well-being, for the organization in terms of staff absence and turnover rates, and for the quality of patient care” (p. 2246). In 2009, Lipp determined that practicing abortion nurses demanded of themselves impossible attributes such as constantly maintaining unconditional non-judgmental attitudes and care-giving behaviors. Lipp (2011) later theorized that, in the absence of achieving (the impossible to achieve) unwavering non-judgmental mindset, nurses actually conceded and concealed their judgments as a method of self-preservation in challenging abortion work. Meanwhile Gallagher, Porock, & Edgley (2009) positioned nurses’ abortion work as a constant struggle between “attitudes towards” abortion and available ways of “coping with” clinical realities (p. 849). These investigations generally revealed the complexities of abortion work while specifically exploring the multiple strategies nurses use to enact their care roles. The underlying assumption common to all

of these investigations is: how nurses perceive and enact their roles, or how they provide abortion care, ultimately affects the safety of abortion services offered to women.

The emotional impact of abortion work on nurses.

The emotional impact of abortion work on nurses was also determined to be a significant aspect of abortion nursing (Hanna, 2005; Huntington, 2002; Lipp & Fothergill, 2009). Lipp & Fothergill (2009) reported that nurses providing abortion care encounter numerous stressors related to their level of involvement in the procedure, their ability to suspend judgment, experiences of moral distress, and engaging in emotional labor. These stressors were found to result in both positive outcomes for abortion nurses such as high job satisfaction, and negative outcomes for nurses such as compassion fatigue and burnout (Lipp & Fothergill, 2009). Hanna (2005), aiming to study the lived experience of moral distress (and not abortion per se) examined the impact of abortion work on nurses. She identified three types of moral distress including shocked, muted, and suppressed moral distress. These were related to “situational conditions, recognition of moral ends, quality of coping processes, and temporal breadth” (p. 95). She explicitly connected moral distress to abortion work by identifying “physical symptoms of moral distress” in abortion nurses, such as “sleeplessness, loss of appetite, nausea, diarrhea or other gastrointestinal upset, migraine or other type of headache, [and making] decisions about tubal ligation based on what they experienced by assisting in elective abortion procedures” (p. 116). Huntington (2002) similarly finds that abortion work can be emotionally distressing to many nurses, which, in addition to harming nurses, can also influence patient care. She notes that participating in the “multidimensional and often emotionally demanding situation” of abortion as a patient or as a nurse “has the potential to be psychologically unsafe for both partners” (p. 276).

Abortion patients’ experiences of nursing care.

The idea that nursing care affects the physical and psychological safety of abortion patients is supported by research examining abortion care from the patient’s perspective. Two studies in particular demonstrated that women perceived staff attitudes and behaviors as influencing their experiences of abortion (Slade et al., 2001; Aléx &

Hammarström, 2004). Slade, Heke, Fletcher, & Stewart (2001), for example, found that 6% of medical abortion patients and 7% of surgical abortion patients perceived that aspects of staff attitudes and behavior, such as lack of support and feeling criticized “made the experience more stressful than necessary” (p. 74). Conversely, 60% of medical patients and 61% of surgical patients perceived that aspects of staff attitudes and behavior such as friendliness, being sympathetic and non-judgmental, and providing explanations sensitively (among others), “helped with feeling more relaxed” (p. 74). In another study (Aléx & Hammarström, 2004), women who underwent medical and surgical abortions described both positive and negative experiences with staff, finding them: “supportive, positive and informative, cold, negative and ignorant, inducing feelings of shame, sadness, loneliness and uncertainty” (p. 163). According to research from patients’ perspectives, nursing care affects their experiences of abortion.

Thus far, relevant literature indicates that nursing-specific factors, such as an unwillingness to participate in abortion work, potentially affect abortion access and safety by limiting both the number and method of procedures made available to women (Ferris et al., 1998; Kade et al., 2004). Additionally, factors such as how nurses perceive and understand their work, the emotional impact of providing abortion services, and in what ways they are able to enact their care roles also appear to affect abortion safety in particular—not by restricting the availability of services, but by influencing the quality of care delivered to women. In this body of literature, “quality of care” ultimately describes the psychological aspect of abortion safety. Women who *are* able to find, travel to, and pay for physically safe professional abortion services, but who receive those services in demeaning or dehumanizing ways or in unsupportive care environments (i.e. who receive poor quality of care), are not accessing safe abortion care. Nurses who are prevented from delivering the appropriate quality of abortion care are necessarily prevented from delivering safe abortion care. In order to ensure women’s access to safe abortion care, it is necessary to determine what prevents nurses from delivering safe care and to develop strategies that target those barriers. Unlike previous investigations with these goals, this inquiry explicitly focuses on how professional discourse affects, and can be used to,

improve nurses' abilities to provide abortion care. The next section of this paper outlines the methodological processes required to make those determinations.

Methodology

Discourse analysis.

To expand the collective understanding of nurses' contributions to abortion services, I approach the common questions of how nurses come to perceive, understand, and enact their abortion care roles through the lens of constructivist discourse theory and discourse analysis. This new approach allows for an investigation of how the "abortion nurse," as a professional identity, and the ideas, practices, or actions associated with "abortion nursing," came into being. Phillips and Hardy (2002) explain that, "whereas other qualitative methodologies work to understand or interpret social reality as it exists, discourse analysis endeavors to uncover the way in which it is produced" (p. 6). Uncovering and understanding the ways particular social realities (such as those that support nurses' abilities to provide safe abortion care) have been and continue to be produced is a crucial step towards deliberately creating and maintaining positive and healthy social practices and environments (such as safe abortion services for women). As such, discourse analysis is particularly valuable for investigating nurses' abortion work and its effects on abortion safety. Yet, discourse analysis is a broad term that encompasses many different theoretical approaches (Phillips & Hardy, 2002). Before outlining what particular discourse analytic approach guides this investigation, it is necessary to define the fundamental terms for this inquiry: discourse, discourse analysis, and professional identity, and to explore how they inform each other.

Defining professional identity and discourse.

In this inquiry, I investigate abortion nurses and abortion nursing as social objects using the term *professional identity*. Professional identity refers to the specific ideologies and practices that are permitted and expected of members who belong to a particular professional group (Fagermoen, 1997; Phillips & Hardy, 2002). To identify and examine the professional identities of abortion nurses, then, is to identify and examine what

abortion ideologies and practices are permitted and expected of them as they engage in abortion nursing. Professional identities (what members are allowed or expected to say and do in certain circumstances, such as when taking on abortion work,) are constructed and reconstructed, communicated to members, and maintained over time through professional discourse (Jóhannesson, 2010; Phillips & Hardy, 2002). *Discourse* refers to “an interrelated set of texts, and the practices of their production, dissemination, and reception, that brings an object into being” (Phillips & Hardy, 2002, p. 3), and *professional discourse* is an interrelated set of texts (and the practices of their production, dissemination, and reception) that are generated by or for a particular group of professionals. Jóhannesson (2010) explains how professional identity is created or “brought into being” through professional discourse: “as members of professional groups consciously and unconsciously participate in professional discourse, they come to “accept a variety of ideas and practices as professional truth ...” (p. 253); that is, they come to adopt particular professional identities that tell them what is permitted or prohibited of them in practice. Phillips and Hardy (2002) similarly explain: “dominating and emerging discourses in organizations and societies provide a repertoire of concepts, which can be used strategically by members of the community [or profession] to influence the social construction of identities and to support the institutionalization of practices ...” (p. 32). Analyzing professional discourse, then, is a compelling and unique method for examining how professional identities, professional truths, and professional practices (in other words, how their social realities) are constructed and made available to nurses. Moreover, historical discourse analysis can be employed to examine how those processes have operated in the past and over time to create and maintain particular constructions of professional identity.

Historical discourse analysis and social linguistic analysis.

Because the discourse analyst investigates “naturally occurring” (Phillips & Hardy, 2002, p. 70) discourse (or text that is generated independently from the researcher and the research process), discourse analysis can be used to investigate historical text and discourses (Jóhannesson, 2010). The ability to study historical text and discourse is

especially valuable as, noted by Park (2006), it allows for the investigation and potential “articulation of the forces that have constituted *and* continue to shape the society and the profession[s] in which we live and work” (p. 170). Historical discourse analysis can be used to “examine the past in order to illuminate a present day problematic” (Park, 2006, p. 172) or to “make visible the discursive practices of the present” (p. 172). In this inquiry, I use historical discourse analysis guided mainly by a social linguistic theoretical approach.

Social linguistic analysis is concerned with the discursive organization and construction of phenomena (Phillips & Hardy, 2002). It is “constructivist and text-based” (Phillips & Hardy, 2002, p. 22), which means social linguistic discourse analysts carefully study individual texts to explore how broader phenomena, or social realities, have been constructed (Phillips & Hardy, 2002, p. 22). Social linguistic discourse studies are “useful in understanding how social phenomena—decisions, organizations, identities—are produced by specific discursive actions ... “ (Phillips & Hardy, 2002, p. 23). In this inquiry, I employ historical discourse analysis, informed by social linguistic theory, to investigate what has shaped and what continues to shape abortion nursing in Canada by examining how the abortion nurse came into being. I interrogate individual historical professional nursing texts for what professional nursing identities or social realities have been discursively created for abortion nurses as abortion nursing. I specifically focus on what abortion ideologies or practices were permitted and prohibited of those nurses as professional truths and how those ideologies and practices affected abortion safety for women in the past. I examine the historical discursive construction of abortion nursing to build a foundation from which to examine, understand, and evaluate contemporary professional discursive processes, so that future discourses may be deliberately operated to construct particular identities and realities for nurses that support them to provide safe abortion care.

Data collection.

The data collection and sampling goals of the discourse analyst are to “identify a manageable, relatively limited corpus of texts that is helpful in exploring the construction of the object of analysis” (Phillips & Hardy, 2002, p. 72). This inquiry explores the historical discursive constructions of the professional abortion nurse and the practices of abortion nursing; therefore, I collected data from the national professional nursing journal, a key producer and distributor of professional discourse, *The Canadian Nurse*³. This journal identifies itself as an influential and historical producer and disseminator of professional discourse as follows:

For over 100 years, [*The*] *Canadian Nurse* has been Canada’s leading nursing journal, presenting new ideas, opinions, promising practices, and the latest nursing research—to inspire and support registered nurses in every area of practice. [*The*] *Canadian Nurse* is published by the Canadian Nurses Association and serves as the primary communication tool for keeping nurses informed of the association’s work in advancing the nursing profession. Published nine times a year (monthly except for July, August and December), in both official languages, [*The*] *Canadian Nurse* represents the diverse nature of nursing, professionally and demographically. We publish short articles, peer-reviewed features, and opinion pieces from both experienced and emerging nurse authors. (*The Canadian Nurse*, 2010, About us section)

Working exclusively from *The Canadian Nurse* established appropriate limits for collecting relevant primary source material from a manageable, yet theoretically justified, library of text. As a result, this investigation was limited only to the journal and I did not seek out other examples of professional abortion discourse, such as in text books or practice manuals, for analysis. Further narrowing the “corpus of text” for consideration, I limited my search for abortion-related material in *The Canadian Nurse* to those issues published between the years 1950 and 2000. These limits ensured I collected data from a range of legal abortion eras in Canada, including: (a) 1950-1968, when abortion and abortion work were strictly illegal; (b) 1969-1987, when the abortion laws were relaxed

³ *The Canadian Nurse* is sent directly to all members of the Canadian Nurses’ Association: “subscription” to the journal is automatic and included in membership fees.

and nurses could legally participate in abortion care under certain restrictions; and, (c) 1988-2000, when abortion was decriminalized and the concept of nurses legally providing abortion care was no longer new. Focusing on the legal progression of abortion set additional, justifiable, limits for data collection.

Having identified *The Canadian Nurse* (from 1950 to 2000) as an appropriate source of professional discourse relevant to the construction of professional identities and social realities of abortion nurses, I next had to choose which individual texts would constitute the “sample” of this investigation. Not wanting to neglect any potential data in this early phase of collection, I searched each issue of *The Canadian Nurse* and collected every article, by-line, advertisement, editorial, letter to the editor, book review, product review, news item, or photograph that mentioned or alluded to abortion or abortion nursing in any way that I noticed. I consulted the published indices and table of contents of each issue and manually scanned each available page of the journal. I photocopied and archived the pages that I thought were potentially relevant to the topic. I did not create strict limiting criteria for what might be relevant before I started the search (except to collect anything that explicitly mentioned abortion), yet common subjects emerged throughout the collection process as potentially informative. Thus, I paid careful attention to materials related to unintended pregnancy, unwed motherhood, family planning, gynecology, obstetrics, and maternity care, contraception, venereal disease, sexual education, and women’s health. When all of those texts were collected, I was left with a large secondary volume of professional discourse. I began to consider each one for whether it would be “helpful in exploring the construction” (Phillips & Hardy, 2002, p. 72) of the professional identities of abortion nurses. In doing so, I began the processes of data analysis. The specific documents that I deemed most relevant or that most profoundly informed my conclusions are described in more detail within the Key Findings section of this paper.

Data analysis.

In keeping with the fundamental assumptions of discourse analytic methodology, the system of analysis brought to this particular data set allowed for individualistic, interpretive, and emergent conclusions. To begin, Jóhannesson (2010) suggests that, in some cases, “the reader should simply start and let the actual ways of working and thinking about the material evolve during that process” (p. 256). This was my approach in the early phases of analysis; I simply started to read and review the texts I had collected. Next, also drawing from Jóhannesson’s suggestions, specific guiding questions were brought to each text to identify and record: (a) the format of the text (i.e. feature article, letter to the editor, advertisement, or editorial); (b) the general subject and specific abortion-related content of the text; (c) the context of the material (such as the date of publication, the author of the text, and the author’s occupation); and, (d) the initial reflections and interpretations I had (as they emerged). Then, “struggles and tensions in the discourse” were considered in order to identify the significant discursive themes and “legitimizing principles” at work (Jóhannesson, 2010, p. 256) as, recognizing and exploring discursive themes and legitimating principles are vital to understanding how discourse affects ideology and practice.

Jóhannesson (2010) contends that certain words and ideas, or behaviors and practices—what Phillips and Hardy (2002) might term “discursive units” (p. 4)—are consciously and unconsciously repeated by participants in discourse construction and performance, while other discursive units are unconsciously and consciously forgotten or silenced. As discourse progresses and changes, the robust discursive units become “discursive themes” (Jóhannesson, 2010, p. 252). Discursive themes, in turn, can be forgotten and silenced or repeated and reconstructed through discourse processes and discourse “patterns that are shaped and reshaped in the social and political atmosphere of the past and the present” until they become “legitimizing principles” (Jóhannesson, 2010, p. 252). Legitimizing principles ultimately “constitute the available means for the participants for what is appropriate or safe to say at certain moments or in certain places” (Jóhannesson, 2010, p. 252). In the context of professional identity and professional practice, legitimating principles are constructed and maintained through discourse

processes, taken up or accepted by members as professional truth, professional identity, or social reality, and subsequently used (consciously and unconsciously) to normalize or legitimize certain utterances and practices, and to silence or punish others. The social linguistic discourse approach is particularly appropriate for examining how these elements operate in discourse, as it calls for a close reading of individual texts (Phillips & Hardy, 2002).

In this investigation, historical patterns of abortion-related words, phrases, behaviors, and practices (or discursive units) were recorded and examined. Their transformations from discursive units to discursive themes and legitimating principles were reconstructed such that the specific models of professional truths, social realities, and professional identities constructed and made available to nurses could be examined for their impact on nurses' abortion attitudes and practices. Ultimately, this analysis constitutes an understanding of the past discursive processes that normalize or legitimize what is and is not appropriate for professional nurses to say, do, or be vis-à-vis abortion and abortion care.

In this chapter, I have identified the research problem as follows: although it is essential to their health and well-being, access to physically and psychologically safe abortion care is unattainable for many women in Canada. I have reviewed the literature, which suggests that nurses may contribute to the problem—both in their unwillingness to participate in providing abortion care at all, and by the harmful attitudes and practices that they sometimes bring to their actual abortion work. Conversely, nurses can improve abortion safety by participating in abortion work, thus making more abortion services available to women and by bringing supportive, empowering, and caring attitudes and practices to the abortion work that they do. One clear approach toward improving abortion safety, then, is to enable and support nurses in bringing appropriate attitudes and practices that create safety to their abortion work.

I have argued that because professional attitudes and practices (or professional identities) are created, maintained, and made available to members of professional groups

through professional discourse, professional discourse can be deliberately operated to create appropriate abortion attitudes and practices for nurses that enable them to promote and provide safe abortion care. I have suggested that investigating and understanding how historical professional discourse has shaped abortion nursing in the past will reveal what has and continues to shape abortion nursing today and provide a lens through which to examine and evaluate contemporary discourse processes and nursing practice. Historical discourse analysis, guided by social linguistic principles, of past professional nursing discourses emerges as the best method for guiding this inquiry.

I have identified a body of professional discourse (the issues of *The Canadian Nurse* published from 1950 to 2000), from which I have drawn a collection of texts relevant to exploring the discursive construction, maintenance, and distribution of the practices and attitudes permitted of abortion nurses. Next, I have outlined an interpretative and emergent scheme of data analysis with which to analyze the historical documents for the following insights: what professional identities (attitudes and practices) have been discursively created, maintained, and made available to abortion nurses? What have nurses been permitted or supported to do or say regarding abortion over time? How have these attitudes and practices affected abortion safety? The ultimate question of this investigation is: how can professional identities (attitudes and practices) that enable and support nurses in providing safe abortion care be discursively constructed, maintained, and made available to professional nurses today and in the future?

In the following three chapters, I set forth an account of the historical discursive production of the abortion nurse and abortion nursing in Canada over time. In the final chapter, I position that account within the context of contemporary discursive processes and contemporary abortion nursing to identify strategies to improving abortion safety through nursing care. I evaluate the processes of creating and upholding rigor in this inquiry to assess and demonstrate the quality or credibility of the findings. Finally, I make recommendations for nursing practice and future research.

Chapter 2: Findings and Discussion: “Child by Child We Build a Nation”— Prohibiting Abortion Work as Nursing Work

In the 1950's and early 1960's, abortion discourse in *The Canadian Nurse* is constructed in three distinct ways: explicitly, implicitly, and by omission via three different textual formats including: a variety of feature articles, one advertisement, and one piece of filler text. Published in the official space of the journal (where the pertinent educational articles or substance of the journal is located, as opposed to the unofficial space or social pages of the journal where obituaries and other community messages are published), these texts are presented to the reader as instructional or factual. In addition to appearing in the journal's official space, the majority of the articles are written by authority figures or experts, such as physicians (Atlee, 1951; Coffey, 1964); a police inspector (LeDoux, 1950a; 1950b; 1950c); and a government health consultant (Robertson, 1960), which assigns power to the information conveyed. When written by non-experts, such as student nurses (Nordwich, 1953; Schroeter, 1959), these articles appear equally credible—due to their locations in the official space of the journal and because they express many of the same orthodox messages communicated by experts. Thus, the nurse-reader of this era receives authoritative messages about abortion in both general and professional contexts from a variety of sources.

In this era, abortion is discursively constructed as: harmful, unnecessary, dangerous to women's lives, and ultimately, detrimental to community well-being. The people who participate in abortion work are constructed as: unprofessional, unethical, and malicious. As such, the roles discursively constructed for and made available to nurses performing (or considering performing) abortion work at this time are of unethical and unprofessional practitioners who contribute to the degradation of society. The abortion activities that are legitimized for nurses through discursive processes in this era are: counseling against abortion, refusing to participate or assist in the procedure, reporting colleagues and criminals involved with abortions, rehabilitating women who have attempted but failed to abort, or ignoring the existence of abortion completely. Alternatively, there is scant evidence that nurses may sometimes perform actual abortion work, but only for each other and only very secretly; this representation is so ambiguous

and implicit however, that the nurse-reader is unlikely to acquire an alternative professional identity that legitimizes actual abortion activities from it.

Explicit Mention

In the discursive mode of explicit mention, abortion is expressed overtly and straightforwardly, albeit rarely. Authors use the actual words “abortion” or “termination of pregnancy” to directly convey messages about both abortion and the social actors involved to the reader. In the 1950 to 1964 discourse era, abortion is explicitly articulated in only four articles, a shortage which reinforces the illicit connotation of abortion. When abortion is explicitly discussed in this era, it is done so rarely and only in certain contexts. Further, the direct messages sent to readers about abortion condemn it, and the social actors sympathetic to it, in clinical and moral contexts.

In the first two examples of explicit abortion expression in *The Canadian Nurse*, the authors straightforwardly proclaim induced hospital abortion in the clinical context as alternately unnecessary and potentially harmful. In 1955, for example, Guerard dismisses hospital abortions as an option for pregnant women who have tuberculosis. First, she positions hospital abortion as an out-dated treatment for tuberculosis patients stating, “Thirty years ago, the prognosis for the pregnant tuberculous [*sic*] patient was so bad that termination of pregnancy was usually advised” (Guerard, 1955, p. 625). Next, she intimates that abortion has by 1955 become clinically unnecessary, and further, may even be harmful to the pregnant tuberculosis patient. She explains, “There has been great controversy as to the beneficial effects of terminating pregnancy in the tuberculous patient” and, “At the present time, the prognosis, far from being poor, is fairly good and [pregnancy is] actually considered somewhat beneficial to the tuberculous patient” (p. 625). The message sent to the nurse-reader at home is: abortion was once available to tubercular pregnant women but is now deemed medically unnecessary. Furthermore, as pregnancy may be somewhat beneficial to women with tuberculosis, abortion is potentially harmful to the mother. Through this message, the practicing nurse-reader is encouraged to counsel her own patients against abortion and teach other nurses (who may

practice with outdated information that abortion is an option) that remaining pregnant is best for tubercular women. There is no abortion nursing work to be done here except to counsel against the procedure as outdated, potentially harmful, and clinically unnecessary.

In the second example of explicit abortion articulation from this era, nurse Nelson (1959) examines abortion not as a potentially legitimate clinical option, but in the context of failed criminal procedures. In contrast to Guerard (1955), instead of focusing on the pregnant woman, Nelson connects failed abortion to harm suffered by the (un-aborted) child. She warns that criminal abortion attempts are potentially harmful, citing failed abortion as a possible cause of Down's syndrome. She states, "the Mongoloid⁴ anomaly might have its origin in attempted abortion which injures the germ plasm" (p. 453). In this instance, Nelson presents Down's syndrome as a particularly adverse outcome of failed abortion, which, in the case of her patient has resulted in numerous comorbidities including tetralogy of Fallot,⁵ cystic fibrosis, and ultimately, a painful death. Nelson reinforces her presentation of Down's syndrome as particularly devastating when she details the deterioration of her patient:

After his fifth month of life, André began to have periods where he would be very cyanotic and a definite murmur could be heard in his chest. During his last few days, he was covered with small, dark red spots which may have been caused by anoxia from his congested lungs and weakening heart. He was, as are most Mongolians, very susceptible to infection and spent most of his short life in hospital. (p. 454)

Nelson explicitly suggests that any failed abortion attempt could be a possible cause of these (terrible) disease processes and as a result, she condemns abortion as potentially

⁴ "Mongolism/mongoloid" was the terminology used to describe Down's syndrome at the time. Howard-Jones (1979) explains: "until very recent years the genetically determined condition now generally known as Down's disease or syndrome had been known for about a century as 'mongolism' or 'mongolian imbecility'" (p. 102).

⁵ Tetralogy of Fallot is a complex cardiac condition characterized by "a tetrad of (i) ventricular septal defect with (ii) over-riding of the aorta, (iii) right ventricular outflow obstruction, and (iv) right ventricular hyper-trophy" (Apitz, Webb, & Redington, 2009, p. 1462).

harmful in the clinical context. In doing so, Nelson reinforces the notion that abortion is inherently bad in some way (be it clinically harmful as in this case or immoral as in the next case), with the added side effect of implicitly warning the reader against attempting illegal abortion herself or aiding or encouraging others to attempt abortion (by frightening her with the possibility of bearing a child with Down's syndrome). Again, this construction of abortion as harmful means there is no abortion nursing work to be done, except perhaps to counsel against it.

Whereas Guerard (1955) and Nelson (1959) construct a clinical discourse of abortion that situates both in-hospital and criminal abortions (and abortion attempts) as unnecessary and harmful, police inspector LeDoux (1950c) focuses exclusively on criminal abortion, shifting it from the clinical to the legal and moral discursive contexts. After two lengthy articles examining the law and the nurse's role in law enforcement (LeDoux, 1950a; 1950b), LeDoux unexpectedly addresses abortion for the first time in his final article, "The Nurse and The Law." He abruptly introduces abortion as an example within an expository discussion of victims' dying declarations in general. He states, "in the case of a woman dying as a result of criminal interference with a pregnancy, who makes a statement before she passes away implicating the abortionist, the statement could *not* be used on a charge of abortion ..." (p. 637). Although introducing abortion in the context of a woman's death already conveys the message that criminal abortion is extremely dangerous, his language is legal in nature and seemingly objective. However, LeDoux follows his legal exposition with a scathing commentary on the moral character of the abortionist while further positioning abortion as dangerous to the lives of women and the health of the community. He describes criminal abortionists as:

Unscrupulous, callous, and inefficient individuals who practice their nefarious trade on the worried and ignorant expectant mothers. In some quarters there appears to be a friendly feeling towards these harpies of a restless civilization. They [the abortionists] are endowed with an aura of beneficence. Young women speak of being 'helped out' by Mrs. So-and-so, but the help they receive is always

for a cash consideration—a consideration which may even cost them their lives.

The abortionist is usually an untutored and reckless person ... (p. 637)

Ultimately, LeDoux condemns the immoral abortionist as detrimental, not only to the lives of women, but also to the community in general. LeDoux concludes, “putting the abortionist out of business will be a valuable contribution to the community’s well-being” (p. 637).

There are no roles constructed by LeDoux (1950a; 1950b; 1950c) in which health care professionals may legitimately perform abortion work. The physician, for example, is portrayed as a beneficent hero who saves the lives of women endangered by the abortionist, but does not do abortion work himself:⁶ the physician “spurns [the abortionist’s] dirty work, [but] he will not stand idly by if the unhappy victim of their interference develops septicemia” (p. 637). The roles available to nurses are similarly incompatible with abortion work. First, if the abortionist is unscrupulous, inefficient, untutored and reckless, as LeDoux suggests, then the nurse who strives for professionalism and efficiency cannot perform abortion work. Further, LeDoux (1950a) “unequivocally place[s] nurses among the leaders of the community, both by virtue of their work and their high moral standards” (p. 479), and holds nurses responsible for both the “physical condition of the patient ... and his spiritual and temporal rights” (p. 479). By definition, LeDoux’s nurses cannot participate in what he has already deemed unscrupulous, nefarious, and detrimental to the community. Finally, according to LeDoux, the nurse who aspires to professionalism must not only refrain from participating in abortion work, she must also actively help law enforcement apprehend and punish criminal abortionists. Of the nurse’s duty to help the police (in all criminal situations), LeDoux (1950a) states:

It is not sufficient to save [the patient’s] life, but the person guilty of perpetrating this crime must be brought to trial and punished for violating the rights of his victim. The nurse can greatly aid this process and, unless she fully co-operates, she will only have partly fulfilled her pledge to her professional standards and to the community which holds her in such high esteem. (p. 479)

⁶ I use “him” for consistency with LeDoux.

In this example, criminal abortion is portrayed as harmful to women's lives and community well-being. The abortionist is unprofessional and nefarious. The physician is a hero who earns the status of ethical professional by not performing abortion work. And, the nurse must shun abortion work in order to perform her duties and to fulfill her professional standards. There is no professional role constructed by LeDoux in which nurses can do actual abortion work, except to actively crusade against it.

In the final example of abortion's explicit mention in this body of discourse, Robertson (1960), a nursing consultant for the Child and Maternal Health Division of the federal Health and Welfare Department, acknowledges that women do seek abortions, but like Nelson (1959), she addresses it only in terms of failed attempts. Robertson identifies the "mother whose attempts at abortion have failed" (p. 221) as someone who requires special nursing care in the prenatal period such as extra listening, non-prejudicial thinking, team work, and empathy. She reinforces the complexity of nursing care required for the woman who has attempted, but failed, to abort stating, "an adequate discussion of the nurse's role in providing maternity care for mothers with these special problems would require separate detailed consideration" (p. 221). In this example nursing work can only occur after a failed attempt; there is no role constructed that allows for nursing intervention before or during abortion. The legitimate nursing work suggested by Robertson is the rehabilitation of women after attempted abortion and throughout the prenatal period up to labor and delivery. Abortion continues to be constructed as harmful to women. Those who attempt abortion require extra nursing attention, as "the mental health of these mothers may be in a precarious position" (p. 221). Finally, that abortion is expressed explicitly only in the context of its failure (abortion as such did not actually happen), with special attention to its harmful effects (even in failure), conveys the message that abortion is illicit—it can only be discussed outright in terms of failure and only with regard to its negative effects.

These explicit representations: that abortion is harmful to women, un-aborted children, and community well-being; that abortionists are unprofessional and unethical practitioners who necessarily harm women and society; and that physicians and nurses,

who are professionals, cannot do abortion work emerge early in this era as discursive themes. They are representations that will be repeated and recast as professional truths and accepted as legitimating principles that support certain iterations of professional nursing identity, which ultimately determine what kinds of abortion work is permitted of nurses.

Implicit Articulation

Implicit articulation of abortion occurs when authors, without explicitly mentioning it, appear to tacitly acknowledge abortion as something that conceptually exists and actually occurs, and in doing so, simultaneously convey messages about abortion to the reader. As a result, the authors also contribute to the construction of nursing identity by presenting to the nurse-reader what valid abortion work looks like. The implicit abortion messages that occur in *The Canadian Nurse* in this era appear as both primary (or specifically abortion-focused) intentions (Heinz, 1951; International Council of Nurses [ICN], 1960; Scotsman, 1954), and as incidental to the treatment of broader subject matter (Nordwich, 1953, Perry, 1958)—some more clearly than others. Unlike explicit articulation of abortion, whether or not an author has implicitly addressed abortion in any given instance is (by definition) arguable. This feature makes implicit articulation a safer way for authors to convey messages about illegal subject matter. Also, that there are many more articles implicitly addressing abortion than explicitly doing so reinforces the message that, in this era within this official discourse, abortion was only openly discussed rarely and in certain contexts.

Student nurse Nordwich⁷ (1953) provides an example of implicit representation of abortion (and thus participates in the construction of professional abortion discourse) in

⁷ At this time, student nurses were monthly contributors to *The Canadian Nurse* within a section of the journal entitled “Student Nursing.” Their articles were mainly case study presentations of specific conditions or diseases and the subsequent nursing care required, such as “Infectious Mononucleosis” (Madison, 1954) and “Acute Osteoarthritis” (Hartley, 1952).

her article, “Pan hysterectomy.”⁸ In Nordwich’s case study, her patient suffers from the effects of a number of uterine conditions unrelated to either pregnancy or abortion. The patient’s symptoms however, mimic both pregnancy (protruding abdomen) and attempted abortion (profuse vaginal bleeding, elevated temperature,⁹ and absent fetus on abdominal x-ray).¹⁰ Nordwich implicitly expresses abortion when she writes, “sometimes [the patient’s] family put a false interpretation of the increasing volume of her abdomen. This resulted in a rather aggressive-defensive mood [in the patient]” (p. 649). She notes further, “... the patient was very sensitive about any possible *misinterpretation of her condition* [emphasis added], and rather apprehensive in giving details, questions had to be framed with the utmost tact and with a matter-of-fact crispness” (p. 652). Although Nordwich does not explicitly acknowledge it, her patient appears to be concerned that her family (and her caregivers) could falsely interpret her symptoms, general condition, and need for gynecological surgery as resulting from pregnancy and attempted abortion.

Although her references to abortion are incidental, as abortion representation is not the main purpose of her article, Nordwich’s (1953) example nevertheless conveys a few different messages about abortion to the reader. First, by not explicitly referring to abortion, she automatically intimates that abortion is illicit, that it should not be mentioned outright. Second, by only strongly alluding to abortion (but not explicitly mentioning it) in an otherwise clinical or instructional article, Nordwich indicates that abortion is so illicit that it should not be discussed even in a strictly clinical context. Third, of the broader social situation, Nordwich demonstrates that abortion is judged so disapprovingly in 1953 that merely being perceived by either her family or professional caregivers as pregnant and attempting or seeking an abortion warrants so much anxiety that the woman exhibits “a rather aggressive-defensive mood” and causes her to be “rather apprehensive in giving details” about her condition to her nurse. Finally,

⁸ Pan hysterectomy is the “excision of the entire uterus including the cervix uteri” (“Pan hysterectomy,” 2001, p. 1566).

⁹ Elevated temperature was a common symptom of infection introduced during the criminal abortion procedure (Roulston, 1965).

¹⁰ This was before ultrasound was widely used to diagnose and monitor pregnancy (Newman & Rozycki 1998).

Nordwich reveals that “abortion patients” (even if they are not actually abortion patients, but merely look like they are) require special nursing care (i.e. an especially tactful and matter-of-fact crisp approach).

In contrast to Nordwich’s (1953) example of incidental implicit abortion messaging, some texts appear to focus on abortion primarily, yet also implicitly. Because abortion seems to be the primary focus of their texts, these authors are able to convey stronger messages about it to readers as health care professionals and in general. Published as a small piece of “filler” text (seven lines at the bottom of a page), for example, is a list of influential historical figures with the title, “These Might Not Have Been Born ...” (Scotsman, 1954, p. 183). Scotsman, an otherwise un-credited author, identifies each person as having belonged to a large family. He writes:

Napoleon was one of 13 children. Gainsborough was the youngest of 9... Thomas Arnold of Rugby was the youngest of 7 and he himself fathered 9 children, the eldest being Matthew Arnold. ... Thomas Campbell, the poet, was the youngest of 11, as was also Samuel Taylor Coleridge. ... Elizabeth Barrett Browning was the eldest of 9 ... Jane Austen was the youngest of 7. (p. 183)

With no other text accompanying the list of names and birth rankings, the reader is required to draw his or her own conclusions about the greater message of this text. From the ominous title alone, the reader can infer that this is not merely an informative list of trivia. Considering that, in this era, abortion for the purposes of limiting family size was especially discouraged in public forums (McLaren & McLaren, 1986), the greater message in this list is likely a warning against abortion. Perhaps this is a list of writers and artists who “might not have been born” had they been aborted by women attempting to limit family size. Although certainly these people would not have been born had they been aborted for *any* reason, the explicit notation of birth ranking suggests that the text targets abortion-for-family size. The message here, although explicitly documenting the number of siblings Jane Austen had, is rather an implicit warning against abortion.

This text, aside from being published in a professional nursing journal, does not target nurses or health care professionals explicitly, nor create any specific practice roles

for them, but instead contributes to a general atmosphere condemning abortion. This is also an example of (anti) abortion messaging within the context of community well-being. Like LeDoux (1950c), Scotsman puts forth that abortion is detrimental to the community arguing that it potentially deprives community members of important literature and art. Abortion as detrimental to community well-being is emerging a discursive theme that continues to be repeated and reinforced; here it is used as a legitimating principle for why abortion and, by extension, abortion work should be avoided.

A similar example of seemingly primary, yet entirely implicit, abortion messaging occurs in a baby food advertisement (Heinz, 1951). Ostensibly marketing the “quality of [their] infant foods” (p. 371) to nurses, Heinz (the food company) publishes a full-page advertisement which appears to warn against abortion and abortion work by overtly celebrating physicians who *do not* do abortion work. The advertisement is titled (in bold font) “Child by Child We Build a Nation” (Heinz, 1951, p. 371). Building the nation is revered as “a grave responsibility” and a “great task” of physicians. Moreover, it is accomplished by professionals “who, true to their Hippocratic oath, maintain such high ethical standards” and “bring children into the world” (p. 371). Heinz gives physicians who do this work “an enormous share of the credit for building a healthy, happy nation in Canada” (p. 371) and admires those physicians for undertaking such work, noting that bringing children into the world is just “one of the many duties willingly and expertly undertaken by Canada’s medical profession, esteemed throughout the world” (p. 371).

Through their advertisement, Heinz conveys the following messages: building the nation is a most important and laudable task; to bring children into the world is to act professionally and ethically and is worth celebrating outright. Implied in their message is that there are physicians who are not “true to their Hippocratic oath,” who do not “maintain such high ethical standards,” and who do not “bring children into the world”—namely, physicians who perform abortions. Like Scotsman’s (1954) text, this advertisement, aside from being published in a nursing journal, does not seem aimed at nurses at all. The advertisement is explicitly focused solely on physicians, who are cast

again as the beneficent hero when compared with abortionists. As for nurses, they can infer from this ad that as medical professionals or as colleagues who must practice “loyally” to the physician (ICN, 1960; LeDoux, 1950a), they will be similarly celebrated or condemned for participating in abortion work with or without the physician. Ultimately, the nurse who aspires to ethical, professional, and esteemed practice, Heinz warns, should not participate in abortion work. In this advertisement, Heinz repeats the discursive theme that abortion is detrimental to community well-being, as bringing children into the world (the opposite of abortion) builds a “healthy happy nation” (p. 371). Moreover, Heinz continues to reinforce ethical professionalism as incompatible with abortion work, an idea that is also emerging as a discursive theme/legitimizing principle.

The message that ethical and professional nurses do not participate in abortion work is reinforced by the ICN’s “Code of Nursing Ethics” (1960). Tenets of the code that appear to implicitly target abortion specifically include: “the fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health” (p. 546); “the nurse is under an obligation to carry out the physician’s orders intelligently and loyally and to refuse to participate in unethical procedures” (p. 546); and “the nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed” (p. 546). This article (like the Heinz advertisement) appeals to nurses’ commitment to ethical professionalism as a deterrent from participating in abortion work. According to the “Code of Nursing Ethics,” the ethical nurse has an obligation not only to refuse to participate in unethical procedures (such as abortion, which may not conserve life,) she also has a duty to report those who do participate in unethical procedures. Maintaining professional and ethical status continues to be repeated as a discursive theme/legitimizing principle. In this example, it legitimizes nurses’ unwillingness to participate in abortion work and compels them to report colleagues who do participate in abortion.

Thus far, the abortion roles discursively made available to nurses have nothing to do with helping women terminate their pregnancies. Nurses “doing abortion work” in this

era can: caution against it (Guerard, 1955; Nelson, 1959), counsel or attempt to rehabilitate women who have tried and failed to abort (Robertson, 1963), refuse to participate in the procedure, and report other professionals (or non-professionals) for their participation in abortion services (LeDoux, 1950c; ICN, 1960). In other words, the abortion work nurses could do in the 1950's and early 1960's was largely preventative, punitive, or deliberately withheld. However, there is one potential implicit example of nurses doing actual abortion work, or caring for women in the context of real abortion activities, in this era. In an article describing the health service program available exclusively to student nurses, charge-nurse Perry (1958) appears to allude to pregnant student nurses and the abortion services available to them. Although she says nothing explicit about pregnancy or abortion, Perry's description of her patients, their symptoms or conditions, and the staff and services available to them, creates a vague picture of active abortion care available to student nurses. This ambiguous picture of active abortion work comes into focus only when the reader considers all of the elements (patient, symptoms, staff, and services) together.

First Perry (1958) simply creates the potential for the existence of the pregnant student nurse. She describes patients or students seeking health services as follows: "She may be a girl with a problem or a patient requiring skilled medical and nursing care and understanding" (p. 306). The reader familiar with the euphemism "in trouble" to signify "pregnant woman," as nurse-readers at the time certainly were (Bates & Zawadzki, 1964; Reagan, 1997), may similarly recognize Perry's phrase "a girl with a problem" as signifying "pregnancy" or a pregnant student nurse. Admittedly, this possible use of euphemism alone does not provide enough evidence to suggest that student nurses were indeed pregnant and subsequently obtaining abortion services from their school's health service. However, next Perry lists the common conditions of the student nurses seen by the health service: "enlarged infected tonsils, dermatitis, back strain, early varicosities, impacted wisdom teeth, amenorrhea, obesity or loss of weight" (p. 307). Elaborating on amenorrhea in particular, Perry states, "amenorrhea is a phenomenon of and is a great cause of worry to nurses in training" such that "every case is carefully checked to be sure that the function of the reproductive system although dormant has not been destroyed or

impaired” (p. 307). Perry does not state that amenorrhea is also a “presumptive” (“Pregnancy,” 2001, p. 1730) symptom of pregnancy nor that each case is checked carefully to rule out pregnancy, nor what happens if and when a student nurse presents to the health service with amenorrhea due to pregnancy. Perry does explain however, that all the patients of the health service have assured access to a “very understanding doctor” (p. 306), that “the medical and surgical staff [are] at the disposal of the department” (p. 306), and that student nurses “who require surgery are admitted to a private room in the hospital” (p. 308). In this era of illegal abortion, a pregnant student nurse in search of an abortion would indeed need to: see “a very understanding doctor,” who would diagnose the pregnancy and order the abortion; have access to a medical or surgical team, who would perform the abortion; make use of a private hospital room, in which to privately recover from the illicit procedure.

If all of these “clues” do not seem to add up to pregnancy and abortion services for student nurses, consider that Perry (1958) concludes her article by proclaiming,

We [the health service team] feel highly honored and privileged that we are able to help at times when life is dark and they [the student nurses] cannot see the forest for the trees. Then, they need desperately the friendship and assurance we can give . (p. 309).

It is unlikely that, for student nurses with early varicosities or back strain, life is “dark” and they are in “desperate need of friendship and assurance.” Perry’s description seems to better fit the outlook and needs of the pregnant student nurse. Although Perry never mentions pregnancy or abortion in her article, the reader can (at least) reasonably wonder if the health service does provide abortion care to their patients.

Appropriately, this example is the most ambiguous and implicit construction of abortion and abortion work. Obscuring (possible) nursing practices of abortion care quiets potential public expressions of abortion nursing and contributes to a silent or secret discourse of actual abortion, where abortion nursing is a secret practice nurses perform only for each other. In another publication, Bates & Zawadzki (1964) document the ability of medical professionals and students (such as physicians, medical students,

graduate nurses, and student nurses) and their relatives (wives of physicians and wives of medical students) to obtain illicit abortion services from legitimate physicians. These data however, are not available within *The Canadian Nurse* and thus, many readers may not be aware of the secret abortions performed for medical professionals. The successful concealment of abortion and abortion work within this article silences a potential discursive construction and public acknowledgment of nurses as legitimate, actual abortion caregivers. Nurse-readers continue to have very limited or no access to a positive abortion-nurse identity or an abortion-nurse role model because the only one offered is so well hidden it goes unnoticed, or is so ambiguous that nurses cannot be sure it's there. Thus, despite an article that may reveal actual abortion work, the professional identity discursively constructed for nurses who perform (or think about performing) abortion work is ultimately unaltered.

Omission

The third way abortion is discursively constructed in this era is through the complete omission of abortion from the texts in which the reader might otherwise expect it to be acknowledged. In this mode, abortion is not explicitly mentioned nor implied; it is seemingly non-existent. This omission of abortion occurs largely in the contexts of building community well-being and social rehabilitation, but also occurs in the clinical context. By constructing a discourse completely vacant of abortion as a concept, let alone as actually happening in either clinical or criminal contexts, the authors continue to convey messages about abortion to readers: to talk about or participate in abortion is absolutely forbidden—both in general and in the provision of health care—and further, abortion has no place in a well-built community. In this mode of omission, the idea of “ensuring community well-being” continues to act as a legitimating principle for omitting abortion from discourse and social reality. As for nurses, when abortion is constructed as non-existent, potential abortion work required of or permitted of them (even that of merely counseling against it) is similarly silenced.

Three authors clearly omit abortion from their articles, all within the contexts of promoting community well-being and the social rehabilitation of unmarried pregnant women (Loriot, 1960; Schroeter, 1959; Ste. Mechtilde, 1959). Each author presents similar duties for the nurse whose patient is unmarried and pregnant. In her article describing a class “field trip to the Venereal Disease Clinic” (p. 42), student nurse Schroeter (1959) explains:

It sometimes also happens that one of the patients is pregnant. If she is not married she is referred to a hospital where she can stay until delivery and where she has close medical supervision throughout her pregnancy. Plans for adoption if desired will be taken care of in these hospitals (p. 43).

Psychiatric nurse Loriot (1960) describes similar work for nurses with unmarried pregnant patients:

The nurse can help to formulate a realistic plan in such situations. ... Maternity care must be decided upon. Often a private hospital is desired. Community resources such as adoption agencies and foster homes must be investigated. ...

The agencies able to assist in her rehabilitation must be considered (p. 643).

Finally, Ste. Mechtilde (1959), the founder of a home for unwed mothers, explains:

A young woman in need comes to us. Usually she is in a panic, not knowing what is going to happen to her, knowing only that she is in trouble. ... The aim of these homes is to ... eventually make her a useful citizen. (p. 1001)

In each of these articles, abortion is not suggested, nor conceived of, as an option (even as a harmful one) for these women. The responsibilities of the nurse are to refer pregnant unmarried patients to, or work with them at, private hospitals or homes for unmarried mothers, and/or to make adoption arrangements for them.

These nursing interventions are aimed at promoting the social rehabilitation of unmarried pregnant women—a theme that is particularly underscored in Schroeter’s article. Writing of the venereal disease clinic, Schroeter illustrates the general partnership between health care professionals and law enforcement in ensuring social well-being. She explains, “The information [i.e. the conditions of acquiring the venereal disease] obtained from one patient [is] put on a form, one copy of which is sent to the Department of

Health in Winnipeg and the other one to the Police Department. ... Reports are ... sent to the police on those who are brought to the clinic by morality officers... ” (p. 43). In revealing the existence and activities of morality officers and the connections between health and law agencies, Schroeter also reveals a broader social commitment to the idea that forcibly promoting “morality” ensures community well-being. These ideological commitments (or legitimating principles) are manifested in the management of both venereal disease and unwed pregnancy. As such, abortion is omitted from this professional discourse: there are no warnings against abortion in these articles and there are no tales of failed attempts. Abortion as an option for women and as nursing work is completely absent, usurped by private hospital confinements and adoption arrangements. Although it is silent, the message conveyed about abortion is loud and clear: abortion is forbidden. Indeed, describing unmarried pregnant women only as “unmarried mothers,” communicates that there is only one option available to them—motherhood.

Finally, abortion in this era is also omitted from clinical discourse. Even when *The Canadian Nurse* publishes a series of articles explicitly addressing various gynecological conditions and appropriate nursing care (O’Rourke, 1958; Patrick, 1958), neither abortion nor the relevant nursing care is addressed. Likewise, abortion is omitted from a clinical article focused on “the prevention of mental retardation” (Gattinger, 1963, p. 547). Although Gattinger’s (1963) article is premised on preventing “mental retardation” and he acknowledges that “rubella exposure during the first trimester of pregnancy causes physical abnormalities and, in some cases, mental retardation in the baby” (p. 547), he fails to acknowledge that many women obtain abortions to terminate rubella-exposed pregnancies in order to avoid neonatal anomaly or defect (Joffe, 1995; Plotkin, 2006). Omitting abortion as an option at all, Gattinger instead suggests women should be prescribed large doses of vitamin A to “help prevent damage to the embryo” (p. 547). A similar omission of abortion occurs in physician Coffey’s (1964) article detailing the scientific advances made in gynecological and obstetrical medicine. As he describes the numerous new technologies (ovulation suppression therapies, amniocentesis, intra-amniotic fluid monitoring) and the developing specialty roles available to nurses working in gynecology and obstetrics (clinical researcher, rescue team member, delivery room

nurse, obstetrical assistant) he declines to mention the special technologies used in abortion procedures or the specialty roles for nurses who participate in abortion care. In this and the other clinical examples, abortion and abortion work for nurses simply do not exist.

Throughout this era, certain ideologies and practices are presented to nurses as legitimate professional practices and attitudes towards abortion. Within these models of professional identity nurses are permitted to dismiss, actively reject, ignore and/or withhold abortion for the clinical and moral safety of both their individual patients and their collective communities. The ideologies of ethical professionalism and building community well-being are invoked as principles that legitimize or permit those particular abortion-related activities. But for one possible example, which is so implicit and ambiguous that it cannot sustain an alternative identity, the professional identity of abortion nurse (that of a nurse providing actual abortion care) is virtually non-existent.

Chapter 3: Findings and Discussion: “Only in the Gravest of Circumstances”— Legitimizing Clinical Abortion Work

In 1965, there is an abrupt shift in the discursive constructions of abortion within *The Canadian Nurse*. Instead of being explicitly and implicitly dismissed as clinically unnecessary, condemned outright as morally reprehensible, or omitted from discourse completely, such as it was in the 1950's and early 1960's, talk of abortion in 1965 is more explicit and more tolerant. As abortion discourse becomes primarily explicit, abortion is necessarily acknowledged throughout the era as both a concept and an actuality—unlike the years prior to 1965, when abortion was only variably included in professional discourse. Perhaps echoing a broader social shift in values, a renegotiation of legitimating principles in *The Canadian Nurse* newly positions abortion not only as an option for women at all, but as a potentially responsible option in the contexts of community well-being and family planning. Additionally, in 1965 abortion is constructed through specific clinical details for the first time. This begins the slow process of normalizing clinical abortion work and positioning it as appropriate nursing practice. Although abortion remains strictly illegal until 1969, the continued discursive construction of abortion in the clinical context in this era enables the creation of a new type of medically-sanctioned, yet still illegal, procedure: the “therapeutic” abortion. The “new” therapeutic-abortion duties required of physicians and nurses are communicated to readers and the subsequent tentative legitimization of abortion practice as professional work continues. The ongoing normalization of abortion in clinical ideologies and practice realities will come to support physicians' and lawyers' future demands for abortion law amendments. However, in this era, before any changes are made to the law, new professional identities that include actual abortion care as acceptable nursing work are discursively created for the readers of *The Canadian Nurse*.

Family Planning and Abortion Discourse

A significant difference between the constructions of abortion in this era and the previous one occurs on the thematic level. Beginning in January 1965, employing the

idea that population growth is essential to community well-being as a legitimating principle for eschewing abortion¹¹ is temporarily suspended. Talk turns instead to the importance of family planning, which at this time includes abortion (Lindabury, 1972; McLaren, 1986), and limiting the population as essential to community well-being. Thus, the idea that family planning promotes community well-being emerges as an alternative legitimating principle that supports abortion practices. Within this framework, abortion can be constructed as an available, and even responsible, option for women. Moreover, by extension, abortion work can be constructed and normalized as available, responsible, or legitimate nursing practice.

In an article originally published in the *Canadian Journal of Public Health*, and reprinted in *The Canadian Nurse*, Bain (1965) informs readers of Canada's recent induction into the International Planned Parenthood Federation and subsequent commitment to family planning ideologies and practices. Turning away from promoting population growth, Bain introduces family planning and population limits in the context of a seemingly catastrophic "world population explosion" (p. 30). He maintains that limiting, not increasing, the worldwide population is essential to avoiding the "grim facts" of overpopulation and to preserve the health and well-being of people in Canada and around the world. The necessity of family planning to slow population growth is echoed in *The Canadian Nurse* by Pelletier-Baillargeon and Baillargeon (1965). Like Bain, Pelletier-Baillargeon and Baillargeon similarly invoke the concept of overpopulation as an impending catastrophe, stating, "the responsibility for [population] planning ... becomes urgent now that the threat of overpopulating the world is considered by many scientists as being as formidable as the atomic peril itself" (p. 820). These attitudes also occur outside of *The Canadian Nurse* and *The Canadian Journal of Public Health*. McLaren and McLaren (1996) point out that "Canadians were warned by such luminaries as Bertrand Russell ... that uncontrolled fertility ... posed a greater threat to world stability than the risk of nuclear war" (p. 134) Compare these warnings of the risks of overpopulation to claims made in the early 1950's, when building the population was the goal. In 1951, Physician Atlee claimed that, "labor [as in child-bearing labor], for

¹¹ See Heinz (1951) and Scotsman (1954) for examples of this principle at work.

racial reasons, must be repeated—at least three times if we are to preserve our population and more if we are to increase it” (p. 706). As such, according to Atlee, “having a baby is the most important thing any woman can do” (p. 705). Heinz (1951) identified bringing children into the world as a “grave responsibility,” and that only “child by child [do] we build a nation” (p. 371). The messages about abortion sent to readers in these two eras are very different. Before 1965, population growth is essential to preventing “race suicide” (McLaren & McLaren, 1986, p. 15) and abortion is therefore condemned as detrimental to community well-being. After 1965, population growth is repositioned as overpopulation, a formidable threat, and abortion, if it will contribute to limiting birth rates, is supported as promoting community well-being.

Bain (1965) argues for family planning practices for additional reasons that also appear to contradict the representations of abortion constructed in the last discourse era (1950-1964). Bain introduces the “health of the mother” and “welfare of the child” as justifications for implementing family planning (including abortion) practices. Of the health of the mother, he writes: “this concern arose naturally among doctors, nurses and social workers in daily contact with women who had borne large numbers of children in rapid succession and whose health had suffered as a result” (p. 30). Of the welfare of the child he writes: “there should be a space between children in a family to permit each child to absorb the life-giving elements he needs and to sink firm roots into the family complex before a sibling arrives” (p. 30). In the 1950’s and early 1960’s however, the health of the mother and welfare of the child were largely ignored in the celebration and promotion of large families—such as in the “These Might Not Have Been Born” text (Scotsman, 1954). Moreover, Bain explicitly suggests abortion as a “means of preventing the birth of physically and mentally handicapped children” (p. 30). Whereas, in 1963, abortion was omitted from the discussion of prenatal rubella exposure (Gattinger, 1963), even though many women were actually seeking and obtaining therapeutic abortions for rubella exposure at that time (Cooper, 1985). Similarly, Bain briefly mentions “the stability of the family unit” and “women’s rights” (p. 30), arguing that both are diminished in the absence of family planning or birth control options. However, although the connection between women’s rights and abortion was suggested by Bain in 1965,

protecting women's rights was not the initial goal of implementing family planning practices. McLaren and McLaren (1996) note: "not until the late 1960's were many feminists in Canada viewing birth control and abortion as central prerequisites for advancing the independence of women" (p. 143).

In these examples from *The Canadian Nurse*, abortion is positioned within the entirely new legitimizing framework of family planning. The underpinning values of family planning presented by Bain (1965) and Pelletier-Baillargeon and Baillargeon (1965) such as minimizing population growth; ensuring maternal and child health (including cases of fetal anomaly or defect); maintaining family stability; and (albeit briefly) considering women's rights, allow abortion to be constructed as a legitimate, and even responsible, course of action that contributes to community well-being. This results in the presentation of an alternative abortion reality for *The Canadian Nurse* readers.

Although an alternative abortion reality has been constructed and presented to nurses, previous representations of abortion in the moral context linger in professional discourse—especially in relation to unwed mothers. McKain (1965), for example, identifies the goals of nurses working with unmarried pregnant women as: "prevent[ing] dire results, such as suicide or criminal abortion" and as "encourag[ing] the girl to believe that she has not hopelessly destroyed her life, but that she may be brought safely through this pregnancy without undue publicity" (p. 45). Like previous authors (Loirot, 1960; Schroeder, 1959; Ste. Mechtilde, 1959), McKain constructs the unwed mother as a "problem," who has made a "mistake," whose options are: "to continue to live with her parents, stay with relatives or friends, or to seek admission to a home for unwed mothers" (p. 45). The nurse's role, according to McKain is to: "try to help the mother make the right choice [between adoption or keeping her baby] for the child and herself" (p. 45). Again, abortion is not an option for unwed mothers or available to nurses as legitimate work. At the beginning of this discourse era (January 1965), two opposing abortion realities are now available to nurses: abortion as a "dire" outcome to be avoided, or as a legitimate, potentially responsible choice. Subscription to either of these realities will

ultimately inform how the nurse incorporates abortion into her professional identity and subsequent nursing practice.

Clinical Discourse and Therapeutic Abortion

Until now, the abortion realities constructed for nurses have been largely theoretical, as the specifics of hospital-based abortion work have not yet been made available in *The Canadian Nurse*. However, in October 1965 the discursive treatment of abortion shifts to explicit clinical material, resulting in the construction of a clinically-specific abortion reality. Published as a two part article series that includes, “Abortion Causes and Management,” written by a physician (Roulston, 1965), and “Nursing Care in the Management of Abortion,” written by two nurses (Maki & Perlmutter, 1965), the reader is exposed to explicit and detailed, at times graphic, accounts of both abortion medicine and abortion nursing. Roulston (1965) focuses on the etiology, physiology, and specific medical treatments of abortion, and Maki and Perlmutter (1965) concentrate on the clinical and legal responsibilities of the nurse. This is perhaps the first time nurse-readers who do not work in clinical areas where abortions take place have been exposed to the clinical details of actual abortion as, owing to previous discursive silence and dismissal, the clinical aspects of abortion have never been explicitly described in *The Canadian Nurse*.

Although abortion is now explicitly discussed in the clinical context, it continues to be treated very cautiously as an illicit subject by the authors in this era. For example, even though he addresses induced in-hospital and criminal abortions extensively, Roulston (1965) tempers his article by claiming that the hospital abortions are not very common. He tells the audience that, “most abortions have a spontaneous onset” (p. 808) caused by (presumably legitimate) factors such as maternal diseases and uterine abnormalities. He adds, “therapeutic abortions are responsible for only a *small percentage of cases* [emphasis added] in this country” (p. 808). Roulston also recognizes that “the word abortion suggests criminal intent to the laity” (p. 808), who prefer the word “miscarriage.” Yet, the word abortion likely also suggests criminal intent to nurse-

readers who are inexperienced with abortion in both professional practice and professional discourse. Finally, Roulston appears to deny practitioners' knowledge of ongoing criminal abortion activity stating, "interference is usually denied [by women] or information given reluctantly" (p. 808). This declaration subtly reinforces the remaining illicitness of abortion, both in content and by its utterance.

To some extent, the negative connotations associated with abortion are diminished in this era by the construction and discursive normalization of a new abortion classification: therapeutic abortion. Therapeutic abortion is created in contrast with and as an alternative to criminal abortion. Roulston (1965), and Maki and Perlmutter (1965) distinguish therapeutic abortion from criminal abortion first by constructing and maintaining opposing identities for physicians who perform in-hospital therapeutic abortions and criminal abortionists, such as "the woman herself or ... some other person using an instrument, poison or noxious substance" (Maki & Perlmutter, 1965, p. 812). Unlike the opposing identities constructed within a moral framework for physicians (as benevolent practitioners who do not perform any abortions)¹² and abortionists (as nefarious individuals who prey on naïve pregnant women)¹³ in the 1950's, in 1965, physicians and criminal abortionists are distinguished by skill set, clinical technique, and the level of danger they pose to women's bodies. Criminal abortionists are identifiable by the negative outcomes or the "disastrous results" (Roulston, 1965, p. 809) of their "unskilled" (Maki & Perlmutter, 1965, p. 812) work, such as septic infection, and uterine or vaginal perforation. On the other hand, the physician who performs "therapeutic" abortions in hospital is represented as a skilled practitioner—who is capable of competently performing complicated abortion surgeries, such as "a hysterotomy¹⁴ through an abdominal incision" (Roulston, 1965, p. 810) when necessary, and whose treatment orders must be followed (Maki & Perlmutter, 1965). A therapeutic abortion is cast as a medical procedure performed by a skilled physician in the hospital. A criminal abortion remains a necessarily dangerous act owing to the incompetence of the

¹² See Heinz, 1951.

¹³ See LeDoux, 1950c.

¹⁴ Hysterotomy refers to "an incision of the uterus" or Cesarean section ("Hysterotomy, 2001, p. 1053).

abortionist. Because this clinical (not moral) distinction distances professional practitioners from criminal activity, therapeutic abortion can be more readily explored and explicitly constructed as legitimate work within professional discourse.

Creating and maintaining the criminal v. therapeutic abortion dichotomy in 1965 is not only dependent on the operator's identity and skill-level, it is also upheld by an appeal to medical rationalization and, erroneously, presumed legal sanction. According to Maki and Perlmutter (1965), "a criminal abortion is one that is induced ... without legal medical justification" (p. 812), whereas "a therapeutic abortion may be performed when a gravid woman's life or mental state is endangered as a result of the pregnancy" (p. 812). It is now worth reviewing the legal history of abortion in Canada to situate the professional acceptability of therapeutic abortion, as a clinical intervention, within the context of its actual legal status. In 1965, all cases of abortion remain strictly illegal in Canada. There are no statutory provisions or exceptions to the abortion law (Backhouse, 1983). There are however, common-law provisions for abortion in Britain, which stipulate that, "an abortion could be performed in good faith to protect the life and health of the mother" (Dunsmuir, 1998, History section, para. 6). This "life and health of the mother" common law defense was never invoked in Canadian court; therefore it was never adopted into Canadian law (Dunsmuir, 1998). As a result, abortion remains illegal in Canada until the 1969 Criminal Code amendments (Backhouse, 1983; Dunsmuir, 1998). However, by constructing it within a strictly clinical discourse, therapeutic abortion can be granted professional acceptability or legitimacy outside of the legal regulations.¹⁵

Seemingly echoing British common-law, the professional legitimacy or acceptability of therapeutic abortion in *The Canadian Nurse* in 1965 appears dependent on a strict set of clinical indications and authorizations from medical practitioners, as opposed to formal legal sanction. Roulston (1965) informs readers that, "therapeutic abortion is only carried out for a medical condition that may endanger the health and life of the mother. In some hospitals a special committee will decide as to whether or not a therapeutic abortion may be performed" (p. 810). The maternal medical conditions that

¹⁵ Refer to Chapter 1 for a more detailed account of abortion's legal history in Canada.

may warrant these abortions are restricted to “very severe” cases of kidney trouble and heart disease, or psychiatric illness “where the patient has exhibited a suicidal tendency” (Roulston, 1965, p. 810). Similarly, the clinical acceptability of therapeutic abortion for fetal anomaly increases with severity. Roulston explains:

More recently, consideration has been given to the termination of the pregnancy in the belief that the embryo has been deformed by drugs, or the rubella virus. Permission is sometimes given for a therapeutic abortion to be carried out on these patients because of the chances of a *very badly* [emphasis added] deformed child. (p. 810)

Whereas Roulston makes no claim of legal status for therapeutic abortion, Maki and Perlmutter (1965) misinform nurse-readers that therapeutic abortion is legal under certain clinical conditions: “An abortion to preserve the health [or life] of the patient may be done legally, after consultation with the head of the gynecologic staff or a committee set up for such decisions” (p. 812). At this time, these committees are operating outside of legal regulation and will not be mandated to legally authorize therapeutic abortions until after 1969 (Dunsmuir, 1998). Perhaps in recognition of the extra-legal clinical legitimacy bestowed on it, Roulston warns, “therapeutic abortion should be undertaken only in the gravest of circumstances and only following the appropriate consultation” (p. 810). Regardless of its actual legal status, by shifting abortion discourse into almost exclusively clinical language, abortion can now be constructed as “therapeutic.” This discursive shift removes (or at least lessens) the criminal connotation associated with abortion and allows for the construction of professional identities that permit and even encourage participation in abortion work.

With the discursive creation and justification of therapeutic abortion work in place, the concrete details of abortion nursing and the professional identities of nurses who provide abortion care are simultaneously constructed and made available to the readers of *The Canadian Nurse*. Roulston (1965) simply claims that “good nursing care is invaluable,” while Maki and Perlmutter (1965) outline the specific physical, psychological, and legal duties required of the nurse, and also comment on the general demeanor expected of that nurse. In doing so, Maki and Perlmutter construct and

disseminate what nurses are permitted and expected to do, and say, and be, in relation to abortion and abortion work. As such, they participate in constructing abortion-supportive professional identities for nurses.

First, the nurse's clinical responsibilities in various situations, such as monitoring the woman who has spontaneously aborted, or managing severe hemorrhage, are presented to readers. For example, in the case of a woman hospitalized after a criminal abortion:

The nurse must watch for signs of hemorrhage, shock, anuria [absent urinary output], peritonitis, and septicemia. ... Careful record is kept of the patient's intake and output, blood pressure, pulse and temperature. Tepid sponge baths are given for pyrexia [fever]. Any severe abdominal or chest pain is reported to the doctor immediately. ... Intravenous infusions, often with massive doses of antibiotics, are frequently established. The patient must be kept as comfortable as possible and the arm with the infusion in it checked closely for inflammation due to the medication. Frequent perineal care is very important, since there is often a large amount of foul, vaginal discharge. Observations should be made at this time as to its color, amount, odor, and consistency. It is also important to note if the abdomen is distended or rigid. (Maki & Perlmutter, 1965, p. 812)

Reading this description, the audience acquires a very clear picture of exactly what clinical duties the nurse actually performs in the physical care of the patient. Next, the reader learns what psychological care the nurse might provide to the patient:

The patient may be upset and depressed, troubled by anxieties that such measures [such as "reading or a favourite handicraft" (p. 812)] cannot relieve. If the nurse gives the impression that she has time and is willing to listen, and her attitude suggests that she will not judge, the patient will be encouraged to talk about her feelings. ... The attentive nurse will be aware of [the patient's] concern, and obtain the assistance of a social worker, if possible (Maki & Perlmutter, 1965, p. 812)

After describing the physical and psychological care required, Maki and Perlmutter describe the demeanor expected of the nurse: “the nurse must remain calm at all times and perform her duties quickly and efficiently” (p. 812). Furthermore,

If the patient passes a macerated fetus, the nurse must be careful to show no signs of revulsion [*sic*]. An efficient, calm, understanding manner is necessary. The nurse must remember that her business is to give good nursing care, not to censure the patient for what she has done. (p. 812)

Finally, the one other role assigned to the nurse is a legal one. The nurse needs to “be aware of the laws concerning abortion” and furthermore, “see that all the therapeutic abortion committee forms, together with those signed by the husband and wife to safeguard the hospital and the doctor, are on the chart before the patient leaves the ward for surgery” (p. 812).

Aside from providing interesting and educational clinical material, these explicit descriptions tell *The Canadian Nurse* readers that nurses who provide abortion care do exist and moreover, detail exactly what work they can or should do. Consequently, Roulston (1965) and Maki and Perlmutter (1965) construct a professional nursing identity that includes abortion work, dictate exactly what abortion ideology and what nursing actions are appropriate within that professional identity, and make it available to nurses via *The Canadian Nurse*. Treating abortion and abortion nursing in this explicit clinical manner, in the official space of the journal, works to normalize or legitimize this particular professional identity.

At the end of 1965, after 15 years of abortion discourse, the reader is left with multiple abortion realities and corresponding professional identities. This particular (1965) representation of abortion constructs a reality very different from the previous account of abortion as necessarily harmful, medically unnecessary, dangerous to women’s lives, and detrimental to community well-being where nurses, if professional and ethical, were responsible for counseling against abortion or ignoring it completely. Now, in the interest of women’s health and well-being, abortion can also be a “therapeutic,” life-saving, medical procedure. Moreover, to promote community or

population well-being, abortion can be a responsible option requiring expert, professional nursing care.

Chapter 4: Findings & Discussion: “That’s What We Want for Christmas”— Expanding the Scope of Nurses’ Abortion Work

The effects of constructing abortion and abortion nursing with explicit clinical language supported by alternative legitimizing ideologies in 1965 were the production and normalization of new abortion realities, clinical roles, and professional identities for nurses and the maintenance of passive discursive roles for *The Canadian Nurse* readers. Since 1950, abortion and abortion nursing have primarily been constructed and communicated through didactic feature articles written by authority figures who were granted expert status within the journal. This process requires a non-expert (or learning) audience, whose members can only act as consumers of discourse and who are therefore prevented from participating in the construction processes taking place in the journal. In 1967 however, *The Canadian Nurse* begins to publish alternative formats of abortion-related material, authored by individuals of variable expertise, such as independent editorials and readers’ letters to the editor. Thus, new modes of discourse construction and performance are made available to, and by, a newly active, variably expert readership. Consequently, readers are able to participate more actively in constructing new realities, roles, and identities for themselves—in both nursing practice and professional discourse performance.

Editorial and Letter Writing

For two years after the clinically focused abortion articles are published (Roulston, 1965; Maki & Perlmutter, 1965), *The Canadian Nurse* is silent about abortion. Abortion coverage is not resumed until December 1967 when, for the first time, an editorial that explicitly addresses nurses and abortion (Lindabury, 1967) is published. Although editor Lindabury (1967) dedicates only a few lines of her full-page editorial to abortion, these lines appear to catalyze two new modes of abortion discourse construction distinct from the previous practice of communicating abortion messages through feature articles: independent editorial and letter writing. Unlike the somber didactic abortion articles of the 1950’s and early 1960’s, Lindabury’s editorial is playful. She titles it

“*That’s what we want for Christmas!*” and in it, she proceeds to tell “a red-jacketed, rotund gentleman” that Canadian nurses want (among many other things) abortion law reform “for Christmas” (p. 27). Lindabury’s playful words, although certainly conveying a serious message, are distinct from the severe clinical¹⁶ and moral¹⁷ languages used to construct earlier abortion articles. The editorial is also distinguishable from the previous modes of discourse construction simply because it is not a feature article, nor is it merely an adjunct to or a comment on a feature article; this editorial is an independent unit conveying a unique message about abortion law reform. Regardless of the message expressed, this discursive mode is new: readers have not yet seen abortion explicitly constructed in an independent editorial, nor in a light-hearted tone, before. With this stand-alone, abortion-explicit editorial, Lindabury introduces a new mode of abortion discourse to *The Canadian Nurse* readers.

Lindabury’s editorial work additionally differs from the previous modes of discourse construction due to the uncertainty of her expertise. Although she is an acknowledged editor of *The Canadian Nurse*, a position that most likely accords her a degree of credibility, her actual professional credentials do not appear at the end of her individual editorials—or anywhere else in the journal—as they do for the authors of previous feature articles. For example whereas “Dr. Atlee, M.D., F.R.C.S is with the Department of Obstetrics and Gynecology, Dalhousie University, Halifax” (Atlee, 1951); “Sister Ste. Mechtilde is the founder-superior of the Rosalie Jettée Centre [for unwed mothers], Montreal” (Ste. Mechtilde, 1959); and “Mrs. Maki is head nurse of the gynecological unit [...] at The Winnipeg General Hospital” (Maki & Perlmutter, 1965), at the conclusion of her editorials, Lindabury is simply credited by her initials: V.A.L. (Lindabury, 1967; 1970a; 1970b; 1972). With no other identifying information available, even if Lindabury is an acknowledged or known expert outside of her duties as editor of *The Canadian Nurse*, readers of the journal are left to guess at Lindabury’s qualifications or expert status. Unlike the authors of feature articles, Lindabury’s authority is not explicitly assured. This detail sets her, and the editorial mode of discourse construction,

¹⁶ See Roulston (1965).

¹⁷ See LeDoux (1950a; 1950b; 1950c).

further apart from the previous (acknowledged) expert authors and their authoritative official feature articles. Nevertheless, Lindabury successfully cements independent editorial writing as a new and distinct discursive mode by continuing to publish explicit abortion-related editorials that are not tethered to feature articles (Lindabury, 1970a; 1970b; 1972).

As an author of uncertain or unacknowledged expert status who successfully creates abortion discourse outside of authoritative feature articles, Lindabury encourages and makes it possible for readers of similarly unknown and variable expertise to actively participate in informal modes of discourse construction; namely, letter writing. Through her editorials, Lindabury facilitates interactions between readers and editorial staff that ultimately evolve into explicit conversations about abortion amongst readers within the unofficial spaces of the journal. The initial reader/editor interaction does not begin as a reciprocal conversation per se, but appears as a call-and-response performance instead: Lindabury publishes an editorial (the call) and readers react to it via their individual letters (the response). This effect occurs with all four abortion-related editorials published by Lindabury (1967; 1970a; 1970b; 1972). The first editorial (Lindabury, 1967) immediately garners one letter of response from a registered nurse congratulating Lindabury “on a timely, provocative editorial” (Rosenfield, 1968, p. 4). The second editorial (Lindabury, 1970a), generates three responses over two years: Rogers (1971), a Canadian University Service Overseas volunteer nurse, supports the statements made in the editorial, but both Constantin Morgan (1970) and Smith (1970), who are credited as registered nurses, explicitly challenge Lindabury’s claims. The third editorial (Lindabury, 1970b) prompts two supportive responses from Cleary (1971), whose credentials are not stated, and Good (1971), the Director of the University of Calgary’s School of Nursing. Finally, Lindabury’s 1972 abortion editorial stimulates three responses of resolute opposition from Doyle (1972), a physician; Nowak (1972), no credentials listed; and Wadden (1972), a registered nurse. Increasing from just one editorial and a single letter of response, by 1972, editorial and responsive letter writing are well established as available modes of abortion discourse construction and performance.

Letter writing evolves beyond the simple editor/reader call-and-response into a more complex conversation about abortion amongst an increasingly active readership. In 1970, *The Canadian Nurse* begin to publish readers' letters directly addressed not only to Lindabury (as they were previously), but also to each other. For example, Constantin Morgan's (1970) reaction to Lindabury's (1970a) editorial generates two responses challenging her comments (Anonymous, 1970; Melnitzer, 1970). Melnitzer (1970) in particular, is "most disturbed by [Constantin Morgan's] views on abortion" (p. 4). Expanding the discussion further, two additional letters commenting on Melnitzer's letter are published (Hewko, 1971; VanDeSype, 1971). VanDeSype (1971), for example, is "appalled" (p. 5) by Melnitzer's letter, and Hewko (1971) writes her entire letter in response to what "[Melnitzer] stated in the December issue of *The Canadian Nurse*" (p. 6). From Lindabury to Hewko, this specific example of reader/editor interaction is four (published) layers deep. Thus, this exchange operates beyond the editorial-call and reader-response pattern, and as such, it allows readers to interact with each other (and not just with Lindabury) to actively create discourse amongst themselves within the pages of *The Canadian Nurse* for the first time.

Letter writing continues to evolve as an accessible discursive mode, as readers begin to stimulate reader-to-reader interaction themselves, independently from Lindabury.¹⁸ In 1971, readers start to write unprompted letters that do not explicitly respond to editorials or other published work. Instead, they use the unofficial "letters to the editor" journal space to communicate unsolicited opinions about abortion, or ask specific abortion-related questions of other readers. Roach (1971), for example, writes an independent letter addressing "the recent controversy over the liberalization of abortion legislation," asking fellow nurses, "are we for life or death?" (p. 4). Similarly, an anonymous nurse (Anonymous, 1973) asks readers for advice about the responsibilities of "an operating room nurse" (p. 5) who is required to attend abortion procedures. These letters, in turn, provoke direct responses from other readers and continue to do so over

¹⁸ Lindabury appears to have no explicit voice in these interactions at all. However, as editor of *The Canadian Nurse*, she most likely plays a role in choosing specific letters for publication—this privilege gives her the opportunity to (silently) participate in this seemingly reader-driven mode of discourse construction.

time, thus creating a reader-engendered abortion conversation. For example, Kergin (1971) replies to Roach, claiming that Roach's views are "restrictive" (p. 5). Similarly, the anonymous operating room nurse receives two sympathetic letters in October (Anonymous RN, 1973; Poole, 1973) and one challenging response in November (Crumb, 1973). Published over months and years outside of the official space of the magazine, and communicating specific suggestions, questions, and direct responses to each other, these letters operate as ongoing conversations explicitly about abortion among *The Canadian Nurse* readers: readers are now actively participating in creating and performing abortion discourse.

It is uncertain whether the generation of and participation in this conversation could have occurred without Lindabury's establishment of independent editorial writing as a valid mode for abortion discourse construction and performance. Perhaps Lindabury, with her (slightly) questionable expert status or her playful-yet-serious tone, permits readers to consider her suggestions more critically than those of the previous didactic expert authors and, setting the example that one can address the topic of abortion outside of a feature article, she therefore prompts readers to write their own letters. Alternatively, readers may have been writing letters responding to the expert authors, but were simply not published in the journal. Whichever the case (i.e. no letters had been written or no letters had been published), the first reader-letters were written in direct response to Lindabury's editorial and were explicitly published as such. Without Lindabury's (1967) editorial, Rosenfield's (1968) letter would perhaps not have been written. And, even if Rosenfield had written her letter independently of Lindabury's (1967) Christmas editorial, considering the complete absence of explicitly abortion-related letters responding to feature articles in the past, Rosenfield's letter would perhaps not have been published at all. Furthermore, without that precedent, the later abortion-related letters would most likely not have been written and/or published. Thus, independent editorial writing, aside from functioning as a new mode for abortion discourse construction, appears to have stimulated both responsive and spontaneous letter writing as additional modes for discourse construction—modes that encourage and enable readers to take

increasingly active roles in constructing and performing abortion discourse within the professional journal.

Editorial and letter writing prove robust modes of discourse construction that enable readers to continue to actively participate in discursive processes over time. From December of 1967 until June of 1972, editorial and letter writing are the primary discursive modes used to convey explicit abortion messages in the journal. Until the middle of 1972, there are no feature articles addressing abortion published in *The Canadian Nurse*. Thus, between 1966 and 1972, readers receive all of their professional messages about abortion from editor Lindabury and from each other. Furthermore, letter writing remains an available (and seemingly attractive) discursive option for readers even when feature articles conveying “official” messages about abortion are published. In 1972, *The Canadian Nurse* begins to publish readers’ response letters to feature abortion articles. Ehrlich & Holdren’s (1972) “Abortion and Morality” article draws 14 primary responses from August to December of 1972 (Aikenhead, 1972; Anonymous, 1972a; Anonymous, 1972b; Borden, 1972; Bouchard, 1972; Foort, 1972; Lee, 1972; Lenzmann, 1972; May, 1972; McCabe, 1972; Nowak, 1972; Sherrington, 1972; Walsh, 1972; Warner, 1972). Adamkiewicz’s (1976) article, “What are the bonds between the fetus and the uterus?” generates six published response letters (Czartorski, 1976; Hall, 1976; Kish, 1976; Lawson, 1976; Scheffer, 1976; Ward, 1976). Similarly, four letters (Anonymous, 1977a; Anonymous, 1977b; Cope, 1977; Ratcliffe, 1977) are published in reaction to Easterbrook and Rust’s (1977) article, “Abortion Counseling.” Indicating an enormous volume of readers’ response letters to feature articles, in December of 1972, editorial staff cease publishing letters related to Ehrlich and Holdren’s article, stating, “this is the last month in which correspondence regarding the article ‘Abortion and Morality,’ published in June, 1972, will appear” (Editor, 1972, p. 8). Despite the Ehrlich & Holdren response letter cut-off, letter writing is confirmed as a viable discursive mode, as independent and responsive reader letters and subsequent conversations about abortion and abortion nursing continue to be published well into the late 1990’s.¹⁹

¹⁹ See Smith (1988) and Read (1988)—both in response to Miller (1988)—and Guenther (1988), Kingswood (1988), and Paras (1988) in response to Smith and Read for an

The most significant aspect of editorial and letter writing is the subsequent impact on the discursive construction of professional nursing identity with regard to abortion. Specifically, these modes facilitate explicit or overt discussion and debate about professional nursing practice and professional identity amongst readers. Through their letters, nurses (and the occasional non-nurse reader)²⁰ are able to explore and challenge the abortion-related roles previously created for them in the journal; articulate their support for or opposition to recommended ideologies and practices; and propose or create new abortion care roles for nurses. In doing so, nurse-readers actively participate in new discursive processes and are able to reinforce or erode previous constructions of professional identity.

Creating New Nursing Roles: Political Activism

By actively participating in discourse construction and performance processes, nurses are able to create new abortion care roles for themselves. Until 1967, the (few) abortion practice-roles made available to nurses within *The Canadian Nurse* were limited to hospital-based, direct patient care. In 1967 however, Lindabury directs nurses' attention away from the clinical context of abortion to the political arena; an action that subsequently allows for explicit articulations (or discursive constructions) of new non-clinical roles and activities for nurses who are willing to engage in abortion work.

Although by the mid-1960s, abortion has already been established as a key issue for Canadian politicians and lawmakers (McLaren & McLaren, 1986; Jenson, 1992), Lindabury (1967) contextualizes abortion as a political *nursing* issue when, on behalf of "the nurses of Canada" (p. 27), she requests "changes in laws involving social problems that nurses cannot ignore" (p. 27) for Christmas. She identifies the "thirty thousand

example of this kind of (letters to the editor-exclusive) conversation. Alternatively, see Tufts (1996), Laroche (1996), Wolf (1996), and Tendrick (1996) in response to Mably (1996).

²⁰ See physician Doyle's (1972) letter or minister Kingswood's (1988) letter, for example.

illegal abortions [that] are reported to be carried out in the country yearly” (p. 27) and the subsequent “great risk to [women’s] lives” (p. 27) as the primary “social problem” that is un-ignorable by nurses. With these statements, Lindabury ostensibly attempts to communicate nursing priorities, and their underlying ideologies, to lawmakers. However, by making this pretend Christmas-request within the confines of the journal, where it is unlikely to impact (or even be seen by) said lawmakers, Lindabury actually conveys this abortion information to nurse-readers. Her principal message to nurses: abortion is not only professionally relevant as a clinical issue; it is also professionally relevant as a social and political problem. Additionally, she informs readers of the wider non-nursing political examination of abortion and anticipated federal law reforms, stating, “changes proposed recently will do little to reduce the number of illegal abortions” (p. 27), but Lindabury fails to explain the laws currently in effect or the specifics of the proposed changes²¹. In this editorial, Lindabury’s only intention seems to be raising nurses’ awareness (albeit superficial awareness) of abortion as a political issue that is relevant to them. She does not to encourage actual political action or create new roles for nurses. In fact, Lindabury asks for law reform as a gift and not as something nurses can pro-actively work toward; she makes her request within the confines of the professional journal with a presumably limited readership; and she limits the potential political action of individual nurses by casting them as mere audience members or witnesses to editorial opinion. However, by first positioning abortion as a political issue relevant to nurses professionally, Lindabury enables the subsequent construction of active, non-clinical roles (or professional identities) for nurses who do abortion work.

In her letter directly responding to Lindabury’s (1967) editorial, it is reader (and registered nurse) Rosenfield (1968) who first explicitly proposes new, non-clinical abortion-related roles for nurses. Specifically, she suggests that nurses, both as individuals and as a collective professional body (i.e. as the Canadian Nurses’ Association [CNA]), can and should participate in politically conscious activities to bring

²¹ In fact accurate abortion laws, even when the laws were changed significantly in 1969 and 1988, are never explicitly communicated to nurses anywhere in the journal (see Maki & Perlmutter (1965) for an inaccurate description of abortion laws).

about changes in abortion law. In particular, Rosenfield is “waiting for the Canadian Nurses’ Association and its publications to take a stand on the social issue of abortion” (p. 4). She asks pointedly, “What is the CNA position?” (p.4). She implies that collectively, nurses must commit to political or social (not clinical) abortion ideologies and then make “some constructive suggestions to ... federal legislators” (p. 4) regarding abortion law reforms. Similarly, she hopes that for individual nurses, because of the new discursive construction of abortion as a professionally relevant political issue, “some thought may be encouraged, and perhaps some action will be initiated”(p. 4). Rosenfield notes, “action to be initiated is seen as advising the often uninformed Members of Parliament of the professional women’s view-points to legalize therapeutic abortions” (p. 4). Actively communicating their opinions, priorities, and the relevant ideological underpinnings of their preferred abortion policies to politicians and lawmakers is a new role for nurses; it is new nursing work. Previously, nurses have been passive recipients of professional ideology (such as in 1950’s-early 1960’s)²² or active participants in clinical abortion care (such as in 1965)²³ only. However, now Rosenfield (taking an active role in professional discursive performance herself) suggests that nurses take non-clinical yet active approaches to their abortion care roles.

Rosenfield (1968) justifies these proposed non-clinical, political activities as appropriate nursing work. She contends that nurses who take on clinical abortion roles are, at present, politically and socially silent; yet, it is exactly their intimate clinical experiences of abortion that best equip nurses in particular to explicitly address abortion politically. Of nurses’ clinical knowledge and silence, she states:

From the professional side of the coin, we, as nurses, see and care for thousands of women whose bodies are ravished by infection and debilitated because of blood loss, all thanks to our antiquated laws and backroom abortionists. Yet we remain silent. Further, we see adolescents and others who are required to carry to term pregnancies that are the result of rape or incest. (p. 4)

²² See LeDoux (1950a; 1950b; 1950c).

²³ See Roulston (1965) and Maki & Perlmutter (1965).

Because of these clinical experiences of abortion, Rosenfield argues, nurses can emerge in the political arena as professionals whose clinical knowledge is invaluable to creating positive social change. Of the necessity of political nursing action in abortion law reform, Rosenfield concludes: “M.P.s need information from knowledgeable women if sound decisions are to be made in halting social injustices” (p. 4). According to Rosenfield, nurses who enact clinical abortion roles are virtually compelled to step into political roles as well.

To what extent nurses actually became involved in the 1969 abortion law reforms as political activists is unknown. Whereas the influence of physicians and lawyers as instigators and advocates of the legalization of therapeutic abortion is well documented (McLaren & McLaren, 1986; Jenson, 1992), reports of nurses’ activities in both *The Canadian Nurse* and broader historical accounts are absent. Aside from Rosenfield’s (1968) letter encouraging individual and collective political action and Lindabury’s (1967) editorial merely wishing for law reform as a gift, nurses’ ideas about, support for, or opposition to the 1969 law reforms remain unheard and perhaps unsaid. Jenson (1992) succinctly describes the proactive roles of physicians and lawyers in abortion law reform:

Doctors who did admit doing abortions but who feared the legal ambiguity of their situation led the reform campaign, which began in the mid-1960s. By 1963 professional associations of doctors, the Canadian Medical Association (CMA)—and of lawyers—the Canadian Bar Association (CBA)—began at their annual meetings to question the Criminal Code’s regulation of abortion. The intra- and inter-professional discussion continued until 1969, paying little attention to the needs of anyone but doctors or lawyers (p. 25).

Moreover, in 1969, “the amendments to the Criminal Code [...] did emerge, [as] promoted by traditionally dominant intellectuals—doctors, lawyers, and clergymen [...]” (Jenson, 1992, p. 26). In contrast, there are no accounts of the Canadian Nurses’ Association similarly campaigning for the 1969 amendments. As the CNA (and the profession it represented) was predominantly comprised of women in the 1960’s (Rosenfield, 1968), their absence as abortion-law activists may perhaps be explained by

Jenson's analysis of women's (general) inability to collectively create political change at that time:

Women, organized as women [...] had as yet no status as political actors. Women in the mid-sixties did not have the political resources to press their positions or even a language in which they could express them. [...] Moreover, existing organizations of women were either weak or non-confrontational—or both” (pp. 25-26).

Whether the CNA was non-confrontational, weak, or generally lacked the language with which to communicate the priorities and ideologies of nurses-as-women is uncertain. The total absence of nurse-action from documented abortion-law history however, strongly indicates that before 1969, nurses did not or could not enact the new political roles created for them as professionals.

After the 1969 abortion law amendments, nurse-readers (and editor Lindabury) continue to explicitly discuss and debate the appropriate level of involvement of individual nurses and collective professional associations in political abortion activities via letters to the editors and editorials (Lindabury, 1970a, 1970b; Cleary, 1971; Constantin Morgan, 1970; Good, 1971; Melnitzer, 1970; Smith, 1970).²⁴ As a result, non-clinical abortion work continues to be constructed (i.e. not silenced) as nursing work in this particular mode of professional discourse. Thus, although nurses before 1969 did not (or could not) enact these non-clinical roles, repeating and re-constructing these practices and ideologies as nursing work in professional discourse normalizes, legitimizes, and makes available to nurses expanded abortion care roles, or professional identities, for future adoption and enactment.

²⁴ The issue of whether or not nurses and nurses' associations should be involved in political lobbying for abortion law reform was additionally communicated to readers through multiple news items (headlines and short articles), the analyses of which are beyond the scope of this paper. For examples, see “RNs react to abortion issue” (1971) and “CNA board rescinds all statements on abortion” (1971).

Chapter 5: Conclusions

In this investigation, I have conducted an historical discourse analysis, guided by social linguistic analysis theory, to explore past constructions of professional identity for nurses in the context of abortion work. I have collected a body of abortion-related professional discourse from *The Canadian Nurse* and examined it for the discursive processes of constructing, legitimizing, and maintaining specific abortion ideologies and practices as professional nursing identity. Through this analysis, I have connected the professional identities available for nurses to adopt and enact into practice with nurses' abilities to provide safe abortion care. Specifically, the availability of professional identities that support abortion as legitimate nursing work enables nurses to provide and promote safe abortion services; whereas the absence of those abortion-supportive roles or the widespread availability of identities that forbid abortion work as professional practice undermine nurses' abilities to provide and promote safe abortion care. In this analysis, I have identified a number of "discursive moves" (Phillips & Hardy, 2002, p. 23) that shape professional identities as supportive or prohibitive of abortion work for nurses. It is my contention that an understanding of how professional identities were constructed in the past facilitates the shrewd evaluation and management of contemporary discursive processes, such that future professional discourse can be optimally maneuvered to encourage and support nurses to provide and promote safe abortion care. Furthermore, this investigation advances nursing knowledge more broadly in the context of professional identity. This research contributes to the discipline's conceptualization of professional identity construction, acquisition, and impact on practice and yields additional methods for approaching professional identity in nursing research, practice, education, and policy.

The next section of this paper summarizes the key findings from this investigation, including what professional abortion identities have been discursively constructed in the past and how these constructions have affected nurses' abilities to participate in safe abortion services. In this section, I briefly contextualize the historical findings in contemporary nursing discourse and practice. In the next section, I explicitly

evaluate the processes of analysis and review how rigor was created and upheld throughout this investigation. Finally, I discuss the applications of the findings and make recommendations for future approaches to research, policy, education, and practice.

Professional Identity Construction in the Context of Nurses' Abortion Work

The discursive processes that shape nurses' professional abortion-related identities include explicit messaging about what nurses are and are not and what nurses should and should not do—both as members of the profession in general and in relation to abortion work specifically. These nurse-focused messages are combined with frank constructions of abortion that are seemingly independent from nursing action but which, nevertheless, inform the degree of legitimacy ascribed to abortion work for nurses. Moreover, nurses' abortion care identities are explicitly and implicitly constructed in comparison with and in contrast to the separate constructions of other social actors involved with abortion, such as the women who seeks abortion services, criminal abortionists, physicians, and the fetus. These messages are delivered in various ways—didactically through feature articles or informally through letters to the editor, for example—and by various authors, including both experts and non-experts. It is the varied combinations, or entanglements, of these elements that produce the legitimating principles from which particular professional identities for nurses are constructed that, in turn, support and prevent them from providing safe abortion care to women.

Prohibiting abortion work as nursing work.

In the professional abortion-related nursing discourses of the 1950's and early 1960's, abortion and its significant social actors were constructed implicitly and explicitly in multiple ways. Abortion itself was constructed as clinically unnecessary, immoral, detrimental to community well-being, and inherently dangerous to the lives of women and children. Women who sought abortions were criminal, spiteful, calculating, naïve, secretive, ostracized, and ignored. As abortion was strictly illegal at this time, abortionists were necessarily criminal: they were menacing back-alley butchers and falsely kind, greedy neighborhood laywomen. On the other hand, the physician was either

a benevolent ethical doctor who brought children into the world and did not perform abortions (but would treat women suffering from failed or infected criminal procedures), or an unethical agent who operated outside of “his” Hippocratic oath to perform the procedure. The fetus was positioned as a valuable potential member of the community, generically essential to building the post-war population and individually destined for future achievement, in art or literature for example. Finally, nurses were explicitly constructed as leaders of the community and were provided with a code of ethics that precluded abortion work from which to practice.

These constructions of abortion, non-nurse social actors, and nurses themselves were presented to nurse-readers through professional discourse as social reality and professional truth. As such, they communicated to nurses what abortion attitudes and activities were permitted and expected of them and operated as legitimating principles (or justifications) for that abortion work. According to this professional discourse, when abortion is immoral and dangerous to women and the community; the women who seek it spiteful or simply naïve; the aborted fetus valuable; and, the people who participate in abortion criminal, unethical, and unprofessional, the legitimate abortion roles constructed for nurses are clear. Nurses may counsel against it, refuse to participate or assist in the procedure, report colleagues (and others) who are involved in abortion work, encourage the rehabilitation of women who seek abortions and those who have attempted, but failed, to abort, or ignore the concept and practice of abortion completely. As a result, in the 1950’s and early 1960’s, there were no professional identities available to nurses to adopt and enact that enabled or supported them to take up actual abortion work. Nurses were explicitly and implicitly prohibited from providing physically and psychologically safe abortion care to women.

When these discursive moves and legitimating principles continue to operate in contemporary professional discourse to construct professional identity, nurses are similarly challenged to provide safe abortion care to women. For example, when nurses are challenged to act as “caregivers, not killers” (Mably, 1996, p. 5) and abortion is constructed as murder (“when an ‘operator’ in an operating facility hands you, the nurse,

the ‘products of conception’ to put in the garbage, you have now become an accessory to murder” (Pawluck, 1988, p. 54), abortion work cannot be nursing work. To participate in abortion care, then, is to operate outside of this particular professional nursing identity. The widespread availability of this kind of abortion-work-limiting professional identity creates a social reality in which nurses are not expected nor permitted to take on abortion care roles. In other words, nurses are encouraged to refuse to participate in abortion care. When fewer nurses participate in abortion work, women’s opportunities to obtain professional abortion services at all are limited (Ferris et al., 1998; Kade et al., 2004). Further, a shortage of nurses willing to do abortion work creates increased nurse-patient ratios and heavier workloads for already busy nurses, which limits the amount of time and energy they can devote to providing complex physical and psychological care to individual patients (Huntington, 2002; Kane, 2009; Marek, 2004; Nicholson, 2010). Moreover, nurses who adopt these abortion-rejecting professional identities (because there are no alternative identities available or because alternative identities are not supported) but who work in abortion care areas regardless, risk providing physically and psychologically unsafe abortion care to women. These nurses may interact with their patients in judgmental or “moralizing ways” (Garrett, 1972, p. 41; see also Lipp, 2009; Slade et al., 2001) or physically unsafe ways—by denying them adequate pain control, for example (Aléx & Hammarström, 2004). Thus, when nurses are prevented from enacting abortion-supportive professional identities, women experience decreased access to any care at all and decreased access to optimally safe care.

Legitimizing clinical abortion work.

In 1965, the discursive processes of constructing abortion itself became primarily explicit and abortion was newly positioned and legitimized within clinical and family planning contexts. Constructed through clinical details for the first time, nurse-readers could come to recognize abortion as an indisputably medical phenomenon. The “therapeutic” abortion procedure, which necessarily required professional medical and nursing care, was solidified into professional reality. As such, women who sought and underwent abortions became legitimate *patients*. Therapeutic abortion was conceived of

as an option for women who had been exposed to teratogens, such as the rubella virus, or suffered from severe conditions that would be fatally exacerbated by continued pregnancy. As a result, the fetus was newly constructed as possibly irrevocably damaged or harmful to women. Additionally, as it potentially contributed to overpopulation, the fetus was also potentially harmful to community well-being. From these perspectives, for the first time, abortion became an option available to women in professional discourse—and a potentially responsible one. Abortion work became legitimate medical and nursing work even while it remained strictly illegal. Physicians were constructed as highly skilled, technically competent abortion providers whereas criminal abortionists, in contrast, were incompetent and unskilled. Readers of *The Canadian Nurse* were exposed to detailed clinical elements of abortion work including the etiology, physiology, and medical treatments of abortion and the clinical and legal responsibilities of nurses. Abortion attitudes (that abortion could be a responsible or therapeutic option) and practices (the specific clinical and legal duties) that supported actual abortion work were created for and communicated to nurses as permitted and expected nursing care roles, or professional identities and professional truths.

When abortion is constructed straightforwardly in the clinical context as a therapeutic medical intervention or surgical procedure, and when abortion-seeking women are subsequently portrayed as patients who require complex physical and psychological care, nurses who engage in abortion work can practice as professional, even expert, caregivers. Continuing these discursive moves in contemporary professional discourse enables nurses to adopt and enact these professional identities into practice. They are able to claim, “Abortion is a legal medical procedure. Our clients have the right to proper medical care,” (Smith, 1988, p. 3). Furthermore, in this social reality, professional nurses can do abortion work because, “the nurse’s responsibility is to provide necessary *therapeutic* [emphasis added] care, including support, whatever the [abortion] decision may be” (Melnitzer, 1970, p. 4). Conversely, these abortion-supportive constructions enable the identification of nurses who refuse to provide abortion care or who provide it in demeaning or dehumanizing ways as unprofessional: they are cruel, judgmental, or incompetent practitioners. Condemning abortion-seeking

women or refusing to provide care is thus “unbecoming” of the profession (Laroche, 1996, p. 5) and even “sadistic” (Garrett, 1972, p. 41). Instead, professional nurses have “the responsibility to alleviate suffering to the best of [their] ability, and to respect the wishes and beliefs of [their] clients” (Wolfe, 1996, p. 5). Consistently making abortion supportive professional identities available to nurses through professional discourse encourages them to adopt and enact these ideas and activities into clinical practice while censuring abortion-prohibitive ideologies and activities. Women’s opportunities to access safe abortion care are therefore, increased.

Expanding the scope of nurses’ abortion work.

By 1968, abortion care roles for nurses were beginning to be constructed outside of the clinical context. Abortion was primarily positioned as a social issue—as opposed to an exclusively medical or moral problem. Supported by the legitimating principles related to preventing overpopulation, promoting women’s rights, and protecting maternal-child socioeconomic health that were merely introduced in 1965, professional nursing discourse focused on abortion as potentially socially responsible. Therefore, by extension, engaging in clinical abortion work was also a socially responsible act for nurses. In this era, abortion work for nurses was expanded to include non-clinical activities, such as political advocacy for abortion law reform, as legitimate nursing work. Whereas much of the professional discourse up until now was created through didactic feature articles written by experts, this new model of professional identity was more informally created by nurse-readers and the editorial staff of *The Canadian Nurse* within the letters to the editor section of the journal. Ultimately, these informal constructions created and legitimized additional professional identities for nurses that removed them from “beside” abortion care and encouraged them to promote women’s access to safe abortion care in other ways.

Continuing these discursive moves in contemporary nursing discourse widens the scope of nurses’ permitted professional abortion-related identities and thus increases women’s access to a greater number of abortion services. Aside from taking individual

and collective political action (Cleary, 1971; Good, 1971; Melnitzer, 1970) and participating in bedside clinical abortion care, nurses' abortion work can be expanded to: providing in-hospital patient and staff education (Easterbrook & Rust, 1977; Howard, 1985); engaging in out-patient genetic/therapeutic abortion counseling and facilitating decision making (Katz, 1998; Rowland, 2008; Rudd & Youson, 1976); establishing and staffing community-based abortion and contraceptive counseling and liaison services (Bannin, 1981; Garrett, 1972; Hall, 1974; Nichol, 1989; Wright, 1991); and, contributing to ethical decision and policy making (Dunbar, 1998). Moreover, including nurse-led abortion care research in professional discourse—by publishing research abstracts and full feature articles in *The Canadian Nurse* and other professional journals (Dunbar, 1988; McKay, 1975; Watts, 1975)—works toward legitimizing the abortion-related nurse-researcher professional identity for nurses as well. Making these professional identities (or specific attitudes and practices) available to nurses to adopt and enact into practice today enables and supports them to provide a range of safe abortion services for women in both clinical and non-clinical settings. Additionally, this expanded discourse encourages a further widening of imagination for what abortion-supportive nursing work could be in the future, how discourse can create and shape that work, and how nurses can improve women's access to safe care. These conclusions and the relevance of this investigation to nursing theory and practice will be evaluated, in part, by how they came to be known. Therefore, explicit reflections on the methodological processes of this inquiry are warranted at this stage of the discussion.

Methodological Reflections

Before extending these findings to consider recommendations for contemporary nursing discourse and practice, I will reflect on the processes of analysis, the creation and maintenance of rigour throughout this inquiry, and the limitations of the investigation. In doing so, I offer the reader an opportunity to evaluate the credibility or quality of the investigation in advance of reviewing its practical applications.

The process of analysis.

Recognizing that discourse analysis precludes a standardized approach (Phillips & Hardy, 2002), I developed a system of analysis specific to my research goals. Intending to explore the discursive processes of constructing and maintaining professional truths or professional identities in the context of abortion care for nurses, I created and brought deliberate “guiding questions” (Jóhannesson, 2010, p. 256) to each text. I aimed to answer those particular questions while also allowing for multiple meanings, tensions, and contradictions about abortion and nursing ideologies and practices to emerge. At first, I simply read each text for content and made note of key identifying markers—the title of the work, name of the author, author’s occupation, date of publication, and genre of text—for each one. Next, I asked identical summary questions for each of the documents: Why was the article/letter/advertisement ostensibly written? What does it explicitly say in general? What are the main points of this article? Narrowing my focus to abortion, I asked more specifically: What does this text explicitly and implicitly say or not say about abortion? What does it say about nursing—both as a profession in general and with regard to day-to-day practice? How are abortion and nursing related or connected in the article? Finally, for each text I asked: what are the potential discursive themes in this article and what ideologies seem to be acting as legitimating principles to support the authors’ messages? Employing the principles of social linguistic analysis, I carefully examined the texts for the rhetorical tools used by the authors (implicit and explicit messaging, for example) to make their claims. I created a template of these specific questions to guide and track my thinking in the initial phases of the analysis. I recorded and archived my tentative “answers” on this template for each document.

Next, while working with the individual documents, I allowed for broader ideas about the connections between nursing identity, practice, and abortion to arise. Following Phillips & Hardy’s (2002) example, I also attended to how social actors other than the particular object of analysis (nurses, in this case) were discursively constructed in the professional nursing discourse. These broader ideas directed my focus away from the individual articles and authors, shifting it to the body of collected texts and back again. As a result, I was able to work with the data in an iterative manner, shifting my analysis

back and forth between the individual texts and the body of professional discourse: this process was aided by the templates I had already completed, as I could compare many documents side-by-side simultaneously. Additionally, I positioned my findings within the broader contexts of abortion's medical and legal histories. Widening the scope of the inquiry in this way advanced the investigation from narrative or content analysis to discourse analysis (Phillips & Hardy, 2002). Through these analysis processes, I came to an understanding of how discourse shaped nursing identity and nursing practice in the past. This understanding provides a foundation from which to evaluate current discursive practices and devise and operate future professional discourses to support nurses in providing and promoting safe abortion care. Before I make recommendations for future discursive practices however, I will review how rigor was created and upheld throughout the investigation and outline the limitations of the study for the reader's consideration.

Creating and upholding rigor.

Evaluating and demonstrating the quality, or rigor, of discourse analytic research is, as Nixon and Powers (2007) note, “alarmingly complex, and [yet] at the same time [it] is vital to the development of new knowledge that will be taken seriously within the evidence-based context of present healthcare delivery” (p. 73). The conceptualizations and applications of rigor across discourse analytic research are numerous and often contradictory and as such, “there are few clear guidelines for what constitutes rigor in a discourse analytic study” (Nixon & Powers, 2007, p. 71). Challenged by this ambiguity, Nixon and Powers reviewed and critiqued the varied strategies for creating and upholding rigor in discourse analysis and created a six-element guiding framework for evaluating and achieving rigor in discourse analytic research. Applying Nixon and Power's framework to this investigation, I will demonstrate where and how I have been able to create and uphold rigor throughout this inquiry.

The first requirement for creating rigor in discourse analytic research is the identification of a clear research question that is appropriately for discourse analysis methods (Nixon & Power, 2007). My research questions: (a) what professional identities

have been discursively created and made available to nurses who provide abortion care; (b) how have specific constructions of professional identity supported or discouraged nurses to provide safe abortion care; and, (c) how can professional identities that permit and support safe and accessible abortion services be discursively created and enacted by and for nurses practicing today and in the future are precise and explicitly discursive in nature. To ensure clarity, I have overtly addressed the fundamental elements of the questions: I have explicitly defined safe abortion and professional identity; outlined the common clinical practices and responsibilities of abortion nurses; and reviewed barriers to abortion access in Canada. Discourse analysis is an appropriate approach to these questions because professional identities and social realities are discursively constructed. Therefore, an analysis and comprehension of discursive processes, which can only be executed via discourse analysis, is essential for understanding past and present professional identities and enacting effective change.

Next, Nixon & Powers (2007) call for a “clear definition of discourse and species of discourse analysis” (p. 76) for upholding rigor. In this investigation, I have explicitly employed Phillips & Hardy’s (2002) definition of discourse as “an interrelated set of texts, and the practices of their production, dissemination, and reception, that brings an object into being” (p. 3). Furthermore, I have relied on their conceptualization of discourse analysis as a methodology for uncovering the ways social reality and professional identity are produced (or, in other words, the study of how those objects are “brought into being” through discourse), which is in opposition to other methodologies that “work to understand or interpret social reality as it exists” (Phillips & Hardy, 2002, p. 6). Furthermore, I have named social linguistic discourse analysis as the guiding “species” of discourse analysis for this inquiry. These definitions are clearly explained in the Methodology section.

Third, Nixon and Powers (2007) claim that an “effective use of theoretical framework [and] clarity and explicitness in epistemological and ontological positioning” (p. 76) is necessary for upholding rigor. I have made use of Jóhannesson’s (2010) theoretical conception of how professional member’s conscious and unconscious

participation in discursive processes normalize and legitimize or silence and prohibit certain practices and ideologies as professional identities. Ontologically, I accept that social realities are constructed through discourses and, as suggested by Phillips and Hardy (2002), I therefore accept that there is no one true reality or “‘real world’ other than the one constructed through discourse” (p. 80). Similarly, because the discursive processes, or ways of constructing professional identity, are non-linear (Jóhannesson, 2010), I accept that multiple legitimate, potentially contradictory, professional identities (or social realities) may operate simultaneously. Moreover, because my particular system of discourse analysis is interpretive, epistemologically, I am committed to individual interpretation as a way of “coming to know” social reality, and further, that social reality is “knowable” (in some way) through discourse. These commitments are explicitly addressed in the Findings sections of this inquiry.

The fourth condition required for upholding rigor is “transparency in analysis methods and application of theory to the analysis” (Nixon & Power, 2007, p. 76). I have been transparent in the processes of analysis and application of theory in a number of ways. I have provided a clear description and evaluation of the system of analysis used in this inquiry. I have constructed and supplied a detailed narrative of findings that plainly traces my analysis and application of theory; an account that relies on in-depth descriptions of the primary texts and includes many direct quotations as evidence to support the interpretive claims made. Finally, in addition to maintaining transparency within this discussion, I have also done so during the actual processes of data collection and analysis. I have chronologically archived all of the primary texts collected for this project and have retained individual records of initial identification and analysis processes with each document such that another investigator or reviewer could follow my path.

Fifth, Nixon and Powers (2007) call for “clarity in selection of talk/texts” (p. 76). I have explicitly identified *The Canadian Nurse* published from 1950 to 2000 as an appropriate source of abortion-related professional discourse; outlined how individual texts were selected from the journal for analysis; and clearly described the documents

consulted within the Findings and Discussion section of this paper. I have also articulated a more in-depth evaluation of my selection processes in the Limitations section for increased rigor.

Finally, Nixon and Powers (2007) identify “concepts/criteria/strategies to guide analysis” (p. 76) as the sixth element of the rigor framework, claiming “context, intended audience, timing/sequencing, membership categorization ...” (p. 77) as examples of this element in their own work. The concepts, criteria, or strategies that have guided my analysis include positioning discursive processes within “historical conjunctures” (Jóhannesson, 2010, p. 253), which in this case are the intersecting historical legal, political, and medical conditions of abortion. Additionally, the concepts of discursive themes, legitimating principles and normalization, as described by Jóhannesson (2010) guide this analysis.

When evaluated with Nixon and Power’s (2007) framework for rigor in discourse analysis, I have created and upheld rigor throughout this inquiry. I have asked clear and precise research questions that are appropriate for discourse analysis and have defined and explained the fundamental elements of each question. I have provided concise definitions of the relevant methodological terms, (discourse and discourse analysis) and brief descriptions of the supporting theoretical frameworks and philosophical underpinnings of the method of inquiry. I have been transparent and clear in my selection of texts, data collection, and data analysis processes via detailed accounts of the texts within the discussion of findings and the maintenance of comprehensive document/analysis archives. Finally, I have used and defined appropriate concepts and criteria to guide my analysis and contextualize the findings. Creating, upholding, and demonstrating rigor are essential to “ensure that readers, especially editors and reviewers, understand why and how the findings are legitimate” (Phillips & Hardy, 2002, p. 79). In a similar vein, reviewing the limitations of the study allows readers to evaluate the processes of the investigation and prompts them to consider their willingness or ability to enact the recommendations made from these particular data into their own specific

practice areas. Thus, the next section of this paper will outline the limitations of this inquiry for the reader's consideration.

Limitations.

Many of the limitations of this investigation are related to the general sampling problems inherent in discourse analytic research coupled with the independent nature of this particular study.

Selection of texts from one publication.

As with most discourse analyses, this investigation was primarily limited by what texts were selected and excluded for analysis. As Phillips and Hardy (2002) point out, "the challenge is not to find texts but deciding *which* texts to choose" (p. 72). When choosing texts for this inquiry, I reasoned that although the discursive processes of professional identity construction can be investigated through a number of varied sources, owing to the time span of interest (1950 to 2000); the generalized nature of the research (an initial inquiry into nurses' abortion identities in Canada); and the time constraints of the project, sampling from one publication exclusively was appropriate at this time. The risk of sampling from one publication is that certain voices or discursive processes that have contributed to constructing the object of analysis or the broader social reality may be overlooked; this is especially problematic in critical discourse analysis if marginalized or vulnerable voices are neglected (Phillips & Hardy, 2002). However, sampling from *The Canadian Nurse* actually enabled me to "allow different voices to pervade the text" (Phillips & Hardy, 2002, p. 85) while maintaining a manageable number of documents for master thesis analysis. For example, abortion discourses in *The Canadian Nurse* were created by expert and non-expert authors of varied occupations including: nurse educators, clinical nursing leaders, physicians, student nurses, and practicing and retired bedside nurses who practiced in a variety of clinical settings. Sampling from this professional publication, (as opposed to textbooks or policy manuals written by experts, for example), allowed those potentially neglected voices of non-expert, bedside nurses to be considered in this investigation. Moreover, sampling from *The Canadian Nurse* in

particular, (as opposed to more specialized professional journals, such as *The Journal of Obstetric, Gynecologic, and Neonatal Nurses*), allowed those voices of general, non-specialized Canadian nurses—in addition to the specialized voices—to be considered.

Similarly, although I collected and reviewed a large volume of abortion-related text from *The Canadian Nurse*, it is certain that I overlooked some material that explicitly or implicitly addressed abortion—due either to the inevitable application of my own interpretive framework (i.e. what I considered to be related to abortion) or to other factors, such as time constraints. As a result, particular discursive moves or participant voices may have gone unacknowledged in this study. Moreover, after gathering a large volume of abortion-related documents, I deliberately eliminated certain genres of text²⁵ (such as book reviews and news items) from the data set in order to sustain the “manageable, relatively limited corpus of texts” (Phillips & Hardy, 2002, p. 72) necessary for discourse analysis. Thus, additional bodies of discourse (including one that I have already collected and set aside) that potentially demonstrate additional discursive processes and voices—which may lead to alternate interpretations of professional identity construction—remain available for analysis. Although these sample-reducing limitations potentially contribute to a narrowed analysis, Phillips and Hardy (2002) remind us that, “a discourse can never be studied in its entirety, merely that clues to it can be found in text, of which only a small subset of texts can be identified, collected, and analyzed” (p. 85). However, to “acknowledge that not all possible voices appear in the text” (p. 85) is to recognize and accept “the incomplete nature of the [discourse analytic] research project” (p. 85). Thus, this inquiry, like all discourse analyses, remains unavoidably incomplete.

Independent study.

Other limitations of this inquiry are related to my independent approach. This study was undertaken as an individual masters-level research project in an academic

²⁵ Note that all documents from these genres were excluded from the data set to maintain consistency in the analysis and to facilitate multi-document comparison.

setting. As such, conceptualizing the research problem, choosing and implementing appropriate data collection strategies, and enacting the analysis and evaluation processes of this inquiry were primarily individual endeavors. The potential challenges of independent inquiry are related to one's limited ability to identify, collect, and analyze a large and varied body of discourse and a possible narrow frame of interpretation, which may, again, leave certain discursive voices or discursive moves overlooked. Expanding this study from an individual to a team investigation would certainly enable the identification, collection, and analysis of a larger number of abortion-related texts from a wider variety of publications. More significantly, in a team setting, additional/different guiding questions (created by team members with varied individual frameworks) could be brought to the texts for an increased scope of interpretation. Even barring the creating of vastly different guiding questions, the team approach allows for valuable collaborative processes, such as debating, discussing, and "signing off" on team member interpretations and analyses (Phillips & Hardy, 2002, p. 76)—the result of which could be additional insights about the discursive construction of professional identities that may have further implications for practice.

Increasing the volume and variety of data sources or conducting analyses from a team approach would likely result in new stories or arguments about discursive processes, abortion, and nursing. However, as a discourse analyst, I recognize that there are multiple stories to be told and that the account presented here is just one. As noted by Phillips and Hardy (2002), "the endpoint [of analysis] comes not because the researcher stops finding anything new, but because the researcher judges that the data are sufficient to make and justify an interesting argument (p. 73). Thus, although I acknowledge that there are many more data to consider and many more arguments to be made, yet, as an independent researcher, I have reached one endpoint, made and justified an argument, and told one story about discourse, professional identity, and abortion care based on the data collected within these limits. Recognizing that discourse analytic research is always incomplete, one advantage of explicitly identifying these limits is the stimulation of future research strategies for advancing the understanding of the object of analysis. Recommendations for expanding this research and suggestions for modern applications

of the findings to abortion care improvement and understanding professional nursing identity in general are outlined in the next section.

Implications and Recommendations

The findings of this investigation, which connect professional discourse processes to professional identity construction in the context of abortion care, are significant to nursing scholarship, practice, policy, and education in the contexts of abortion nursing specifically and professional identity in general. First, this interpretation of the impact of discourse on nurses' abilities to provide and promote safe abortion care facilitates the evaluation, construction, and implementation of contemporary discourse processes required for improving women's access to safe abortion care. Second, because this inquiry into abortion care is but one clinical context for investigating discourse processes and nursing practice, the theoretical frameworks, processes, and findings of this research are potentially relevant for guiding additional research or policy and practice changes in other clinical areas as well. Finally, exhibiting professional identity construction and acquisition as discursive processes stimulates new ways for the discipline to approach professional identity in research, practice, policy, and education.

Improving women's access to safe abortion services.

Previous investigators have explicitly linked women's access to safe abortion services to nurses' unwillingness to participate in abortion work (Ferris, et al., 1998; Kade, et al., 2004; WHO, 2011) and their negative attitudes and perceptions toward abortion and women who seek it (Marek, 2006; Marshall et al., 1994; Natan & Melitz, 2010; WHO, 2011). The findings of this investigation demonstrate that nurses' unwillingness to participate in abortion work, their negative attitudes, and perceptions regarding abortion and the women who seek it are, in part, generated and maintained through the discursive processes taking place in professional discourse. The findings from this inquiry indicate that discursively constructing, maintaining, and making available to nurses abortion-supportive professional identities, enables them to promote and provide safe abortion care, which increases women's opportunities to access safe

care. As such, I recommend a deliberate engagement in discursive processes such as an evaluation of current professional discourse and the mindful construction of and participation in future discourse that enables nurses to practice safe abortion care. Continued construction and reconstruction of professional identities (social realities and professional truths) that sanction abortion work as legitimate nursing practice must take place in the arenas of nursing research, education, policy, and practice.

Research.

Thus far, investigators have examined abortion nursing via grounded theory (Lipp, 2008, 2009, 2011; Lipp & Fothergill, 2011); phenomenology (Hanna, 2005, Nicholson et al., 2010); thematic content analysis (Gallagher et al., 2009; Slade et al., 2001); and quantitative, non-experimental description techniques (Marek, 2004; Natan & Melitz, 2010). Thus, this inquiry provides a new conceptualization of how abortion nursing can be studied and knowledge created through discourse analysis. Recommendations for future discourse analytic research aim to capture additional discursive moves or voices that could not be included in this investigation. First, I suggest widening or shifting the scope of discourse collected to include other sources of text—especially current texts. In addition to *The Canadian Nurse*, specialized professional journals that necessarily include more abortion-related content, such as *The Journal of Obstetrical, Gynecological, and Neonatal Nursing*²⁶, are other valuable sources of abortion-related professional discourse. An increased acceptance of abortion as legitimate nursing work in these journals may yield more effective legitimizing or normalizing discursive moves than what is available in the generic national journal. Additionally, as professional discourse is not limited to published journals or magazines (Phillips & Hardy, 2002; Jóhannesson, 2010) abortion-related discourse collected from other private and public sources is also appropriate for this kind of analysis. Private documents include archival data such as facility-specific policy and procedure manuals, meeting minutes, emails and memos, internal reports, hospital newsletters, patient records, and so forth (Phillips & Hardy, 2002). External professional discourse includes textbooks, regional

²⁶ See jognn.awhonn.org

and international policy reports (WHO, 2011), nursing-specific best practice guidelines (see Registered Nurses Association of Ontario, 2011), professional association websites, and external advertising campaigns. These sources of discourse can additionally be examined and maneuvered to increase the legitimacy of abortion work for nurses.

In addition to widening the scope of discourse for analysis, shifting the theoretical framework of the investigation to another species of discourse analysis with a reframed research question could yield additional findings. Critical discourse theory, for example, which is concerned with the discursive construction and maintenance of social power (Phillips & Hardy, 2002), could guide an investigation of the power relationships between physicians, nurses, and women seeking abortions in professional discourses for what affect they may have on abortion nursing care. Finally, expanding the investigation to a team approach could be employed for increased ability to collect and examine multiple texts and for the application of varied interpretive frameworks, which would potentially yield new discursive moves or alternative voices that were overlooked or not available in the data from this inquiry. There are myriad ways discourse analysis can guide abortion-nursing research, this inquiry is just one example. Expanding this investigation leads to increased understanding of professional discourse processes in abortion care—knowledge which can be integrated into nursing education to normalize and legitimize abortion work as “real” nursing work for students.

Education.

In the context of nursing education, it is critical that abortion-supportive identities are constructed, maintained, and communicated to undergraduate and graduate nursing students as legitimate and available professional identities. Abortion, then, must be formally integrated into nursing curricula. This one action itself works toward legitimizing abortion as nursing work for both students and faculty. Before taking on abortion-education however, educators must review (individually or collectively) their own attitudes toward abortion and abortion seeking women. They must familiarize themselves with the discursive processes of professional identity construction (by examining investigations such as this) and consciously participate in them. With attention

to their own words and discursive practices, educators can create abortion-specific lectures and lecture notes that introduce both the physical and psychological aspects of abortion nursing, encourage students to explore their own abortion attitudes and ideologies, and provide accurate descriptions about what abortion is and what abortion work entails exactly. Including abortion physiology and pharmacology on exams further normalizes and legitimizes it as regular nursing knowledge. Students engaged in lab work may role-play how they would provide (or fail to provide) psychologically safe care to women and journal about their own attitudes toward abortion and abortion seeking women. Finally, offering clinical placements at abortion facilities also works toward legitimizing abortion work for students. Phillips and Hardy (2002) stipulate that discursive “texts may take a variety of forms, including written texts, spoken words, pictures, symbols, artifacts, and so forth” (p. 4). Thus, these lectures, labs, projects, and clinical placements are themselves discursive strategies for normalizing abortion care. Yet, also making discourse theory explicit for students provides them with tools they can consciously employ to construct abortion-supportive professional identities in the work place throughout their careers.²⁷ In the realm of written text, abortion-supportive identities can be constructed for students in textbooks or textbook supplements, journal articles, and class-specific websites. Authors of these documents must straightforwardly construct abortion, abortion nurses, and other social actors as legitimate practitioners through detailed clinical descriptions for example.²⁸ Women seeking abortions can be constructed as legitimate patients or clients through case studies, for example²⁹. Finally, educators must accurately inform students of the applicable abortion laws, which may dispel potential misconceptions that abortion practice is illegal or risky in some way. Making these legitimate abortion identities available to students enables them to confidently take up abortion work as nursing practice and to provide safe abortion services to women. Students with knowledge of discourse processes that legitimize abortion work can bring these strategies to policy-making, both in their own work places and to the national and international policy-making arenas.

²⁷ This is discussed more thoroughly in the Professional identity section, p. x.

²⁸ Such as those found in Roulston (1965) and Maki & Perlmutter (1965).

²⁹ See Howard (1985).

Policy-making.

In the context of policy-making, abortion-supportive, *nursing-specific* ideologies and practices can be communicated to nurses as professional identity through broad public practice guidelines, such as the WHO's "Safe abortion: technical and policy guidelines for health systems" (see WHO, 2011) and nursing association's best practice guidelines (see Registered Nurses' Association of Ontario, 2011). These public documents make abortion-supportive identities available to nurses (and non-nurses) who otherwise do not have access to what nurses are expected and permitted to do regarding abortion work (and who, with enough information about their duties and responsibilities, may choose to work in clinical abortion areas). While these policies should explicitly tell nurses what they are permitted and expected to do clinically, they also implicitly communicate what abortion ideologies are acceptable. Similarly, facility-specific policy, procedure, and orientation manuals are private discourses where abortion-supportive professional identities can be communicated to nurses. Nurses involved in policy-making can bring these discursive strategies to their work such that appropriate abortion ideologies inform and pervade policy at all levels, as policy is professional discourse.

Nursing practice.

The ultimate goal of engaging in discourse analysis and deliberate discourse operation in research, education, and policy-making is the construction of safe abortion care environments for nurses and women. Nurses can continually bring discursive strategies both to these avenues and to their own individual practices. In practice, many investigators encourage nurses to participate in straightforward discussions of their attitudes and judgments (Huntington, 2002; Lipp, 2009; Lipp & Fothergill, 2009; Marek, 2004), experiences of providing care (Lipp, 2008; Nicholson et al., 2010), and their perceptions of the meaning of their work (Gallagher et al., 2009; Wolkomir & Powers, 2007). I suggest that these discussions can be enhanced by explicit examinations of and conversations about discourse processes and professional identity construction: nurses can examine where in discourse their abortion attitudes and ideologies originate, what kinds of discourses are available to them in their workplaces and more broadly, and how those discourse processes impact their abilities to provide safe abortion care. Moreover,

practicing nurses can begin to produce their own discourses (through unit-policies, patient education materials, nurse orientation manuals, their own patient documentation, and everyday speech and interaction) that support abortion work as legitimate nursing practice. Accepting and normalizing abortion work can potentially decrease the emotional distress associated with incongruent professional ideals and practice realities, as normalizing abortion work through discourse is dependent on communicating professional ideals that support abortion service as professional truth and social reality. Improving nurses' attitudes and judgments about abortion and women seeking abortion; their perceptions of what abortion care is; and their abilities to reconcile professional identity with practice through discourse production and participation can enable them to consistently provide and promote physically and psychologically safe abortion care for women.

Next, I will discuss the implications of this investigation for professional nursing identity in general and make recommendations for advancing professional identity knowledge through research, education, policy, and practice.

Professional identity.

This investigation can also be located within the discipline's broader understanding of professional identity in order to determine what implications the study has for nursing research, education, policy, and practice. In many cases, employing the processes of discourse analytic research can enhance or add another perspective to what has already been accomplished in the field. Because the discipline of nursing accepts multiple epistemologies and ontological paradigms, discourse analysis can be employed as an additional method for creating, acquiring, and advancing "knowledge" in nursing. Thus, although the individual researcher must be committed to the epistemological and ontological framework of the inquiry, the findings of this investigation do not necessarily preclude those of others for nursing. As such, I will briefly contextualize this investigation within professional identity nursing literature in terms of what discourse analysis may add to research, education, practice, and policy in this area.

The working definition of professional identity for this investigation—the specific ideologies and practices that are permitted and expected of members who belong to a particular professional group—echoes what is accepted as professional identity in the nursing literature. There, professional identity is defined as: “the values and beliefs held by the nurse that guide her/his thinking, actions and interaction with the patient” (Fagermoen, 1997, p. 435); and, the “expected knowledge, behaviors, skills, attitudes, values, roles, and norms deemed appropriate and acceptable to [a] chosen profession” (MacIntosh, 2003, p. 725). Inherent in each of these definitions is that professional identity informs nursing practice and thus affects patient care. This aspect of professional identity is significant for both nursing research and nursing practice, as research devoted to professional identity has direct implications for nursing practice. The findings from this investigation demonstrate that discursive constructions of professional identity affect nursing practice in abortion care. However, employing discourse analysis to examine the relationships between discourse, professional identity, and practice is not limited to abortion care; it can also be expanded to other clinical care areas. For example, this kind of investigation is appropriate for examining and improving services in other controversial fields where the legitimacy of nursing work has been or continues to be threatened, such as in supervised safer-injection and harm reduction work (see Lightfoot et al., 2009). Research questions, data collection strategies, and analysis processes similar to those constructed for this investigation could be appropriately applied in these other contexts. Alternatively, similarly examining the relationships between discourse, professional identity, and practice in well established and well researched clinical care areas may yield fresh perspectives and practice strategies in those areas as well. Furthermore, the specifically historical discourse analytic approach used in this investigation can be expanded to other historically significant or historically un-charted clinical areas.³⁰ These kinds of discourse analyses will not only contribute to comprehensive understandings of other specific clinical areas, which is critical for

³⁰ When collecting data for this investigation, for example, I noted two such fields where sufficient text appears to be available for historical discourse analysis: Cold War civil defense nursing in Canada in the 1950’s and 1960’s and the development of Canadian HIV/AIDS nursing in the 1980’s.

improving patient care, but they will also contribute to the collective understanding of professional identity development in nursing, and of the discipline in general. Thus far, however, nursing scholars have focused their professional identity investigations on the general processes of acquiring or developing professional identity—as opposed to examining it in the contexts of specific clinical practices.

In nursing scholarship, as in my investigation, acquiring professional identity refers to “the process[es] whereby individuals acquire and integrate into their lives” (Macintosh, 2003, p. 725) the expected behaviors and ideals of the profession. That professional identity is constructed and made available to nurses through discursive processes, and that nurses can take up professional identities through unconscious and conscious participation in professional discourse is a departure from what the discipline has long accepted and what nursing scholars have recently proposed for how professional identity and professional status are obtained. Therefore, this investigation provides a new understanding of professional identity and professional identity acquisition and thus can enhance what others have proposed for professional identity research and education.

The commonly accepted understanding of professional identity acquisition is that professional identity, or professional status, is bestowed on graduates once—at the beginning of their careers (Macintosh, 2003). According to Macintosh (2003), the discipline of nursing has come to adopt a set of criteria that, when met by graduates, accords them professional status: they are considered prepared and able to enact the behaviors and ideologies expected of them as nurses (Macintosh, 2003). In British Columbia, these criteria are established by the College of Registered Nurses of British Columbia (CRNBC), the professional regulating/licensing body. Currently, to achieve professional status, which is manifested as a legal license to practice nursing and the right to use the title of Registered Nurse, nurses in British Columbia must have: “completed a nursing education program, met competence requirements, passed a national examination, and consented to a criminal record check” (CRNBC, 2011, What to expect from nurses, para. 4). These kinds of criteria, according to Macintosh, are commonly accepted throughout the discipline. However, contemporary nursing scholars are

challenging the idea that professional status and professional identity can be bestowed upon nurses in this static way.

Guided by grounded theory, Macintosh (2003) determined that professional identity is less acquired in nursing education programs (by mastering technical competencies and preparing to pass the licensing examination) than developed in practice through a “career-long, iterative process of reworking professional identity” (p. 739). Macintosh maintains that nurses develop their professional identities in the workplace *after* the socialization processes traditionally offered in education programs—and do so in three stages: “assuming adequacy, realizing practice, and developing a reputation” (p. 730). She suggests that these findings are especially important for nursing education as increasing students’ awareness of these processes or offering them this new understanding of professional identity acquisition helps them to “develop more realistic expectations and self-responsibility for being professional and to anticipate a period of adjustment to practice” (p. 739). She claims that graduates’ oft-encountered professional identity anxieties and challenges may be reduced or better managed by nurses with this alternative perspective. Macintosh concludes that through these processes, “individual nurses may begin to examine their professional identities and identify how they wish to change” (p. 739).

Building from Macintosh’s (2003) suggestion, I propose that offering students the additional discursive conceptualization of professional identity construction and acquisition encourages them to further develop expectations about professional identity (that go beyond automatic acquisition upon graduating and passing the licensing exam) that will support them in practice. This awareness empowers students and graduates to examine, evaluate, and manage their professional identities throughout their careers by examining and evaluating professional discourses and deliberately managing their conscious participation in professional discursive processes. In the education setting, students can explore discourse theory through explicit attention to it in nursing theory curricula. Through assignments, they can actively learn about (and practice) the processes of discourse analysis by investigating the constructions of professional identity in journal

articles, lecture notes, textbook chapters, or other professional or educational texts. Students can be encouraged to mindfully enact positive discursive processes in their work by attending to and formally evaluating how their talk and text (what they say in oral presentations or include in class hand-outs, for example) contributes to the class understanding and construction of professional identity. In the professional setting, graduates with an awareness of the discursive processes of constructing professional identity can participate and contribute to professional discourse by publishing articles in professional journals, bringing discursive strategies to policy-making, and contributing to their workplace-specific discourses (procedure manuals, hospital news letters, employee orientation handbooks, and so forth). Understanding and enacting discursive professional identity construction empowers nurses to examine their professional identities, identify how they wish to change, and initiate those changes.

Similar to Macintosh (2003), Roberts (2000) conceptualizes professional identity as dynamic and something that can be developed by nurses throughout their careers—as opposed to being bestowed on them at the beginning of their careers. Roberts approaches professional identity in a purely theoretical manner by applying non-nursing models of oppression to professional identity development in nursing. Roberts claims that nursing’s professional identity is oppressive to nurses; that nursing is categorically subject to medical dominance. As a result, Roberts argues, many nurses suffer from low self-esteem and further, there is internalized hostility between the members of the profession. These factors drive nurses’ behaviors and practices in negative ways that decrease the quality of patient care. Roberts suggests that developing a positive professional identity can free nurses from oppression, which will result in “greater unity, purpose, and empowerment” (p. 71) for the profession and (presumably) an improvement in patient care. Based on non-nursing models of oppression and informal observations, Roberts constructs a nursing-specific liberating model of professional identity development.

I suggest that Roberts' (2000) work can be expanded, and shifted into an evidence-based framework,³¹ through discourse analytic methods. The issue of oppressive professional identities is especially appropriate for critical discourse analysis, which focuses on how power relationships are constructed and maintained through discourse (Phillips & Hardy, 2002). In this case, professional discourses could be examined for what discursive moves contribute to oppressive professional identities. There are countless research questions and discursive data sources available for this kind of investigation; for example, one could explore oppression in the professional identities that are constructed and made available to bedside nurses through internal hospital memos written by nurse managers. My abortion-focused study demonstrates that discourse analyses can yield practical strategies to enact change in professional identity and practice. As such, it follows that discourse analyses of oppression in nurses' professional identities can yield practical discursive strategies for constructing (and making available) positive professional identities that facilitate liberation from oppression.

I suggest that policy-making, in particular, is one area where discursive investigation and action are effective for creating change in professional identity and constructing positive professional identities. As this research demonstrates, even when professional discourse does not explicitly articulate what nurses are or what nurses do, professional nursing identity is nevertheless constructed and disseminated through it. This analysis indicates that professional nursing identity is not constructed in a vacuum; nursing identities are constructed in comparison with and contrast to other social actors (i.e. physicians and patients) and social objects (i.e. diagnoses and procedures). Health policy is one area of professional discourse where all of these factors: social objects, social actors, and articulations about what practitioners should do are commonly present, thus health policy emerges as a genre of professional discourse where nursing identity is inevitably constructed. Returning to Roberts' (2002) aim of liberating nurses' from an oppressive professional identity, one could employ critical discourse analysis to examine professional policy for how oppressive (or liberating) identities are constructed and made

³¹ See Craig & Pearson (2007) for a discussion of evidence-based health care.

available to nurses (and their oppressors). Based on the findings from this abortion-focused investigation, one might hypothesize, for example, that worldwide interdisciplinary health policies embedded with positive constructions of nurses as autonomous practitioners or equal members of interdisciplinary teams make liberating nursing identities widely available for nurses to adopt and for others to accept. Undertaking discourse analytic investigations of this nature could reveal valuable discursive moves that, when appropriately applied in policy-making, work towards liberating nurses from oppression.

Contextualizing this investigation within these examples clarifies that professional identity-focused discourse analyses can contribute to and enhance nursing knowledge in this area. To create change in nursing practice and improve patient care, these kinds of investigations can be expanded to various clinical areas such that professional identities that support appropriate ideologies and behaviors can be deliberately constructed and made available to nurses. In nursing education, explicitly exploring professional identity as something that is discursively constructed and made available to nurses—as opposed to something that is achieved only once, after graduating and passing a licensing exam—enables students and graduates to examine, evaluate, and manage their professional identities throughout the course of their education programs and the span of their careers. Bringing discursive investigations and strategies to policy-making can ensure that nurses' professional identities are suitably constructed in those particularly powerful sources of professional discourse. Finally, in the context of nursing research, this investigation contributes an alternative model of professional identity construction and acquisition from which to frame future investigations; this particular study demonstrates but one application of the theories and processes of discourse analysis.

In this inquiry, I have examined the discursive construction and acquisition of professional identity in the context of abortion care. I have consulted an historical body of professional discourse that includes articles, editorials, advertisements, and letters to the editor that were published in *The Canadian Nurse* from 1950 to 2000. Within that discourse, I have identified the multiple professional identities that were constructed and

made available to nurses and attended to how the ideologies and practices that were permitted and expected of professional nurses enabled or undermined their abilities to provide or promote safe abortion care over time. From the analysis, I have identified a number of discursive strategies that can be used to evaluate and operate contemporary professional discourse such that abortion-supportive professional identities can be continually constructed, reconstructed, maintained, and made available to nurses within the avenues of practice, policy, and education. Furthermore, I have made recommendations for future discourse analytic research that can additionally improve the safety of abortion care for women. Finally, this investigation also constitutes a novel approach to professional identity in general for the discipline. Thus, I have located these findings within the existing body of professional identity nursing literature and made recommendations for future discursive processes in research to advance nursing knowledge about professional identity construction and acquisition. Further, I have recommended practical ways to integrate these processes and findings into nursing practice, policy, and education. Ultimately, this research lays groundwork for future investigations not only of abortion services or other clinical care areas, but of professional nursing identity as well.

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