

The option to look: patient-centred pregnancy tissue viewing at independent abortion clinics in the United States

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Abstract: *Abortion providers' approaches to patient-centred pregnancy tissue viewing (PCV) – when a patient requests to see their products of conception – is understudied in abortion care. This mixed-method study aimed to identify: (1) if, when, and how PCV is facilitated at US independent abortion clinics; (2) how staff are trained to offer viewing; and (3) provider experiences facilitating PCV. We surveyed administrators from 22 independent abortion clinics affiliated with the Abortion Care Network about their PCV practices and then completed in-depth semi-structured interviews with 25 providers to better understand their experiences facilitating PCV. Results indicate that most of the clinics that provide PCV do so by patient request. A variety of providers facilitate viewing, including counsellors, educators, physicians, nurses, and medical assistants. Timing, viewing location, and staff training vary by facility. Benefits of and barriers to PCV emerged through three themes: (1) patient-centred care; (2) misinformation about fetal tissue; and (3) personal navigations as providers. Providers and administrators report PCV aligns with their patient-centred clinic missions and offers patients opportunities for choice, closure, and access to information. Yet, anti-abortion misinformation about fetal tissue impacts the ways providers must navigate complex conversations about PCV professionally and personally. Clinic resources and concern about adverse patient reactions to identifiable fetal parts present barriers to offering viewing. Understanding providers' experiences and approaches to PCV is an important first step to developing quality practices that can be shared across clinics. The findings of this study support the need for more research and training on PCV in abortion care. DOI: 10.1080/26410397.2020.1730122*

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Introduction and background

Products of conception, also known as post-abortion pregnancy tissue,^{*} is present in every case of pregnancy termination. This tissue is expelled during medical abortions, usually at home, or is removed by a clinician during abortions performed in a clinic or medical facility.² Surgical abortions

account for approximately 70% of the 926,200 abortions performed annually in the United States,³ resulting in almost 650,000 instances of post-abortion tissue handled by staff in the clinic setting. Seeing pregnancy tissue is a daily experience for abortion providers and staff, but it is seldom discussed outside clinic walls. Patients may ask to see their tissue after a surgical abortion, but we do not know how, when, and why these requests occur, how clinicians respond, and if or how providers facilitate patient-centred pregnancy tissue viewing (PCV).

Studies that have explored patient preferences for viewing fetal images in pre-abortion ultrasounds found that patients appreciate the choice to see their ultrasounds in non-mandated settings and that viewing could help with decision-making and satisfying curiosity.^{4–6} In pregnancy loss

^{*}Embryonic and fetal tissues are often referred to as “products of conception” (POC) in medical settings.¹ Language used to refer to POC varies by provider as well as scholar. The acronym POC is also widely used to mean “people of color” in social and reproductive justice work. As such, the terms “pregnancy tissue,” “fetal tissue,” and “tissue” will be used here in order to reflect the various terms utilised by providers in this study as well as to avoid confusion between the different “POC” acronyms.

scenarios such as stillbirth, miscarriage, and termination due to fetal anomaly, patients are allowed and sometimes even encouraged to view or memorialise the fetus.^{7–10} Staff who perform the ultrasounds have reported the desire to meet patient needs, the ability to provide relief for early abortion patients, decreased comfort with showing or viewing the image as gestational age increases, concern about patient reactions like distress or sadness, and worry about unintentionally impacting patients' abortion decisions.^{4,11,12} Still, little information exists regarding when and how PCV is facilitated after abortions for reasons other than a fetal anomaly, and how staff feel about this aspect of their work.

Fetal development guides created by and for US abortion providers in the early 1990s indicate requests for PCV have occurred for decades.^{13,14} The few studies that have examined patient experiences with PCV found that while not all patients want to see their tissue, they appreciate the option and most who view do not find it makes their abortion decision more difficult.^{7,15} Only one study, based in Canada, has reported how abortion clinic staff themselves feel about showing tissue to patients receiving first-trimester abortions. Although staff feel positive overall about providing PCV, several expressed a preference for showing early gestation tissues and discomfort as gestation increases and fetal parts become visible.¹⁵ This reflects US and UK providers' personal accounts of seeing and handling fetal remains in abortion work and how they navigate visceral reactions to identifiable fetal parts.^{16–20} To date, no study has assessed the prevalence of PCV at multiple clinics and what approaches US providers use in response to patient requests to view their pregnancy tissue.

The National Abortion Federation does not specify patient-centred tissue-viewing approaches in its *Clinical Policy Guidelines for Abortion Care*, and tissue viewing is not measured by the US Centres for Disease Control and Prevention's abortion surveillance data.^{1,21} It is important to understand how abortion providers who facilitate PCV approach their work, and how many clinics provide this service before we attempt to measure how patients experience the viewing scenario. Similarly, because abortion laws, accessibility, and stigma vary significantly by country and region, PCV practices may differ accordingly. In recent years, anti-abortion activists have falsely accused US abortion providers of selling fetal parts, bringing fetal tissue in abortion settings

into public discourse and political debate.^{22,23} As such, this research is both relevant and timely because it can speak to the frequency and importance of seeing and discussing fetal tissue in abortion care, highlight the everyday experiences US providers encounter and understand how PCV fits into patient-centred care.

Independent abortion clinics, defined as free-standing community-based facilities separate from national family planning healthcare centres (like Planned Parenthood), perform two-thirds of all abortions in the United States.²⁴ Many independent clinics have long embraced centring the patient in the medical process, which includes expanding education and counselling services as well as involving the patient in all clinical decision-making.²⁵ The fetal development guides for US abortion providers in the 1990s were created at an independent clinic in Ohio and are thought to be the only pro-choice images of aborted fetal tissue by gestation in existence.²⁶ Most people can only learn about what aborted fetal tissue looks like through anti-abortion imagery and misinformation.^{27,28} Inside the clinic may be the only place where accurate information about aborted fetal tissue can be shared between patients and providers.

Limited literature exists about whether PCV occurs at clinics, how the tissue-viewing scenario unfolds, and who facilitates the process. There is also a deficit of research that addresses providers' experiences with this aspect of abortion care. This study addresses some of these gaps by examining PCV strategies and providers' reactions to fetal tissue at US independent abortion providers and aims to inform future research and practice needs.

Methodology

This mixed-methods study aimed to understand both institutional (clinic) approaches to, and personal (provider) experiences with, PCV in the United States. We utilised surveys and interviews to assess (1) if, when, and how PCV is facilitated at independent abortion clinics; (2) how staff are trained to offer viewing; and (3) provider experiences facilitating PCV. This study targeted clinics affiliated with the Abortion Care Network (ACN) as ACN is the only national association specifically for independent providers in the US.²⁹ During data collection in 2016, ACN had 67 member clinics in 30 states. Given the dearth in knowledge on PCV,

our double pronged methodology is particularly useful as it provides both an overview of PCV practices in clinics and an in-depth look at providers' perspectives on its provision.

Study population, recruitment, and data collection

Surveys

Survey participants were recruited via emails sent to all 67 ACN-affiliated clinic administrators and tabling at a national abortion providers meeting. Any administrator who worked for an ACN-affiliated clinic met the inclusion criteria. Administrators who managed multiple clinics were asked to complete one survey per facility to understand how tissue viewing approaches may vary by site. Participants completed online Qualtrics surveys after completing an informed consent page. Demographic questions included the type of abortion facility, the state where the facility is located, and the respondent's position at the clinic. Questions about PCV assessed if, when, and where tissue is shown to patients at the facility. Additional open-ended questions asked about PCV policies, staff training and resources for facilitating viewing, benefits of and barriers to offering viewing, and additional relevant information about PCV. Respondents could request follow-up communication from the primary investigator to discuss their clinic's PCV approaches via staff interviews. Surveys took approximately 20 min to complete.

Interviews

The first participating clinic was identified through an independent consultant who works with ACN clinics in the United States. An additional four clinics were recruited through administrators who completed the survey. Administrators emailed an invitation for participation to their staff and provided an on-site introduction to the primary investigator, highlighting her experience as a former abortion care worker. This strategic disclosure³⁰ aimed to increase transparency, decrease stigma associated with abortion work as "dirty,"³¹ and help participants feel more comfortable in a study led by someone who has worked in abortion care and with fetal tissue. "Abortion providers" were defined as staff members who provided any element of care at the facility, and those who interacted with patients and post-abortion tissue during their normal clinic duties met the inclusion criteria. Providers signed up for interviews via email or in-person meetings with the investigator.

Individual in-person interviews occurred in a private office at each clinic during regular business hours, away from patient activities. Each participant reviewed and signed a written informed consent form and selected a pseudonym prior to their interview. Interviews lasted from 10 to 125 min (mean, 51 min) and included open-ended questions about experiences with PCV followed by demographic and employment questions. Data saturation was achieved after 25 interviews conducted at five separate clinics in five different states produced no new themes.

Data analysis

Survey results were entered into a database, and interviews were digitally recorded and transcribed verbatim. We inductively analysed all qualitative responses using Atlas.ti version 8. The data underwent several stages of open coding and memoing as we constructed several versions of a coding scheme.³² We then created thematic categories and examined the overlap between specific codes. Descriptive statistics, main qualitative themes, and selected quotes to exemplify each theme are presented in the following section. The University of Illinois Institutional Review Board approved the protocol for this study, and the Augustana College Institutional Review Board approved additional data analysis.

Results

This study yielded survey data from 22 clinics and interview data from 25 abortion care providers. We will first provide a quantitative overview of PCV practices across the 22 clinics, followed by a more in-depth look at the individual experiences of providers working with PCV.

Surveys

Clinic demographics

Respondents from 22 (33%) of the 67 ACN-affiliated facilities completed the survey (Table 1). Most identified as a clinic director (68%), 18% identified as another type of administrator, and 14% were physicians. Administrators represented clinics from the Northeast (45%), Midwest (27%), South (18%), and West (9%). Facilities included freestanding abortion clinics (59%), ambulatory surgical centres (with government-regulated standards for abortion) (23%), physician's offices (14%), and a hospital-based facility (4%). Almost all (95%) of

Table 1. Survey: abortion care facility characteristics (N = 22)

Facility characteristics	Number (%)
Region	
Northeast	10 (45)
Midwest	6 (27)
South	4 (18)
West	2 (9)
Facility type	
Freestanding abortion clinic	13 (59)
Ambulatory surgical center	5 (23)
Physician's office	3 (14)
Hospital based clinic	1 (5)
Administrator respondent	
Clinic director	15 (68)
Other administrator	4 (18)
Physician	3 (14)
Gestational limits in weeks LMP	
≤14	2 (9)
15-24	13 (59)
≥24	2 (9)
No answer	5 (23)
PCV offered	
Yes	16 (73)
No	5 (23)
Not applicable	1 (5)

the facilities provided first-trimester surgical abortions. The majority provided second-trimester abortions (68%) and two provided abortions beyond 25 weeks since last menstrual period. Most of the responding facilities (73%) provide tissue viewing, 23% did not, and one responded that tissue viewing is “not applicable” because they only provide medical abortion and do not handle fetal tissue in-clinic. Only one of the clinics that does not provide PCV indicated a reason for not showing tissue, stating that most of their second-trimester patients seek abortions for fetal anomaly and do not ask to see their tissue. The following analysis examines the 16 facilities that provide tissue viewing.

Tissue-viewing approaches

Facilities that provide PCV do so in different ways (Table 2). The majority allow it if the patient requests (75%) and others offer PCV verbally (usually during pre-abortion counselling) or in writing via intake paperwork. Patients request PCV “occasionally” or “rarely,” though it is unclear if they know they have the option to request to see their tissue. Multiple types of clinic staff facilitate PCV, including counsellors, educators, physicians, nurses, and medical assistants, reflecting the multiple roles many providers play at their clinics. Respondents noted that PCV could take place in the procedure room (25%), a private room (25%), or the laboratory (13%), and occurs either immediately after the procedure (44%) or after the patient's recovery (44%). This difference in timing depends on the abortion procedure and what kind of sedation the patient received, as sedated patients need recovery time before viewing their tissue. Several clinics explained that the location and timing of tissue viewing might change depending on space availability and the patient's needs. For example, one clinic that performs first-trimester abortions with local anaesthesia provides viewing in the procedure room immediately after the abortion while another clinic that performs abortions for fetal anomaly will provide extended viewing time in a separate room for a grieving patient.

The survey asked respondents to describe their clinic's PCV policies. Fifty-six per cent of the clinics do not have a specific policy although PCV is available to those who ask. About one-third of clinics provide additional education or counselling regarding what the patient can expect to see, including verbal descriptions of the fetal tissue or by showing drawings or photographs of fetal development via the Fetal Development Guides for Abortion Providers.^{13,14} Tissue may be shown floating in water in a clear dish, lit from beneath by a light; this is the same way clinicians examine post-abortion tissue to ensure the abortion is complete.¹ Providers may opt to show just the specific pregnancy tissue (as opposed to all tissues removed from the uterus) to the patient after a clinician has examined it. Some providers will point out aspects of the tissue (sac, villi, and pregnancy) while others will allow the patient to look and ask questions as needed. One clinic requires the patient to sign a consent form prior to viewing. Two clinics specified that patients undergoing second-trimester abortions receive more education prior to viewing to prepare them for seeing identifiable fetal parts. A

Viewing practices	Number (%)
How PCV is offered	
By patient request	12 (75)
Multiple methods	3 (19)
Verbally by staff	1 (6)
Who facilitates PCV	
Multiple staff	6 (38)
Counsellor/educator	5 (31)
Physician	3 (19)
Nurse/medical assistant	2 (13)
PCV location	
Procedure room	4 (25)
Private room	4 (25)
Based on patient need	4 (25)
Laboratory	2 (13)
Recovery room	1 (6)
No answer	1 (6)
PCV timing	
After procedure	7 (44)
After recovery	7 (44)
No answer	2 (13)
Clinic has PCV policy	
Yes	7 (44)
No	9 (56)
Ultrasound viewing policy	
State-mandated	8 (50)
By patient request	6 (38)
No answer	2 (13)
Pre-abortion fetal development education policy	
State-mandated	10 (63)
By patient request	5 (31)
No answer	1 (6)

provider will explain that the fetus may not be intact as the soft tissue breaks up easily during the abortion procedure and other intrauterine

material like blood and uterine lining may be visible. The patient would then confirm whether they want to proceed with viewing their tissue.

Half of the administrators reported that state laws mandate they offer patients the option to view pre-abortion ultrasound images and the remaining respondents said patients can view their ultrasound if they desire (Table 2). Sixty-three per cent of facilities were located in states with fetal development education requirements, though respondents reported most state-provided materials are inaccurate. Several respondents explained that they utilise pro-choice fetal development guides^{13,14} and allow PCV as a means to counteract inaccurate images. Providing the option for PCV also aligns with each facility's mission; respondents described tissue viewing as allowing patient autonomy and choice, meeting patient needs, providing healing and closure, being honest about all aspects of abortion, and helping satisfy patients' curiosity. Administrators reported that patients who request to view their tissue benefit by gaining closure, exercising choice and control during the abortion, satisfying their curiosity, and receiving visual reassurance that the abortion is complete.

Staff training and comfort

Ten clinics (63%) that offer PCV provide specific training to staff (Table 3), usually during general staff training or counselling training (40%). Training includes learning about fetal development and how to talk about it with patients. Most administrators perceived that their staff feel positive about PCV (63%) and only one (6%) reported their staff feel ambivalent; none reported negative staff feelings and the rest either did not know how staff felt or did not respond.

The majority of facilities (81%) have support systems in place for staff who express discomfort or ambivalence with tissue-viewing work and 13% reported no such policy exists because staff have never expressed apprehensions. Staff supports range from discussing their concerns with management, receiving additional training on PCV, opting out of tissue work, or a combination of these (Table 3). One respondent elaborated that management proactively checks in with staff who do tissue work to ensure comfort and avoid potential burnout.

Some (31%) of the clinics that provide PCV specified that offering this service benefits staff. Patient-oriented staff benefits include honouring requests and being able to assure the patient that the

Table 3. Survey: clinics that offer PCV (N = 16)	
Staff training and comfort	Number (%)
Staff trained to facilitate PCV	
Yes	10 (63)
No	5 (31)
No answer	1 (6)
Admin perceptions: staff feelings about PCV	
Positive	10 (63)
No answer/do not know	5 (31)
Ambivalent	1 (6)
Support for staff discomfort/ambivalence	
Meet with admin/senior staff	6 (38)
More training	3 (19)
Staff can opt out	2 (13)
Multiple support outlets	2 (13)
No policy	2 (13)
No answer	1 (6)

abortion is complete; provider-centred benefits include connecting staff with the reality of abortion care, strengthening their commitment to abortion work, and helping them practice empathy for patients. Half of the administrators mentioned barriers to facilitating PCV, including the resources needed to appropriately train staff, concern about adverse patient emotions, staff discomfort with tissue, and some staff not understanding why a patient would request to view tissue. One-quarter of respondents reported that they see no drawbacks to offering tissue viewing to patients.

Interviews

Twenty-five abortion providers from five ACN-affiliated US clinics participated in semi-structured interviews (Table 4). Providers were mostly women (92%), mostly white (72%), reported some form of religious or spiritual affiliation (64%), and have worked at their clinic for an average of nine years (range, from three months to 35 years). Respondents reported that they work at a variety of roles at the clinic, even if their job title does

not reflect it. Almost all were non-physicians (95%). Specific to PCV, all providers agreed that patients should have the opportunity to view their tissue if desired and most (92%) have direct PCV-related duties, yet only half (52%) have been directly trained on how to facilitate viewing. This may be due to the infrequency of viewing requests, as 28% reported not knowing how many requests occur and others guessed patient requests for PCV range from three times a week to only one or two times per year. Although patient requests to view their tissue occurred rarely, providers felt it is an important service to offer. Providers described benefits and barriers to PCV, which emerged through three themes: (1) patient-centred care; (2) misinformation about fetal tissue; and (3) personal navigations as providers.

Patient-centred care

Across interviews, we found a persistent trend to frame PCV as part of a patient-centred approach to healthcare. Within this framing, providers emphasised choice and autonomy as reasons for granting patients the option to view their pregnancy tissue. Many cited the need for abortion to be respected in the same ways as miscarriage and birth and acknowledged that each patient processes their experience differently. Due to the wide range of abortion experiences and modes of processing, providing PCV can empower patients to make the abortion process their own, honours patient requests, fulfils curiosity, and can facilitate closure. Many participants drew comparisons to the curiosity of wanting to view other forms of tissues after surgery. For instance, Lindsey said:

“It’s just like when you go and get your tonsils out, if you ask to see it, then they let you see it. So I don’t understand why you wouldn’t let them see the pregnancy if they’re asking to see it.”

Other participants mentioned the tradition of viewing the body at a family member’s funeral, and how it can help with the grieving process. By providing the option to view, providers feel they are fulfilling multiple patient needs that might potentially arise. This connects with administrators’ survey responses where benefits of PCV included honouring patient requests and assuring the patient that the abortion is complete.

Emma contextualised tissue viewing and abortion as on a continuum of pregnancy experiences:

Pseudonym†	Gender	Race	Faith	Years at clinic	Position
AJ	M	W	Religious Nomad	1	Trans* Health Advocate
Alexandra	W	W/H	None	33	Assistant Administrator
Alisha	W	W	None	2	Recovery Room
Amy	W	W	Jewish	32	Physician
Armana	W	B	Baptist	0.66	Patient Advocate
Ashley	W	W	NP Christian	5	Office Manager
Emma	W	B	Spiritual	26	Health Services Director
Frances	W	W	None	4	Patient Advocate
Iris	W	L	None	2	Health Educator
James	GNB	-	Jewish	5	Health Services Representative
Kate	W	W	Secular Humanist	8	Patient Advocate
Lindsey	W	W	None	7	Director of Nursing
Lindsey U	W	W	Buddhism	3	Doula
Maggie	W	W	NP Catholic	9	Executive Director
Marsha	W	W	NP Catholic	10	Surgical Coordinator (LPN)
Megan	W	W	None	0.25	Patient Advocate
Peg	W	W	Atheist	35	Director
Petunia	W	W	None	4	Nurse (RN)
Rosa	W	W	None	14	Medical Specialist
Rosemary	W	W	Protestant	14	Owner
Sarah	W	W	Pagan	7	Variety
Shanel	W	B	Christian	0.33	Nurse (LPN)
Tatiana	W	B	NP Christian	4	Patient Services Director
Veronica	W	W	None	0.42	Patient Advocate
Yolanda	W	L	Catholic	5	Products of Conception Lab

Notes: *Gender*: Man (M), Woman (W) and Gender non-binary (GNB); *Race*: Black (B), Hispanic (H), Latina/o (L) and White/Caucasian (W). Trans*, transgender; NP, non-practicing; RN, registered nurse; LPN, licensed practical nurse. †chosen by participant.

“Many women don’t get to have closure around their abortion experience. It’s the same as women who have miscarriages, they need to have closure. There isn’t a lot of acknowledgement that they had a pregnancy that ended. Closure is a positive and empowering thing that can help people move forward and get stronger.”

This quote speaks to the capacity of PCV to provide closure and to facilitate grieving when needed. Participants reported this to be the case for a wide range of scenarios, including for patients with fetal anomalies, religious patients, and those seeking early gestation abortions. Providers report that seeing the tissue itself “makes it more real” than simply viewing an ultrasound image and that some patients request hand and footprints and, in infrequent cases, request taking home the tissues.

In addition to the many patient-centred benefits of PCV, providers also listed a few common barriers to providing tissue viewing. Barriers included the additional time needed to prepare patients to view their tissue during the education and counselling process, patients being “too squeamish” to view medical products containing blood, and concern about emotional patient reactions to seeing fetal tissue. Participants reported that, even with some of the challenging aspects of PCV, helping patients who want to see their tissue is part of patient-centred, quality abortion care. They view access to information and the option to look as part of trusting patients to choose what is best and granting them their full autonomy, whether to fulfil curiosity, to cope with or grieve the end of a pregnancy, or merely to come to terms with the experience.

Misinformation about fetal tissue

Providers report a wide range of perspectives on how a patient’s abortion experience impacts their desire for PCV, including the reason for the abortion, gestational age of the pregnancy, and personal emotions surrounding the abortion. Despite this range, all PCV experiences seem to be connected by a common thread: widespread misinformation about pregnancies, the fetus, and abortions themselves. Across the interviews, respondents frequently mentioned the impact of protestors’ signs outside the clinics, as well as misinformation online, and the way these inaccurate images of fetuses shape expectations of aborted pregnancy tissue. Such images contribute to

internalised abortion stigma and a dearth in the knowledge of pregnancy tissue, which is then challenged when a patient views their own tissue. Consider Maggie’s description of how the anti-abortion signs outside the clinic differ from her patients’ lived experiences:

“I think for patients who are exposed to anti-abortion rhetoric, and especially to the signs that some of the antis carry outside clinics... it’s a fetus that’s probably I would say about 19 weeks or so, but at some point something happened to these fetal remains, like they’re old, I think, maybe they were frozen, there’s something up with the picture, so it almost looks like the remains were burned. ... I think for those patients, being able to see what their fetal tissue actually looks like – their own from their own body – it can be an incredibly affirming experience.”

As Maggie and other respondents report, viewing one’s fetal tissue can be a positive experience, particularly when contrasted with inaccurate images intended to dissuade one from having an abortion. For these patients, PCV might result in surprise or relief. Providers who have been present when a patient views their tissue in early pregnancy remarked at the variety of responses upon seeing it. They report patient reactions range from positive proclamations like, “Wow,” and “Amazing” to neutral or surprised reactions like, “Huh?” and “Oh, that’s it?”

In many cases, particularly for early gestation abortions, PCV can have a destigmatising effect for patients. As several providers explained, anti-abortion imagery can often lead to patients holding fear around the procedure and the pregnancy tissue. James describes the confusion many patients have due to ambiguous understandings of fetal development:

“Sometimes someone will ask ‘is it a baby?’ or something like that. A lot of times they are just asking about size, because my interpretation is that all the anti-[abortion] stuff... like from [Juno], ‘your baby has fingernails!’ A lot of times people think it’s a tiny miniature baby you’d see delivered, but really it’s like, ‘oh you’re 6 weeks so it’s really a sac and villi.’”

This echoes themes from the survey where administrators highlighted PCV as a tool to counteract inaccurate images from state-required materials.

Providers note a stark contrast in PCV approaches for patients who have abortions due

to fetal anomalies compared to patients who have abortions for other reasons. They highlight that abortions for anomalies require the most empathy and care, and often include additional services like ink hand and footprints, or memorial certificates. Lindsey describes how patients undergoing terminations for anomalies may want a more interactive PCV process, especially when the abortion results in an intact fetus:

“The only time I ever leave anyone alone is when it’s a fetal anomaly, and I’ll tell them don’t be afraid to touch the baby. So, I always touch it without gloves on, so they know it’s okay. And if you want to pick the baby up, you can. Do whatever you need.”

For early gestation abortions, a lack of proper education about abortion and fetal development can lead patients to internalise misleading messages from the media and anti-choice imagery. The identifiable fetal body in later abortions may resemble anti-abortion imagery, so providers take extra steps to ensure the patient is prepared for the viewing experience. Because of this dichotomy, many providers described the clinic as the sole location for accurate information about the aborted fetus. They see PCV as helping patients feel more comfortable in their abortion decision while also debunking abortion myths and destigmatising abortion itself.

Personal navigations as providers

Providers participating in PCV must balance the complexities of misinformation about the fetus and a wide range of patient abortion experiences, all while managing their own personal emotions and expectations. Though the initial goal of our interview guide was to assess provider training and the impact of PCV on patients, many interviewees disclosed their own personal experiences viewing fetal tissue. Providers shared stories about seeing aborted tissue for the first time or seeing later gestation tissue with identifiable fetal parts, and how these experiences challenged their own internalised stigmas and misinformation as they conducted their jobs. Several respondents explained that the complexity of doing this work also makes it more rewarding. Rosa describes how these rewarding exchanges can create a sense of pride for providers, especially in their role as caregivers:

“People who deal with [tissue] on a daily basis... it brings up the challenging work that we do anyway, and it’s hard. It’s intense for some people, and for

other people it’s not. But even the hard stuff feels really good. It’s just another piece of helping somebody.”

Most of the providers saw post-abortion tissue for the first time during clinic training or by specifically requesting to view it for educational purposes. The length of gestation, and whether the tissue had identifiable fetal parts, impacted most participants’ initial comfort with seeing it. The majority said that seeing tissue became a normal part of daily clinic experience. Tatiana shared her own process of coming to terms with her clinic’s addition of later abortion services:

“When we decided as a clinic that we were going to go further into the gestation, I was unsure how I would feel seeing the [tissue], and... I had to see it just to kind of feel more comfortable about it, I think. But now the contact that I do have, like what I’ve said when I do the handprints or the footprints, I just feel like that’s just such a gift to the patient that there’s never any negative thoughts or feelings surrounding that. It’s always great for me to be able to experience that.”

Many providers mentioned that part of clinic work includes managing their personal feelings about fetal tissue while performing professional duties. Most of the respondents try to avoid influencing patient decisions to view their tissue regardless of the provider’s feelings about it. Armana expressed how her commitment to patient-centred care outweighs her personal comfort with tissue:

“I wouldn’t worry about my feelings, because if that’s a request of the client, that’s what I have to do. I’m going to have to put those feelings aside because this is my job description and this is what I’m going to have to do. Like I said, if they want to see it, that’s fine. Having the option, that’s fine. I’m not going to say hopefully I don’t have to, but if it don’t happen, great.”

Several providers shared how PCV work evokes memories of their own pregnancy experiences. Emma remembered seeing aborted pregnancy tissue that was the same gestation as her wanted pregnancy. Armana repeatedly mentioned her discomfort with fetal tissue while simultaneously clarifying her personal interest in viewing her own after her abortion years before, and her disappointment with not being allowed to view. This illuminates one limitation of the word “comfort” when describing providers’ lived experiences, since their tissue-viewing stories do not necessarily imply a negative emotion that requires

amelioration. Sarah described how her own abortion experience motivates her work and commitment to offering PCV:

“I had an abortion when my son was 3, and he’s 29 now, and I [crying]... I was really interested in taking the POC and was not able to have that voice because I didn’t have an advocate. That’s kind of why I’m here.”

Every provider described a process of seeing various stages of fetal development every day at work, regardless of how long they have worked in the clinic. Some mentioned sitting down to discuss their experiences with other staff or administrators, and many decompress with loved ones at home. A few providers recounted facing stigma when sharing their work with family, which contributes to feelings of social isolation. Armana explains:

“It’s on my mind a lot, but I don’t [talk about it]... When I told my daughter about [seeing fetal tissue] she said, ‘I don’t think that’s the right place for you. I don’t want to tell people you kill babies.’ I don’t talk to her about it because I don’t want her to say those things, and I don’t want her to be emotional.”

In contrast, Veronica shared how her support networks helped her process the tissue-viewing experiences that accompanied being a new employee:

“When I first started here I nearly passed out in the procedure room the first time. The smell, the tightness of the room, the energies floating around consumed me. To go from that to two months later viewing an 18 week pregnancy, it was a huge experience. I got to put on gloves and touch it. I went home and sat on my couch and just processed it for an hour. I called my sister and talked to her about it, then talked to my partner about it. It was great to have those outlets to talk to about it and process it. It was awesome.”

While the survey results indicate that administrators believe the vast majority of providers feel positive about PCV, the interview findings add nuance to this story. As these excerpts show, providers must manage highly complicated, and often contradictory emotions, expectations, and external cultural meaning surrounding abortion and fetal tissue. The consensus across interviews indicates that providing patient-centred quality care is their priority, and for most providers, the surprises and challenges of seeing aborted tissue subside as it becomes an ordinary part of their work routine. However, providers who are not completely comfortable with seeing tissue and who have fewer

social outlets for support may have increased challenges to providing PCV.

All of the participants spoke at length about the complexity of seeing, discussing, and showing tissue, including how public images shape assumptions about what fetal remains look like. While they were concerned that accurate descriptions of tissue could accidentally trigger anti-abortion language or imagery, they also acknowledged that tissue viewing was educational and could help both patients and providers create new neutral or even positive understandings of the post-abortion tissue, which could elevate standards of abortion care.

Discussion

This study revealed that many US independent abortion providers facilitate PCV even though approaches, policies, and staff training vary by clinic. The variety of PCV approaches described in this study – including who is trained to show tissue, when and where viewing occurs, and how viewing benefits patients and staff – demonstrates that independent providers have long developed practices that best fit their missions, clinic resources, and patient needs. Understanding PCV as a component of quality, patient-centred abortion care echoes prior work on tissue viewing following surgical abortion, miscarriage, stillbirth, or termination for fetal anomaly,^{7,15,33} as well as pre-abortion ultrasound image viewing,^{4–6} where patients express appreciation for the option to view, regardless of whether they end up viewing or not. Abortion providers in this study elaborated that PCV options promote access to information, freedom of choice, and the exercising of rights, which aligns with independent clinics’ historic patient-centred and stigma-fighting frameworks.³⁴

Providers from states with ultrasound and/or fetal development education laws saw PCV as a tool that could combat state-required misinformation while honouring patient requests to guide their own abortion experiences. They believed PCV allows patients’ choice, closure, and access to honest information about abortion and fetal development, which aligns with the limited existing literature on the benefits of tissue viewing.^{13,14,33} Providers reported a lack of neutral language to discuss fetal tissue and concern that the prevalence of anti-abortion imagery impedes discussing it with patients. These findings support other research on external messages about the fetus^{20,27,35–37} and suggest that abortion providers constantly navigate

misleading rhetoric and attempt to reconcile it with their own experiences of seeing and handling post-abortion tissue.

While most providers felt positive about PCV, several articulated complex feelings about seeing tissue with identifiable fetal parts, reflecting apprehension with fetal recognisability cited by abortion staff in other studies.^{15–17,19,38} Our findings suggest that providers perceive fetal tissue as a particularly stigmatised subject in the abortion field. This echoes previous research regarding the spectrum of stigma that clinicians face in abortion care,^{39,40} and is a significant issue to explore further, especially considering the current political climate surrounding abortion restrictions based on fetal gestational age in the United States. Providers expressed valuing patients' experiences over their own comfort and found ways to amend internal tensions in order to provide better care, exemplifying skills learned from the values clarification training³⁴ that many reported receiving. Being patient-centred, however, is not without its own challenges, as some providers faced stigma from loved ones when they disclosed their work with fetal tissue. Understanding how providers constantly negotiate when and how they will discuss PCV and the fetus – whether with patients, loved ones, or in public – is important for challenging routinely silenced stories (“dangertalk”) and creating more nuanced pro-choice narratives for providers and patients alike.^{40,41}

Clinic resources required to facilitate PCV and concern for patients' emotional reactions present challenges to providers even though requests to view are not common. This could indicate that limited clinic resources and infrequent patient requests impact staff training, and training may impact providers' confidence in facilitating this complex aspect of abortion care when it does arise. Administrators from the survey and providers from the interviews requested more training and information about PCV practices across clinics. To address this need, the primary investigator is collaborating with ACN-affiliated clinics to develop and pilot a best practices guide that helps independent clinics implement PCV services and trains staff on patient tissue-viewing needs.⁴²

One of the most interesting phenomena that arose from this study was the information sharing that occurred between the participants and interviewer, who used to work in abortion care and with fetal tissue. All of the participants utilised terms and acronyms used in abortion care and seemed to speak unreservedly, without pausing for clarification as

they might have done with an investigator who was not familiar with their daily work. Similarly, providers freely shared information that was not asked by the interview script, which helped shape the next phases of this research project. Most of the providers expressed gratitude for being able to discuss a complex topic with someone who understands their roles and experiences, reflecting sentiments reported by participants in abortion provider share workshops.⁴⁰ This also suggests that the interview setting may act as a location of self-disclosure, social support, and destigmatisation for providers whose experiences are often silenced in pro-choice discourse, demonstrating some benefits of qualitative data collection and the interviewer's strategic disclosure.^{30,41} Future applications of this research should include group story-sharing where providers can discuss the nuances of their fetal tissue work with each other. This can help reduce feelings of isolation, identify best approaches to PCV, and strengthen providers' commitment to patient-centred care.⁴³

Limitations

Despite the important contributions of this study, there are several limitations that impact generalisability. We targeted US-based independent clinics affiliated with the Abortion Care Network, which represents only a portion of all independent abortion providers in the US and does not include other abortion-providing organisations like Planned Parenthood. Viewing requests occurred infrequently and therefore providers' experiences might not reflect those at clinics where viewing is offered to all patients, occurs frequently, or not at all. Similarly, we only assessed PCV after induced abortion and did not examine medication termination scenarios. This study's sample may indicate self-selection from clinics that allow PCV and feel positively about the practice and does not analyse clinics that do not provide viewing or their reasons. The interviewer strategically disclosed her status as a former abortion clinic worker, which may have influenced the information that participants chose to share. We did not evaluate cultural differences that may have impacted participant responses.

Conclusion and implications

Understanding providers' experiences with post-abortion pregnancy tissue viewing is an important first step in developing quality PCV practices. We cannot accurately assess patients' feelings about and experiences with viewing aborted fetal tissue

until we know how provider comfort and preparation impact the viewing dynamic. This study is the first of its kind to gather PCV practices from multiple clinics and insights from a variety of US providers who interact with pregnancy tissue in the abortion setting. This mixed-methods study design provides both a broad look at PCV practices and a deeper understanding of the complexities of its provision. Our findings reveal that independent providers employ a variety of PCV approaches tailored to patient needs and clinic resources. Abortion providers can utilise tissue-viewing requests to improve realistic understandings of fetal development, support patient autonomy, and challenge anti-abortion imagery and misinformation. This can help decrease stigma for both the patients who are interested in viewing tissue and the providers who facilitate these processes. Abortion providers outside of the United States can use this study to assess if, when, and how patient requests to view tissue occur at their respective organisations, and if PCV can be a useful tool for patient-centred care. Future research should examine how approaches to PCV can help providers reclaim narratives about the fetus in abortion care, expand

patient agency during and after the abortion procedure, and develop patient-centred best practices in a variety of abortion settings.

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Résumé

Les méthodes des prestataires de services d’avortement pour montrer les tissus de la grossesse quand une patiente demande à voir ses produits de la

Resumen

Los enfoques de los prestadores de servicios de aborto con relación a la visualización de los restos ovulares (VRO) centrada en la paciente, cuando la

conception font l'objet de trop peu d'études dans les soins en cas d'avortement. Cette étude à méthodologie mixte visait à déterminer: (1) s'il est possible de voir les produits de la conception dans les centres d'avortement américains indépendants, à quel moment et de quelle manière; (2) comment le personnel est formé pour proposer cette pratique; et (3) l'expérience des prestataires de services d'avortement lorsqu'ils proposent de montrer les tissus de la grossesse. Nous avons enquêté auprès d'administrateurs de 22 centres d'avortement indépendants affiliés à l'Abortion Care Network sur leurs pratiques en matière de présentation des tissus de la grossesse, puis nous avons complété des entretiens semi-structurés approfondis avec 25 prestataires pour mieux comprendre leur expérience. Les résultats indiquent que la plupart des centres qui présentent les tissus de la grossesse le font à la demande des patientes. Divers prestataires facilitent cette présentation, notamment des conseillers, des éducateurs, des médecins, des infirmières et des assistants médicaux. Le moment et le lieu de la présentation de même que la formation du personnel varient selon les centres. Les avantages de cette pratique et ses obstacles sont apparus autour de trois thèmes: (1) soins axés sur les patientes; (2) fausses informations sur le tissu fœtal; et (3) navigations personnelles comme prestataires. Les prestataires et les administrateurs indiquent que la présentation des tissus de la grossesse est alignée sur leur mission clinique axée sur les patientes et qu'elle offre aux patientes des choix, la possibilité de tourner la page et d'avoir accès à l'information. Pourtant, les informations erronées des militants anti-avortement sur le tissu fœtal ont des répercussions sur la manière dont les prestataires doivent gérer des conversations complexes sur la présentation des tissus de la grossesse du point de vue professionnel et personnel. Les ressources cliniques et les préoccupations quant aux réactions indésirables des patientes face aux parties fœtales identifiables constituent des obstacles à l'offre de la présentation. Comprendre l'expérience des prestataires et leurs méthodes de présentation des tissus de la grossesse est une première étape importante pour élaborer des pratiques de qualité pouvant être mises en commun par les centres. Les conclusions de cette étude appuient la nécessité de recherches supplémentaires et d'un complément de formation sur la présentation des tissus de la grossesse dans les services d'avortement.

paciente solicita ver los restos ovulares, han sido poco estudiados en los servicios de aborto. El objetivo de este estudio de métodos mixtos era identificar: (1) si, cuándo y cómo la VRO es facilitada en clínicas de aborto independientes en EE. UU.; (2) cómo el personal es capacitado para ofrecer visualización; y (3) las experiencias de los prestadores de servicios facilitando la VRO. Encuestamos a administradores de 22 clínicas de aborto independientes, afiliadas a la Red de Servicios de Aborto, acerca de sus prácticas de VRO y después realizamos entrevistas a profundidad semiestructuradas con 25 prestadores de servicios para entender mejor sus experiencias facilitando VRO. Los resultados indican que la mayoría de las clínicas que ofrecen VRO lo hacen a petición de la paciente. La visualización es facilitada por una variedad de prestadores de servicios, tales como consejeros, educadores, médicos, enfermeras y auxiliares médicos. El tiempo y el lugar de la visualización, así como la capacitación del personal, varían según la unidad de salud. Los beneficios de la VRO y las barreras para ofrecerla se pueden abordar en tres áreas temáticas: (1) atención centrada en la paciente; (2) información errónea sobre el tejido fœtal; y (3) navegaciones personales como prestadores de servicios. Los prestadores de servicios y administradores informan que la VRO está en consonancia con las misiones de la clínica centradas en las pacientes y ofrece a las pacientes oportunidades de elección, cierre y acceso a información. Sin embargo, la información errónea antiaborto sobre el tejido fœtal afecta la manera en que los prestadores de servicios deben navegar complejas conversaciones sobre VRO profesional y personalmente. Los recursos y preocupaciones de las clínicas con relación a reacciones adversas de las pacientes a partes fœtales identificables presentan barreras para ofrecer visualización. Entender las experiencias y los enfoques de los prestadores de servicios con relación a la VRO es un primer paso importante para desarrollar prácticas de calidad que puedan compartirse entre todas las clínicas. Los hallazgos de este estudio corroboran la necesidad de realizar más investigaciones e impartir más capacitación en VRO en los servicios de aborto.