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Title: The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revisited

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Abstract

The recent 50th anniversary of the 1967 Abortion Act provides the opportunity to revisit what has been termed the ‘remarkable authority’ this Act ascribes to doctors. This paper does so using as its starting point a seminal commentary on this question by the renowned medical sociologist Sally Macintyre, published in this journal in 1973 as ‘The Medical Profession and the 1967 Abortion Act in Britain’. We revisit themes from that paper through an analysis of the findings of interviews with 14 doctors who, throughout lengthy careers, have provided abortions and led the development of the abortion service in England and Wales. We contrast our findings with Macintyre’s, and argue that our interviews highlight the shifting meaning of medical authority and medical professionalism. We show that those doctors most involved in providing abortions place moral value on this work; uphold the authority of women (not doctors) in abortion decision-making; view nurses and midwives as professional collaborators; and consider their professional and clinical judgement impeded by the present law. We conclude that medical sociologists have much to gain by taking abortion provision as a focus for the further exploration of the shifting meaning of medical authority.

Key Words

England and Wales, abortion, law, medical authority, Sally Macintyre

Introduction

The professional work of doctors providing abortions in England and Wales is shaped by a legal backdrop marking abortion as unlike other medical procedures. The law,

including case law, is extensive and complex, but includes two important Acts of Parliament. The 1861 Offences Against the Person Act contains an offence of ‘unlawful procurement’ of a miscarriage, which is punishable by possible ‘penal servitude’ for life. An offence is committed both by any ‘woman being with child’ or by a third party who performs an abortion. A separate offence imposes a lesser sentence for anyone who supplies the means of doing so. The Abortion Act 1967 did not repeal these prohibitions but, rather, carved out an exception which provided that the abortion will be lawful where two ‘registered medical practitioners’ agree ‘in good faith’ that an abortion should be provided under one of the grounds laid down in the Act. No-one else (including the pregnant woman herself or any other health professional) has the legal authority to judge that an abortion is necessary or to provide one. The law, as Jackson puts it, thus vests ‘remarkable authority’ in medical practitioners (2001, p.71).

The 50th anniversary of the Abortion Act 1967 provides the opportunity to reconsider this ‘remarkable authority’ and we do so here by revisiting an assessment of it by the renowned medical sociologist Sally Macintyre, writing in this journal back in 1973. In ‘The Medical Profession and the 1967 Abortion Act in Britain’ Macintyre analysed ‘statements made by members of the medical profession in debates preceding the 1967 Act’ in order to explore the ‘crucial theme’ of ‘the boundary of the [medical] profession’s sphere of competence and authority’ (Macintyre 1973, p.121). She sought to consider ‘role expectations’ and through this example, test the validity of Parsonian assumptions regarding the basis for the social authority of the medical profession on the one hand, and the challenge to those assumptions developed by Friedson.

Macintyre's focus was on 'doctors' conceptions of their own competence, authority and relations with patients and society' (1973, p.122). She showed that there were two levels of debate at that time. The first was about 'medical ethics'. Some doctors, as she detailed, expressed 'extreme repugnance' for abortion operations, questioning whether it should be permissible for doctors to 'kill' or 'take life'. Others responded by emphasising 'health', and the responsibility of the doctor to improve it. The second level was about the reasoning surrounding 'health' and the relation between an imperative to improve health, and the authority and responsibility of the medical profession. Macintyre concluded of this relation that:

...the medical profession holds a wider conception of its own role than that imputed by Parsons. Even those doctors who attempted to restrict their activities to their traditional sphere of competence and training, demanded recognition of their views concerning wider aspects of abortion on the basis of their professional status. This was a repudiation of the concept of functional specificity, since most of the arguments were not based on "clinical medical grounds", but on political, moral and quasi-sociological grounds concerning which, it can be argued, the medical profession has no more competence to be heard than other members of the community (1973, p.132).

Macintyre's claim then, was that doctors, including those supportive of abortion being legally available on 'health' grounds, laid claim to having their views 'recognised' on the basis of their 'professional status'. She questioned the validity of that claim, suggesting that doctors, arguably, had no more insight about 'wider aspects of

abortion', that is whether it should be provided and to whom, that anyone else. In this paper, we reconsider Macintyre's assessment in the light of our own interviews with doctors who have spent lengthy careers providing legal abortions and in leading service development. Before detailing our findings, we first discuss the context for our research and outline the design of our study.

Background to the research

Since Macintyre's study, further research has considered the opinions and attitudes of doctors (Francome and Savage, 1992; Roe, Francome and Bush, 1999; Francome and Freeman, 2000; Theodosiou and Mitchell, 2015). The volume of this research is, however, small, and there is no recent qualitative work of the sort reported here, that investigates specifically the experience of doctors who provide and perform abortions. While there is some qualitative work based on interviews with women about their experiences of accessing abortion services, this too is limited. Lie et al.'s review found an 'extraordinarily small body of peer-reviewed research papers' of this kind (2008, p2), with Purcell likewise finding qualitative research papers to be 'thin on the ground' (2015, p285).

This gap in the literature may partly reflect changes to abortion provision, whereby health professionals other than doctors play a growing role. While there is limited research exploring any kind of health professionals' experience of working in abortion services (Lindström et al, 2011) some has been published. Lipp reviewed 25 studies which investigated experiences across a wide range of professional groupings, using data from different countries (2008). Other studies have been published since;

for example, recent qualitative research carried out with ‘health professionals’ in Scotland generated interesting insights about attitudes, including about age, class and motherhood in professionals’ descriptions of women who have abortions (Beynon-Jones, 2012); their conceptualisations of abortion at later gestational stages (Beynon-Jones, 2011); and the extent of a focus on women’s rights and needs in providers’ accounts (Purcell et al. 2017). This work overall reflects a context of the growing use of miscarriage-inducing pills at early gestational stages (Early Medical Abortion, EMA). The pills are usually provided to women by nurses or midwives with the involvement of doctors increasingly confined to medically complex cases. Our findings reflect, in part, this changed landscape of abortion provision.

The most detailed research relevant to ours discusses doctors working in the US (Freedman, 2010; Joffe, 1995). There is also excellent, relevant comparative sociological work that considers abortion in the US and England (Halfmann, 2003, 2012). This paper, which focuses on England and Wales, does not attempt a comparative analysis. However, observations made by Joffe (1995), and later Freedman (2010), based on their interview studies with doctors, resonate with our findings. In particular, our research echoes the important finding of these studies regarding the moral value that doctors attach to providing abortion.

The ethical orientation of doctors most closely involved in abortion provision after 1967 has also been noted in socio-legal scholarship investigating the relationship between abortion, the law, and the medical profession. Most notably, McGuiness and Thomson explore ‘how the competing interests of different specialisms played out in abortion law reform from the early twentieth-century, through to the enactment of the

Abortion Act 1967, and the formation of the structures of abortion provision in the early 1970s' (2015, p.178). Of particular interest for our purposes is their commentary on what they describe, borrowing from Joffe's work, as 'doctors of conscience'.

McGuinness and Thomson reviewed work written by key figures involved in campaigning for abortion law reform before the 1967 Abortion Act and in advocating for legal abortion subsequently, and a major finding was the degree of fracturing and differentiation within 'the medical profession'. From their analysis, 'the medical profession' appears less as a 'profession' acting with one voice to further common interests, than as what these authors term 'stratified groups' (McGuinness and Thomson, 2015, p.196). They also briefly explore one outcome of this differentiation: the development of abortion provision outside the NHS after 1967 in response to the antipathy towards abortion on the part of many NHS obstetricians and gynaecologists. The emergence and growth of this 'independent' sector that provides abortion (now primarily the British Pregnancy Advisory Service and Marie Stopes Clinics) is an important feature of the development of services in England and Wales. Relevant also for our research is McGuinness and Thomson's observation that, historically, there has been a 'stratified' subset of doctors who are differentiated from other members of 'the medical profession' due to their decision to prioritise abortion provision as central to their work.

Our purposive sampling of participants was intended to select doctors who can be thought of as members of this 'stratified group'. Their outlook is not claimed to be typical of 'the medical profession' in general or even of the specialisms in it to which they belong. Rather, they are a group of doctors worthy of research attention,

precisely because they are leaders in the delivery of abortion services and are best placed to describe aspects of change to abortion provision. Our data thus offers a sound basis for re-exploring the tensions and problems with the legal arrangements established in 1967 and explored by Macintyre almost five decades ago.

Study design

We interviewed 14 individuals, purposively selected on the basis of long-term involvement in abortion provision and in policy and service development. This sample was not intended to be representative of all doctors who have involvement in abortion provision (including, for example, General Practitioners who refer women for abortion, or doctors whose involvement is restricted to signing authorisation forms). We recruited doctors who: had worked for a minimum of 10 years in providing abortions; who not only authorise but also perform abortions; and for whom this role or is the exclusive or major part of their work as Consultants in Obstetrics and Gynaecology or in Sexual and Reproductive Health. Three participants had recently retired, having worked previously for well over a decade providing abortions. There was a fairly even split by gender (although we did not take account of gender in the design of this study or seek to explore gender in the analysis of the data). We recruited those providing abortion in NHS facilities (n=10) and solely in the independent sector (n=4). We also purposively recruited to include doctors working in clinics located in large cities and in more rural or less densely populated areas of England and Wales. This allowed us to consider whether this had any bearing on any aspect of participants' experiences of providing abortions.

Ethical approval for the study was obtained from the Research Ethics Committee of the authors' University and from the independent service provider for which some interviewees worked. All participants were offered anonymity, with this reflected in the removal of identifying details and the use of numbers to attribute quotations below. We also agreed to obtain specific consent before quoting any material that might be considered particularly sensitive. This was sought and gained for some of the interview data included below.

The doctors who took part in our study were interviewed face-to-face using a semi-structured interview schedule between June and December 2016. The timing is important as the interviews were conducted in the wake of a lengthy public debate about 'sex selection' abortion during 2012-2015, where accusations were made that doctors who provide abortion had been acting criminally, authorising and providing abortions purely on the basis of fetal sex. Legal authorities eventually decided not to proceed with criminal prosecution and an effort to change the law to specifically criminalise 'sex selection' abortion failed (Lee, 2017). However, a few doctors were suspended from their duties and two faced an attempted private criminal prosecution under the 1861 Offences Against the Person Act, funded by an organisation opposed to abortion. As part of our interviews, we asked respondents to tell us how these events has impacted on their work.

The interviews covered: perceptions of recent debates about abortion provision; interviewees' day-to-day work; and opinions on the abortion law. They were transcribed verbatim, and analysed thematically, with a coding frame derived from themes identified by Macintyre (1973). Macintyre began her discussion with 'ethics',

documenting responses to claims which emphasised ‘killing’ and ‘taking life’ utilising a ‘concept of health’ to argue that medical duty can be expressed as ‘commitment to the health of the patient’ and the ‘well-being of the mother’. She then drew attention to the potential problems raised by this concept of health, and its reflection in the terms of the 1967 Abortion Act through the Act’s framing of ‘decision-making’ and ‘professional relationships with society’. In what follows, we work with Macintyre’s themes of ‘concepts of health’, ‘decision-making’ and ‘professionalism’ to discuss our interview data and reflect on changes since 1967. Those we interviewed had a great deal to say about health, decision-making and professionalism. However, as we show, they engaged these themes in ways that contrasted with Macintyre’s assessment. We argue this expresses new tensions within the law.

Doctors’ accounts of their work

1. Concepts of health

The doctors we spoke with all included abortion services as an integral part of ‘health’. This took different forms but all framed abortion as part of ‘medical care’. Providing abortion was presented as ‘just one aspect of medical care’ (5) or, ‘part and parcel of care like any other care; like having appendicitis, like having headache, like having mental health problems, [these] all are different elements of care that we provide’ (12). Abortion was also defined in terms of ‘health’ because emotional care is central to the services offered: ‘obviously there are formal definitions of illness and fertility and unwanted pregnancy can fall into that, but primarily our role is to relieve distress’ (15).

Some presented abortion as one part of a continuum of 'reproductive health':

It's just another reproductive health issue that I've been trained to manage so in my mind there is no difference between abortions and deliveries or managing still births or whatever it is (13).

Another participant detailed 'three broad areas' that comprise reproductive health care:

One is to conceive and have a family. The other is since the '60s when contraception separated the sexual act from reproduction..... That brings in termination as part of the interventions necessary for that aspect.

The third was defined as 'the care needed to address infertility'. This is the 'broader context of reproduction' concluded this doctor, 'and termination is just part of that' (11).

Linking abortion and 'medical care' was presented by some as contentious. The doctor who described abortion as 'part and parcel of care like any other care' completed this representation of abortion with the comment, 'frankly women should not be made to feel guilty because they wish to have a termination' (12), suggesting that presenting abortion as a normal part of healthcare was not so much stating an accepted fact, but making an argument that needed to be made, in the interests of improving the emotional experience of women. The doctor who emphasised the role

of medicine in 'relieving distress' expressed both total certainty that this is what makes providing abortion so important in their 'professional practice', while recognising that this is 'appreciated' only by those 'involved in the service':

I've absolutely no doubt that this is one of the main areas in my whole professional practice where we make a bigger difference to an individual patient or their family I think you have to be involved in the service to appreciate that... I've always found it to be sort of paradoxically rewarding, mainly because you can make such a big difference so easily (15).

This sense of tension between participants' perception that 'medical care' and 'abortion' go together, with a simultaneous recognition that this relationship is not recognised by others, was apparent in most interviews. It was also articulated in what was said about the experience of becoming a doctor who does this work, as part of the provision of healthcare; one doctor told us: 'I think we [doctors who provide abortion] are a different breed' (1). Most of those we interviewed described specific moments, or experiences, often during their initial training, that made them actively decide to focus on abortion provision.

Concepts of health and the meaning ascribed to what medical care *should* be were therefore central to descriptions of abortion provision as valuable medical work.

While Macintyre identified these concepts as primarily acting to refute moral objections to abortion those we interviewed used them differently: to uphold the value of abortion provision in a positive way. Providing abortion was presented as 'good' and 'fulfilling' work to which doctors were strongly committed: indeed they would

fight to provide it. Commonly occurring terms used variously by all interviewees to describe their professional experience in providing abortion services were ‘pride’, ‘satisfaction’, ‘pleasure’, ‘achievement’, and ‘enjoyment’.

2. Decision-making

It’s interesting because quite often people say, “Ooh, I couldn’t do your job,” and it’s funny because it really doesn’t feel like that...it can feel incredibly rewarding to be able to help somebody around making decisions about something that is going to have such an enormous impact on their future (3).

The doctors we interviewed were firmly of the view that ‘health’ is a strong justification for providing abortion to women. How did this connect to their understandings of decision making in abortion? How did they perceive their role as a doctor in relation to this decision? In most accounts there was a dominant view that making the decision to have an abortion is a decision of particular significance; for example, in the extract above, as one that ‘is going to have such an enormous impact on their [the woman’s] future’. It was this aspect of the work that made it so ‘rewarding’ but that others often did not comprehend, and far from making this doctor not want to do their job, this was a central motivation for providing abortion.

Interviewees gave no indication that they perceived ‘health concepts’ to lead them to want *authority* in decision-making. Indeed, and in contrast to Macintyre’s findings, they more frequently explicitly upheld the opposite idea: that the *woman should*

decide. One doctor directly challenged an ‘ethic of life’, through upholding both ‘care of the woman’ and her decision-making authority:

You may say it destroys but destroys what? Destroys the fetus you may argue but would you rather destroy the woman than the fetus? ... some women have taken their lives because of finding themselves with the dilemma of unplanned pregnancy. So when you talk about ethics, the ethics is about care and is about the care for the woman first and foremost and, yes, about the care of the unborn child but who is the best judge about the need of the woman? The woman herself or me? I think it’s the woman (12).

Present in most accounts was an explicit emphasis on the primacy of the woman as the decision-maker:

The bigger picture is of women in the world and individuals really in the world being able to make decisions about really personal things like reproduction (13).

Allowing a woman to have control over her reproductive life to my mind is absolutely key to her being able to have a healthy life (3).

Women have reproductive rights and those rights include not continuing your pregnancy for whatever that reason might be....at the end of the day no woman should be made to continue a pregnancy that she doesn’t want to

continue. No woman should be made to terminate a pregnancy she wants. To me they're the two sides of the same coin (8).

The meaning given to decision making was notably anti-paternalistic. This did not mean, however, that doctors saw their medical role either as purely technical or insignificant. Professional commitment to the provision of abortion throughout a medical career was rather presented as involving essential sensitivity towards women and to the importance of abortion.

However, it was also notable that the sensitivity needed to provide abortion well was not considered inherently connected to being a doctor:

I think you need somebody with the right attitude and good experience of abortion and experience talking to women. It doesn't need to be a doctor (1).

The bottom line is not about who you are, what profession you are in, but being appropriately trained and having to work within the same standard and if a nurse or a doctor can work towards a same standard I have no difficulties with that at all (12).

The boundary of professionalism was thus defined as inclusive of other groupings, for example nurses and midwives. As we go on to discuss, one aspect of criticisms made of the current law is that it prevents the expansion of the existing role of those other than doctors in providing and performing abortions.

In so far as doctors were seen to make a specific contribution to abortion services, some interviewees identified this as arising not from any special insight into whether an abortion was appropriate but from the medical expertise which they could offer in certain situations. 'Difficult' or 'complex' cases were thus cited as a reason for needing doctors in abortion provision, for example:

I do think that you need to have a supervising doctor because things go pear shaped or there are some that are difficult (1).

Clinically complex cases. ...Just like they do in maternity, just like they do everywhere in obs and gynae... They [nurses] can provide abortion care, and the doctors have to supervise the training and they have to be there for complex cases because they'll always happen (14).

Checking on safety and making sure about women who've got any kind of medical problems ...any complications. The rest of it nurses do (7).

The accounts of our interviewees seem to contrast with Macintyre's finding that 'concepts of health' bring with them claims for authority in decision making. We have also highlighted a strong view regarding the perceived ethical importance of abortion provision as part of healthcare. We have shown that an understanding of this ethical importance, combined with a practical role in providing abortion, was not considered the exclusive preserve of doctors. We now discuss our third theme, professionalism, to explore how aspects of these doctors' work were seen as difficult, frustrating and

even a source of anger, showing how this flowed in part from perceptions of problems with the law.

3. Professionalism

Those we interviewed communicated a strong perception that the law undermines their medical professionalism. This was not because they considered law gives them insufficient ability to make ‘political’ or ‘moral’ judgements, as discussed by Macintyre, but because the law was presented as a force that hampers the exercise of clinical judgement, and the ability to act as a ‘good doctor’. We illustrate this point through discussion of two key aspects of the 1967 Abortion Act. We then discuss the criminal law, focussing on respondents’ perceptions of the effects of the ‘sex selection’ investigation, and views on the ‘decriminalisation’ of abortion.

Two doctors’ signatures

The 1967 Act partially decriminalised abortion, making its provision legal where certain conditions were met. Key to these is the requirement that ‘two registered medical practitioners agree in good faith’ that an abortion is justified in the specific case at hand; this is how law makes medical authority in decision-making explicit. In practical terms, complying with the law means an abortion certification form has to be signed by two doctors and returned to the Chief Medical Officer for England or Wales. This is separate to obtaining consent for treatment. This form has to be completed by doctors regardless of gestation of pregnancy, abortion method, or the involvement of other staff such as counsellors or nurses in providing to the woman an

explanation of processes or procedures, or provision of miscarriage-inducing pills.

The second signature may be a referring doctor working outside the abortion clinic, often a General Practitioner (GP) or doctor working in the clinic or another part of a hospital, if that is where the clinic is located.

In general, we found the requirement for two signatures was strongly resented. Most talked about the 'two doctors' requirement in markedly critical terms, as 'crap', 'bizarre', 'unnecessary', 'valueless', 'irrelevant', 'superfluous', 'completely outdated', 'silly', 'stupid', 'pointless' and 'ridiculous'. Overall, we were given a very clear impression that these doctors had strong feelings about the deficits of this part of the law. Objections varied with most respondents raising all of those set out below.

The first objection drew a 'bright line' between the professional responsibility to obtain consent to treatment and the 'authorisation' requirement:

It's something that you discuss with someone and informed consent is the basis of all medical interventions and that is all there should be (1).

A woman needs to decide it and that's what she does. All the doctors of course ask. If they've already signed a [consent] form and the woman says, "Actually I'm going to continue with the pregnancy," nobody's going to drive her into the operating theatre and say, "We've signed it, you have to have an abortion!" (14).

The interviewee who described this part of the law as ‘silly’ explained the ‘silliness’ in relation to the fact of consent to treatment being needed anyway: ‘It should go with the consent..... that’s a big issue’ (10). Another who argued obtaining consent should be sufficient described completing additional paperwork as ‘unnecessary and that it begins to impact [on services] making an access problem’ (11).

This suggestion, that the requirement for authorising signatures has negative consequences that go beyond ‘stupidity’ and ‘daftness’, was made by most interviewees. Accessing abortion, we were told, becomes harder than it should be for women, partly because the ‘two signatures’ requirement creates delays and partly because it can make it seem to women as though their access to abortion is in question. Interviewees commented: ‘It does hold things up enormously, the second signature’ (1); ‘The biggest problem is time. Sometimes scrapping around finding somebody to sign a form’ (8); ‘It slows things down...it compromises the service’ (2); and ‘If you don’t have two doctors in a clinic you’ll have to wait for another doctor to sign the immediate impact is that of delay and unnecessary inconvenience... The regulation is about putting barriers rather than doing things that would benefit the individual in terms of quality’ (12).

One particular issue raised was how to develop a service in a way concordant with good clinical practice, based on self-referral where delays could be reduced because a woman will not have to wait initially to see her own GP, thus facilitating the provision of abortion at earlier gestational stages. Some were frustrated by the difficulties of doing this. As one told us, there needs to be, ‘two doctors in one place in order to deal with avoiding a delay when somebody hasn’t got a signature from the GP’. This

doctor also emphasised the additional problem for women in more rural areas:

‘Clinics in rural environments... there’ll be no second doctor’ (4). Another commented:

I have the people that are around and I can usually find somebody if there isn’t a second signature and I’ll go and describe what the circumstances are briefly and someone will sign it. But I can imagine if you’re working in a place where you don’t always have two doctors, it really is a limiting (9).

The problem of having to do this duplicate form-signing when a woman was attending a clinic was also presented as having negative effects for women in another way, because it ‘stigmatises abortion’ (8), which, we were told impacts negatively on women’s experience of abortion services. One doctor told us how they attempt to deal with this:

I try to do it before they come into the room’ [the form signing] but some women I think are aware that there’s something going on in the background about forms and criminal law and I think it very unfortunate that women have to have anything to do with that because I don’t think they should (7).

Early Medical Abortion: nurse-provided abortion and ‘home use’

The law’s perceived negative impact on the ability to practice professionally was expressed in a similarly striking way in comments about provision of early medical abortion. The law was written when doctors offered only surgical abortions but given technological developments, primarily the widespread use globally of abortion pills in

early pregnancy, the clinical context looks very different 50 years later. EMA is provided up to 63-70 days, and a miscarriage is induced using two doses of medicine usually given with 24 to 48 hours between. The 1967 Abortion Act is interpreted to mean that both doses both have to be taken with a doctor's authorisation on NHS or other licensed premises. These arrangements were a source of sometimes powerfully expressed consternation.

Without exception, those we spoke to supported allowing nurses to prescribe the pills but some went further. Notably, given the experience and seniority of our participants, they argued, on the basis of what is needed to provide abortion safely and effectively, that there was no reason to see abortion as 'doctors' work' and very good reasons to view it another way:

There are lots of instances where procedures are done just as well by other kinds of staff and we've got now lots of data accumulating about 'mid-level providers'people like nurse-midwives in Sweden [who] provide services in just the same way as doctors. [The legal restriction] needs to be swept away because that's way out of date....I'm not saying it should be unregulated...but I'm saying it should be regulated in the same way as health generally (6).

Others also indicated strong support for a much more fluid boundary between doctors and nurses, and this included making the case for doctors having much less to do with providing abortions altogether: 'I mean you don't need a doctor at all really. Not at all. In fact there's a set up where you could train up nurse practitioners to do the whole lot' (2). In this respect there was not only no evidence of these doctors seeking

to uphold their exclusive medical authority over abortion, but to the contrary they viewed law that conceptualises abortion provision this way as contrary to their medical opinion about what is required, given the evidence base regarding the clinical safety of nurse and midwife led services.

This claim about the law went still further, with some discussing how abortion provision should be thought of entirely differently, with women self-administering medication, and doing so at home, away from a clinic. Support for this approach was expressed in terms of varying strength, with variations between this:

I think on the whole it's better if it's done in a medical environment except for very early termination which fair enough, six weeks could probably be done at home (5).

And this:

Misoprostol should be available in any reproductively active woman's bathroom cabinet basically in my view (2).

The case for 'home use' of abortion medication was argued for partly on the basis that abortion is routinely provided safely and effectively this way in other parts of the world and that British practice should reflect that evidence. Indeed, subsequent to the completion of our interviews, in Autumn 2017 it was announced that 'home use' had been approved in Scotland.

We found striking, manifest anger and frustration expressed by some participants about the present legal situation, because medication has to be administered in the clinic:

It's extraordinary that you can subject women to travelling mid-abortion. I mean I find that unbelievable that the government can do that and why? (1).

...to make women come back when they're potentially going to be travelling, bleeding and in pain which happens all the time, why would you do that? (5).

Other than to just control even further what women are trying to do safely... I think it's absolutely horrific (9).

Our interviewees felt that doctors were being legally required to provide abortion services in a way that ran contrary to their professional judgement and best practice, posing particularly acute problems in rural areas of the country:

We're a very big rural area, and [have] very poor public transport and yet we force all our patients to come to a central service ... obviously the worse scenario is they start miscarrying on the bus or in the train ... we would much rather be able to deliver these services more locally, so at GP surgeries or dotted round the county (15).

The 1861 Offences Against the Person Act: the threat of prosecution, a culture of fear, and the case for decriminalisation

As we noted above, our interviews were carried out in the wake of an extensive public debate about ‘sex selection’ abortion, attendant investigations of abortion clinics, and of some individual doctors. This debate was initially provoked by undercover filming by journalists working for the *Telegraph* newspaper of discussions between doctors and a pregnant journalist, who pretended to request an abortion. Those using this filmed footage to promote the need for investigation of the doctors involved, had claimed that providing abortion on grounds of fetal sex fell outside of the provisions of the 1967 Abortion Act, and thus constituted an offence under the 1861 Offences Against the Person Act. They argued the film footage was evidence that some doctors were not only prepared to provide illegal abortions but, further, that they considered themselves above the law and were unconcerned about the rights and needs of women and girls. Their claims were taken seriously by the then Secretary of State for Health, leading unannounced inspections of all abortion clinics as well as to police investigations of a small number of doctors (Lee, 2017).

This episode, including the possibility of criminal prosecution that was part of it, gave rise to some of the most impassioned accounts provided to us about the undermining of abortion provision. This was discussed primarily in terms of its effect on doctors, who might feel fearful and change their practices accordingly. About half of those we interviewed placed strong emphasis on fear and insecurity regarding medical practice, arising from the threat of prosecution; the ‘sex selection’ furore had a ‘massive impact because it made doctors frightened’ (14) and ‘I think it heightened that idea that providers felt quite fearful’ (3).

One doctor had been directly subject to the filming organised by the *Telegraph*. She had not provided or authorised any abortion, following a request for one on the grounds of fetal sex. ‘Clearly I didn’t realise it was a journalist, and what it was, but it was so odd. It didn’t follow any pattern of a normal consultation’ she said. She had referred the case to a colleague and sought to discuss what had clearly seemed to be strange and confusing peculiarities of the consultation. This doctor was nevertheless suspended from work and the fear and distress experienced was obvious and palpable even in an interview carried out many months later. She described, in tears, how ‘My children were chased down the street by journalists’ and how the investigation that followed, ‘hung over me for 18 months and at times things were very difficult’ (9).

She did eventually return to her prior position at work, but another interviewee told us that the effects of fear worked out for other doctors:

I worked alongside one of the doctors that was suspended for a short time locally who then didn’t want to be involved in this service although it’s something that they’d done all of their career (6).

Fear thus led to some doctors abandoning abortion provision. A further connected issue described to us was the ‘chilling’ effect on what would otherwise be considered good, routine practices in abortion provision; these episodes, ‘make people over cautious and ultra-cautious’ (7).. One of the doctors who told us about frightened colleagues explained how this worked. ‘They say, “Well if we don’t cross this and if we don’t tick that then somebody’s going to take our registration away,”it’s got nothing to do with good clinical care and I’m furious about it. It’s really not doctor-

think' (14). These problems, we were told, impacted differentially, with the most powerful effect on those who were 'not confident' and worked in 'unsupportive' settings, for example, 'overseas doctors who are very cautious and really don't want to put a foot wrong' and who are 'scared of doing something wrong all the time' (1). One doctor spelled out the detrimental effects for what they considered good medical care this way:

It sends fear, it sends sometimes a disorganised response, so it does disorganise and destabilise doctors who are functional people who wanted to do a specific task (11).

The other effect of fear described to us was the deterrent it created to younger doctors considering getting involved in abortion provision. Abortion provision was described as carrying an increased 'degree of stigma' (3) arising from:

All of the negative light that's been shown on abortion ...to see if doctors are breaking the law. I think those things are deterrents to junior doctors going into the field and wanting to get training and also I think it dis-incentivises providers in the NHS where all the training happens from developing and supporting services where junior doctors can be trained (13).

We did not directly ask participants about their views regarding campaigning work seeking to bring about the 'decriminalisation' of abortion that had begun shortly before we carried out our interviews. However, some comments were made about this

campaign, indicating consideration was being given to whether legal change of this sort might address the problem of fear and uncertainty:

The discussion around decriminalisation both invites some enthusiasm for some doctors to think okay, well this will be outside the criminal code and that's positive and it might make it easier for them to want to engage in abortion care because the threat of prosecution isn't there. At the same time I think it might lend some degree of insecurity to some doctors who feel in a way protected by the fact that the law is in place and that if they work within a certain rubric that they will avoid prosecution (13).

Conclusions

The starting point for this article was the 50th anniversary of a key piece of legislation – the 1967 Abortion Act – which scholarly work has often presented as a reflection of the interests and dominant social position of the medical profession (Keown, 1998; Thomson, 2013). Sally Macintyre's seminal study conducted at the time of the Act's introduction drew attention to difficulties and tensions regarding the operation of medical authority, considering specifically how 'concepts of health' reflected in the terms of the Act might affect medical 'decision making' and 'professional relationships with society'. We have revisited these issues through qualitative research with doctors for whom abortion provision is central to their medical work, and who speak with particular authority as they are leaders in their field. Our interview data is not therefore necessarily representative of either the medical profession as a whole, or doctors who have more limited involvement with abortion

provision. Our sample was likely to generate accounts highlighting problems with the current legal arrangements and we suggest has generated new insights because of this.

The central insight to emerge from our research overall concerns the shifting meaning of medical authority and medical professionalism. The legal scholar Michael Thomson (2013), building on Keown's (1998) work on abortion, doctors and the law, encourages us to think of medical professionalism as a process, and consider the importance of boundaries. Abortion can be thought of as a 'boundary issue', he argues, and thinking of abortion this way, 'draws attention to specific sites where professional groups return to defend, assert or extend their interests' (2013, p.194). Boundaries that come to be solidified in law, and can appear firm and concrete, are in fact are always open to question, he argues, as meanings given to medical authority and medical professionalism are complex and shifting. Through this article, we have shown that our participants did assert 'interests' in abortion, but in ways that are notably different to those emphasised by Macintyre, draw attention to the ways boundaries have shifted, and in turn indicate new tensions for the law.

We have shown that those we interviewed did discuss abortion in relation to a 'concept of health', and did so in ways that more or less explicitly contradict the assumptions about medical authority underpinning the present law. In a way resonant with the idea of 'doctors of conscience', our interviewees communicated a strong sense of commitment to the moral worth of providing abortions, as part of medical care. We interpret this as having important implications for how they understand both authority and professionalism, which contrast with Macintyre's findings. We found evidence of an almost uniform refutation of a claim to authority in abortion-decision

making. It was, most doctors indicated, their responsibility to provide healthcare in the form of abortion services, and this meant *upholding* decision-making by women. In upholding women's decision-making, however, the doctors did not present themselves as lacking in medical authority. Rather, they expressed strong ideas about what they thought best and right, by merit of their professional experience. On this basis, they communicated powerful objections to the requirement for 'two signatures' that is central to the 1967 Abortion Act which they perceived as impeding the provision of good medical care.

We have also discussed the place of medical technology, specifically the use of abortion pills and their provision by nurses and midwives, in bringing about shifts in understandings of medical professionalism. In general, what we have reported is in line with findings of a large body of research documenting the effects of this technology for abortion provision, including in England and Wales (Sheldon, 2016) and in Scotland (Purcell et al, 2017). In our study, the most interesting aspects of participants' comments regarding EMA were, firstly, about shared expertise and knowledge and an emphasis on others' professionalism being equal to that of doctors'. This reflects a rejection of medical hierarchies absent in Macintyre's study. Second, we detected a powerful moral dimension in the sometimes passionate objections to a legal framework that requires EMA to be provided in a way that departs from best clinical practice, with a clear negative impact on women's experience.

When Macintyre published her article, no attempt had yet been made to use the provisions of the 1861 OAPA to prosecute a doctor for acting outside the terms of the

1967 Act in authorising or providing an abortion. Our research was carried out in the aftermath of one concerted attempt to do so. We have discussed evidence of participants perceiving there to be a culture of fear operating as a result. This finding is perhaps most striking of all we have reported, in regards to the question of medical authority. It suggests that the doctors most centrally impacted by the abortion law do not experience it as making them socially powerful, as Macintyre suggested might be the case. Rather, the present abortion law can have outcomes that, in the case of some individuals at least, were reported to have undermined their ability to work altogether or led to a remarkable level of disruption of their lives and that of their families. Across the sample, we also found expressions of concern about the morale and sense of security of doctors who provide abortion and about involvement in abortion provision being discouraged.

We end by noting that subsequent to the completion of our interviews, all of the main relevant UK medical organisations have made public their commitment to removing abortion from the criminal law. The Council of Royal College of Obstetricians and Gynaecologists and the British Medical Association have voted to support the decriminalisation of abortion and the Faculty of Sexual and Reproductive Healthcare has made public its support for this change. The current president of the Royal College of Obstetricians and Gynaecologists (RCOG), Professor Lesley Regan, has also publicly contested the centrality of ‘the registered medical practitioner’ to the certification of legal abortion (Campbell, 2017).

The abortion law has been strongly criticised for years by those identified with feminism and ‘pro-choice’ activism. However, it now seems doctors most centrally

affected by the law have also come to consider it unsatisfactory and they are supported by their professional bodies in this view. Medical sociologists interested in pregnancy and abortion might well take this development as one that provides good reason to further revisit and rethink long held assumptions about the meaning of medical authority in this context.

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Highlights

It is useful to revisit Sally Macintyre's 1973 assessment of the British abortion law

The British abortion law is based on an outdated idea of medical professionalism

Doctors who provide abortions in England and Wales place moral value on their work

Early Medical Abortion has acted as a key driver to change in recent years

The continued inclusion of abortion in the criminal law undermines abortion

providers