FACULTY OF MEDICINE

Master's Program in Public Health

"The Unavoidable Ambiguity of Abortion Legislation"

Navigating through the great state of Missouri in a post-*Roe* world

A Constructivist Grounded Theory Study

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Abstract

Background: The Supreme Court's *Dobbs v. Jackson Women's Health Organization* ruling was monumental for sexual and reproductive health and rights in the United States. This shifted the legislative power over the right to an abortion from federal to state government. Missouri's post-*Roe* legislation banned abortion statewide. Health care providers (HCPs) are facing unique facilitators and barriers that influence their capabilities to engage with abortion related care.

Aim: To understand how HCPs experience and perceive Missouri's post-*Roe* abortion law and context and discuss the potential implications on occupational agency in abortion related care.

Methods: Utilizing a constructivist grounded theory methodology, seven interviews were conducted to explore HCPs experiences and perceptions of navigating Missouri's post-*Roe* abortion law and context.

Findings: Three theoretical themes emerged from the constant comparative analysis (1) *learning the law's limits and extents*; foundational and configuring elements of Missouri's abortion law that directly impact HCPs occupational capabilities (2) *balancing the breaking branches*; choices and situations HCPs actively balance in the clinical setting concerning abortion related care and (3) *professional pushes and pulls*; profession-related factors that influence HCPs involvement in the abortion discourse beyond their occupational duties. These aspects contribute to the emerging main concept of *curating occupational agency*, the process of HCPs actively navigating Missouri's post-*Roe* abortion law and context to curate their occupational agency, both individually and collectively.

Conclusion: HCPs curate their occupational agency by navigating through the post-*Roe* landscape. As HCPs comprehend, integrate, and organize their individual and shared reality, they are curating their occupational agency, which in turn impacts how they engage with abortion related care and the abortion discourse at large. Thus, their engagement with abortion related care and the abortion discourse will impact the sexual and reproductive health and rights landscape in Missouri and across the United States. Although the post-*Roe* world is ambiguous, HCPs can still provide care and protect people's health and wellbeing through autonomously curating their occupational agency.

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Introduction

<u>Abortion in the United States</u>

The Due Process of Dobbs

Friday, June 24, 2022, the United States Supreme Court's (SCOTUS) ruling on *Dobbs v. Jackson Women's Health Organization* concluded that the United States Constitution does not grant a right to abortion (1). This decree has repealed the longstanding jurisdictions set by *Roe v. Wade* in 1973 and *Planned Parenthood v. Casey* in 1992 (2, 3). As the pivotal legislative foundations for women's reproductive rights, both historically monumental cases paved way for the expansion and protection of sexual and reproductive health and rights in the United States. This dismantling decision has inherently positioned foundational principles for public interrogation; thus, questioning the empirical extent and meaning to justice, liberty, freedom, and autonomy.

The post-*Roe* landscape has crafted a haphazard battlefield of sexual and reproductive health and rights (SRHR); subsequently fueling the fire of social stigmatization and inadequate justification of abortion legislation at the state level. Now, each state government holds the power over the right to an abortion. Considering the existing sociocultural feuds and politicization of abortion, the disparities in state legislature concerningly revolve around how officials choose to define and value *life* itself (4). These interpretations promote religious and moral entanglements with legislation; inevitable intersections considering the nature of abortion, but trivial to the reality of abortion and necessity of access to abortion care. It perpetuates narratives and stereotypes that hold social control over women and their bodies, support patriarchic-principles, and stunt progression for gender and health equity and equality (5). Subsequently, skewed discussions and representations infiltrate the media, contributing to the problematic spread of misinformation and provoking hypotheticals (6, 7, 8).

In less than a year's time, SCOTUS' judgement on *Dobbs v. Jackson Women's Health Organization* has profoundly burdened the already volatile health care system in the United States. Evidently, communities in states with outright bans and heavy restrictions are disproportionately faced with the consequences and injustices of insufficient abortion care and reproductive freedom (7, 9, 10). Immediately following the *Dobbs* ruling, one state pounced on the opportunity to wield their newfound legislative power and instantaneously implemented a statewide ban on abortion; this was the great State of Missouri.

Abortion in Missouri

Conservative Contingents

The *Right to Life of the Unborn Child Act 2022* is the primary law in Missouri that addresses the legal boundaries on abortion. In summary, the law bans abortions completely, except in the case of a medical emergency to save the mother's life. Legal repercussions are exclusive to the provider and include prosecution of a class B felony (i.e., between 5-15 years in prison) and revocation of medical licenses (11). Missouri's conservative approach was no surprise due to the states' historic record of opposing the right to abortion. Since the 1970s, abortion care has been heavily regulated through targeted restrictions on abortion providers (TRAP Laws) (e.g., demanding providers to have admitting privileges at a hospital within 30 miles and requiring a 72-hour wait period after state-mandated counseling for patients to receive an abortion) (12, 13). The state government' efforts anti-abortion agenda to restrict goes beyond legislation; for instance, the state government has recognized and endorsed a car number plate that says "Choose Life" as an official state license plate since 2009 (14).

Challenges to the Ban

Although the United States Constitution addresses the necessity to separate church and state, this supposed divorce has yet to transpire in the governing over abortion in Missouri (15, 16). Certainly, sacred discourse can foster constructive societal reflection and introspection; but practical consideration of religion is an independent choice not a societal responsibility. State officials' response to unconstitutional claims lack democratic merit and reason the law is fair because personally, their faith aligns with the incorporated religious morals (16). Subsequently, this impartial legislative bias perpetuates faith-based constructs and ideologies. For instance, practicing abstinence inherently becomes the socially accepted standard and politically justified solution for woman that demand reproductive freedom; exclusively placing consequences of sexual activity on the woman and reduces sexual engagements to the means of procreation (17). Missouri's sociocultural and legislative chokehold over abortion fundamentally resists the progression of health equality and equity. Considering community and social context are social determinants of health, how these factors are understood and perceived can significantly influence how they are navigated and considered in providing health care and services (4, 18).

The Importance of Health care Providers in Missouri

The overturning of *Roe v. Wade* has caused a collective commotion amongst health care providers (HCP). As they grapple to clarify legal and practical occupational boundaries, HCPs are still expected to continue confidently providing the best care. Essentially, HCPs serve as the public service street-level bureaucrats; their occupation directly engages with the practicalities and faces the legal repercussions of abortion laws (19). Contextual factors influence individual perceptions and experiences, which conversely impact behavioral and social processes. The responsibility of comprehending and navigating contextual factors is not overtly stated in a HCPs job description, but they inherently employ and develop this soft skill through occupational experiences (20). Regardless of the abortion law, discretionary authority over the provision of care remains under HCPs jurisdiction; it is the foundation of their occupational agency (19, 20, 21, 22). Thus, HCPs occupational agency, both individually and collectively, has immense power in the progression of the abortion discourse and landscape in the United States.

Missouri's abortion law and dominate conservative sociocultural context situate HCPs in a unique occupational position. HCPs work amid laws and policies in juxtaposition to medical evidence-based training and expertise (10, 19). How HCPs engage with abortion care can lead to irreparable repercussions and significantly alter the quality and access of sexual and reproductive health care (6, 7, 21). Exploring HCPs perceptions and experiences with Missouri's post-*Roe* abortion law and context can enhance the understanding of sociocultural implications on occupational agency. Moreover, it can raise discussion and strategic thinking about how contextual factors can be addressed and overcome in the health sector.

The post-*Roe* landscape in the United States has considerably transformed the collective and individual realities of HCPs. Since this monumental shift in legislative power over the right to abortion happened less than a year ago, academic research on the impacts is minimal; although, the amount of research continues to advance daily (4, 6). Considering the controversial nature of abortion and legal vulnerability, minimal investigations from HCPs point of view has been conducted. Despite these setbacks, HCPs post-*Roe* realities are valuable and deserving of space in the abortion discourse. Therefore, above all, this research provides a safe space and opportunity for HCPs to voice their narrative and help fill knowledge gaps concerning United States' post-*Roe* world.

Aims and Research Questions

The overall aim of this qualitative study is to understand how HCPs experience and perceive Missouri's post-*Roe* abortion law and context and discuss the potential implications on occupational agency in abortion related care.

Main Question: How do HCPs perceive and experience Missouri's abortion law and context in the post-*Roe* world?

Sub-questions focus on the following:

- What contextual factors do HCPs perceive as relevant to their occupational agency?
- How has the abortion law impacted their occupational engagement in abortion care?
- How can HCPs agency impact the abortion discourse and health care landscape?

Method and Materials

Research Design - Constructivist Grounded Theory

This study utilized data collected from interviews to explore HCPs perspectives and experiences with the post-*Roe* abortion law and context in Missouri. To investigate the subjective views of Missouri's abortion care landscape, qualitative methodology was applied. This emergent study design intentionally draws the focus on HCPs and highlights their construction of meaning and intuitive tactic knowledge in relation to abortion related care (23). Qualitative methodology prioritizes conducting research in participants' natural settings and emphasizes the importance of thick contextual descriptions, power dynamics, and thoroughly prolonged engagement. These elements are particularly vital to consider when exploring a controversial and sensitive topic such as abortion, especially to accentuate the complexity of individual realities (24). The nature of qualitative methodology moves through a continuous cycle of data collection and analysis, refining the problem and hypothesis until the phenomenon is understood thoroughly (23).

Understanding the implications of Missouri's abortion law and context post-*Roe* through subjective realities is best supported by a multi-dimensional and context-sensitive qualitative methodology such as constructivist grounded theory (CGT). CGT derives rich detail from qualitative data to better understand how individuals react to conditions and social processes. These understandings and constructions of meaning are heavily dependent on time, culture, and context of the phenomenon (25). For this study, these elements are relating to the current United

States post-*Roe* era, specifically in the conservative and rural state of Missouri. The innate constructivist epistemological position of CGT recognizes multiple realities and understands that knowledge is built jointly; thus, the researcher's and participants' influences collaboratively construct the meaning of a phenomenon (25, 26). Moreover, CGT's interpretive paradigm systematically approaches data collection and analysis simultaneously; often referred to as the process of theoretical sampling (27). A study's emerging theory is based in the interpretive insights derived from the experiences and perceptions of participants (28). Although this study is context-specific, apparent insights are transferable to the extensive network of HCPs navigating similar post-*Roe* circumstances across the United States. It is hoped that voicing the realities of a few will empower the many to share their stories to support sustainable change in abortion care.

Setting

Missouri's abortion law and sociocultural context has significant implications on the state's health care system, especially for the sexual and reproductive health field. Interviews were conducted to better understand HCPs navigation of Missouri's post-*Roe* landscape. Majority of Missouri's health network consists of religiously affiliated institutions; often employing policies that further regulate clinical interventions relating to sexual and reproductive care (22). The city of St. Louis serves as a major health hub for the rural state, especially for abortion related care. This is due to the city's geographic location, which sits right on the state's mid-eastern border; conveniently neighboring the progressive-leaning state, Illinois. Therefore, the physical space between the two polarizing legislative state's is slimly divided by the Mississippi river (10). Even with close proximity to abortion providing facilities, HCPs in St. Louis still face major occupational obstacles related to the provision of abortion related care.

Methodologically, CGT prioritizes time spent in the natural setting to validate the researcher's understanding of a phenomenon; and enhance researcher's relationship with participants. Considering confidential and time-demanding nature of HCPs occupational environment, participation in the natural setting or repetitive connection with participants was limited. Though these are methodologically disadvantageous for a CGT approach, the researcher's innate positionality to the sociocultural Missouri context helps stabilizes these shortcomings.

Sampling

HCPs in the OB-GYN field are the target population due to the traditional and clinical relevance to abortion related care. This sub-population of HCPs are the primary professionals actively navigating the post-*Roe* abortion care law and landscape in Missouri. To accurately encompass the pervasive range of health professionals readily engaging in abortion related care, the inclusion criteria was open to HCPs of varying clinical degrees and certifications (e.g., nurse practitioners, physician's assistants, and OB-GYN physicians). Notably, non-clinical occupational roles (e.g., medical technicians, receptionists, and office admins) were excluded from this study due to the lack of engagement and clinical experience with abortion related care.

A purposive sampling technique was employed to target licensed physicians first, which built rapport and expanded the pool of potential participants. As connections were established through initial participants, snowball sampling identified additional HCPs. In total, 25 HCPs were contacted directly with an invitation letter via email (see Appendix 1). From this pool of 25 potential participants, 2 HCPs were immediately recruited and interviewed. These 2 interviews were transcribed and started undergoing initial coding. Every few weeks, 2 new participants were recruited and interviewed, which ultimately yielded a total of 7 participants. This incremental process aided the researcher in adopting the CGT method of simultaneous data collection and analysis, alongside cyclical reflection and interview guide adaptation (25). Potential participant that did not respond to the initial invitation email were send follow-up emails consecutively throughout the weeks as well. Additional methods to recruit participants, such as phone calls to offices, were conducted, but unfortunately, did not yield any response.

While the sample is minimal, considerable depth and breadth relating to the post-*Roe* occupational realities of HCPs in Missouri was discovered. Considering the legal repercussions of Missouri's abortion law, sharing the intimate experiences and perceptions positions HCPs in a significant vulnerable situation. Thus, to strengthen participants' comfortability and trust, the consent form ensured autonomy over specific identifying factors. The two least descriptive identifiers, jo title and general area of professional scholarly, were unanimously selected across participants. Thus, the summary of participant's is as follows: 1 OBGYN Physician's Assistant, 2 Nurse Practitioners, and 4 OBGYN Physicians. These title identifiers will be removed from individual contributions to ensure protection of participants' confidentiality and autonomy.

Data Collection

Semi-structured, in-depth interviews were conducted, which are well-suited for constructivist grounded theory studies (29). The interview guide consisted of open-ended questions, supplemented by follow-up and probing questions (see Appendix 2). Inquiries elicited to topics of interest; but the direction of questions was dependent on what the participant deemed important or essential to perspectives and experiences of HCPs in Missouri post-*Roe*. Semi-structured interviews are commonly used to explore a wide range of thoughts, feelings, and beliefs; and in-depth interviews aim to derive detailed information of such experiences and behaviors (23). Combining semi-structured and in-depth approaches enhanced the realities of HCPs and stressed hidden nuances and implicit meanings.

Initial questions were developed from preliminary literature review of Missouri's current abortion situation coupled with the researcher's inherent knowledge of the states' sociocultural context; thus, remaining consistent with a model-building scheme adopted by CGT (25). Additionally, the co-construction and evolution of meaning is key; if new concepts were introduced, the interview guide was altered to incorporate these emerging novelties in future interviews (25, 29). Adjusting questions did not definitively direct the research, but rather granted flexibility for continuous refinement to explore aspects not previously considered. Interviews proceeded in efforts to achieve both thematic saturation by the breadth of data collected, and theoretical saturation through the depth of data analyzed (28). In CGT, saturation does not imply that new concepts will not materialize if the process of data collection and analysis continue, but instead assumes that the data thus far is sufficient enough to attain adequate understanding of a phenomenon (29). Moreover, when addressing and evaluating the degree of saturation achieved in thus study, it is important to factor in the limited timespan of the master's degree course.

Interviews were conversational in style, lasted roughly 45 to 55 minutes, and conducted via "Zoom" for participant convenience and researcher's accessibility to the target population. All interviews were audio-recorded to ensure transcription accuracy. The transcripts were shared with participants to review and confirm their quotes for data validation. Employing this approval protocol reiterates the importance of establishing participant-researcher trustworthiness and data dependability in qualitative research (23, 24).

Analytical Approach - Constant Comparative Analysis

HCPs interview transcriptions were analyzed through a constant comparison method, a cyclical process of comparing and contrasting codes and concepts. to using a constant comparison method to uncover similarities and concepts. This process is divided into three coding phases: *initial, focused,* and *theoretical* (30). During initial coding, individual words and phrases were descriptively labeled, essentially coding to account for and summarize each segment of data. Although this process was extensive, this phase encompassed immediate ideas following interviews and produced useful inductive information. Initial coding drew out the implicit and explicit meanings of data, representing as HCPs actions, descriptions, or tactic knowledge of an event (27, 30). Then focused coding followed, which dissected concepts further and generated subcategories. In this phase, dimensions and properties of HCPs feelings, behaviors, and attitudes were connected to emerging incidents or ideas. The most significant concepts were identified and compared to selectively condense data for the last coding phase (30).

In theoretical coding, a constant comparison of codes and concepts continued while simultaneously integrating analytic memos and annotations. These supplementary documents were developed throughout the data collection and analysis by the researcher to account for biases, emotional reactions, and assumptions (29, 30). The researcher's influences are not addressed to merely increase transparency; the researcher's contributions are acknowledged as active components to constructing connections between findings. A classical grounded theory approach requires the researcher to remain detached; but with CGT, the researcher is able to incorporate tactic knowledge of Missouri's sociocultural context to enhance supporting evidence of the emerging theory (29). These insightful additions are used as tentative tool to expand the scope of connections and highlight underlining nuances, not to control or reduce the emerging theory (25). A conceptual model of the emerging theory with analytical acknowledgements provides a visualization of the coding process in relation to developing the foundational theoretical elements (see Appendix 3). Additionally, the analytical transformation of the raw data unit of codes to categories and ending in theoretical theme is exemplified in Table 1. The entire coding process was facilitated using NVivo and other supportive software such as Google Sheets and Microsoft Word.

Ethical Considerations

Considering the controversial and sensitive nature of the abortion in the United States, ethical concerns were meditated thoroughly with vigilance. Weighing the risks and benefits was a continuous reflective process of evaluating the study's value to science and society (31). Acknowledging the risks posed to HCPs is vital to understand how scientific and social value serves as justification for investigating a vulnerable group as such. The legal, occupational, and sociocultural abortion landscape in Missouri is considerably delicate, which has required HCPs to strategically balance occupational engagements with abortion care for many years. Missouri's post-*Roe* abortion ban still poses significant threats to HCPs livelihoods, especially when professional responsibilities are closely related to or are easily misconstrued. Speaking about abortion is not only risky for HCPs in terms of occupational vulnerability, but it is a difficult discussion to have in general when considering the interrelated emotionally heavy sociocultural topics (31). Therefore, the main goal was to ensure HCPs felt protected and comfortable.

A consent form was distributed to each participant prior to the interview that was designed in relation to the ethical guideline considerations outlined by the Council for International Organizations of Medical Sciences (31). In the consent form, participants are able to decide how they wish to be identified in the thesis. For instance, disclosing their place of employment might raise questions and consequences if information about defying institutional policy is discussed in the interview. Hence, HCPs autonomous control over identify is essential in reducing risk. Moreover, participants could withdraw at any time and were provided the opportunity to review their transcript.

HCPs willful choice to participate symbolizes passion and desire to speak on this controversial topic, despite potential risk. Often, review boards withhold ethical approval on the basis of exposure to risks (32). HCPs undergo rigorous training that extensively covers ethical conduct and consideration. Thus, their professional education is credible justification to independently weigh risks without the intervening of an ethical review board. Thus, ethical approval was not sought for this precise reason. HCPs voices have been censored by this hypothetical double edge sword; speaking up can lead to irreparable repercussions and scrutiny, but remaining silent perpetuates irreversible health and systematic consequences.

The knowledge gained from this study emphasizes how HCPs can constructively contribute to legislation; their occupational legitimacy and relativeness is deserving of space in

legislation provision. Investigating how HCPs are processing and managing the post-*Roe* world is scientifically and socially invaluable. Gaining insight through the realities of HCPs bridges knowledge gaps and can identify opportunities to mitigate undesired implications that stunt sustainable change and progress towards health equality and equity in Missouri and across the United States.

Researcher's Positionality

As a Missouri native, I have a general interest for the health and well-being of those residing in the state. My understanding of Missouri's context, especially relating to socio-cultural nuances, is supported by years of living in and being exposed to the St. Louis community. Considering my close relations to the participant's natural setting, it would be unethical to not acknowledge the presence of preconceived notions about the abortion care landscape in Missouri. Thus, as the researcher of this study, I was transparent on my positionality with participants and applied an analytical approach that accounted for my influence as the researcher. Moreover, my position as a contributor to the knowledge being developed from this study, along with the subject experts, permits a level of reflexiveness that adequately supports a constructivist approach (26, 29). For instance, reflexivity in the data collection phase is addressed through the use of memos, which is concurrently advantageous in the data analysis phase and in structuring the theory. As previously mentioned, data collected from each discussion is considered by incorporating newfound concepts into the interview guide. Deciding what emerging and past ideas were continuously explored primarily depended on its prominence in the interviews, but simultaneously encouraged continuous literature review. Moreover, conducting literature review throughout the research process aided the ability to include any developments in the abortion discourse, which is a significant amount considering the legislature is constantly evolving at the state level. Further analytical explanation and support of my positionality is detailed in the following section.

Results

Conversely to traditional grounded theory's use of generalizable theme(s), CGT aims to illustrate results in a narrative or story-like structure (29). The categories reflect conditions, conceptual relationships, and consequences to highlight HCPs social processes and behaviors; these are detailed in Table 2 (27). The constant comparative analysis process yielded 3 theoretical

categories: (1) Learning the Law's Limits and Extents, (2) Balancing the Breaking Branches, and (3) Professional Pushes and Pulls. Each theoretical category is supported by 2 main categories, which further breakdown into sub-categories.

Collectively, these theoretical categories and their supporting parts all contribute to the main emerging concept, *curating occupational agency*. This overarching idea encompasses the process of HCPs developing individual and collective occupational agency through actively navigating Missouri's post-*Roe* abortion law and context. These findings are detailed in the following sections, with bolded-underlined theoretical categories, italicized-bolded main categories, and italicized sub-categories.

Learning the Law's Limits and Extents

This theoretical theme encompasses the foundational and constructing elements of Missouri's abortion law that directly impact HCPs occupational capabilities. Participants detailed these features as implicitly and explicitly influential to the array clinical interventions associated with abortion related care. HCPs perceptions and experiences concerning abortion related legislative parameters can indicate their professional approach to abortion related care in post-*Roe* Missouri.

Grasping the Groundwork

HCPs professional environment and labors are inherently linked to Missouri's abortion legislation. Participants quickly revealed that from a technical standpoint, the guidelines and clinical capabilities to manage abortion related care have not really changed. The newly implemented abortion ban is *conventionally malleable* to pre-*Roe* conditions; thus, HCPs occupational roles are easily adapting to post-*Roe* reality in Missouri as well. Participants understanding of the new abortion ban and its influence on their occupational functions as HCPs reflected somewhat of an unfazed concern to the already familiar restrictions.

"…there's still that difficulty for patients to access abortions and such facilities. Yes, Missouri's law changed, but as a whole, not many locations provided abortions anyways." -HCP 2

Considering the state's dominating religiously affiliated health care network, many HCPs are well acquainted with restrictions on care related to abortions; thus, occupational mechanisms to remained relatively stagnant. Participants reiterate that these policies have long been restricting

aspects of sexual and reproductive care that partially related to abortion care as well. These additional restrictions have been an existing concern for many HCPs, which has now been accentuated with a statewide abortion ban in place.

> "…patients of faith-based organizations knew they couldn't go to their OB and say, "Hey, I have this unwanted pregnancy", we would've referred them out anyways." -HCP 1

> "I'm not allowed to provide the patient with any information. I should not be giving them phone numbers of where to go or names of facilities. The only advice we are able to give patients is that if they are seeking to terminate a pregnancy, they would be better off going out of state…a lot of time times when I'm having a patient who desires to terminate a pregnancy, it's after an ultrasound that's showing some sort of anomaly with the baby, so they're a little too late to have a procedure done in Missouri, even prior to the law changing." -HCP 4

HCPs who personally do not offer elective abortion services have continued operating per usual since the abortion legislation never really impacted their technical operations prior. Participants communicated a rather detached perspective on the legislative shift entirely; a disconnect based on the lack of impact to occupational practicalities, which was slightly overshadowed with a general disinterest.

> "I'm a practicing Catholic, so I don't perform abortions…but in private practice in St. Louis, we don't…there's always been abortion providers…I am so far removed from it. I kind of feel like right now, if you're an OBGYN or in female medicine, the day in and day out of what I do, it hasn't really changed. It's not because of anything personally, it's just the nature of what we do for a living." -HCP 5

> "…I am pro-life, but I have some pro-choice views as well. It really hasn't impacted my practice because I don't provide abortions…the morning after pill is available to at any pharmacy, they don't need a prescription" -HCP 6

Occupational social environments are inherently impactful to how an institution functions, especially for HCPs practicing in large facilities such as hospitals. Participants hinted at having slight expectations to experiencing shifts in these communicative spaces, but most have not noticed significant differences between pre- and post-*Roe* social dynamics at work.

> "It's a still kind of the same as it was. I work at a religious institution, so many people here that are pro-life. Those people have and continue to voice their pro-life opinions…Those of us who are Pro-Choice still continue discuss and try to fight the fight, but we were already in this situation before the law changed." -HCP 3

Missouri's abortion ban has been amenable to overarching pre-*Roe* HCP standards, but HCPs ability to navigate legislative limits practically is not as harmonious. Participants vented about

the law's vagueness in relation to *unavoidable ambiguity* in the clinical setting. Immediately following *Dobbs*, power and authority over clinical decisions was at its peak. A haze quickly shadowed over HCPs clinical engagements with abortion related care, and still looms within the walls of health care facilities and inside the minds of HCPs. Participants continue to question and challenge these power dynamics to keenly understand the bounds of their clinical position.

"Do we have that power to make that judgment call on medical necessity or not? That's still unclear to me…Is that my call or someone else's?... Is the government somehow going to know…will this fall or backfire on me?" -HCP 1

"What if there is a mom that prematurely ruptured and having a spontaneous labor or delivery? What do you do for that? Do you stop a baby's heartbeat and then deliver? Do you wait and then have NICU care costs? Are there mental health challenges for mom and maybe even for the infants?" -HCP 2

Participants explained how ambiguity was a catalyst for reluctancy, which has spread like wildfire across the clinical setting since *Dobbs*. Discussions relating to the abortion law are discouraged in the workplace, which conversely influences the position of HCPs engaging in abortion related care in broader occupational communities.

"Nothing was said to the OBGYN department; it was unspoken…right now people are walking on eggshells around abortion. Who's listening? If they overhear, will it be taken to administration and get you in trouble?" -HCP 3

Participants illustrated an added layer of stress related to with care that evidently not clinically considered abortion care but has the potential to be misconstrued as such in a court of law. Thus, other areas of sexual and reproductive care linked to abortion in the slightest often fall to the demise of ambiguity. Although HCPs are trained and well-versed in their field of expertise, sometimes hypothetical fears and uncertain boundaries are reasonable enough to avoid even the slightest actions that could potentially result in legal repercussions.

"…it all feels a little unclear; what I can and can't say. There's this big fine, jail time, and other repercussions. It affects the way I talk to patients or the amount of information I provide. I want to provide care for every single patient holistically and fully, but I also don't want to lose my license, my livelihood." -HCP 7

If ethical approval is sought by a HCP in a semi-related abortion case, most ethics committees are cooperative in authorizing clinical intervention for evidently emergent situations; for example, the patient is hemorrhaging from an ectopic pregnancy. Unfortunately, some ethics committees perceive legal vagueness as an opportunity to assert power in favor of personal

interests. Thus, the ambiguous gaps between legal and medical definitions of what constitutes as a medical emergency allows for multiple interpretations, amplifying negative outcomes.

> "Even if we know the patient on her way to becoming septic, ethics requires a strict criterion. You can indisputably prove a patient is sick, and ethics responds with – "She's not sick enough." You challenge back – "So, before we intervene, you want her to get so sick that I'm scrambling to save her life?" They respond with "yes"." -HCP 3

Plainly, the slightest lack of clarity can sway the line between life and death. The participants who experienced such loss firsthand varied in response, adding yet another layer of ambiguity to the situation. A situation can be relatively identical but have considerable different outcomes, and the unaddressed legal ambiguity is contributing to these undesired consequences.

> "We didn't know anything about what the laws looked like or what we could do; the procedure is technically filed under abortion, even for an ectopic pregnant. She ultimately died because of it. In that moment, his hands were tied… It shouldn't be, "hold on, let me call the lawyers", which is what he was forced to do. We're supposed to do no harm, but because we have to first call someone to figure out if we can even act, it ends up doing harm." -HCP 1

> "Nobody's going to fall cheap treating an ectopic pregnancy or women hemorrhaging from a miscarriage." -HCP 6

There is no right or wrong way to navigate the ambiguity in the clinical setting. Simply, participants' collective experiences illustrate the undesirable truth of the matter. Until the obscure legal boundaries of Missouri's abortion law are clarified, ambiguity will continue feeding irreversible health consequences, both systematically and personally.

Powers over Practice

The lack of consideration for medical expertise and scientific evidence is evident in Missouri's abortion law. Participants' awareness of *religious rationalization* embedded in the abortion law was remarkably introspective. From the title alone, HCPs were responsive to the underlining messages being conveyed and supported by Missouri's state legislators.

> "It's very weighted terminology, and very opinion-skewed towards their own personal beliefs. The language and terms are very pointed and have a lot of weight. Instead of personal beliefs and morality being taking out, which is your job as a government official, the "pro-life" belief is very much evident in the law." -HCP 3

From a personal standpoint, some participants agreed with the law, but argued against religious infringements on the entirety of health care. Many explained how their personal belief influence

the range of services they provide or how they approach abortion related care; but they would never intentionally withhold information or alternatives options from patients.

> "I do tell them all their options. I lean a little towards the pro-life equation...My hope, and I think the way I present it, is that they continue with their pregnancy…this is a miracle and you're very lucky. That pregnancy, it's a life; I will take care of you if you choose to go on with the pregnancy, but at the end of the day, it's your decision." -HCP 6

Conversely, religious morality often disputes evidence-based care, which is the standard training for clinical health practice. For participants not in personal agreement with the law, expressed considerable frustration on the imminent presence of religion, not only in relation to abortion care, but in health care overall.

> "It's easy to say "We shouldn't kill. It's in the Bible. We shouldn't murder." Yeah, we shouldn't be killing anyone. But, whenever we're talking about a clump of cells, then what? Your argument falls short. It absolutely does. All of the arguments fall short whenever you think about the reality of it." -HCP 1

> "My problem lies in how religion is dictating how all people have to live their lives…we would rent out a room for vasectomies one day a week because they weren't allowed at the hospital. There's such a disconnect…limiting interventions that prevent pregnancy doesn't help the typical religious mission." -HCP 7

Subsequently, sacred standards are being extended beyond clinical abortion intervention and into the foundational elements of becoming an HCP. Participants voiced fear for future professionals.

> "Programs are full of different providers…there are various ways comprehending and providing care…If everyone is "Pro-life" at an institution, you're getting a very skewed view of the world, health care, and women." -HCP 3

> "Individuals who complete an OBGYN residency can do fellowship in what's called 'Family Planning', but that would be something to complete outside of a state like Missouri, if you want to receive adequate training." -HCP 4

Criticisms on religion were not directed at religiously practicing HCPs or institutions. Many participants' concerns related to societal impact; how the religious principles in support of the abortion ban become nonexistent in the aftermath of consequences.

> "Are we just trying to grow the population here?! It's insane that we are forcing women to have babies…Why are we fiercely protecting these little beings in creation, but not once they're out of the womb? You can't tell me that this is an argument about human life. If it was about human life, society would look very different, our laws would look very different, the conversation we're having would look very, very different." -HCP 1

"We seem to forget about the life of the mother. A living, breathing human, and so many risks go into being pregnant; your life changes…it's always about the "unborn", but it's never about when they are living. There are not many resources, and then I end up treating those children in youth shelters and foster care systems." -HCP 7

Given the abortion law directly impacts the health sector, the *inadequate clinical considerations* in Missouri's state government is considerably troubling for participants. Participants did not perceive governing bodies as underqualified to govern per say but did acknowledge the apparent gaps in medical and health care knowledge. The lack of sufficient and appropriate expertise in forming legislation poses direct threats to HCPs occupation. This was not taken lightly by participants; it presented as a core source to their frustration with how the state is handling the abortion law. Participants urge for a diverse and inclusive assembly to ensure alternative perspectives and interests are adequately considered.

"If you're not having a diverse set of team members, then you could be missing something…politics try to make everything so black and white when there's so many areas of gray." -HCP 2

"This polarized far left and far right; they're confusing the actual core problem by their own agenda." -HCP 6

"They are politicians, I wouldn't expect them to have a good understanding of it all. At the same time, I wouldn't expect them to make laws as if they do. When you have government officials' who don't even know what an ectopic pregnancy is but discuss banning them…things are bound to go wrong." -HCP 7

HCPs are consistently offering up evidence to legislative officials on the harms of banning abortion, yet these efforts have been thoroughly disregarded when governing decision are made in Missouri. The post-*Roe* legislation portrays abortion to be a cookie-cutter issue, a yes or a no debate, but there are many nuances to consider. For HCPs who care for patients through the incomprehensibly difficulties of abortion, enforcing illiterate legislation is viewed as blatantly ignorant and a targeted bias towards SRHR. Moreover, it encourages harmful and contradicting opinions to have more weight in deliberating the law over facts and data.

"It's interesting…the people who are Pro-Life, the conservative population, tend to be the same people that fight the government on vaccine requirements. They were not okay with the government requiring vaccines, but they want the government to say that I can't have a termination. That is being hypocritical. You can't pick and choose what parts of health care the government has a say in and what they don't have a say in." -HCP 3

"It's ironic that most of the people making these laws don't own a uterus. It's very easy to make laws on something that doesn't affect you…no understanding of all the facts or feelings associated." -HCP 4

Participants conveyed feeling that governing officials are unappreciative and lack respect towards HCPs expertise and efforts in keeping patients safe and healthy. For legislative officials, governing in the public's best interest is not a choice, but a fundamental responsibility of their occupation. The abortion law explicitly indicates officials' skewed idea of equality. In turn, participants feel they are unable to fulfill their foundational duty as HCPs, which is to provide and protect the public's health adequately and equally.

> "It's frustrating that I have the tools to help these people, but I can't use them. I have to send patients somewhere else, where I don't know about the care they're receiving and cannot guarantee that it's safe or reliable. Most opinions, especially politically conservative ones, don't really have a leg to stand on." -HCP 1

> "…the limited resources I can provide because of the law. I feel I'm doing patients a disservice, because I'm not giving all the care that I should and could be giving." -HCP 7

Balancing the Breaking Branches

In post-*Roe* Missouri, HCPs engaging with abortion related care have been put under a microscope. How they interact with the instable terrain of abortion related care is a carefully balanced process. Coupled with the legislation's fragile flexibility, the abortion discourse circulates compelling arguments and opinions that distress patients. Participants elaborate on risks and collective confidence required to configure an environment that enhances their occupational capabilities in abortion related care.

Contemplating Conflicts

Under typical circumstances, HCPs provision of care does not revolve around thoughts of lawfulness or government backlash. The primarily concern is the health of patients. While this intentional mindset is ideal, it is not easy to maintain in post-*Roe* Missouri. HCPs must weigh circumstances diligently, because overstepping the red tape wrapped around abortion care could cost them their livelihood. Determining the spaces where legislation can *bend without breaking* is a process participants have become well acquainted with, but HCPs interpretations of this in practice can differ vastly. It depends on how the risks and rewards are balanced, what resources are available, and how confident HCPs are to act without external approval.

> "An ectopic pregnancy with a heartbeat, those are a little hairier…If the woman is actively bleeding or unstable, that's different. You intervene immediately, no questions asked. You don't wait for a patient to be compensate…. although, I've heard stories where that happened." -HCP 4

Most participants hint at private practice being the most suitable atmosphere to bend rules in place. HCPs can feel more in control of their practice, even if they are not in control of the legislation. Participants who expressed a clear sense of autonomy over their actions perceived substantial individual capability to flex the rules instead of following them precisely by the book.

> "If my patient needs something for her health or her life, I just do it and ask for forgiveness later. I wouldn't second guess it at all. I'm not changing what I believe is right and doing what I believe is right." -HCP 3

> "I make decisions based on what I feel is moral and right, and that to me is a larger power than the government. I would never be making a decision that would put me in that situation. But even so, with the way the law is written, or as I understand there is not anything that I would be doing that would go against that law." -HCP 5

Though HCPs do not intentionally break laws by any means, being open to flexing rules can support providing comprehensive care under heavily restrictions. Many participants were hesitant to open up about the exact ways they go about this process but concluded that their methods could help other HCPs navigate murky waters in legal ways.

> "I still give out information, but again, it's more *hush hush*. I don't have pamphlets that I hand people, I verbally tell them things, because then it's not on the record… I tell them to pull out their phone and go to this website or tell them where they need to go over in Illinois." -HCP 1

> "At my hospital, I'm not allowed to counsel them towards abortion, but I do talk to them about all their options and give them resources. I just don't document it in the chart." -HCP 3

These decisions are not made hazardously; HCPs must be mindful over their influence in such a sensitive setting as providing abortion related care. For HCPs, *keeping hands clean* is not a choice, but rather a responsibility, both for personal and professional protection. Often, participants circled back to correct anything vaguely spoken to ensure their intentional message was accurately understood. Sometimes, it emerged internally as a means to remain at peace with decisions made in the clinical setting.

> "I think most of us can…you can justify almost anything in your mind. Whatever helps you sleep at night if that makes sense… but I think it's still hard to do and some things are case by case." -HCP 4

Other times, it was about external security, and not flexing rules to safeguard their professional position. Sometimes, even the slightest bending of a rule could end in breaking the law. This was

a fine line, because second can be the matter of life and death for a patient, but one wrong move and then there will be one less HCP providing care.

> "The doctor was on the phone with a legal team for multiple hours, figuring out how take action legally." -HCP 1

> "When we do intervene for the health of the mother, we call ethics for approval. They are the buffer..." -HCP 3

Participants aimed to seek this protection in situations that professionally benefitted while not posing harm to the patient by delaying action. If a patient could be safely transferred to a different facility, this helps HCPs steer clear of sticky situations as well.

> "Maybe that's because we live very close to the Illinois border and if need be, we direct patients to the same place I've always directed them. And maybe that's me kind of washing my hands a bit, but you know that all those options are still available for those patients." -HCP 5

Prioritizing the Patient

The abortion discourse has always been a controversial subject, but the overturning of *Roe* has emphasized dialogues primarily focused on aspects unrelated to the clinical practicalities and medical needs of patients. In Missouri, individuals who utilize sexual and reproductive health care services, especially abortion related care, have expressed feeling unsupported and minimized by the state government. The decision to enforce a statewide abortion ban when *Roe* was overturned significantly increased the space for conservative and religious narratives to flourish. Popular misconceptions and stigmas relating to abortion circulating in Missouri and across the United States has led to intensified anxiousness and fear among patients. Now more than ever, patients are seeking support beyond traditional clinical care, and HCPs are being placed at these highly sensitive intersections between scientific evidence and public opinion. Participants noted that trends in the abortion discourse are reflected in patients concerns and desires. The process of providing support and guidance has become a means of *handling hypotheticals*, which shifts HCPs occupational responsibilities from clinical care to complex conversations.

> "What's bothering me more is that I spend a lot more time talking patients off ledges. They're super nervous about pregnancy…if something goes wrong and they wanted an abortion, would it be available to them?" -HCP 3

> "There's a lot of misinformation…fetal heartbeat and a fetus having fingernails…so many skewed stories. Most patients have minimal scientific backgrounds, so those things become scary and are triggering." -HCP 7

HCPs guide patients' away from rash decisions; for instance, wanting permanent sterilization out of fear hypothetically miscarrying and bleeding to death because no HCP would intervene to save their life. Some patients have been adamant about moving to a different state entirely in fear for their health and safety. Participants mentioned endless streams of hypotheticals that have plagued patients' minds since Missouri implemented the abortion ban.

> "I have patients that say like they want to move before they get pregnant to a different state that supports them, and it hasn't even been a year." -HCP 3

> "I did have very young women wanting permanent sterilization and that's really tough…I talk to them about regrets…I try to push them towards a less permanent choice like an IUD, which I would have done pre- or post-abortion ban…I've done more counseling for that in the last 6-9 months than I've ever had in the past" -HCP 5

The doctor-patient relationship has been strained by the implementation of the statewide abortion ban, but not to a point of no return. Fortunately, many HCPs share strong bonds with their patients, especially in the sexual and reproductive field due to much of the care relating to rather intimate health subjects. Participants highlighted that their close connections with patients have helped tremendously in maintaining their trust. Although, post-*Roe* has been exceptionally difficult for patients and many HCPs to process, so patients speak about *going the extra mile* whenever they can to instill security. For some participants, this was extra attention and awareness of patients' needs when debating a pregnancy rather than their personal beliefs. This clinical time and space with patients are not meant for SRHR discourse, but patients are urging for this discussion with HCPs to attain a sense of relief.

> "We all like to present as neutral because we're there to discuss health concerns. I don't go in rooms with guns blazing about my position on reproductive rights. If it's brought up, then I'm very verbal and passionate." -HCP 1

> "…recognizing that I am not that patient. I don't walk her walk. This is her journey. The room is a safe space, and the patient leads the conversation with her thoughts and feelings; and just offering unbiased information." -HCP 2

Participants intentions to center the patient was clear; but at the same time, respecting their own personal boundaries. Taking the extra step is about being authentic with patients and prioritizing interpersonally with them. Often, participants emphasized this element as something they were especially appreciative about in their line of work, and that it helps guide and provide care for different patients effectively.

> "I think anytime, you can have open conversations and discuss concerns in a safe, non-judgmental place. I don't ever try to push my feelings or my beliefs on anyone, and I would hope my patience respects the same. I respect people's opinions, everyone has different personal beliefs, and it's not just with abortions." -HCP 5

> "It depends on how much you, as the provider, put yourself into your care…recognizing that I am not that patient. I don't walk her walk. This is her journey…I tell patients that the room is a safe space. I let the patient lead the conversation." -HCP 2

A significant point addressed by participants was this internal sense of integrity to their profession. This integrity of going the extra mile was exclusively in support of patients, not their license. This is a delicate balance between license and law, but it becomes less difficult when framed as a choice between a piece of paper or the living person. This hard-hitting realization has been eye-opening for many participants in their occupational role post-*Roe*.

> "A lot of people think you should protect your license with everything you have, but whenever I became a provider, I took an oath to protect my patients. They matter more to me than my license." -HCP 1

<u>Professional Pushes and Pulls</u>

This theoretical theme illuminates the factors of HCPs profession that structure their involvement in the abortion discourse beyond their occupational responsibilities. Participants illustrate these traits as pushes away or pulls towards participation. Their occupational positionality constructs unique opportunities to engage with the abortion discourse past the clinical setting. Although, how HCPs individually experience these profession-related pushes and pulls can dictate their degree of interest and investment to the broader abortion discourse.

Depletion of Devotion

Participates elaborate on the elements of their occupations that hinder their participation in the abortion discourse past professional efforts. Although they are directly engaging with patients who seek abortion related care, being an HCP quickly *exhausts external engagement* with the abortion discourse. Participants explain that this does not reduce their urge as HCPs to provide care, but their excessive exposure can take a toll on their discourse participation.

> "Honestly, at the end of the day, it's all so bogged down with patient needs and desires, and insurance factors. It's enough just to see your patients and chart and not have the opportunity to even extend beyond that." -HCP 2

“It inhibits because I'm already trying my best to work. Sometimes you just need to leave things at work and not let it take over your life. I know I’m doing what I can, where I am, and I don’t let my emotions... I can't bring everything home with me because it's my career.” -HCP 7

Conversely, the lack of professional engagement with abortion related care encourages a continued disassociation from the discourse. Inherently, the scope of OBGYN and sexual and reproductive care is extensive, and not all HCPs are directly involved with abortion related care frequently. Some participants attributed to the neutrality occupational responsibility as additional reasoning for their reluctancy, which simultaneously was a form of professional protection.

“As much as I disagree with the *Dobbs* decision, I don't think about this on a day-to-day basis. It doesn't come up so much. Maybe I’m not as enraged as I should be… maybe if my job was at Planned Parenthood... “-HCP 3

“That's how I've always protected myself from it, and I don’t know if that’s right or wrong, but I just… I don't get involved. I don’t advocate one way or the other, and that that's how I've chosen to practice it.” -HCP 5

Often, the stigma and stereotypes aimed towards HCPs soils their external efforts. Participants sourced much of their disengagement with the discourse to the circulating *disingenuous deceptions* of their profession. Although the circulating misconceptions fuel irritation and frustration, they do not necessarily fuel HCPs external actions. Participants illustrate that excessive opposing opinions from outsiders discourages their participation in the discussion; it is expressed as a relentless battle that frankly ignores any contributions to defend their profession.

“So much is based on people's opinions of what we do and not the knowledge that we have as providers… We’re not people that are just killing babies. There are so many misconceptions, and *Roe* exacerbated this one. We are not the enemy; we’re not paid extra to push meds or keep you sick. This is a thankless career. People minimize it and think we are just over here cutting big check because we are in health care and that’s all we do.” -HCP 1

“A lot of people are upset about other people being upset about the abortion laws. I hear a lot of “I can't believe people are upset that we can't kill babies,” and that's not quite what it's about.” -HCP 4

“It’s so misleading, the media is full of spin doctors. When they're having conversations about these policies and how they affect the community, just be honest, you know…” -HCP 6

Perseverance and Purpose

Although aspects of the HCP profession can reduce and discourage desires to participate in the abortion discourse outside occupational responsibilities, Missouri’s post-*Roe* abortion law and

sociocultural context has stimulated HCPs to assess their professional positioning. Participants expressed a sense of involvement with the abortion discourse through internal reflections that generated a magnitude of *questing queries* for the intersections of abortion related care and abortion related legislation; trying to determine the focus and direction.

> "This makes it more important to determine where the power should lie? Should it lie in local government more or should the federal government step in at certain times to kind of ensure the protection of people's rights?" -HCP 3

> "Where do you draw the line? And I'll tell you, if you did see an 8-week or 12-week pregnancy, it has everything there that we have. But at 5 weeks I can't see anything. I am pro-life, but I think it's a woman's choice too. And so, I'm pro-choice. I just feel like at some point you need to draw the line somewhere." -HCP 6

Often, these inquiries were expressed these as direct requests and suggestive solutions to improve the conditions of the abortion discourse, both in Missouri and nationally. Primarily, these suggestions were directed towards the general public and governing bodies; two extremely influential stakeholders in how the abortion discourse is shaped and impacted.

> "They should let us, and the patient make that decision. We don't even choose anything unless it's life or death. It's her choice, not anyone else's. Stay out of that equation. Have whatever opinion you want, that's fine. I'm not saying you can't think the way you want to think; but I am saying you should not be a part of the conversation." -HCP 1

> "I will typically say it all comes down to just the education and the contraception. Teaching abstinence isn't really, in my opinion, effective. It's certainly someone's choice, but it shouldn't be a forced upon choice." -HCP 2

> "The government should stay out of health care in general. It's not their decision to make. They should focus on road potholes and lacking infrastructure, food deserts; all these other things and not worry about health care. They should never decide what I do for my mental or physical well-being. It is my body. If I have cancer, they can't tell me I have to go through chemo. They can't decide if I have a vaginal delivery or a C-section, or any other decision concerning my own body. They should not be making the decision for abortions either." -HCP 3

The legislative shift in Missouri has inspired personal consideration of purpose in relation to the abortion discourse. This motivation was illustrated by participants through *intensions and extensions*; what their occupation means to them, to the discourse. Participants articulated meaning through connections between the discourse and their reason of being an HCP.

> "I show the patient at 8 weeks their baby, and most patients are pretty much amazed at what they're seeing. I think that in itself is the statement of what life is all about. You see fingers and hands, a foot, a knee, a face and eyes. It's pretty much life." -HCP 6

> "Most people will agree, no one "wants" to have an abortion. I'm not in support of abortion; I'm in support of helping my patients in whatever way I can." -HCP 7

Some HCPs are finding meaning through their intrinsic passion to help people. It has encouraged a disconnect from occupational responsibilities; to hold a level of self-accountability in the abortion discourse without attaching to their professional identity. Participants acknowledge the harmful narratives being widely supported in the United States' and are working to redefine the discourse to promote compassion, understanding, and equality.

> "Honestly, it shows where we are in America. The fact that women are still seen as merely vessels to procreate, and nothing more…The organ inside of the baby maker should not be more important than the baby maker." -HCP 1

> "I need to put my money where my mouth is. I can donate and support these organizations and businesses that do support women, their decisions, and their right to choose; so, they have the money to help fund peoples' travels and to carry out care being limiting from laws of one state." -HCP 3

Discussion

Overview of Findings – Curating Occupational Agency

The main theoretical theme, *curating occupational agency*, emerged from this study's exploration of HCPs experiences and perceptions of Missouri's post-*Roe* abortion law and context. This idea embodies how HCPs curate occupational agency by actively navigating through Missouri's post-*Roe* abortion landscape, both collectively and individually. Essentially, occupational agency includes the decisions, abilities, explanations, and actions of HCPs in the clinical setting; their autonomy in engaging with abortion related care (33). As the post-*Roe* landscape continues to evolve in Missouri, HCPs occupational agency will continue evolving. Agency is not a consistent state, but instead a fluid concept that configures and adjusts depending on how contextual factors are perceived and approached. The themes involved with this process included (1) learning the law's limits and extents, (2) balancing the breaking branches, and (3) professional pushes and pulls.

Understanding the Scope of State Legislation

This theme reflects the foundation of HCPs navigation process of their post-*Roe* realities in Missouri. Learning the law's limits and extents demonstrates that understanding the law, implementing the law, and attributing meaning to the law are not as linear as often expected.

Collectively, participants perceived and experienced the law in a polarized fashion, which evidently reflects a disconnect between the theoretical understanding versus the practical implementation.

HCPs pre-*Roe* and post-*Roe* landscapes in Missouri are relatively identical in terms of abortion related care resources and protocols, which theoretically, allows for an easy transition. A new law that *conventionally malleable* to preexisting conditions does not demand much additional consideration to unforeseen consequences. Thus, participants understanding of the abortion ban was shaped by passively transferring pre-*Roe* knowledge and experiences to their new post-*Roe* realties. Although participants expressed the transition from pre- to post-*Roe* as rather smooth theoretically, this was not the case for practical implementation. Missouri's post-*Roe* abortion law and its threatening legal repercussions have been and continue to haze the clinical setting. The lack of sufficient legislative clarity leaves HCPs to feel and experience a range of fears and undesirable consequences. HCPs are navigating a legislative paradox, positioning them in situations that threaten the health of patients and alter their perceived occupational agency. Although participants do not share identical occupational conditions, their experiences reflect how contradictions of legislative confinements urges self-doubt and waves of uncertainty, even with extensive training and knowledge in abortion related care. Typically, it is in this expertise where HCPs find the reassurance necessary to move forward in times of uncertainty, but participants demonstrate how Missouri's post-*Roe* legal ambiguity challenges their intuition to act; to have occupational agency.

Since the law is rooted in sacred principles and enforced by non-clinical officials, HCPs lack the confidence to rely on their medical expertise as a means to justify any engagement with abortion related care. As HCPs, scientific evidence is the foundation of their occupation, yet the state law does not support the protocols of evidence-based medical interventions to manage abortion related care. Instead of promoting the scope of medical intervention, the law promotes the personal interests of religious morality and political regimes. The lack of consideration and inclusion of scientific based evidence minimizes HCPs autonomy over their occupational agency significantly. The overwhelming frustration with Missouri's officials for using religious morality as a basis for justification and irrevocable professional implications as a threat to their occupational agency is undeniably present in the participants' contributions. The law's controversial structure not only diminishes HCPs occupational agency, but it increases patients'

exposure to irreversible health risks. Legislative clarity and pertinence were valued as significantly influential to occupational agency by participants, regardless of their personal opinions on religion and abortion. Participants with personal beliefs similar to the law's principles still voiced concern, but diligently angled their reasoning to reflect concern with religion playing a role in individual medical decisions and less about the ties between religion and the restriction on abortion related care interventions. Overall, the undesirable consequences of Missouri's post-*Roe* abortion ban were acknowledged and seen as relatively problematic for collective occupational functionalities and individual autonomy over occupational agency.

Synthesizing the Stability of Situations

The exceptionalism of abortion in the United States have positioned HCPs under watchful eyes and stressful scenarios. In post-*Roe* Missouri, HCPs are needing to balance the instable abortion care landscape diligently. If able, some HCPs utilize the ambiguous spaces of legislature expand their occupational intervention capabilities. Importantly, HCPs are not breaking laws, but simply finding the gaps to flex them in their professional favor. Participants explain that this process is highly sensitive, but also incredibly transformative to their occupational agency. It opens opportunity to improve the provision of care and better suit medical ethics, while remaining adherent to legal limits. Participants illustrate how this process in and of itself is flexible to a HCPs unique position and personal comfortability in testing the ambiguous waters of abortion care; thus, contributing to agency in a positive light, regardless of how it is individually constituted. It indicates a clear connection to participants value of autonomy and flexibility in the clinical setting, allowing them to provide patients care with freedom and self-assurance.

HCPs level of autonomy and confidence are key to managing patients concerns and doubts in the post-*Roe* world. Participants sense of agency was heightened when they were able to guide and comfort patients through these troubling thoughts. Internally, it was almost as if they felt a sense of pride in protecting the truth of the matter and proving their loyalty to patients' wellbeing. Although this exacerbated requirement to delicately weigh risks and rewards is not ideal for HCPs, it is a part of their new realities in providing abortion related care. HCPs can either choose to work against or flow with the new current. It is important to note that putting the patient first and flexing the rules seems relatively simple at face value, but participants hesitancy to even share these experiences and perceptions indicates that the process is far from easy. It

significantly elevates risk; challenging the laws elasticity, but simultaneously, it enhances the rewards; being a reliable and supporting actor in patients' abortion related care journeys. While this enhances HCPs occupational agency through autonomy, it also enriches the interpersonal bonds between provider and patient. Thus, even with the changing plains of legislation, the core doctor-patient relationship and occupational efforts to maintain care standards remains ever-present in Missouri's post-*Roe* world.

Processing Professional Positionality

This theme illuminates the factors of HCPs profession that influenced the level of participation in the broader scope abortion discourse. For participants, these elements were constantly shifting and changing; either encouraging or discouraging contributions external to their occupational responsibilities. The nature of their work does not necessarily constant revolve around abortion related care but is a mix of sexual and reproductive activities. Despite the daily number of interactions with abortion related care, they are central actors to women's sexual and reproductive health. HCPs who work in SRHR fields are inherently integrated into the discourse occupationally, but this does not indicate their personal investments in the discourse. Although their occupational position opens unique opportunities to conjure great change, many participants felt pushed away from these prospects due to their work environments' extensive relativeness to the discourse. Moreover, misleading information and opinions related to HCPs occupation are constantly circulating through discussions. This discourages any additional time and energy spent on the discourse, because participants often experienced it to be a waste, and that their efforts are better appreciated and acknowledged in the clinical setting.

Simultaneously, HCPs expertise and firsthand experience in managing abortion related care ignites their motivation to speak up and partake in the discourse. Their occupational position allows them an insight to the realities of abortion that most other actors in the discussion will never understand unless they are an HCP. Participants were able to provide extensive ideals and solutions to how the abortion landscape in Missouri and across the United States could be improved or modified to better support HCPs and patients. These suggestions do incorporate their personal opinions, but majority are based in their real-life experiences with abortion. Thus, this element is not controlled by legislation or occupational responsibility, but rather it is in the hands of HCP themselves. Although, how they perceive their potential and desire to be a

prominent voice in the discourse is dependent on how they experience these pushes ad pulls. In terms of their occupational agency, these facilitators and barriers can promote their agency to expand beyond the wall of health care facilities or diminish their aspirations to make change. Considering their irreplaceable occupational insights and knowledge, increasing HCPs involvement in the abortion discourse past their occupational role would be extremely powerful for the progression of SRHR in the United States, so acknowledging their reservations and incentives to participate is essential for the external discourse and their internal agency.

Relating Results to Existing Literature

Considering the *Dobbs v. Jackson Women's Health Organization* decision occurred less than a year ago, there has not been an extensive amount of research conducted on this topic specifically, especially not from the perspective of HCPs. Most existing literature related to *Dobbs v. Jackson Women's Health Organization* focuses on the access and quality, economic, sociocultural, and political impacts of the legislative power shift at the state and national level (6, 7, 10, 34, 35). For heavily restricted states like Missouri, a considerable amount of health policy research has been conducted focusing on how it influences the population in general, social constructs, and health related outcomes (10, 36, 37, 38). A weighty portion of this study refers to the public's perception on abortion, which is a distinct concept in the United States considering the fifty-split divide of contexts. How participants described the occupational influence of the public's perception is supported by previous findings that suggest sociocultural context, along with political and media exposure, can significantly sway how abortion as a public health issue is understood and internalized. (8, 17, 39).

For HCPs occupational experiences and perceptions of abortion related care in regard to abortion laws, previous research highlights the importance of political will and leadership from HCPs is an essential factor to the provision of abortion related care (40). Both in and outside the United States, HCPs have reported a desire to provide abortion related care in highly restricted regions, regardless of stigma and legislative marginalization (19, 40, 41). Although this study is context specific, the challenges that HCPs have reported in terms of working under heavy abortion restrictions are relative to other restricted states, specifically the southern region of the United States (19). Moreover, the claims and worries attributed to the education of future HCP cohorts and general provisionary capabilities was supported by a recent study that investigated

Ohio-based OBGYN HCPs, both certified and in training. The research found that these HCPs too faced barriers prior to the overturn of *Roe v. Wade* that significantly reduced their opportunity to develop sexual and reproductive care skills and experiences, and expect this to continue decreases post-*Roe* (42). These studies were the most relevant to the current study in terms of context, time, and place, which are essential to the employed analytical methodology (26). The concept of occupational agency has extensive literature, but for HCPs, this idea is central to how they interpret their environment and contribute to the production and reiteration of their occupational structures and rules. Their agency is constructed and reconstructed continuously by and through the systems they identify with (33, 43).

Methodological Considerations

Although the sample size was limited, the credibility of the present study was managed through prolonged engagement with the natural setting, which simultaneously built rapport with the participants (23, 44). Although physical presence in the HCPs occupational setting was unattainable, the researcher is innately familiar with the natural sociocultural setting and dynamics of St. Louis, Missouri. Subsequently, this was shared with participants for a transparent connection to build rapport. Most participants acknowledged that they desired to speak on this subject and appreciated the interest in this important subject, but realistically, their occupation is considerably demanding. Thus, the recruitment process was slow and yielded a relatively small sample but gaining 7 participants from this occupational field still produced vastly different experiences and perspectives, which portrays considerable credibility.

Moreover, the dependability and confirmability was supported throughout the study by the utilized CGT methodology (23, 26, 27). The consistency of finding was established using strategic data collection and analytic tools such as detailed field notes, audio recordings, and thorough transcriptions to document the process accurately. Additionally, the researcher was extensively reflexive through the use of analytic and theoretical memos to acknowledge assumptions and biases; reflexivity supported the establishment of confirmability as well. The co-construction of knowledge between the researcher and participants was acknowledged throughout the report and provided transparent details to how the knowledge is applied to the emerging theory.

As mentioned previously, this study is context-specific to the state of Missouri. At face value, the minimal level of transferability is a significant limitation. Although, if considerable connections can be drawn through contextual and legislative characteristic, this research can readily be applicable to other restricted regions in the United Stated. The transition from pre- and post-*Roe* is no means identical for two states, but many states share similarities with Missouri in relation to abortion related care and sociocultural landscape. Thus, to enhance transferability, significant attention was paid to Missouri's contextual setting.

Conclusion

The emerging theory aims to encompass HCPs reality in post-*Roe* Missouri through investigating their experiences and perceptions of the state's post-*Roe* abortion law and context. Essentially, how HCPs understand the scope of legislation, synthesize situations, and configure professional positionality can significantly influence their occupational agency. The monumental power shift over the right to abortion has been felt deeply and affected many communities. Missouri's post-*Roe* abortion landscape has placed HCPs in a uniquely confined position. How HCPs curate occupational agency impacts their engagement in abortion related care; thus, influencing the abortion discourse and health care landscape in Missouri. Collectively, HCPs general aspiration is prioritizing the health and wellbeing of people. Although the abortion legislation is ambiguous, HCPs can still provide and protect sexual and reproductive health and rights. Through curating their occupational agency, HCPs are able to effectively navigate through the complexities of post-*Roe* and make sustainable and widespread change.

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Table 1: Example of Analytical Progress from Data Unit to Theoretical Theme

Raw Data Unit (from transcription)	Codes	Sub-Category	Category	Theoretical Theme
"We didn't know anything about what the laws looked like or what we could do; the procedure is technically filed under abortion, even for an ectopic pregnant. She ultimately died because of it. In that moment, his hands were tied… It shouldn't be, "hold on, let me call the lawyers", which is what he was forced to do. We're supposed to do no harm, but because we have to first call someone to figure out if we can even act, it ends up doing harm." -HCP 1	Trying to determine the parameters of intervention Hands are tied/Needing guidance Causing undesired harm	Unavoidable Ambiguity	Grasping the Groundwork	**Learning the Law's Limits and Extents**
"It's very weighted terminology, and very opinion-skewed towards their own personal beliefs. The language and terms are very pointed and have a lot of weight. Instead of personal beliefs and morality being taking out, which is your job as a government official, the "pro-life" belief is very much evident in the law." -HCP 3	Language is bias towards individual Reliant on beliefs and morality the responsibility of the government pro-life legislation	Religious Rationalization	Powers over Practice	

Table 2: Overview of Main Concept, Theoretical Themes, Categories, and Sub-categories

Main Concept	Theoretical Themes	Categories and Sub-categories
Curating Occupational Agency	**Learning the Law's Limits and Extents**	***Grasping the Groundwork*** - *conventionally malleable* - *unavoidable ambiguity* ***Powers over Practice*** - *religious rationalization* - *inadequate clinical considerations*
	Balancing the Breaking Branches	***Contemplating Conflicts*** *bend without breaking* - *keeping hands clean* ***Prioritizing the Patient*** - *handling hypotheticals* - *going the extra mile*
	Professional Pushes and Pulls	***Depletion of Devotion*** - *exhausts external engagement* - *disingenuous deceptions* ***Perseverance and Purpose*** - *questing queries* - *intensions and extensions*

Appendix I: Invitation Letter

Information and Invitation Letter

Hello, you are invited to participate in a master's thesis about the implications of abortion restrictions. Specifically, this thesis explores the perspectives and experiences of healthcare professionals practicing in fields relating to abortion care on Missouri's abortion law.

About the interviewer:

My name is Madisen Brewer and I am a master's student in the Public Health program at Lund University. To understand more about the implications of Missouri's abortion law, I will conduct interviews with healthcare professionals practicing in fields associated with abortion care to collect data for my master's thesis project. The purpose of this interview is to investigate how healthcare professionals perceive and experience Missouri's abortion law. Participation will contribute to the knowledge gap regarding the relationship between healthcare workers and state abortion laws. This could provide guidance for public health officials and healthcare professionals in Missouri and other states navigating the confines of abortion restrictions, and identify opportunities to mitigate implications to improve the quality of abortion care.

Information about the interview:

The interview is estimated to last roughly **1 hour**, and will be conducted via **"Zoom"**. Before the interview, participants are required to sign a consent form highlighting their rights—such as the right to withdraw at any time without suffering any negative consequences—and pertinent information related to the ethical conduct of this study, including information about participant confidentiality, data security, and potential study risks. In addition, you will be asked to give oral consent once the interview begins. The interview will be recorded as a basis for analysis, and the results will be presented in a master thesis presentation session at Lund University.

If you have any questions, please do not hesitate to reach out. If you are willing to participate, please send a confirmation email indicating your date/time(s) of availability with a completed Consent Form. Thank you for your time and consideration. I look forward to hearing from you.

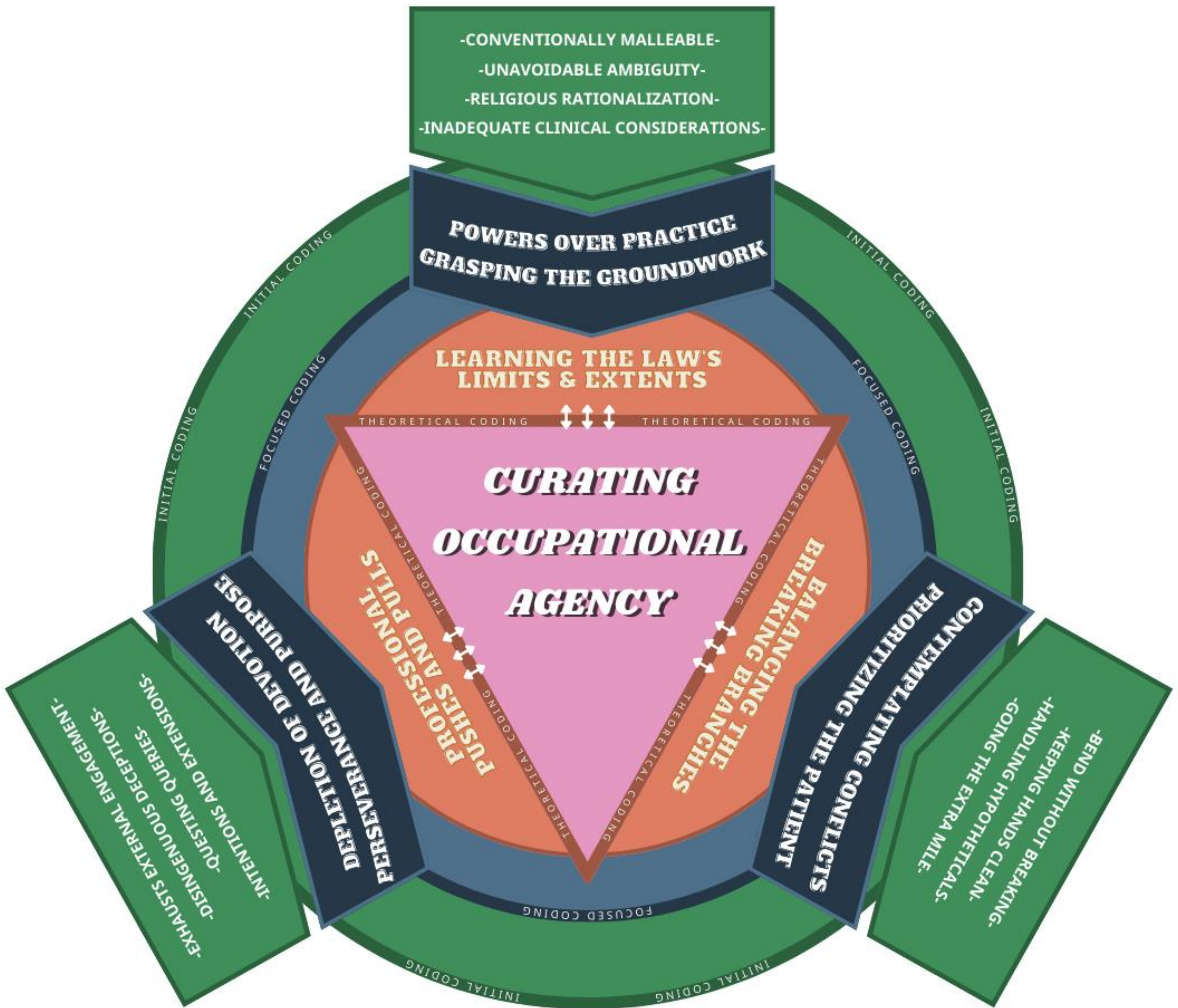
Sincerely,

Madisen Brewer: email: mlbrewer11@gmail.com | phone: +1 (314) 699-7293 (text only)

Appendix II: Interview Guide

QUESTIONS	PROBE/FOLLOW-UP QUESTIONS
Can you tell me about your current position?	How long have you been practicing? Have you always practiced in Missouri?
Could you tell me how your profession relates to reproductive care services?	What do you think your work means to these individuals?
Could you tell me why you were willing or interested to take part in this interview?	
What is your understanding of Missouri's current abortion law?	What does this law mean for your occupation? How does the current abortion ban compare to pre-*Roe* legislation?
How have the legal repercussions (i.e., prosecution of a class b felony and revocation of medical licenses) influenced your experiences with providing abortion related care post-*Roe*?	How do you feel about these repercussions?
Can you elaborate on your experience with an ethics committee in relation to the provision of abortion related care post-*Roe*?	What happens if there is a disagreement? If you have experienced a disagreement as such, how does it play out practically?
Could you elaborate on how a medical emergency is evaluated in relation to engaging in abortion care?	
The official name of Missouri's abortion law is cited as the "Right to Life of the Unborn Child Act". What is your perception of the language/terminology used in this law?	
What do you think of the political power that the state exercises in relation to the restrictions and repercussions on abortion care in Missouri?	If anything, what do you wish Missouri's General Assembly understood about your experience in navigating the abortion law?
How would you describe discussions relating to abortion in your work environment post-*Roe*?	
What is your perception of the additional restrictions imposed by religiously-affiliated healthcare institutions?	
What is your perception of future access to sexual and reproductive health care in Missouri?	
Can you elaborate on the experience of caring for a patient who seeks reproductive services that are not able to be provided legally in Missouri?	What feelings do you experience in these situations? What support tools are available to help you?
How would you describe the influence of Missouri's restrictive abortion landscape on your doctor-patient relationships?	Have you experienced shifts in interpersonal aspects with patients post-*Roe*?
Is there anything that you would have liked me to ask about that I didn't?	

Appendix III: Conceptual Model of the Emerging Theory



Appendix IV: Popular Science Summary

The United States' Supreme Court overturned the precedence set by *Roe v. Wade,* which shifted the legislative power over the right to an abortion from federal to state government. The right to abortion is an extensively controversial and sensitive public health issue, and significantly influences the landscape of sexual and reproductive health and rights in the United States. Missouri state's law bans all abortion except in the case of a medical emergency. This directly impacts the clinical interventions of sexual and reproductive health care providers; thus, influencing the access and quality of abortion related care.

The aim of this study was to understand how health care providers experience and perceive Missouri's post-*Roe* abortion law and context and discuss the potential occupational implications. The study wanted to determine what factors are influential to occupational agency and how this impacts the abortion discourse and health care landscape in Missouri. Seven interviews were conducted and analyzed through a constant comparison analysis.

The findings showed that health care providers' realities in Missouri's post-*Roe* world involve *learning the law's limits and extents, balancing the breaking branches,* and *professional pushes and pulls*. As health care providers navigate through these elements, they are *curating occupation agency,* which encourages them to enhance engagement with abortion related care in post-*Roe* Missouri. Comprehensively understanding the factors that influence occupational agency can significantly impact the abortion discourse and health care landscape. Despite the unavoidable ambiguity of abortion legislation, health care providers can still prevail in providing and protecting the publics sexual and reproductive health.