Difficult Questions With Many Gray Areas: Nuanced Abortion Attitudes Among Physicians

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ABSTRACT

Introduction: Abortion is a polarizing social and medical issue, even among physicians. Though the public may expect physicians to hold purely scientific attitudes about abortion, their attitudes and behaviors are just as strongly informed by social and political factors as the public's. In a recent survey study of physicians at an academic medical center about their abortion attitudes, most reported strong support for abortion access. However, more were unwilling to consult in abortion-related cases, and many perceived little or no professional connection to abortion and were reticent to publicly advocate for their position.

Methods: In order to investigate the nuances in physicians' abortion attitudes, we analyzed the open-ended, qualitative responses provided by physicians at the end of a quantitative survey using modified concept mapping procedures and theme generation.

Results: Two hundred twenty-two open-ended responses resulted in 487 data units. We categorized respondents' comments into 2 main groups: attempts to depersonalize or distance oneself from abortion and expressions of nuance or ambivalence about abortion. Ambivalence and nuance in abortion attitudes centered around multiple factors that varied from individual to structural.

Conclusions: Our findings support previous literature suggesting that physicians' abortion attitudes are not binary and add that nuanced attitudes may be perceived as unwelcome. Acknowledging ambivalence and addressing physicians' tendency to depersonalize abortion could result in more honest, open, and nuanced discourse and contribute to addressing structural issues that result in poor health outcomes, achieving broader reproductive justice goals and greater access to abortion services.

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INTRODUCTION

Abortion is a polarizing social and political issue; thus, individual attitudes about abortion are often perceived to be binary (ie, pro-choice or pro-life).[1–3] Although some survey research has captured only the "central tendency" of individuals' abortion attitudes,[4] other studies have observed significant ambivalence about abortion.[5] Those who identify as pro-life tend to experience ambivalence in contexts of "traumatic abortion" (ie, abortions sought due to rape, fetal anomalies, or threats to maternal health), and pro-choice individuals experience more ambivalence in contexts of "elective abortion" (ie, abortions stemming from unintended pregnancies).[6]

Due to their medical training, physicians might be expected to hold more unambiguous, "scientific" abortion attitudes compared to the public. However, physicians and other health care providers have nuanced or inconsistent attitudes about abortion.[1] While some physicians may experience true ambivalence, or the simultaneous "presence of opposing considerations,"[7] other "respondents who are well-educated and well-informed about policy questions might be able to provide the arguments of both partisans, while adhering more strongly to one, or to neither."[6] False dichotomies between pro- and anti-abortion attitudes ignore clinicians with complex abortion attitudes, including those who generally oppose abortion but find it acceptable in specific cases, those who generally support abortion but find it unacceptable in certain contexts, and those who are willing to help patients access

abortion care even in contexts that they personally find morally objectionable.[1,8,9]

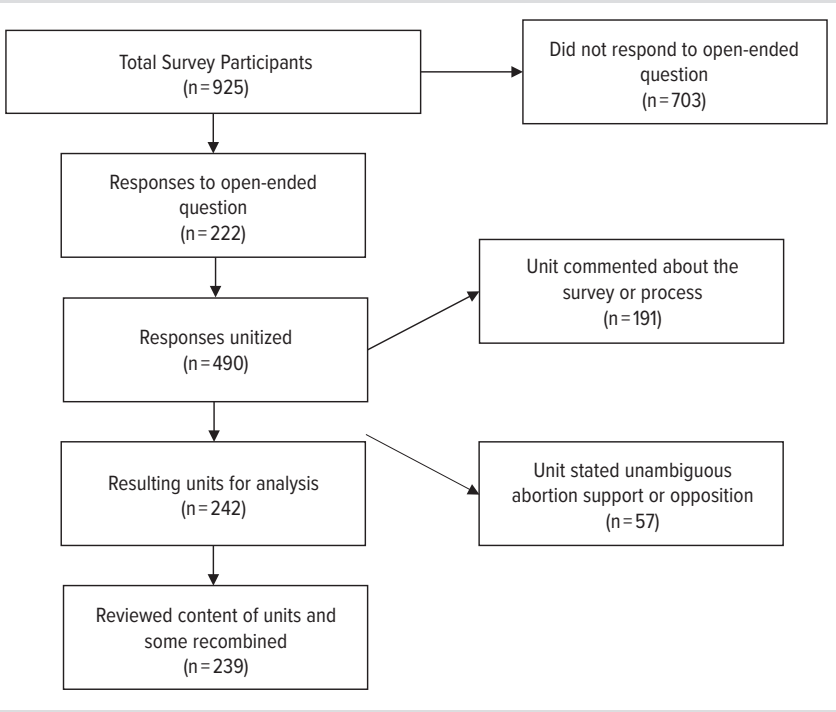
Physicians' attitudes have consequences for abortion access, especially when they translate to willingness to participate in abortion-related care. Clinicians must balance their (potentially conflicting) personal and professional attitudes[10] against empathy for patients, patient safety and autonomy, fiduciary or professional responsibilities, religious or moral orientation, and desire to respect the beliefs of colleagues.[8,11]

Medical specialty may be related to abortion attitudes, though the relationship is likely a two-way street. In one study, pediatric and obstetric specialists asserted that their primary responsibilities were to fetuses and to pregnant patients, respectively—a relationship that might be explained by a priori alignment of their values and professional pursuits.[12] Many abortion providers describe their work as politically and socially important.[13] They also have described both general and contextual ambivalence about abortion, including about when life begins,[14] when a fetus is "viable,"[14] the balance between professional responsibility and conscientious objection,[2] and funding for abortion services.[15,16] For some physicians, attitudes about abortion or willingness to participate in abortion-related care fluctuates with their own life circumstances (eg, if they are currently pregnant or have recently had a miscarriage or stillbirth).[11]

Many physicians still experience shame and stigma about abortion work due to restrictive laws, policies, and workplace cultures.[13,17] Stigma and restrictions place limits on physicians who might otherwise be willing and able to provide abortions[13,18,19] and prevent abortion from being integrated into full-spectrum obstetrics and gynecology and primary care settings.[20]

Not all physicians have the skills and expertise to directly participate in abortion care. However, many have opportunities to provide abortion-related counseling, referrals, or consultations, and their abortion attitudes can, therefore, affect access to abortion services.[21] In a recent survey regarding physicians' abortion attitudes, strong majorities supported abortion access and their colleagues who provide abortion services. However, relatively fewer physicians reported participation (or willingness to participate) in any aspect of abortion-related care or consultation.[22] To further investigate nuances in physician abortion attitudes that are often obscured in survey research, we analyzed open-ended responses provided by physicians at the end of a primarily quantitative survey.

Figure 1. Flowchart of Data Collection and Unitizing Processes



METHODS

The parent study consisted of a 45-item survey gauging physicians' knowledge, attitudes, and practices regarding abortion. Investigators recruited all currently practicing physician faculty members at a large academic medical center in Wisconsin. Quantitative findings were reported previously.[22]

The institution's survey research center disseminated the survey via web and mail.[23] All 1357 practicing physician faculty members received individualized introductory letters containing $5 cash incentives and unique study URL/passcode combinations. Nonresponders received a series of email reminders. A paper questionnaire was mailed to nonresponders after 6 weeks. We fielded the survey from January to April 2019. The Institutional Review Board deemed this study exempt from full review.

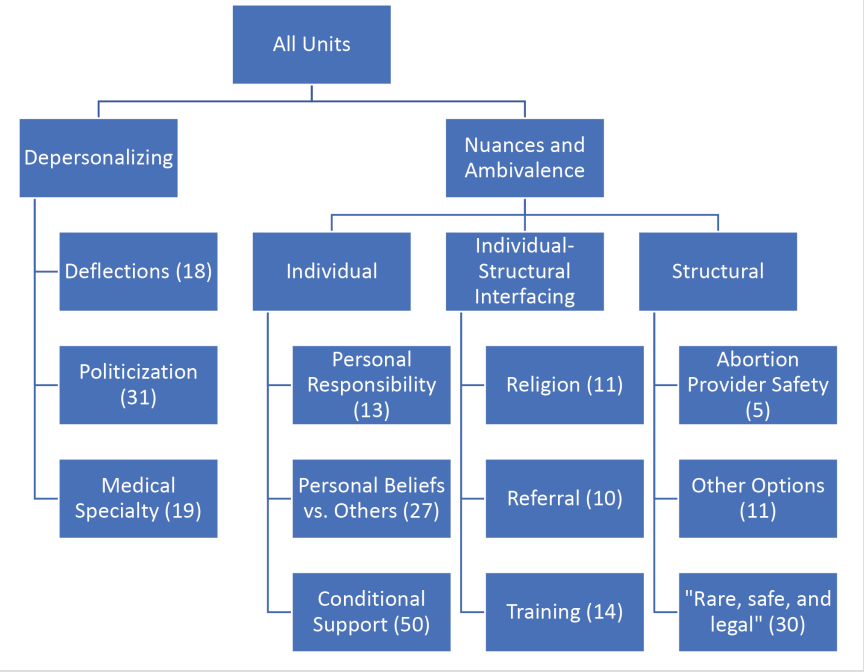
Of note, these data were collected significantly before the US Supreme Court decision to overturn *Roe vs Wade*,[24] which had upheld a constitutional right to abortion for several decades. Most survey questions were closed-ended.

The final survey item was an open-ended text entry box preceded by the prompt, "If you have any other comments or feedback about this survey, please share it below." Qualitative responses, which ranged in length from a few words to several sentences, are described in this report.

Data Analysis

Three researchers conducted thematic content analyses of the open-ended responses inspired by Jackson and Trochim's approach to quasi-qualitative data.[25] First, they independently

Figure 2. The 12 Resulting Unit Groups (and the Number of Units in Each Group), Reflecting 2 Major Themes: Depersonalizing the Issue of Abortion and Expressing Nuances or Ambivalence



divided qualitative responses into conceptual units (single-concept phrases). Next, they worked together to separate units into 2 umbrella categories: (1) comments about the survey itself (eg, technical issues or methodological suggestions); and (2) substantive comments about abortion and related topics. Only units in the second umbrella category were analyzed. All 3 analysts independently sorted units into conceptually consistent groups, without overlap. Through an iterative process, the researchers discussed re-sorted units until they reached 100% agreement about groupings. The team then discussed the relationships between unit groups and noted emergent themes across unit groups.

RESULTS

We sent the survey to 1357 physicians and 913 (67%) responded. Of those, 222 entered an open-ended response (24%), resulting in a total of 487 data units. Open-ended responses that related directly to the survey or process (191 units), such as "thank you for doing this survey" or "I detected bias in this survey," or stated unambiguous support or opposition to abortion (57 units), such as "please don't allow abortion" and "I do support abortion and abortion care," were excluded from further analysis. The remaining 239 units were sorted (Figure 1).

Twelve unit groups emerged from the qualitative analysis, reflecting 2 major themes: (1) depersonalization of or distancing oneself from abortion and (2) expressions of nuance and/or ambivalence. Expressions of nuance or ambivalence were further grouped into 3 levels: individual, structural, and individual-structural interfacing. Figure 2 displays unit group categories, and the Table summarizes each group and provides examples of units within each.

Depersonalizing Abortion

Three unit groups comprised the theme of depersonalizing abortion. The units in these groups reflect some respondents' indifference toward the abortion debate or resistance to stating a clear-cut opinion. In the "deflections" group, some asserted that abortion was not relevant or of interest to them (eg, "I personally do not have an interest in the area of abortion."). Relatedly, units in the "medical specialty" group conveyed the idea that certain specialists are exempt from abortion-related care and, therefore, abortion-related opinions.

A third group, "abortion is political," functioned to depersonalize abortion by designating it as a political topic separate from medicine and science. These units commented on the politicization of abortion without expressing the participants' own views (eg, "the polarization around abortion makes it nearly impossible to discuss."). One respondent wrote, "I trust this is medical and not political research," implying that any abortion research is politically motivated.

Nuance and Ambivalence in Abortion Attitudes

In the 9 remaining unit groups, respondents expressed ambivalence about abortion, expressing that they could see "both sides" of a particular debate, or shared specific nuances and complexity in their opinions. These nuances spanned from very individual to very structural in scope.

Individual

Three unit groups represented ambivalence or nuances that were characterized in individualistic or personal terms. The "personal responsibility" group included units that expressed 2 divergent views on the concept of personal responsibility as it relates to abortion. Some asserted that people seeking abortions are taking personal responsibility for their lives (eg, "Most patients I have interacted with consider having an abortion very carefully."). Contrarily, other units implied that abortion results from a lack of personal responsibility (eg, "This is a problem that is much greater than abortion in America, which is TAKING RESPONSIBILITY [sic] for your own actions.").

A group of units labeled "personal beliefs versus the needs of others" conveyed how respondents managed gaps between personal beliefs and professional behavior. These units reflected an awareness that respondents' own beliefs or moral codes were not necessarily shared by others and a desire to avoid imposing them

Table. Each of the 12 Unit Groups, Themes Within Each Group, and Exemplars of Units in Each Group

Unit Group	Themes	Exemplars
DEPERSONALIZING		
Deflections/lack of interest/relevance	Abortion is not relevant to the participant's life or interests.	"I haven't stopped to think about [abortion] in so long." "I personally do not have an interest in the area of abortion."
	Most people don't want to think or talk about abortion.	"This kind of work is treated as a black box in medicine and society."
Medical specialty	Abortion is not relevant to the participant's specialty or expertise.	"I do not engage in such care in my role as a behavioral health provider." "I could not answer many questions because a pathologist does not deal with the issue."
	Abortion is particularly relevant to primary care specialties.	"The issue of abortion and pregnancy outcomes is a constant presence in primary care practices."
	Abortion should be isolated from other health care.	"I propose that an abortionist be restricted in practice merely to provide abortion care."
Abortion is political	Pessimism about the potential to discuss abortion productively because it has been so politicized.	"The polarization around abortion makes it nearly impossible to discuss." "This is such a polarizing issue I do not think a consensus can be built." "I trust this is medical and not political research."
	Abortion politics have undermined physicians' medical expertise.	"I think that the intrusion of legislators into health care decisions is a travesty. It is that mindset that does not make me like being a physician in this state, and I have on occasion considered leaving, though not just on this issue." "I am more worried about the political thinking of physicians interfering with appropriate care than politicians." "I am shocked that this has become such a political problem and has not remained a physician-patient problem."
	Participants question whether a publicly funded health care system should engage in abortion care.	"Offering abortion services in a public university supported by taxpayers is too controversial and violates the conscience of many taxpayers." "While many people [in urban areas] probably support your efforts, we have to remember that a large and vocal majority of conservative people also live throughout the state, are taxpayers, and use [health care] services."
	Participants mention concerns about specific policies.	"I think overturning Roe vs Wade would overstep the boundaries of government and remove free will from the patient." "I think that health care for women has suffered and I fear that it will continue to get worse if there continues to be restrictive changes to the laws."
NUANCES AND AMBIVALENCE		
Personal responsibility	People seeking abortions typically have carefully considered their options and are taking responsibility for their lives.	"Most patients I have interacted with consider having an abortion very carefully." "No woman I have ever provided anesthesia for who received an abortion ever made this choice frivolously."
	People who are against abortion assume that patients have failed to take personal responsibility.	"It is apparent that the 'right to life' anti-abortion forces have a very distorted view of why women have abortions… No one in the 'pro-abortion' camp thinks abortion is a good form of birth control."
	Needing or having an abortion represents a lack of personal responsibility.	"This is a problem that is much greater than abortion in America, which is TAKING RESPONSIBILITY [sic] for your own actions." "A woman should absolutely have control and say over her body… This does include who and what precautions she takes or has the male partner take to prevent pregnancy."
Personal beliefs vs needs of others	A provider's religious or political beliefs should not dictate whether a patient has access to abortion care.	"I personally have strong beliefs against abortion but also feel that it is my job as a physician to provide patients medical facts and options and not impose my personal views on them and their decisions. So I hope the survey reflects this dichotomy in my personal beliefs and how I would act towards patients." "Though I might pray that individuals choose against abortion except in the most medically serious circumstances, I know this is a decision I should not make for the patient. It is a decision she must make for herself. And shame on me if I were ever to judge someone for such a choice."
	Participants were against abortion for themselves but would not restrict options for others.	"I would personally struggle if I had to undergo an abortion, but also do not feel that any woman should be forced to proceed with a pregnancy against her wishes." "I am pro-life, I have been offered an abortion and declined… but politically + professionally I am pro-choice. A woman should be informed and allowed to choose."
	There may be professional consequences for particular personal beliefs.	"It is very difficult to be a faculty member in this department with any degree of opposition toward termination, and those individuals are silenced and devalued by the leadership."
Conditional support	Abortion is only a morally acceptable choice in cases of threat to maternal life, fetal anomalies incompatible with life, or when the pregnancy is the result of rape or incest.	"I acknowledge that abortion is unequivocally necessary and morally justifiable in cases of rape." "In the tragic cases of rape and incest and for the question of saving the life of the mother, my degree of moral objection is much less than in other cases, and the particular instances would require the utmost of care and sensitivity for the people suffering in this abominable way, and, based on particulars of the case, may even be 'morally ambiguous'." "The questions that lumped together 'rape, incest, and life-threatening conditions' were difficult to answer as I personally believe that conditions that threaten the life of the mother should be its only category based on the ethical beliefs around beneficence."

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Table. Each of the 12 Unit Groups, Themes Within Each Group, and Exemplars of Units in Each Group *(continued from page 215)*

Unit Group	Themes	Exemplars
Conditional support *continued*	"Late-term" or third trimester abortions are less or not at all morally acceptable.	"The only restriction I would support is eliminating late abortions." "My only headscratcher is what to think about third trimester abortions or, more specifically, when the fetus can almost certainly survive outside the womb. For example, is 1 day before the due date OK? 4 weeks before? Should this change with technological advances in preemie care?... I also have no answer to it if the scientific line between fetus and infant is legitimately difficult to define." "It would have been nice to comment how late-term abortions can be classified as morally repugnant." "If she has become pregnant and decides very late in the pregnancy, at the point of fetal viability, that she does not want the child, it is not morally acceptable for her to arbitrarily choose to have the pregnancy aborted, which is taking a life."
INDIVIDUAL-STRUCTURAL INTERFACING		
Religion	A provider's religious beliefs should not dictate whether a patient has access to abortion care.	"I tried to differentiate between my moral views on abortion vs. my professional duties. As a Catholic I'm strongly opposed to abortion. As a medical provider, I feel that the patient should be aware of all options available to her, including abortion, and the provider should not seek to sway the patient based on the provider's moral stance." "Religion should not be allowed to dictate the care of someone who does not participate in that religion; this is a form of religious persecution."
Medical referrals	Providers who do not do abortion-related work would help a patient find an abortion provider.	"If I had a patient who asked me for help finding her a resource to get [an abortion], I would ask no other questions and I would find one for her." "I would not provide a formal referral for abortion but would inform a patient that abortion is an option they could consider if it is permissible within their moral framework and would suggest other options for obtaining a referral to discuss abortive options."
	Participants do not know where to refer patients who might need abortion services.	"I wouldn't even know where to refer a patient besides sending to Planned Parenthood." "It would be very helpful to get resources to primary care providers about who to call to refer for an abortion; I used to know the number during residency but not now, 20 years later."
Medical training	Participants had concerns about the inadequacy of abortion-related training and the resulting impact on provider competency, patient access, and abortion safety.	"My medical school and residency program were not allowed to provide formal training of any kind." "I think it is difficult for residents to get enough training in this procedure, which is the only reason I would doubt a physician's skills in performing it."
	Participants were interested in pursuing and/or supporting abortion-related training.	"[I] would like to know how I can better support the training of abortion providers and the provision of safe, appropriate abortion services in the [health system] and [local] community."
STRUCTURAL		
Other options counseling	Patients should receive counseling for options other than abortion.	"The resources available to a pregnant patient through external organizations or the option for adoption even with serious abnormalities were never presented to patients struggling with difficult decisions." "I would support all other reproductive services, social supports, and good adoption service referrals if she chose not to parent the child." "I struggle to find the right thing to do to help women who seek abortion, for whatever reason they state, and I wish abortion was not needed in this world. But, I do understand the circumstances in which women do seek abortion, and I wish we had other alternatives so that abortion was not needed and women's needs were met, all at the same time."
Concerns about abortion provider safety	Abortion providers are subject to harassment and violence, which presents a major problem for the workforce.	"I would say that one of the major reasons more medical professionals do not participate in abortion services is the fear of harassment or violence against them and their family." "For me, the biggest problem with abortion care is the question of personal safety... There are a lot of extreme anti-abortion groups in [our state], and safety is a huge issue for anyone working in the field." "Support of safe practice/safety for practitioners and patients is one of the top legislative issues."
Rare, safe, and legal	Abortion is not desirable but should remain available when absolutely necessary.	"I think we should do everything we can to make abortion less necessary... An abortion can be seen, to some extent, as some failure in our system to provide choice and care. Despite these misgivings, if a woman becomes pregnant with a child she does not want for any reason, she should have full choice about her options." "I am pro-choice which does not mean I am pro-abortion (who really ever wants that) but my pro-choice trumps all." "I support safe and legal ACCESS [sic] to abortion much more than I support or like the procedure itself."
	Comprehensive pregnancy prevention programs and services should be offered to limit the need for abortions.	"A principle that would work... would explicitly focus on reducing the number of abortions by policy (eg, prevention of teenage pregnancy) while preserving the right to have an abortion." "The anti-abortion lobby contributes to the number of abortions by opposing sex education, which includes birth control and access [to] contraceptives."
	Making abortion illegal would place patients in danger.	"Politicians who dare to think about overturning Roe & Wade [sic] should think first about the consequences of their decision, because abortions will still happen illegally in that case and have much more devastating consequences. They should learn from the experiences of other countries around the world, which have been forced into such ban!" "Women should have the right... to not be subjected to more likely medical complications and death by restricting a procedure that is not without risks but far safer than if it were done illicitly."

on patients (eg, "I personally have strong beliefs against abortion but also feel that it is my job as a physician to provide patients medical facts and options and not impose my personal views on them and their decisions."). This tension sometimes extended to physicians' feelings about coworkers, as described by one respondent:

> I wanted to provide additional explanation regarding how I answered one of the earlier questions concerning abortion providers' 'conscience.' I answered that abortion providers are attentive to their conscience 'less' than other providers. This response was based on a perspective that I hold—namely one that believes that universal abortion care is in conflict with good conscience. However, I also recognize that many health care professionals that provide or participate in the provision of abortion care believe (deep within their conscience) that this form of health care provision is morally right and, as such, their provision of abortion is consistent with THEIR worldview, and, as such, they are attentive to their conscience as much, if not more, than other physicians.

Many participants articulated circumstances in which they found abortion to be morally acceptable or unacceptable. The "conditional support" group encompassed ideas about abortion being acceptable only early in pregnancy or in cases of threat to maternal life, fetal anomalies incompatible with life, or rape. One respondent admitted that they "have no answer" to the complicated question of gestational limits.

Individual-Structural Interfacing

Three unit groups reflected nuances related to individuals' interactions with a larger social system. The "religion" group largely consisted of units expressing the idea that one's religious beliefs should not dictate whether abortion is offered or available to patients. Some units in this group specifically rejected the abortion-related teachings of respondents' religious institutions.

Two other unit groups reflected clinicians' interactions with health care systems. A group called "medical referrals" contained units that expressed clinicians' willingness to help patients access abortion through referral, ranging from proactively connecting patients with abortion providers to simply acknowledging that abortion is a legal option. This group also included units expressing that respondents did not know where to refer patients for abortion services. Finally, the "medical training" group reflected participant concerns about inadequate abortion training and resulting effects on clinician competency, and participants' interest in or support for abortion-related training.

Structural

Finally, 3 unit groups reflected ambivalence or nuanced views about structural issues related to abortion. The "other options counseling" group contained opinions that patients should receive high-quality or thorough counseling about alternatives to abortion if they do not want to parent a child. Some of these units implied that alternative options should be offered in place of abortion access, while others suggested that a range of options be discussed alongside abortion counseling.

The "concerns about abortion provider safety" group addressed how abortion providers can be subject to harassment and violence from anti-abortion activists. These units characterized the fear (or reality) of this violence as a structural reason why health care providers may choose not to participate in abortion care.

Finally, a large group of units expressed the point of view that abortion should be "safe, legal, and rare," implying that abortion is undesirable but the public health consequences of restrictive policies are worse. Units in this group mentioned respondents' specific ideas about how to make abortion rare (eg, comprehensive sex education and contraceptive access) and expressed how illegally obtained abortions would be both inevitable and dangerous.

DISCUSSION

Our findings support previous literature suggesting that physicians have nuanced abortion attitudes and extend those observations to specialties outside of reproductive health care. Nearly a quarter of our sample responded to an optional free-response question at the end of a lengthy survey, expressing ideas that may have been missed or misrepresented by closed-ended survey questions. Many stated that their nuanced, specific, and contextual abortion attitudes had been silenced in their professional lives.

Some physicians also expressed detachment or indifference regarding abortion. This often took the form of deflection, with participants characterizing themselves as removed from the abortion debate either by personal lack of interest or because they practice a specialty not routinely involved in abortion care. Detachment also emerged in the form of vague comments that abortion is a "complicated," "difficult," or "political" subject.

A common type of ambivalence was reflected in the framing that abortion should be "rare, safe, and legal." This sentiment conveys that clinicians may value certain abortion outcomes (eg, bodily autonomy, saving maternal lives, or preventing inevitable infant suffering and death), but disdain other aspects of abortion (eg, ending what the respondent defines as a human life or introducing significant risk). Seeing abortion as a "necessary evil"—harm that is justified in the pursuit of a broader social good—is antithetical to the "pro-choice" versus "pro-life" dichotomy and may be morally distressing to some physicians.[26]

Our findings also suggest that influences on physicians' abortion attitudes are similar to those affecting the general public, including political affiliations, religious beliefs, and personal experiences with pregnancy, childbearing, and infertility. The idea that physicians' abortion attitudes may stem from factors outside of medical and scientific data may be of concern; however, our findings suggest that many physicians aim to separate their personal attitudes from their medical practices.

Notably, some physicians in our sample reported hesitance to provide abortions due to threats to their own safety, rather than moral ambiguity. While physician voices of support could be instrumental in increasing abortion access at multiple levels,[18] it may be unreasonable to expect all abortion providers—regardless of their enthusiasm—to speak openly about their work, given the safety issues involved in doing so.[17] Our study further indicates that fears about safety among abortion providers and advocates meaningfully impact the medical discourse around it.

Limitations

Several limitations of this study should be considered. First, free-response opportunities allow survey participants to elaborate upon quantitative responses or provide context beyond the questionnaire, but they do not allow researchers to follow up. Thus, the data analyzed here lack some of the detail that traditional qualitative methods generate. Nonetheless, in many cases, these data describe not only what physicians think about abortion but how they think about it. Alongside the quantitative results,[18,22] these findings can help future researchers examine the attitudes of the substantial proportion of physicians who do not place themselves on the extreme ends of the "pro-life" versus "pro-choice" spectrum.

We also cannot determine the extent to which the 67% of physicians who responded to the larger survey represent the entire population. If response bias occurred, we cannot know whether responders tended to be those with special interest in the topic, enthusiastic supporters, or vehement opposers. Regardless, we did not aim to develop a generalizable measure of physician attitudes, but rather to understand the nuances in abortion attitudes expressed by a group of people empowered to facilitate or deny access to abortion.

Implications

New approaches to abortion discourse with physicians may contribute to broader efforts to work towards reproductive justice. Reproductive justice is a set of principles that affirm "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[27,28] Reproductive justice takes a broader view than the reproductive rights framing, incorporating access to abortion as one—but not the only—critical issue. Resisting the pervasive "for or against" framing, we may generate broader consensus around the shared values of autonomy over reproduction and healthy family-making. Encouraging or allowing more nuanced conversations about abortion within and outside of public health spheres might feasibly result in greater access to abortion by inviting physicians to enact the nuances of their consciences. For some people, this might mean declining to participate in a few abortion cases or actively referring those cases to physicians who do not have the same moral objections they do. For others, it might mean that, occasionally, they will feel that abortion is justifiable and help facilitate it.

Unfettering the conversation in this way could engage a broader spectrum of reproductive justice allies and address structural issues that result in what are perceived as only bad options. For example, this framing might invite physicians who think about abortion as a "necessary evil" to contribute to the reproductive justice-oriented goals of effective sex education, universally accessible contraception, policy supports for parents and families, and expanded health coverage. This shift could also reframe the concept of "conscientious objection" as the only option for managing gaps between clinicians' personal moral frameworks and patients' needs for abortions. "Conscientious provision" posits abortion provision (and not just objection) as an act of conscience and centers clinicians' obligations to meet patients' needs and offer all available medical options.[2,29]

This shift in messaging about abortion also may combat the assertion that many of our respondents made: that certain medical specialties have "nothing to do" with abortion. This is especially significant for specialists in fields like psychiatry, pathology, pediatrics, and anesthesiology, who are likely to encounter a patient or clinical situation involving abortion. Some specialty providers may represent some patients' main access point to health care.

Implications for Practice

Our study highlights the need for intervention to destigmatize abortion, particularly among those who feel ambivalent or exempt from an opinion, because these attitudes ultimately may lead to decreased or delayed access and quality of care. Given that risk of abortion-related morbidity and mortality increases with gestational age,[30] reducing delays in abortion access protects the health of pregnant people.

"Values clarification" exercises have been shown to decrease abortion stigma among health care providers.[31] Participants reflect on their abortion attitudes, how those attitudes align or conflict with their values, and how they might be influenced by broader sociocultural forces. Through this process, participants arrive at more nuanced opinions about abortion care and intentions to support abortion care increase, especially among those with the most negative baseline attitudes.[32] Fostering communication about abortion among clinicians, administrators, and key stakeholders may lead to improved access to care, clinical outcomes, and patient satisfaction.

Future Research

Our data suggest that dichotomous abortion discourse is dissatisfying to physicians. Future research might test messaging or communication strategies to create a more justice-oriented climate around abortion in health care settings and to reduce hostility and mistrust between clinicians who have different views.

Finally, it remains unclear how much clinicians' attitudes and opinions about abortion (among both general supporters and general opposers of abortion) results in abortion-related stigma felt by patients. Studies that focus on patient experiences with clinicians who hold various attitudes toward abortion would help identify priority areas for intervention to reduce stigma experienced by patients seeking abortion or with a history of abortion.

ENDNOTE

The data and analysis reported here were completed before the 2022 *Dobbs v Jackson Women's Health Organization* Supreme Court decision,[33] which overturned the court's previous ruling in *Roe v Wade*.[24] This decision has created a new legal and political context surrounding abortion in Wisconsin and beyond. Thus, more research should be conducted regarding physicians' attitudes and behaviors related to abortion in this new context.

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REFERENCES

1. Harris LH, Cooper A, Rasinski KA, Curlin FA, Lyerly AD. Obstetrician-gynecologists' objections to and willingness to help patients obtain an abortion. 2011 Dec;118(6):1424]. *Obstet Gynecol.* 2011;118(4):905-912. doi:10.1097/AOG.0b013e31822f12b7

2. Harris LH. Recognizing conscience in abortion provision. *N Engl J Med.* 2012;367(11):981-983. doi:10.1056/NEJMp1206253

3. Jelen TG, Wilcox C. Causes and consequences of public attitudes toward abortion: a review and research agenda. *Polit Res Q*. 2003;56(4):489-500. doi:10.1177/106591290305600410

4. Feldman S. Answering survey questions: the measurement and meaning of public opinion. In: Lodge M, McGraw KM, eds. *Political Judgment: Structure and Process*. The University of Michigan Press; 1995:249-270.

5. Alvarez RM, Brehm J. American ambivalence towards abortion policy: development of a heteroskedastic probit model of competing values. *Am J Polit Sci.* 1995;39(4):1055-1082. doi:10.2307/2111669

6. Craig SC, Kane JG, Martinez MD. Sometimes you feel like a nut, sometimes you don't: citizens' ambivalence about abortion. *Polit Psycho*l. 2002;23(2):285-301. doi:10.1111/0162-895X.00282

7. Zaller J, Feldman S. A simple theory of the survey response: answering questions versus revealing preferences. *Am J Polit Sci*. 1992;36(3):579-616. doi:10.2307/2111583

8. Homaifar N, Freedman L, French V. "She's on her own": a thematic analysis of clinicians' comments on abortion referral. *Contraception*. 2017;95(5):470-476. doi:10.1016/j.contraception.2017.01.007

9. Bennett CL, McDonald DA, Finch A, Rennie S, Morse JE. North Carolina medical student views on abortion. *N C Med J*. 2018;79(1):14-19. doi:10.18043/ncm.79.1.14

10. Martin LA, Seewald M, Johnson TRB, Harris LH. Martin LA, Seewald M, Johnson TRB, Harris LH. Trusted colleagues or incompetent hacks? Development of the Attitudes About Abortion-Providing Physicians Scale. *Womens Health Issues*. 2020;30(1):16-24. doi:10.1016/j.whi.2019.09.002

11. Astbury-Ward E. Staff perspectives. In: Rowlands S, ed. *Abortion Care.* Cambridge University Press; 2014:211-218.

12. Brown SD, Donelan K, Martins Y, et al. Does professional orientation predict ethical sensitivities? Attitudes of paediatric and obstetric specialists toward fetuses, pregnant women and pregnancy termination. *J Med Ethics*. 2014;40(2):117-122. doi:10.1136/medethics-2012-101126

13. Britton LE, Mercier RJ, Buchbinder M, Bryant AG. Abortion providers, professional identity, and restrictive laws: a qualitative study. *Health Care Women Int.* 2017;38(3):222-237. doi:10.1080/07399332.2016.1254218

14. Chung GS, Lawrence RE, Rasinski KA, Yoon JD, Curlin FA. Obstetrician-gynecologists' beliefs about when pregnancy begins. *Am J Obstet Gynecol.* 2012;206(2):132.e1-132.e1327. doi:10.1016/j.ajog.2011.10.877

15. Dodge LE, Haider S, Hacker MR. Attitudes toward abortion among providers of reproductive health care. *Womens Health Issue*s. 2016;26(5):511-516. doi:10.1016/j.whi.2016.06.005

16. Chuang CH, Martenis ME, Parisi SM, et al. Contraception and abortion coverage: what do primary care physicians think? *Contraception*. 2012;86(2):153-156. doi:10.1016/j.contraception.2011.11.069

17. Harris LH, Martin L, Debbink M, Hassinger J. Physicians, abortion provision and the legitimacy paradox. *Contraception*. 2013;87(1):11-16. doi:10.1016/j.contraception.2012.08.031

18. Higgins JA, Schmuhl NB, Wautlet CK, Rice LW. The importance of physician concern and expertise in increasing abortion health care access in local contexts. *Am J Public Health*. 2021;111(1):33-36. doi:10.2105/AJPH.2020.305997

19. Freedman L. *Willing and Unable: Doctors' Constraints in Abortion Care.* Vanderbilt University Press; 2010.

20. Freedman L, Landy U, Darney P, Steinauer J. Obstacles to the integration of abortion into obstetrics and gynecology practice. *Perspect Sex Reprod Health.* 2010;42(3):146-151. doi:10.1363/4214610

21. Bazelon E. The new abortion providers. *New York Times*. July 14, 2010. Accessed November 13, 2020. https://www.nytimes.com/2010/07/18/magazine/18abortion-t.html

22. Schmuhl NB, Rice LW, Wautlet CK, Higgins JA. Physician attitudes about abortion and their willingness to consult in abortion care at a Midwestern academic medical center. *Contraception*. 2021;104(3):278-283. doi:10.1016/j.contraception.2021.04.030

23. Dykema J, Jones NR, Piché T, Stevenson J. Surveying clinicians by web: current issues in design and administration. *Eval Health Prof*. 2013;36(3):352-381. doi:10.1177/0163278713496630

24. *Roe v Wade*, 410 US 113 (1973).

25. Jackson KM, Trochim WMK. Concept mapping as an alternative approach for the analysis of open-ended survey responses. *Organ Res Methods*. 2002;5(4):307-336. doi:10.1177/109442802237114

26. Margolis JD, Molinsky A. Navigating the bind of necessary evils: psychological engagement and the production of interpersonally sensitive behavior. *Acad Manage J.* 2008;51(5):847-872. doi:10.5465/amj.2008.34789639

27. Ross L. Understanding reproductive justice: transforming the pro-choice movement. *Off Our Backs*. 2006;36(4):14-19.

28. Reproductive justice. SisterSong. Accessed February 4, 2021. https://www.sistersong.net/reproductive-justice

29. Parker W. *Life's Work: A Moral Argument for Choice*. Simon and Schuster; 2017.

30. Bartlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol.* 2004;103(4):729-737. doi:10.1097/01.AOG.0000116260.81570.60

31. World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems.* 2nd ed. World Health Organization; 2012. Accessed May 1, 2021. https://www.ncbi.nlm.nih.gov/books/NBK138196/pdf/Bookshelf_NBK138196.pdf

32. Turner KL, Pearson E, George A, Andersen KL. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. *Reprod Health.* 2018;15(1):40. doi:10.1186/s12978-018-0480-0

33. *Dobbs v Jackson Women's Health Organization*, 2022. Accessed August 2, 2022. https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

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