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Abstract
This study aimed to elicit some of the affective attributes in nurses and midwives involved in caring for those undergoing abortion and explore how they may affect the care given. Nurses and midwives face challenges in caring for women during abortion. Recent advances have resulted in more nursing/midwifery input into abortions. Impending legislation is also likely to increase nursing involvement and yet little is known of the likely impact on those involved. Twelve nurses and midwives working in termination of pregnancy services throughout Wales were interviewed using a grounded theory approach. An early affective attribute was being non-judgemental, but the core category derived from comparative analysis revealed that nurses and midwives conceded judging the women, but then concealed their judgements. To help them conceal their judgements maxims were used such as 'there but for the grace of God go I'. Goffman's work on stigma was used to challenge and integrate the grounded theory into the literature. As being non-judgemental is an aspiration, acknowledging that judgement occurs may be more appropriate for clinical nurses in order for them to devise strategies to conceal judgements in a considered manner.

Keywords
abortion, grounded theory, gynaecology nursing, medical/surgical termination of pregnancy, stigma

Introduction

Induced abortion remains a contentious issue that raises polemic debate from both pro-choice and pro-life lobbies. In 2006, 193,700 abortion were performed in England and Wales, a rise of 3.9% from 2005 (Department of Health, 2007).

Abortions can be performed in two ways (RCOG, 2004): through vacuum aspiration, a minor surgical procedure usually performed under general anaesthetic, or via administration of two stages of medication. The first stage of medication is administered to the woman

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as an outpatient and the second stage is given in hospital where the woman aborts after around 6 hours. The method of early medical abortion has been refined since 1991 when it was first introduced to the UK and in 2006 accounted for 30% of the total in England and Wales, the proportion more than doubling in the previous 5 years (Department of Health, 2007). Sixty five percent of abortions took place under 10 weeks compared with 51% in 2002. Unlike surgical abortion, a minor surgical procedure where the woman is unaware, in first trimester medical abortion the nurse/midwife remains with the woman as the medication takes effect and the foetus is expelled, ostensibly undergoing the experience with them.

Government response to a recent Parliamentary Select Committee recommended an increase in nurses' responsibilities in abortion care and treatment (Secretary of State for Health, 2007). Allowing early (first trimester) medical and surgical abortions to be nurse-led was also supported by the British Medical Association (BMA, 2007). This would include, subject to appropriate training, prescribing abortifacients for medical abortions and performing early surgical abortions. These increases in responsibilities would require a change in legislation, currently being debated in Parliament.

The rise in the number of abortions, particularly medical abortions together with the potential increase in nursing/midwifery input as a result of impending legislation forms the rationale for this research.

Background and literature review

Several studies have been undertaken into the views of nurses and midwives on abortion. Alex and Hammarstrom (2004) researched women's experiences undergoing abortions in Sweden. They concluded nurses and midwives needed to be aware of the complexity of abortion in order to support and empower the women. However, in order to do this, it is important that nurses/midwives are cognisant of the effect of their own intense involvement in such a complex experience.

Another Swedish study attempted to gain the views of midwives and gynaecologists involved in abortion (Hammarstedt *et al*., 2005). They found the participants deeply committed to the issue with few dropouts. The majority supported legislation on induced abortion and believed the decision for abortion was the woman's alone. In general, there were few differences between the two professions, but attitudes improved over time when exposed to abortion. When comparing their results with those of two earlier studies they concluded that respondents had become less restrictive in their views to abortion over time (Hammarstedt *et al*., 2005). An erstwhile UK quantitative study by Marshall *et al*. (1994) explored nurses' attitudes towards abortion and in contrast to Hammarstedt *et al*. (2005) they discovered that attitudes deteriorated over time.

McCreight (2005), in her study of perinatal grief through unintentional loss, emphasised the challenges of nurses simultaneously managing their own emotions alongside those of the women. Although the emotions of the women may differ in abortion, it is plausible to extrapolate these data to the challenges faced by nurses/midwives in managing their own emotions in medical abortion.

A mixed method study set out to capture the effects of abortion on nurses and was performed during the first year of legalised abortion in South Africa (Poggenpoel *et al*., 1998). It found amongst other things that nurses would like to be able to choose whether to be involved and that they felt turmoil regarding life and death.

Despite this research, no study has elicited from nurses the affective attributes they require for working in abortion care. It is the intention of this research to provide a baseline from which further research can be undertaken as the nurse/midwife contribution to abortion care increases.

Aims of the study

The aims of the study were (1) to determine the affective attributes of nurses/midwives involved in abortion and (2) to explore how the attributes affect care given by nurses/midwives involved.

Method

Grounded theory was chosen because it allowed exploration of an emerging situation in abortion care. Early medical abortion is a relatively new phenomenon and has been introduced in most trusts in the last decade. The attributes necessary for greater involvement of nurses/midwives in abortion care has not been explored making grounded theory an appropriate method, helping to make sense of its social processes and social structures (Polit and Beck, 2006). The specific attraction of grounded theory was its pedigree; combining the qualitative approach of Strauss and the quantitative background of Glaser (Strauss and Corbin, 1990). This was a method developed to put a systematic slant on what could otherwise be a chaotic experience. Nevertheless the intellectual creativity necessary in analysing data grounded in practice is highly valued in this approach (Strauss and Corbin, 1990) making it a suitable method for this study.

Heath and Cowley advocate that novice researchers should set aside 'doing it right anxiety' and adhere to the major principles of grounded theory. As a relatively novice researcher undertaking this study, the present author also had the responsibility to ensure that it was undertaken rigorously. To aid this I have adhered to principles for ensuring rigour in grounded theory outlined by Chiovitti and Piran (2003). I leave it to the reader to decide the level of rigour based on Table 1.

Methodology

King (1994) differentiates method as the mechanical way in which data are collected compared with the underpinning epistemology or methodology. Symbolic interactionism was used to underpin this grounded theory study. It was founded by George Herbert Mead and then defined and refined by Herbert Blumer (1969). It is centred at the individual rather than the societal level and it aims to explain the meanings of interactions between actors, their actions and the actions of others (Porter, 1998). For example, we attach cultural significance to abortion even though the process of undergoing a minor medical procedure could be applied in many different situations. The meaning of this process to those who care for women undergoing abortion has been symbolically constructed in a very different way to any other minor procedure. The symbols associated with abortion were interpreted by the participants in this research (Porter, 1998). Although synonymous with grounded theory, the application of symbolic interactionism was held in abeyance until data analysis was underway to avoid premature conceptualisation (Polit and Beck, 2006).

Table 1. Principles for ensuring rigour in grounded theory (adapted from Chiovitti and Piran (2003))

Standards of rigour	Suggested methods of research practice	Methods to ensure rigour in this study
Credibility	1. Let the participants guide the inquiry process.	Constant comparative analysis.
	2. Check the theoretical construction generated against the participants' actual words in the theory.	Verbatim quotes used in the findings section.
	3. Use participants' actual words in theory.	Judgements, maxims ('there but for the grace of God go I').
	4. Articulate the researcher's personal views and insights about the phenomenon explored by means of:	
	a. Postcomment interview sheets used as a tool	Reflexive journal used.
	b. A personal journal	
	c. Monitoring how the literature was used	Literature was used in the background and discussion
Auditability	5. Specify the criteria built into the researcher's thinking.	An outline of methodology used.
	6. Specify how and why participants in the study were selected.	Outlined in section on participants
Fittingness	7. Delineate the scope of the research in terms of the sample, setting and level of the theory generated.	Delineated in the abstract.
	8. Describe how the literature relates to each category which emerged in the theory.	Using the categories as headings, literature was drawn upon in the discussion.

The participants

Letters were sent to all nurses/midwives working where abortions take place at all NHS trusts in Wales, UK via the nurse/midwife lead. Twenty-seven expressed an interest in participating in the research out of around 250 who potentially care for women undergoing surgical and medical abortions. The decision of who to interview was made on a purposive basis ensuring a reasonable geographic and trust spread (O'Leary, 2005). Homogenous sampling was used which enabled the abortion subgroup of nurses and midwives in gynaecology to be accessed (Norwood, 2000). Purposive sampling in grounded theory allows a greater potential for data saturation (Morse, 1995). Twelve participants were purposively chosen from 9 of the 13 trusts in Wales. They were chosen as the study progressed allowing its direction to be guided by the initial findings (Parahoo, 1997). The participants chosen were viewed as being able to contribute substantially to the research, as they were experienced in the field of gynaecology and termination of pregnancy ranging from 10 to over 30 years experience. There were five nurse/midwife specialists, one midwifery practitioner, two family planning nurses, three ward sisters and a ward staff nurse. The educational background of the participants varied from being graduates to having received very little post-registration education. Four of the participants were known to the researcher on a professional basis prior to the interviews. All potential participants, who expressed an interest but were not recruited, were contacted and thanked for their offer to participate.

Ethical and research governance issues

Prior to the study ethical approval was obtained from the UK NHS Multiple site Research Ethics Committee (MREC) and the Research and Development committees for each NHS trust in Wales. MREC guidance was followed to ensure safety, anonymity and confidentiality of written and recorded information. Owing to the sensitive nature of the topic and the potential for discomfort of the participants and the researcher, strategies were put in place to deal with this. For example, the telephone number of a Welsh-speaking academic colleague with abortion expertise was given to all participants to enable debriefing following the interviews. The researcher had a number of identified clinical and academic colleagues to approach for debriefing within confidentiality guidelines. Direct quotes have been identified by interview number to protect identity. To enhance flow and anonymity, the term 'nurse' is used to include all of the participants and their specialities.

Data collection and analysis

Data were collected by individual interviews, which were held at a time and location of the participant's choice. A MREC approved topic guide was used as a prompt for the interviews. The stem question was 'what attributes do you consider important in a nurse/midwife dealing with women undergoing termination of pregnancy?'. Each interview took between 40 and 60 minutes. All interviews were audio taped, with permission, using a digital recorder. This allowed the interviews to be stored digitally, which the researcher transcribed verbatim. A transcript of the interview was returned to each participant for them to be able to validate the accuracy of the data.

Grounded theory demands sensitive interpretation of complex data and ways of rigorously exploring themes and discovering and testing patterns and NVivo 7 was used to assist in achieving this. Initially it seemed stilted and artificial, subtracting something from the intellectual endeavour. However, as the researcher became more familiar with the program the process became less contrived and focus shifted to the data. Supplementary data was drawn upon to augment the interviews such as field notes and a reflexive journal.

Data were collected and analysed concurrently using constant comparative analysis (Strauss and Corbin, 1998). Initially 48 open codes were established from the data. This served the purpose of fracturing the data (Boychuk-Duchscher, 2004) allowing identification of categories and subcategories of which 10 were initially derived. As the interviews progressed, concepts were repeatedly present that had theoretical relevance resulting in 25 open codes that were incorporated into four axial codes. Eventually no new categories were found which was consistent with data saturation (Charmaz, 2006). Intra-axial coding (Tables 2–5) was then performed followed by inter-axial coding (Table 6). Selective coding then provided the platform for integration of the categories and selection of the core category or central phenomenon of 'conceding and concealing judgements' (Figure 1). Describing the process of how the grounded theory was generated via these tables adds to its reliability (Appleton, 1995).

Findings

As can be seen in Figure 1, the model based on the emerging grounded theory is complex and due to the large amount of data from the original study, results cannot described in full. The author takes responsibility for selecting and editing the material and acknowledges that

Table 2. Intra-axial code: conceding, concealing judgements

Paradigm model	Codes
Phenomenon	**Conceding, concealing judgements**
Causal condition	Woman's decision for abortion
Context	Procedure of abortion:
	Assessment
	Admission
	Procedure
Intervening conditions	Reason for abortion
	Repeat abortion
	Existent foetus
Action/interaction strategies	Treating everyone differently
	Use of maxims:
	'There but for the grace of God'
	'Do as you would be done by'
Consequences	Concealing judgements

Table 3. Intra-axial code: expertise in abortion

Paradigm model	Codes
Phenomenon	**Expertise in abortion**
Causal condition	Career in gynaecology
Context	Caring for women at a specific point on abortion pathway
Intervening conditions	Perceived lack of counselling skills
	Abortion knowledge
	Life experience
Action/interaction strategies	Offering advice, offering options
Consequences	Role satisfaction

Table 4. Intra-axial code: personal values and more

Paradigm model	Codes
Phenomenon	**Personal values and mores**
Causal condition	Personal experiences
Context	Current position
Intervening conditions	Abortion knowledge Woman's response to abortion
Action/interaction strategies	Displaying attributes
	Coping mechanisms
Consequences	Justification of abortion role

omissions may be of equal or greater significance to the theory (Horsburgh, 2002). Many affective attributes emerged during the interviews. Those most commonly cited were being a good listener and being open-minded. However, being non-judgemental was cited by all but one participant as a necessary attribute and the core category of 'conceding and concealing

Table 5. Intra-axial code: abortion continuum

Paradigm model	Codes
Phenomenon	**Abortion continuum**
Causal condition	Medical abortion, surgical abortion, miscarriage
Context	Legislation
Intervening conditions	Advances in practice
	Conscientious objection by colleagues
	Interpretation of legislation
	Existent foetus
	Context constrained decisions
Action/interaction strategies	Caring for women on abortion continuum
Consequences	Providing a worthwhile service

Table 6. Inter-axial coding

Paradigm models	Codes
Phenomena	Abortion expertise
	Conceding and concealing judgement
	Personal values
	Abortion continuum
Causal condition	Personal experiences
	Career in gynaecology
	Woman's decision for abortion
	Medical abortion, surgical abortion, miscarriage
Context	Caring at specific point on abortion pathway
	Abortion procedure
	Current position
	Legislation
Intervening conditions	Advances in practice
	Interpretation of legislation
	Conscientious objection
	Existent foetus
	Context constrained decisions
	Reason for Abortion
	Woman's response to abortion
	Repeat abortion
	Perceived lack of counselling skills
	Abortion knowledge
Action/interaction strategies	Offering advice
	Offering options
	Treating everyone differently
	Displaying attributes
	Coping mechanisms
	Use of maxims
	Caring for women on Abortion continuum
Consequences	Justification of Abortion
	Role satisfaction
	Providing a worthwhile service
	Concealing judgements

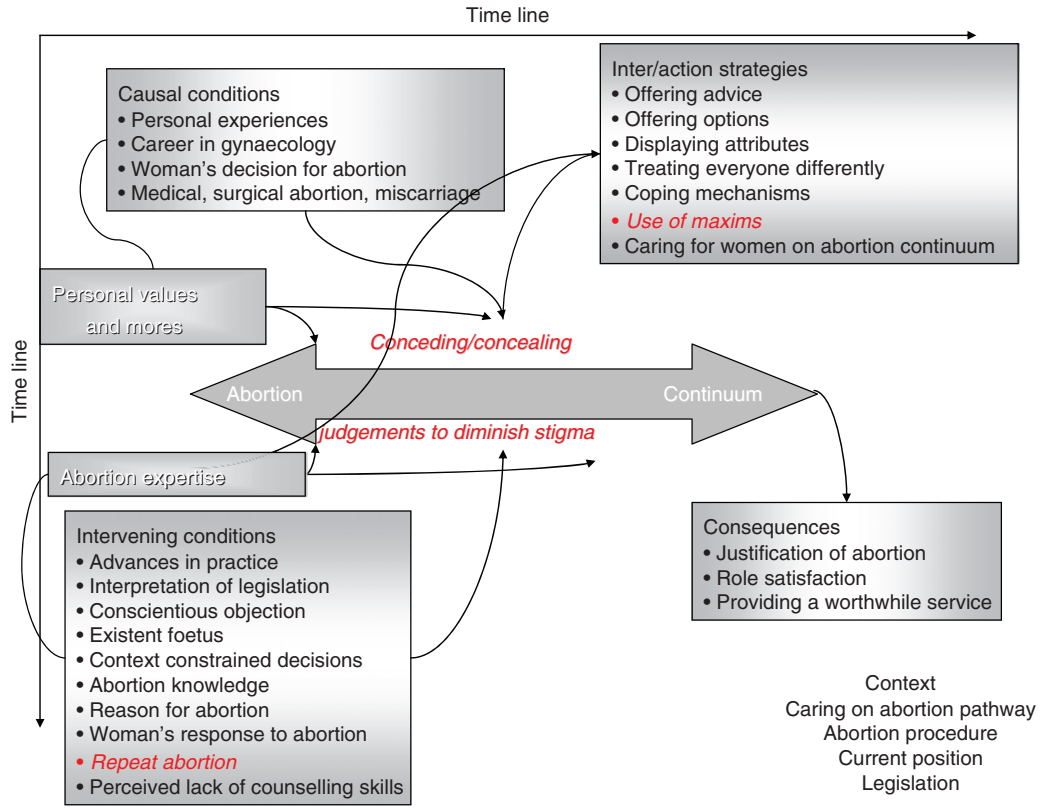

Figure 1. Paradigm model

judgements' was developed from this. The participants conceded that judgements were provoked particularly by 'repeat abortion', a major intervening condition. The 'use of maxims' was used as an interaction strategy to counteract the participants' judgements and enable concealment.

Conceding judgements

The core category was derived gradually from the data, as analysis was undertaken. Although not a core category initially, as the interviews progressed it became clear that all of the participants were keen to cite being non-judgemental as a founding attribute of the abortion nurse. They were unequivocal in their views. This attribute was non-negotiable:

> *'I think really you have got to have an open mind really and be non-judgemental really. You can't judge them really because they have all got different backgrounds and they have all got different histories behind them, social backgrounds, you know'* (Interview 3).
> *'You've got to be non-judgemental that's one of the biggest things and even though you might be shocked at the time you've got to go in without any shock on your face really'* (Interview 10).

As some of the initial interviews were transcribed and analysed the claim for being non-judgemental began to conflict with what was being said. Without exception and unsurprisingly all of the participants judged the women they cared for:

'You know people having intercourse not using contraception, well what do you expect? I love it when they write in abortion clinic ''unfortunately has found herself pregnant''. It tickles me because I think what do they expect?' (Interview 4).
'Some of them look on it as a form of contraception, but that's mainly the social terminations' (Interview 10).

Concealing judgements

Although being non-judgemental was seen as a fundamental attribute for someone caring for women undergoing abortion, when pressed on how that can happen in reality the participants were less clear. A number recognised that they did in fact judge all of the women who attend for abortion but that they concealed their judgements from the women

'I'm not saying we don't talk when they've gone, but you can't be judgemental to them at the time, they must feel that you know? They are not to be judged' (Interview 11).

To express this concealment terms such as 'putting it to one side' and 'keeping it back here' were used. Interestingly in some instances, not only did they conceal their judgements, but they also defended the women against the judgements of others

'To me it's a big decision; it's their (the women's) decision. They can do without people being sanctimonious, or being funny to them. You know they come to the ward and they never say ''I've come for my termination'' only one person said that to me. They say ''I've got an appointment for eight o'clock'' or ''I've come here for a procedure''. They'll never use the word termination' (Interview 4).

The quotes above and below also highlight the disempowered vulnerability of the women attending for abortion:

'We have got assault victims here which I think is another reason why this service is very important. To support them through a decision that they don't want to have to make, but they make because of the situation at home' (Interview 4).

It has been established that despite claiming to be non-judgemental, the participants conceded and concealed their judgements from the women. However, a major intervening condition that provoked judgement was repeat abortions.

Repeat abortions

Despite an initial claim of being non-judgemental, the majority of participants expressed judgement over women using the abortion service multiple times although there was an undercurrent of sympathy for these women

'I know some of them come back year after year for terminations and I don't agree with that to be honest with you. But, erm you give them the benefit of the doubt and there are some tragic circumstances with some of them you know. I feel sorry for a lot of them' (Interview 3).

In some cases, there was concern that the abortion service had failed them:

'It gets a bit frustrating. Because you think "what are we doing wrong from our point of view?" Or is it just that we are giving the information and we are trying our hardest with contraception etc but it just isn't. You can take a horse to water but you can't make it drink sort of thing' (Interview 7).

Overall, it appeared that the number of repeat abortions was low, but that those who attended the service more than once tended to have multiple abortions:

'I just feel numerous abortions oh woah now, I just feel a bit, perhaps are we doing our job properly then, if they are coming back for abortion after abortion after abortion?' (Interview 11).

Use of maxims

To enable concealment of judgements made, the participants used maxims. A maxim is a saying, or statement accepted on its own merits often with a supporting moral message. The participants were able to conceal their judgements and empathise with the majority of women. A number alluded to their own circumstances in an effort to show that it could happen to anyone

'We have all got children of our own and it could happen on anybody's doorstep' (Interview 3).

One sums it up in relation to the use of her own service:

'I think in my head "there is no way on earth I would have an unplanned pregnancy", but I'm sure lots of these women thought that' (Interview 12).

Another referred to a case she had been involved in when a woman had received a back-street abortion. The participant appeared to use this as her paradigm case against which she judged her future actions in abortion with use of a specific maxim:

*'This (*case*) is why, there but for the grace of God go I or whatever'* (Interview 1).

Maxims such as 'do as you would be done by' were used by several participants, which intimates that they empathise with anyone who may need an abortion in particular circumstances:

'I put myself in that situation and I would want somebody to be supportive of me and I treat these ladies as I would want to be treated in that situation' (Interview 6).

The two maxims arise from the duty based theory of Kant with its emphasis on obligation towards treating others with equal respect (Johnstone, 2005).

Discussion

The researcher was familiar with the literature on abortion and relevant studies related to nurses' views on abortion were outlined in the literature review. However, an effort was made to avoid imposing a predetermined understanding on the data by delaying examination of the theories underpinning the study findings until after collection

(Strauss and Corbin, 1998). Throughout this discussion, literature will be drawn on to challenge and locate the emergent grounded theory (Heath, 2006).

Conceding and concealing judgements

Participants claimed that being non-judgemental was a key attribute for nurses involved in abortion. As the interviews progressed, and via constant comparative analysis, the participants conceded judgement particularly in cases of repeat abortion. However, they also revealed strategies to conceal their judgements such as the use of maxims.

There has been some consideration in the nursing literature of the importance of being non-judgemental, but there is little guidance on how nurses can deal with judgements they may make. Koh (1999) argued that non-judgemental care is a professional obligation whereas Hayter (1996) asked whether non-judgemental care is possible particularly in relationship to nurses' attitudes towards patient's sexuality. Hayter presented both sides of the debate and cited Goldsborough (1970) in claiming that being non-judgemental does not mean giving up personal beliefs or changing them to fit with others, it is being aware of their values and the importance of them within their professional relationship with patients. The nurses in this study seemed to subscribe to Goldsborough's (1970) claim in having their own judgements, recognising them and concealing them for the sake of their professional relationship with the patients. This is in contrast to McQueen (1997), in her qualitative research on emotional work in gynaecology nursing where she claimed that nurses caring for women having an abortion seem to avoid considering the patients' circumstances and suspending their judgement.

Bolton (2005), in her longitudinal, qualitative study of gynaecology nursing, conversely found that some nurses were judgemental between themselves and were unable to conceal their judgements being observed as more abrupt in their dealing with some abortion patients. This did not seem to be the case in this study as the participants concealed their judgements in various ways. Some used maxims to overcome judgement and others associated women undergoing abortion with vulnerability and being victims.

The issue of conceding and concealing their judgements as well as viewing some women as victims led to a consideration of Goffman's (1963) work on stigma as abortion remains heavily stigmatised. Stigma originally referred to a brand or mark on Greek slaves, separating them from free men. It is now commonly used to denote a disgrace or defect (Gray, 2002). Even in today's relatively liberal society having an abortion is considered by some to be a disgrace (Major and Gramzow, 1999).

A longitudinal study of 442 women by Major and Gramzow (1999) found that women who felt stigmatised by abortion were more likely to keep it a secret. The associated suppression of thoughts correlated positively with increased psychological distress over time. The need to conceal judgements could be argued to be of great importance when dealing with adolescents as a recent study found that a significant proportion of pregnant adolescents felt stigmatised (Wiemann *et al.*, 2005).

The term stigma was only used by one participant but the concept was evident in the data, for example, one participant described women avoiding the phrase 'termination of pregnancy' when entering the service. This behaviour can be translated into 'felt' stigma in which the woman described would have been feeling ashamed and expecting discrimination (Mak *et al.*, 2007). In fact the participant (Interview 4) specifically defended women against 'enacted' stigma where unfair behaviour (being sanctimonious) by others was

enacted (Scambler, 1998). This chimes with symbolic interactionism, which claims that meaning arises from the process of interaction between people (Blumer, 1969). Thus, the meaning of abortion for the participants transfers to the women through their interactions. By concealing their judgements the participants it could be claimed they reduced the felt stigma.

Symbolic interactionism proposes that by taking the view of others we can see ourselves as they do (Camp *et al*., 2002). Those attending for abortion fall into the category defined by Goffman (1963) as 'newly stigmatised' and must now view themselves as being part of a subgroup that they may previously have renounced.

Repeat abortions

The major intervening condition that influenced the nurses' judgement was repeat abortions. Interestingly, although the participants tended to be more likely to judge the women undergoing repeat abortions they also questioned what they might be doing wrong in allowing this to reoccur. To interpret this through symbolic interactionism, the meaning that the participants attached to repeat abortions was to judge the women, but subsequently judge their own performance as abortion nurses.

Jeffrey (1979) used Talcott–Parson's sick role criteria to measure the legitimacy of casualty patients and when employed in this research it seems that abortion fails to meet the standards of the sick role in two of the four criteria: patients must not be responsible for their illness and they must be restricted in their reasonable activities. This has implications for whether society accepts abortion as a legitimate call on the sick role. For example, if the woman could have avoided her condition, and thus the sick role, by using contraception, then there is likely to be less sympathy for administering treatment, thus stigmatising it further.

In this study, all of the participants viewed women as having a legitimate call on the sick role with the exception of those undergoing repeat abortions. For example, in the sick role patients must not be responsible for their illness and must rely on health professionals for getting better. Overall, the participants did not hold the women requiring abortion responsible and they were accepted into the sick role by being admitted into the service. By requiring repeated abortions these women demonstrated, by not heeding previous advice or taking contraception, that they could be held responsible for their condition. As well as not restricting their 'reasonable activities' (Jeffrey, 1979), in this case using contraception when having intercourse.

The use of maxims

The use of maxims seemed to move participants from conceding to concealing judgement and helped them identify with the women attending the service. The participants stated that it could happen to anyone, even them. This close alliance to the women could be described as possessing an 'affiliate stigma'. This describes the identification of individuals closely associated with the stigmatised (Mak *et al*., 2007). Using Goffman's (1963) terminology, affiliate stigma also acknowledges the nurses as 'the wise'. The wise are those intimately involved in the lives of those with a stigma, which have empathy and understanding of the predicament of those requiring abortion. The wise also accept faults within themselves (Younger, 1995) or recognise that needing an abortion could happen to anyone echoing the participants' maxim of 'there but for the grace of God go I'.

Becoming wise requires a right of passage, which may be via 'a heart-changing personal experience' (Goffman, 1963: p. 41). Many of the participants described events that had made them view abortion more favourably. Some of which had changed their career path such as witnessing the results of an illegal abortion (Interview 1). This process of interpretation of a situation is central to the use of meanings in symbolic interactionism (Blumer, 1969). To become wise the nurse must not only offer herself to the women, but she must also be accepted by them in order to accept them unconditionally (Goffman, 1963). This is where the expertise of the nurses came into play. Indeed, many of the participants found that as they shared their knowledge and experience the women saw them as credible. The options and advice the nurses gave the women allowed them to make the right choices thus validating the nurses' wisdom.

Conclusions

This study was limited by its sample size and the method used. Nevertheless, there are several implications for practice arising from it. First, if being non-judgemental is an aspiration and can never be wholly achieved, then acknowledging and dealing with judgements may be a more honest way forward. Acknowledged judgements could then be discussed in a professional environment such as clinical supervision or guided reflection where strategies could be devised for nurses to conceal their judgements in an insightful, considered manner. Abortion remains a stigmatised area of practice, which was implicit in many of the participants' comments and in their efforts to conceal their judgements. In order to minimise stigma in practice, nurses need to devise ways of normalising abortion within the healthcare system commencing with discussion in a supportive environment such as clinical supervision.

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