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The Professional Identity of Doctors who Provide Abortions: A Sociological Investigation

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ABSTRACT

Abortion is a medicalised problem in England and Wales, where the law places doctors at the centre of legal provision and puts doctors in control of who has an abortion. However, the sex-selection abortion scandal of 2012 presented a very real threat to 'abortion doctors', when the medical profession's values and practices were questioned in the media, society and by Members of Parliament. Doctors found themselves at the centre of a series of claims that stated doctors were acting both illegally and unethically, driven by profit rather than patient needs. Yet, the perspectives of those doctors who provide abortions has been under-researched; this thesis aims to fill that gap by examining the beliefs and values of this group of doctors. Early chapters highlight the ambiguous position of the abortion provider in Britain, where doctors are seen as a collective group of professionals motivated by medical dominance and medical autonomy. They outline how this position is then questioned and contested, with doctors being presented as unethical. By studying abortion at the macro-, meso- and micro-levels, this thesis seeks to better understand the values of the 'abortion doctor', and how these levels shape the work and experiences of abortion providers in England and Wales. This thesis thus addresses the question: 'What do abortion doctors' accounts of their professional work suggest about the contemporary dynamics of the medicalisation of abortion in Britain?'. It investigates the research question using a qualitative methodological approach: face-to-face and telephone interviews were conducted with 47 doctors who provide abortions in England and Wales. The findings from this empirical study show how doctors' values are linked to how they view the 'normalisation of abortion'. At the macro-level doctors, openly resisted the medicalisation of abortion through the position ascribed to them by the legal framework, yet at the meso-level doctors construct an identity where normalising abortion is based on further medicalising services. Finally, at the micro-level, the ambiguous position of the abortion provider is further identified in terms of being both a proud provider and a stigmatised individual. This thesis shows that while the existing medicalisation literature has some utility, it has limited explanatory power when investigating the problem of abortion. The thesis thus provides some innovative insights into the relevance and value of medicalisation through a comprehensive study on doctors' values, beliefs and practices.

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LIST OF ABBREVIATIONS

Abbreviation	Definition
ALRA	Abortion Law Reform Association
BMA	British Medical Association
BPAS	British Pregnancy Advisory Service
BSACP	British Society of Abortion Care Providers
CMO	Chief Medical Officer
CQC	Care Quality Commission
EMA	Early Medical Abortion
FSRH	Faculty of Sexual and Reproductive Healthcare
GMC	General Medical Council
MSI	Marie Stopes International Reproductive Choices
NHS	National Health Service
OAPA	Offences Against the Person Act 1861
PAS	Post Abortion Syndrome
RCN	Royal College of Nurses
RCOG	Royal College of Obstetrics and Gynaecology
SRH	Sexual and Reproductive Healthcare
STC	Science and Technology Committee

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INTRODUCTION

This thesis began as work for an undergraduate and then postgraduate dissertation. I had been researching and wrote about a protracted period of public debate about abortion between 2012 and 2015, focusing on a furore driven in the first place by reporting in the *Daily Telegraph* newspaper about 'sex-selection' abortion. Journalists writing for that newspaper claimed doctors in Britain were providing abortions if a woman said she did not want a baby of a particular sex. Mainly, it was claimed that the abortion of 'girl foetuses' was being requested – and possibly provided – with abortion providers then presented as colluding in sexism. Parliamentary debate ensured, and eventually attempts were made to outlaw 'sex-selection abortion' as part of the Serious Crime Bill (Lee, 2017).

I was working with my dissertation supervisor who was, at the time, writing on this subject. Together we spent a lot of time discussing what to make of this period of contestation about abortion, and the ways in which abortion was being discussed in the media and in politics. The idea for this research emerged out of that work. As an undergraduate and then postgraduate student, I was concerned about the way abortion was constructed as a social problem through this phase in the debate. My main interest was in the claims about abortion that were being made by those opposed to abortion, and how these claims attempted to find a new way to make the case for a more restrictive abortion law and practice. My concern was about the development and effects of claims about the rights of the female foetus and protecting women from the actions of allegedly dangerous doctors.

Scholarship continues to develop about this aspect of the abortion debate (Kasstan and Unnithan, 2020); innovative work explores the connected issue of the development of anti-abortion activism (Lowe, 2019; Lowe and Hayes, 2015; Evans, 2015). This work builds on a body of research that considers the changing framing of arguments and activism against abortion. In wanting to contribute to this research area, I had various choices to make. I decided not to pursue research about the question of the anti-abortion lobby and its claims-making specifically. Instead, I decided to focus on an aspect of abortion that emerged as strongly impacted by the 'sex-selection' debate: the outlook, work and motivations of doctors who provide abortions.

Through the debate in the period 2012-2015, claims made in the media and in the Houses of Parliament centred on presenting doctors who provide abortion, and the services they work for, as selfish, uncaring, driven by greed and unconcerned about women. A small-scale study by one of my supervisors and colleagues has already show some of the effects of this discussion for the experience of doctors working in abortion care (Lee, Sheldon and Macvarish, 2018). This work had shown that although the attempt to change the abortion law had failed, the period of investigation and scrutiny of those working in abortion clinics it had unleashed has had many important impacts. It was this that prompted me to focus my research on doctors who provide abortion. How does a sector of the medical profession – a profession mainly portrayed as having some level of power and authority – make sense of its work when it is subject to the sort of public debate and scrutiny that it has seen in the early twenty-first century?

Everything I had previously read, and all of the evidence that I could find, made claims that doctors who provide abortion were unethical, problematic. For example, the majority of all abortions are funded by the National Health Service (NHS), there is almost no private practice of abortion in England and Wales today through which profit can be made. It therefore seemed peculiar that an argument that doctors are trying to make a lot of money from abortion, at the expense of women, had the effects that it did. I also attended numerous events organised by abortion providers to discuss abortion provision and my experience was of a group of professionals trying, above all else, to help women. It was also the case that both in response to the 'sex-selection' debate, and as part of the growing discussion about the problems of the continued inclusion of abortion in the criminal code, doctors had become more active in responding to arguments made about and against them and were coming to voice their concerns about abortion service more publicly. This struck me as providing a context and opportunity to design and conduct research about an aspect of abortion that had been neglected, at least in sociological analysis, and to do so in a highly dynamic context.

From the beginning of my research project, a campaign has built up with increasing visibility and media attention, within which doctors themselves argued for change in the abortion service. There has been a great deal of public campaigning by doctors and organisations that represent doctors supporting different aspects of change. The Royal College of Obstetricians and Gynaecologists (RCOG) and the British Medical Association (BMA) have both publicly supported the campaign to take abortion out of the criminal law (to decriminalise abortion).

During the time I researched and wrote this thesis, there have been significant modifications to the regulations around the abortion services, and in its practices.

Between October 2017 and August 2018, the Scottish, Welsh and English governments all developed policies to allow the home use of misoprostol, meaning women could complete an Early Medical Abortion (EMA) at home. Although this happened subsequent to the completion of the interviews with doctors carried out for this study, the emergence of the COVID-19 pandemic pushed policy further in this direction. Following a furious period of campaigning, the Secretary of State for Health confirmed two temporary approvals to legislative change in March 2020, so that doctors could prescribe mifepristone and misoprostol from home, and women seeking an abortion under ten weeks gestation are able to take the abortion pills from home rather than attending the clinic. These measures were set out as temporary while the Coronavirus Act 2020 is in place. However, this debate is still ongoing. In March 2020, following a tabled amendment to the Domestic Abuse Bill by Diana Johnson MP,[1] the government agreed to an open consultation on whether to make the temporary COVID-19 measure permanent (Department of Health and Social Care, 2020). This open consultation closed on 26th February 2021, showing how timely research on abortion policy is.

Against this background, the purpose of the research reported here was to explore the professional values and identity of the sector of doctors concerned. Funded by the ESRC, this thesis aims to bring sociological insights about 'professional values' and 'professional identity' to bear in an areas of important policy interest which, as I have indicated, is currently subject to a great deal of change and public debate.

In sociological terms, I have been most concerned through my research to investigate the values of doctors working in the abortion service, and to use this as a way to re-explore the concept 'medicalisation'. As I go on to discuss, this is a sociological concept used very widely in scholarship about abortion. Indeed, it constitutes one of the terms most frequently used to capture the dominant features of the law and practice of abortion in Britain (Sheldon, 1997; Grubb, 1990; Keown, 1988). It was generally taken to draw attention to the powerful position of doctors, as members of the medical profession. Yet as I have discussed, both the debates

[1] Diana Johnson MP entered two amendments, one of which was to allow home use of EMA permanent, rather than temporary while in the pandemic.

surrounding abortion, and the public activities of doctors themselves, seem to contradict this idea of 'medical dominance' and 'medical power'. Doctors who provide abortion have been vilified and investigated. They are also campaigning publicly for legal changes that would make them less powerful.

The intention of this thesis is, given all of this, to reconsider what the medicalisation of abortion in twenty-first century Britain means. The idea that drives this investigation is that the values of doctors who provide abortion are important to the medicalisation of abortion and play a central role in shaping what this might mean. In this regard, the approach I have taken is informed primarily, following the American sociologist Drew Halfmann (2012), by the idea that medicalisation can be thought of as a continuous state, which is ambiguous and subject of modification, rather than a fixed and static phenomenon. It is therefore the tensions and strains in the medicalisation of abortion that constitute the major focus for the discussion that follows, which I investigate through my interviews with forty-seven doctors who have dedicated their professional lives to providing abortion. I now introduce the conceptual framework in a little more detail, before setting out the structure and organisation of the chapters which follow.

THE MEDICALISATION OF ABORTION

Generally, literature about medicalisation presents doctors and the medical profession as in some way engaged in an enterprise of social control. Talcott Parsons' theory of the 'sick role' explored the idea of medicine as an "institution of social control in the 1950s" (Conrad, 1992: 210). Scholars in the 1970s such as Eliot Freidson (1970) and Zola (1972) argued, in contrast to Parsons' functionalist account, that medicine was expanding to facilitate a shift in cultural and social power and is marked by conflicts based on power differences: "medicalisation is a process initiated and perpetuated by the biomedical profession as a means to acquire power", is how this has been summarised (Brennen, Eagle and Rice, 2010: 11). The belief that medicine is a form of social control with negative effects has also been articulated and explored by many feminist writers, who have also developed this argument in relation to women and women's reproductive healthcare. For example, there is a large literature on the medicalisation of childbirth of this sort (Henley-Einion, 2003 and Christiaens, Nieuwenhuijze, Raymond, 2013). Additionally, there is a body of socio-legal literature which has used the concept

'medicalisation' when discussing the legal framework and history of abortion in Britain, and it is this literature which is important to the backdrop of this thesis.

More recently, however, the argument that medicalisation is a form of social control has been revisited and sociologists have raised questions about other possible ways to use the concept of medicalisation. Conrad has suggested a more neutral understanding of medicalisation, including an appreciation of its benefits and drawbacks, which may be a more appropriate approach to the concept rather than seeing it primarily as a method of social control (Conrad, 1992). Given the subject matter of this research and its interest in medicalisation, Halfmann's (2012) work has also provided an extensive exploration of what the 'medicalisation' of abortion has constituted. He has suggested that medicalisation and de-medicalisation (which he suggests can occur simultaneously) can be explored on three different levels the macro- meso- and micro. It is this thinking about medicalisation, and the propositions about how it can be explored as a process, that drives this investigation.

I discuss this framework in detail in Chapter Two, but in brief, the framework adopted in this thesis is threefold (Figure 1) and draws on Halfmann's macro-, meso- micro variables (Halfmann, 2012).

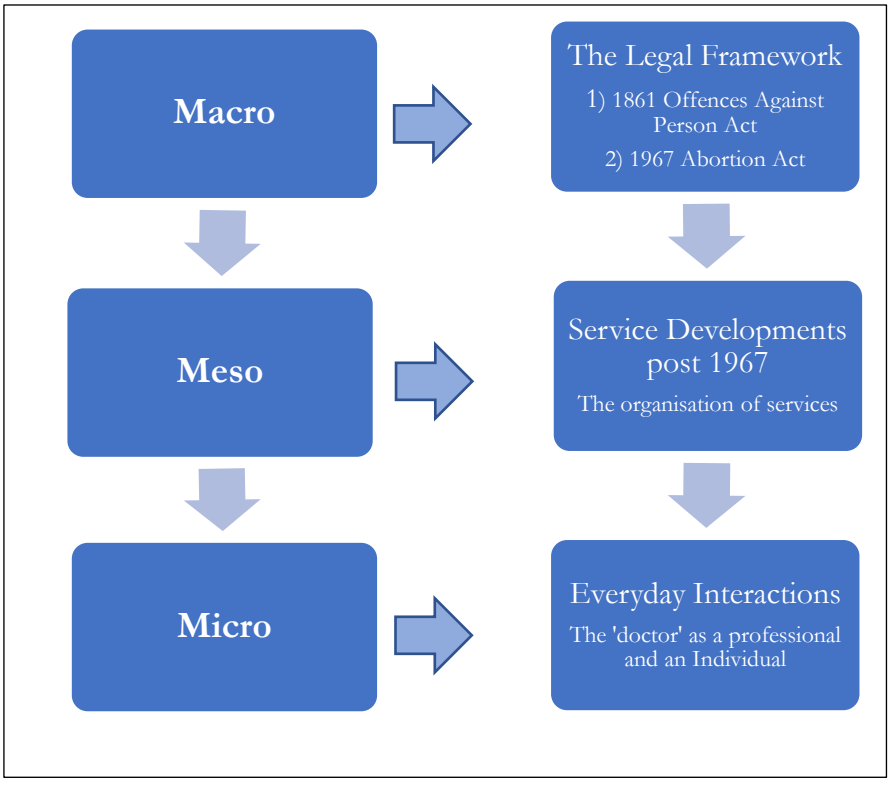

Figure 1: Threefold analysis: Macro- Meso- and Micro (as adapted from Halfmann)

The aim is to investigate doctors' values in relation to each of the three levels. These levels are important to the study of the medicalisation of abortion, as they have and continue to shape the work and experience of abortion doctors. The legal framework and the ways in which the service has developed provide a context that defines the professional role of the 'abortion doctor' and shapes the identity and experiences of doctors. Furthermore, doctors interact with the macro-level through the legal framework, and the meso-level through service developments, by interpreting and acting in relation to them, and this shapes their practices. On the micro-level, the everyday interactions of abortion providers and the experience of 'doing' abortion work are shaped by the context provided by the legal framework and the organisational structure of the services, and doctors construct meaning around what it means to be a 'good doctor' based on these interactions.

This thesis is an investigation into the dynamics of medicalisation, from the law on paper, through service provision to the everyday interactions of individual doctors who have been given the responsibility of gatekeeping legal abortion, through an exploration into the professional identity of these doctors. It is for this reason that the main research question this thesis seeks to answer is: what do abortion doctors' accounts of their professional work suggest about the contemporary dynamics of the medicalisation of abortion in Britain?

ORGANISATION AND STRUCTURE OF THE THESIS

Chapter One of this thesis provides a selective review of the literature about the history of abortion in Britain. No claim is made to provide a complete account of this history; this would be beyond the scope of this thesis. Rather, the aim is to show how the professional identity of doctors has been historically constructed. Firstly, through the legal backdrop of abortion in England and Wales. The 1967 Abortion Act has presented doctors as guardians of morality. This chapter then examines how this construction of doctors as gatekeepers to legal abortion has been contested in the years following the Abortion Act especially in the immediate years after the 1967 Abortion Act and more recent technological advancements. I then explore how these technological advancements have created a tension between the medicalisation of abortion, as set out in the legal framework and the practice of providing abortions today.

Chapter Two continues the literature review and focuses on the theoretical backdrop to this thesis, through an exploration of literature on medicalisation. It considers the sociological ideas on the values of the medical profession by Parsons (1951) and Freidson (1970) and the initial conceptualisation of the problem of medicalisation. Then this chapter draws upon new theories of medicalisation which are important to this study, including those based on the wider values of medicine and the medical profession including theories such as the new professionalism. This chapter also outlines the conceptual framework of this thesis through an analysis of the sociological work of Halfmann (2012) about medicalisation and particularly how it has influenced the methods adopted for this thesis and the design of the data collection organised around considering medicalisation at different levels.

Chapter Three sets out in detail the methodological approach of this thesis. Chapter Three also discusses the methodology which was adopted and explains the reasons for choosing to interview doctors. In addition, this chapter sets out sample characteristics as well as recruitment strategies and ethical implications. Finally, this chapter describes in detail the process involved with analysing the interviews data.

Chapter Four begins the discussion of the findings of the interviews by exploring the macro-level. This chapter sets out my account of how doctors can be seen as resisters of medicalisation on the macro-level. The predominant theme which runs through this chapter focuses on doctors' rejection of key aspects of the current legal framework that surrounds their work, and how they present their values and give meaning to their identity as professionals as a result. I assess how doctors express their values as doctors, in relation to the laws which govern their work. In this chapter I also explore participants' responses to accusations about doctors acting immorally in the debate about sex-selection (discussed above). This chapter highlights that while doctors who work in the abortion service have a shared value when discussing key aspects of the present laws, which can be interpreted as a forthright rejection of medicalisation, there were also differences in how they considered the law in other respects.

Chapter Five explores the meso-level through an account of my analysis of participants' discussion of clinical practice and their medical training. One key but unexpected theme which emerged from the analysis was the significance attached to setting; that is the provision of abortion within an NHS service and by independent sector organisations (namely, bpas and MSI Reproductive Choices (formerly MSI)). As I explain in Chapter Three, I designed the

study to recruit participants working in both sorts of organisational setting, knowing it would have some level of importance. These aspects of service organisation emerged as far more significant than anticipated, the ways in which participants gave meaning to their work as professionals in relation this unusual and distinct aspect of the provision of a medical service this forms the focus for this chapter. I explore how doctors give meaning to the project of 'normalising abortion' in this way, and I consider how this constitutes and important component of the medicalisation of abortion.

Chapter Six is the final chapter based on my analysis of the interviews, and it considers the micro-level. Again, what emerged from the process of analysis was not anticipated and led to the incorporation of the concept of identity work, and the idea of stigma and its management, to the discussion. This chapter focuses on the identity work that abortions providers undertake as they uphold the idea that the work they do is valuable, important and a source of pride. It concludes that this group of doctors manage feelings of pride and fear, and respond to stigma in an active way, and in so doing construct an identity built around the importance and value of the work that they do. As such doctors both acknowledge the need to, at least in some respects, 'demedicalise' abortion and challenge the elevation of the doctor role, and also endow the doctor role in abortion with value and importance.

Finally, Chapter Seven brings together all of the arguments made throughout the thesis through a discussion on what it means to normalise abortion services in Britain and how the medicalisation of abortion can be viewed as bi-directional. By evaluating the new findings this thesis offers, and how these findings support and confirm some for the findings from existing research this final chapter critically discusses the key issues which have been raised by participants on the medicalisation of abortion. This chapter discusses the theoretical implications for this research and the strengths and weaknesses of the research methods used in this thesis. This chapter then offers a reflection of my time completing this research and recommendations for future research.

CHAPTER 1
MEDICALISING ABORTION

1.1 INTRODUCTION

This chapter is the first of two that provide the background and context for this study. It focuses on how the role of the doctor has been constructed in abortion law. First, I provide a selective review of socio-legal literature that focuses on the major aspects of the relevant legal arrangements, primarily the 1861 Offences Against the Person Act (OAPA) and the Abortion Act of 1967. By evaluating the legal backdrop to the provision of abortion in England and Wales, literature shows that abortion has been medicalised. For example, Grubb (1990) has noted that "English law gradually has accepted the medicalisation of the abortion procedure" (p. 147). This has created a unique situation in England and Wales, where abortion providers have been ascribed the role of gatekeepers to legal abortion. Doctors have been given control of who can have a legal abortion, when and where the abortion can take place; law has constructed the professional identity of abortion doctors as gatekeepers and guardians of morality who are in control of who can have a legal abortion.

Following the discussion of the legal backdrop of abortion, this chapter examines how this unique role given to the doctor has created many tensions between the legal framework and the provision of abortion since 1967, all of which highlight the relationship between medicalisation and professionalism.

These tensions, between the legal framework and the practice of abortion since 1967, are discussed through a further selective review of the literature, this time about some of the debates that occurred in the immediate aftermath of the 1967 Abortion Act. In these debates, questions were posed about whether doctors are the best group of people to decide when an abortion can legally take place.

I next evaluate the role of technology and how technological advancements since the 1980s have created a particular tension between the medicalisation of abortion as set out in the legal framework, and the practice of abortion today. Finally, this chapter examines more recent

debates where the values of abortion providers have been directly contested, evaluating the ambiguous nature of the abortion provider and how this has been examined by both the media and politicians. In conclusion, I find that that while the medicalisation of abortion was looked upon as a solution to a problem whereby doctors were given authority as decision-makers, in reality, this did not solve the moral problem of ending an unwanted pregnancy. Instead, the management of abortion in the medical sphere created a context where the medicalisation of abortion became contested by many different groups in society.

1.2 THE LEGAL BACKDROP

Abortion in Britain has a unique and complex history and is predominantly governed by two pieces of legislation, the 1861 OAPA and the 1967 Abortion Act. The 1861 OAPA criminalises both the abortionist and anyone who helps to procure a miscarriage by making any attempts to provide an abortion illegal, even if the woman is not pregnant. While the Act criminalised women and abortionists, literature such as that by Davies (2004) has noted that "it was not the practice to prosecute the mothers in cases of illegal abortion" (p. 79). It was perceived that women seeking an abortion had "suffered a great deal from the circumstances that led them desperately to seek an abortion and from the risk and damage involved in such an undertaking" (Davies, 2004: 79). Instead, the OAPA aimed to criminalise those deemed to provide unsafe abortions. Interestingly, the term 'unlawfully' is used in the wording of the legislation and implies that legal abortions can take place in specific circumstances, although these circumstances are not set out in the law (Davies, 2004). In practice, this meant that "qualified medical practitioners … perform[ed] abortions for therapeutic reasons" (Davies, 2004: 79-80), and prosecutors were reluctant to "challenge medical discretion" (Davies, 2004: 80). This would suggest that 'regular' abortion providers were the only group who were capable of lawfully procuring a miscarriage, further adding to the divide between the regular 'medical men' who had typically trained at university and the ‘irregulars’ at the time, who were “homeopaths, herbalists, midwives, empirics and druggies” (Halfmann, 2012: 192).

Socio-legal literature such that written by Keown (1988), Grubb, (1990) and Sheldon, (1997) have portrayed the OAPA of 1861 as an example of how medical professionals have tried to gain control over an aspect of women's reproduction. Arguing that 'the regulars' were the best group of people to stop the 'irregulars' from performing dangerous and harmful abortions

allowed the 'regular' providers to "stake their claim to the domain or 'task area' of health" (McGuinness and Thomson, 2015: 181). In doing so, regular physicians could encourage the state to deploy its sanctions against their competitors. Portraying abortion as dangerous and abusive further allowed a group of medical professionals to claim that criminalising abortion would be in the public's interest, while the "realities of abortion provision … [meant] a notable number of physicians were terminating pregnancies for a fee" (McGuinness and Thomson, 2015: 181).

In addition, cases such as R. v. Collins (1898) also prove that doctors performed abortions. This case involves a 'medical man' (Keown, 1988) charged with the murder of a woman who died as a result of him allegedly using an instrument to cause a miscarriage. In his closing remarks, Justice Grantham remarked:

> It could be understood that there were cases where it was necessary, in order to save the life of a woman, that there should be forcible miscarriage, and a properly qualified doctor had to say when that time had arrived. That was not unlawful. (Keown, 1988: 52)

This remark by Justice Grantham shows the prohibition of abortion by OAPA was not absolute, even though the law was presented this way, meaning there could be cases where abortion would be considered a necessary evil by the law and, therefore, legal. This ruling and others like it are important in understanding the position of the 'abortionist' during this period of British history. It outlines the clear distinction between doctors and other individuals who performed abortions.

After the 1861 OAPA came a period of time when abortion moved from being a crime to being legalised. However, this move was difficult – not because of any medical or technical barriers but because it was extremely hard to bring abortion out of the shadows and make it visible. One example of the tensions between the 1861 OAPA and medical practices occurred in 1938, when British gynaecologist Aleck Bourne performed an abortion on a fourteen-year-old girl who had been violently raped by four soldiers (Marsh and Chambers, 1981). Bourne was reported to the police, and his trial began. Bourne did not accept a fee, and after a consultation with his colleagues came to the conclusion that continuing the pregnancy would "severely damage her mental health" (Marsh and Chambers, 1981: 12). As Bourne explained, "it would

have been a source of nervous, psychoneurotic and other troubles, and there would perhaps have been secondary physical illnesses all her life" (*British Medical Journal*, 1938: 202). Bourne later denied there was a difference between danger to life and danger to health, rather suggesting that if health was depressed to a great enough extent, life would be shortened (Keown, 1988). Bourne was acquitted of all charges, and the ruling became significant to all medical practitioners. During his summing up, Justice Macnaghten "distinguished between the case … which involved a skilful surgeon performing an abortion openly and charitably, in the belief that he was discharging his duty, [and] a secret termination of pregnancy performed for gain by an unskilful operator" (Keown, 1988: 50).

The Bourne case has been described as a "pivotal moment in the development of abortion law" (McGuinness and Thomson, 2015: 181). The ruling that a doctor is preserving a woman's life if continuing a pregnancy can cause psychological or physical damage to the woman, were significant to how the abortionist is portrayed after this ruling. The Bourne case changed abortion from being viewed as a crime, to abortion being "medicalised through legal protection of the category of 'therapeutic abortion'" (Grubb, 1990: 146). This changed the position of medical professionals as abortionists: the ruling gave doctors the defence that they are able to provide abortions because they are a medical professional terminating a pregnancy to preserve the physical and psychological health of the mother for the first time in history.

The results of the Bourne case have been viewed as an "early success in efforts to liberalise abortion law" (McGuinness and Thomson, 2015: 182). However, in reality, the Bourne case "simply ensured that medical professionals were afforded legal protection" (McGuinness and Thomson, 2015: 182). The Bourne case was important to the position of the 'abortionist' and specifically medical professionals because it challenged prosecutors to question medical discretion, something which prosecutors had previously been reluctant in doing (Keown, 1988: 53). It is for this reason Thomson (2013) notes the Bourne case was purposefully challenging both illegal abortion providers and the legitimacy of law to interfere with clinical decision-making. The fact that prosecutors were reluctant to question medical decisions further highlights the importance of the medicalisation of abortion by suggesting that medical professionals had expert knowledge on when an abortion should be allowed to take place and when it should be considered 'unlawful', on the condition that they acted appropriately as medical professionals. The reluctance to prosecute medical professionals for providing abortions also shows that the medical profession was in an increasingly powerful position

because of their medical professionalism. Doctors like Bourne were openly calling on the police and prosecutors to challenge their medical opinion and actions.

After the Bourne ruling there were concerns from some medical professionals that the law on abortion was based on case law and there was still a fear of prosecution. This meant there was a need for clarification on doctors' position in relation to abortion law. There was also a growing concern amongst elite medical organisations such as the BMA that clinicians could be prosecuted for carrying out abortions. As a result, professional bodies began to see the necessity of abortion law reform.

There were six unsuccessful attempts to change British abortion law following the Bourne ruling and before the Steel Bill was introduced (Marsh and Chambers, 1981), one of which was Lord Silkin's Bill. Marsh and Chambers describe this Bill as making "substantial parliamentary progress" (p. 14) and its primary focus was to "make it lawful for a doctor who honestly believes the mother's life or health are seriously endangered to carry out an operation for abortion" (Keown, 1988: 87). The reason Silkin believed this was important was that "in recent years three judges of the High Court [had] interpreted the law ... [and] doctors were charged with performing illegal operations" (Hansard, 1965).

Similarly, Lord Silkin expressed his concern about the number of abortions carried out by individuals who were not doctors. This concern was for the rising cost of the complications associated with backstreet abortions, since there were between "30,000 and 40,000 cases of abortion, or attempted abortion, admitted into the hospital at public expense; and the number is steadily increasing" (Hansard, 1965). Following the Silkin Bill, David Steel MP introduced a Private Members' Bill, which later became the Abortion Act of 1967. As Paintin recalls, professional bodies began to realise that change to abortion law was extremely likely by 1966. As a result, they were "prepared to back strongly a Bill that made it clear that doctors had the discretion to do abortion legally" (Paintin in bpas, 2007: 36). However, this was not a straightforward process.

The Abortion Act was passed after a "process of negotiation" (Amery, 2015: 555) involving "a significant amount of horse-trading between parliamentarians, the medical profession and pressure groups" (Amery, 2015: 556), and the influence of these medical organisations in the medicalisation of abortion in 1967 was significant. As Gleeson (2007) noted, the BMA

assumed moral and scientific authority throughout the course of the campaign for reform. ALRA realised the "power of medical authority and increasingly came to frame its arguments along medical lines, to the point of conceding to medical pressure which saw the provisions of the Act fall short of its hopes and become fully 'medically circumscribed'" (Gleeson, 2007: 26). ALRA's members quickly realised that the only way to gain a successful reform Bill would be to leave the decision making to medical professionals rather than a woman and with this as Francome (1984) noted, "ALRA therefore turned its back on a woman's right to choose" (p. 84). As Jackson (2000) argued, medicalisation of abortion in 1967 and placing medical professionals at the centre of the abortion provision was a "pragmatically sensitive way of neutralising opposition to the legislation of abortion" (p. 471). This is because portraying abortion as a problem that needs addressing through medical control implies that only doctors are able to make the decision on abortion and removes abortion from political debates.

The 1967 Abortion Act was constructed to resolve the ambiguity surrounding the position of the 'abortionist' created by the combination of OAPA, the 1929 Infant Life (Preservation) Act and the Bourne ruling. The Act has many key aspects that have affected the position of the abortionist, as this chapter will now discuss.

Socio-legal literature has suggested there were two main "parliamentary purposes" of the Abortion Act 1967 (Sheldon, 2016: 287). These were '"to broaden the grounds upon which abortions may be lawfully obtained' and 'to ensure that the abortion is carried out with all proper skill and in hygienic conditions'" (Sheldon, 2016: 287). As a result, the 1967 Abortion Act "decriminalised doctors carrying out abortions in certain circumstances" (Amery, 2015: 555) rather than legalising abortion.

1.2.1 The 1967 Abortion Act and the medicalisation of abortion

The 1967 Abortion Act has been described as 'medicalised' throughout socio-legal literature (Keown, 1988; Sheldon, 1997). By this, socio-legal scholars have suggested the Abortion Act as "fundamentally underpinned by the idea that reproduction is an area of medical control and expertise" (Sheldon, 1997: 24). Grubb (1990) described the 1967 Abortion Act as the "legislation [that] confirmed the medicalisation of abortion in England" (p12). Case law set out by the Bourne trial gave doctors the responsibility to act on behalf of their patients and to

"maintain ultimate control over the abortion decision" (Jones, 2011: 289) showing that doctors were already viewed as moral experts.

There are four main ways existing literature has argued that the 1967 Abortion Act medicalised abortion. These are decriminalising abortion for medical professionals, giving doctors the role of gatekeeper to legal abortion, the conscientious objection clause and the 'class of place clause.' All of which, as this thesis explores, powerfully shape an idea of medical professionalism in connection with abortion provision, and which are more and more filled with tension and contradiction.

DECRIMINALISING ABORTION

Firstly, with the intention of abolishing 'backstreet abortions', the Abortion Act placed terminating a pregnancy within medical supervision. As shown throughout this chapter, there has been a distinction between the 'medical men' and 'irregular' abortionists since the very beginning of abortion law in England and Wales. The 1967 Abortion Act decriminalised doctors who provide abortions in line with the grounds set out in the Act, by explicitly stating a 'registered medical practitioner' can provide abortion and 'not be guilty of an offence'. This is important to the framing of abortion, since it suggests that terminating a pregnancy is a "deviant reproductive act which must be regulated" (Beynon-Jones, 2009: 4).

Decriminalising abortion for medical professionals in this way confirmed that medical practitioners are the only group of people who can legally perform an abortion, which ultimately aimed to drive out untrained abortionists who were performing backstreet abortions in Britain prior to 1967. In doing so, the medical profession was able to gain sole control of this aspect of the woman's reproductive health. For this reason, the Abortion Act 1967 has been described as part of a "broader shift towards medical control of reproduction wherein traditionally 'female' knowledge concerning pregnancy was gradually displaced by medical terminology and expertise" (Amery, 2015: 555).

GATEKEEPING LEGAL ABORTION

One of the 1967 Abortion Act's key features is that the final decision on whether an abortion can legally take place was placed in the hands of the medical professionals, so women could

only 'request' a termination of pregnancy (Sheldon, 1997). This suggests that "women's reproductive decisions should be regulated by 'medical experts'" (Beynon-Jones, 2009: 2) where medical professionals control who accesses abortion. By handing the decision over to medical practitioners, the law ensured that abortions were always carried out for a "good reason" (Boyle, 1997: 64). Doctors were now seen as the "gatekeepers" to legal abortion, allowing the deserving to have a legal abortion (Keown, 1988: 165). Sheldon (1997) has categorised this as 'decisional control' that doctors have over women by controlling "which women should be permitted to terminate their pregnancy" (p. 54).

This has come to be a highly contested aspect of the 1967 Abortion Act because "the decision to terminate a pregnancy is not a medical decision, it is made in the light of the woman's social, economic and personal circumstances" (Bridgeman, 1998: 89), suggesting that the decision on whether to continue a pregnancy is not only medical. The Abortion Act acknowledges the decision is not solely medical, as Section 1. (2) states that medical professionals may take into consideration "the pregnant women's actual or reasonably foreseeable environment". Women are therefore required to "reveal quite intimate details of her personal life in order to justify her request and convince the doctor" (Sheldon, 1997: 68). This has led historians and legal scholars to argue that the 1967 Abortion Act characterises doctors as "responsible and moral actors" (O'Neill, 2019: 172) while labelling women as "irresponsible and irrational", unable to make rational decisions about their reproductive health (O'Neill, 2019: 172). Amery (2015) argued that making doctors gatekeepers to legal abortion "has a disempowering effect on women, whether or not requests for an abortion are granted" (p. 556). This has led scholars to question whether it is, in fact, the medical professionals who are the best group of people to decide whether a woman should have an abortion.

Clause 1(a) in the 1967 Abortion Act, "that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family" is worded in a way that allows the Abortion Act to be broadly interpreted. For example, as Greasley (2017) noted, doctors are not asked to demonstrate proof that continuing a pregnancy will cause any psychiatric conditions, (such as clinical depression), before agreeing that the abortion can take place on the grounds of clause 1(a).

The decision to create a law that can be interpreted in a broad sense is important to the overall aims of the 1967 Abortion Act since it ensures that the decision on whether abortion can take place remains firmly at the hands of medical professionals, while allowing doctors to exercise a significant amount of clinical discretion (Sheldon, 2016). One consequence of the broad scope of the 1967 Abortion Act is that "many medical practitioners have taken a very liberal interpretation of the Act, and the result is that most women are able to obtain a termination if not in the NHS then in the private sector" (Sheldon, 1997: 59). It is for this reason that scholars such as Sheldon (1997) have argued that while "medicalisation of abortion law has had substantial benefits for ensuring women's access to abortion services it also poses substantial problems for that access" (p. 4).

Gatekeeping Legal Abortion

In addition to controlling when a legal abortion is provided, the 1967 Abortion Act gives doctors the option not to provide abortions through Section 4 of the Abortion Act. Section 4 of the 1967 Abortion Act includes a conscientious objection clause. This is an important aspect of the 1967 Abortion Act for medical practitioners. It states that currently no medical professional is required to 'participate in any treatment' to terminate a pregnancy if they consciously object and the woman's life is not in danger. The conscientious objection clause is important to the medicalisation of abortion as it once again allows doctors to control who has access to legal abortion services. Doctors were able to refuse to participate in treatment associated with abortion drawing a distinction between abortion and other areas of medicine. The conscientious objection itself is interesting as it was first used to describe the "refusal to perform mandatory military service because of personal or religious moral objections to killing" (Fiala and Arthur, 2014: 13). Explicitly adding a conscientious objection clause into the Abortion Act suggests that medical professionals are killing when performing an abortion. Literature has also suggested that some doctors who have chosen to exercise their right to conscientiously object to performing a termination of pregnancy have also contributed to a much wider problem—a debate on whether abortion should be legal (Fiala and Arthur, 2014).

Class of Place clause

The final way that the 1967 Abortion Act medicalised abortion was by giving doctors the sole responsibility for the diagnosis, treatment and care. The law specified that an abortion must

take place in a "hospital vested in the Minister of Health or the Secretary of State ... or a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State". This is important to the 1967 Abortion Act, since it aimed to ensure all terminations of pregnancies are carried out in sterile and safe environments using appropriate equipment to ensure that women are extremely less likely to experience infection, maiming or death from visiting backstreet abortionists. Sheldon (1997) described this aspect of the law as 'technical control' as doctors are in "control of the actual performance of abortion operations" (p. 54). As the next section of this chapter will show technology and medical practices have changed dramatically since the 1967 Abortion Act and this aspect of medicalisation has been widely contested since the introduction of the Abortion Act.

This section of the chapter has shown that socio-legal literature has portrayed British laws on abortion as centred around the 'medical man' and medical professionals. It has shown how abortion is rooted in the paternalism of doctors who have control over who can have a legal termination as well as other important decisions such as where and when the abortion can take place. Next, I explore how this form of control given to doctors by the law has been contested since 1967.

1.3 TENSIONS BETWEEN MEDICALISATION AND PROFESSIONALISM

I have outlined how the history of abortion legislation in England and Wales has been one which has been guided by the interests of the medical profession. However, I will now show the relationship between the law and the medical profession is one that has been contested since the legalisation of abortion in 1967. Firstly, I investigate some of the immediate challenges the medical profession faced after 1967, focusing on the Lane Committee and the Corrie Bill to illustrate key points. I then explore some of the technological advancements which have occurred since 1967 and then finally how the paternalistic nature of the provision of abortion in England and Wales has been contested in recent years.

1.3.1 The Immediate Aftermath of the 1967 Abortion Act

The Lane Committee

The 1967 Abortion Act was looked upon as a medical solution to a moral problem. However, immediately after the 1967 Abortion Act was implemented, the NHS was unable to provide services in large areas of England and Wales. This was for various reasons, including some practical issues, such as a lack of funding and space. Additionally, medical professionals' opinions heavily influenced those areas of the country where abortions were performed, since some doctors overtly prevented the introduction of abortion services in their hospitals. This meant that clinics were opened by those determined to ensure women could access abortion, to provide a service in areas where the NHS did not do so, with the main provider being the British Pregnancy Advisory Service (bpas), initially, Birmingham Pregnancy Advisory Service. As Potts, Diggory and Peel explained, "By the end of 1974, bpas had completed over 100,000 abortions" (1977: 302). Unlike private clinics, bpas would "reduce fees, waive them altogether or make loans to women who were too poor to pay the £65-£67 requested" (Potts, Diggory and Peel, 1977: 302). However, even though this now 'independent sector' was set up to help women access abortion in areas unavailable on the NHS, the organisations and those doctors who worked for them faced widespread criticism.

As soon as abortion was legalised in 1967, "members of the public, the press, Parliament and the medical profession criticised the way it was working" (Wivel, 1998: 109); the medicalisation of abortion was contested. For example, claims were made in newspapers that private abortion clinics employed taxi drivers "roaming the airports to pick up clients" (Stetson, 2001: 139). These articles contributed to the argument that London had become the "abortion capital of the world" (House of Commons Debate, 13th February 1970) and that some abortion providers were more concerned with making money than with the health and wellbeing of their patients. This goes against the claims made by medical organisations such as the RCOG and BMA, that the medical profession were trustworthy and morally responsibly.

The claims that the 1967 Abortion Act was being abused by private service doctors resulted in over "250 MPs signing a petition for a government inquiry" (Stetson, 2001: 139). The Lane Committee was set up in 1971 to "inquire into the working of the Abortion Law Reform Act 1967… without reviewing its underlying principles" (Temkin, 1974: 657) and to investigate

"whether any legislative change was needed to combat the reported abuses of the new law" (Dee, 2019: 52). According to Temkin (1974), in addition to the scandal of foreign women flying over to Britain to have an abortion, the main complaints MPs had at the time were that wealthy women were able to have an abortion on demand in the private sector, while poorer women were finding it "increasingly difficult to obtain one on the National Health Service" (p. 657). For example, doctors wrote letters to *The Lancet*, questioning whether the "newly created services … were too closely connected with doctors who would perform abortions, and therefore had a profit motive" (Dee, 2019: 54). There were claims that the fees that independent sector providers charged women were "proportionally larger than an NHS doctor would charge to see the same patient" (Dee 2019: 54).

The claim suggests that medical professionals may not be the best group of professionals to manage legal abortions because some doctors were concerned more with profit than helping women. This undermines "the image of the benevolent, paternalistic physician envisioned by reformists in 1967" (Amery, 2020: 6). It hence goes against claims made about the medical profession during the 1960s when medical groups, parliamentarians and abortion law reformers argued that doctors should be gatekeepers to legal abortion because they were the best group of individuals to make the informed and rational choices that pregnant women were unable to. Instead, we here see a construction of "the 'professional abortionist', a doctor who is irresponsible, profit-hungry and immoral" (Amery, 2020:6).

The setting up of the Lane Committee is important to an investigation of the history of abortion. It demonstrates that there was already tension in the medicalisation of abortion, and that various groups questioned doctors' values through claims that some doctors involved in abortion services could not be trusted because they were driven by self-interest and not by women's health. Over the course of the three years that the Lane Committee gathered evidence, its members "visited a large number of hospitals, abortion clinics, referral agencies and individual practitioners" (Potts, Diggory and Peel, 1977: 314). Additionally, the Committee "received memoranda from nearly two hundred organisations and over five hundred individuals" (Potts, Diggory and Peel, 1977: 314), which made their findings extensive since they took into consideration claims from all sides of the abortion debate.

The Lane Committee published its report in April 1974. The timing of the report was important, since in February 1974 a series of articles was written in the *News of the World* by journalists

Susan Kentish and Michael Litchfield that featured a sequence of "shocking facts" (Francome, 1984:165). These articles alleged that doctors were offering terminations to women, for purely financial reasons. This claim further raised questions about the professional values of doctors who provided abortions, against the idea of medical professionals making informed choices based on good faith judgements as required by the 1967 Abortion Act. The Committee made several recommendations in their report; however, overall, they can be summarised by the statement: "we are unanimous in supporting the Act and its provisions" (Paintin, 2015: 82). The authors continued in their report by stating that, "we have no doubts that the gains facilitated have much out-weighted any disadvantages for which it has been criticised" (Paintin, 2015: 82), and I now briefly discuss the recommendations made, highlighting the representation of medical professionals providing abortions.

The first notable recommendation made by the Lane Committee focused on the concern about women's inability to access abortion services in the NHS. During the time the Committee was gathering evidence, they were informed of a case of a 41-year-old woman, with four existing children, who reported she had:

> … the most humiliating interview in which the NHS gynaecologist expressed his personal distaste for carrying out terminations and succeeded in making me feel both irresponsible and immoral so that I came out in tears. (Potts, Diggory and Peel, 1977: 309-310)

As a result of cases and examples like the one above, the Lane Committee noted in its final report that difficulty in having an abortion in the NHS was "most often the result of the consultant gynaecologists' attitudes" (Wivel, 1998: 120). For example, the report said that some medical practitioners "might have deliberately adopted delaying tactics in the hope that pregnancy would be accepted or that it would be too late to get an abortion" (O'Neill, 2019: 179). This further highlights the development of an argument about tension between the abortion law and the practice of providing abortion, where doctors were not using their medical knowledge and skills to preserve the physical or psychological health of women, as intended by the 1967 Abortion Act, but instead extended their own personal values onto women seeking an abortion.

One of the findings of the Lane Committee focused on the evidence of abuse from the private sector. As explained above, this was one of the main focuses of the inquiry. Potts, Diggory and Peel (1985) believed that "it was predictable that important differences of philosophy will arise between the private sector and the NHS" (p. 164). They believed the concern stemmed from the differences in the way the doctors received their salary. Medical professionals who work in the NHS are paid a "basic salary" (Potts, Diggory and Peel (1985: 164), whereas in the private sector "the motivation to work and the appreciation of cost of the individual procedures" (Potts, Diggory and Peel, 1985: 164). The concern was the number of nursing homes that were approved to provide abortions. For example, "by July 1968 a total of fifty-three nursing homes were approved" (Dee, 2019: 55). The concerns about the procedures taking place in the nursing homes were also highlighted in the media. For example, there were cases reported in newspapers involving the deaths of women who had an abortion there (Dee, 2019). These women's deaths were blamed on "inadequate treatment and care" of nursing homes (Dee, 2019: 55).

This matter was also addressed by Potts, Diggory and Peel (1977) who noted after the introduction of the 1967 Abortion Act "a new group of rather inexperienced surgeons entered the field and while the 1967 Act case out some devils in the form of backstreet abortionists, it also allowed in a few medically qualified goblins" (p. 300). However, even though the media reported that abuse in the private sector was widespread, the Lane Committee reported that "only a few practitioners were involved in profiteering and touting … [there is] very little evidence that touting was a major problem" (Wivel, 1998: 124). The Committee "recommended non-statutory measures be taken to counter private sector abuses" (Amery, 2020: 273-274). They reported that "it should properly be for the medical profession to set and enforce its own standards of ethics and practice" (Amery, 2020: 74).

Another change the Lane Committee recommended was to certify the abortions and notify the CMO. The Abortion Act stated that doctors must certify that their decision was formed in good faith. This is set out by "the Secretary of State for health [who] shall by statutory instrument make regulations to provide a certification of abortion" (Rowlands, 2013: 122). Doctors must certify with a signature the grounds for the abortion by filling out Certificate A (later known as HSA1). The certificate to certify that the abortion was provided on a legal ground "must always be completed before the commencement of the operation" (Addison, 1968: 506).

Interestingly, the abortion did not need to be performed by either of the two doctors who certified the abortion. This means that "the gynaecologist will commit no offence if he does terminate a pregnancy and relies solely on the opinions of two other practitioners" (Addison, 1968: 505). The Lane Committee made a recommendation that both practitioners who certified their opinion on Certificate A state "whether they had seen or examined the patient" (Keown, 1988: 131). This change was made by the Abortion (Amendment) Regulations of 1976 so that both medical practitioners stated if they had "seen/and examined" the woman or not. The significance of allowing a woman to have an abortion certified by two doctors who have not met or examined her is explored later in this chapter when discussing the technological advancements of abortion procedures since 1967.

The final recommendation made by the Lane Committee referred to subsection 1(2) of the 1967 Abortion Act[1] as the 'social clause'. While the Lane Committee did not recommend any changes to the wording of the Act, they "conceded that it was sometimes difficult for a consultant gynaecologist to find time to investigate adequately a woman's social situation" (Wivel, 1998: 120). This would suggest that the 1967 Abortion Act was not being implemented in practice as intended. As a result of doctors not having the time to investigate women's circumstances, the report recommended that a form of counselling would help women to "discuss, gain information, and obtain explanations and advice" (Lee, 2011). By providing a counselling service, doctors would be able to ensure that the woman had freely decided they would like to terminate their pregnancy without being persuaded by another party (Lee, 2011). The Report stated that the creation of an 'abortion counsellor' was not needed because women were in contact with a number of professionals at the abortion clinics such as "health visitors, nurses and midwives" (Lee, 2003b: 540), each of whom could offer the necessary support to women.

The recommendation that women should receive a form of counselling later became a large part of anti-abortion campaigns to restrict abortion. During the 1980s, pro-life groups argued that women need independent counselling because abortion causes psychological damage to women. The argument that abortion impacts the mental health of women features as part of a

[1] Subsection 1(2) of the Abortion Act states that when considering the risk of injury to health medical professions "account may be taken of the pregnant woman's actual or reasonably foreseeable environment".

narrative by pro-life groups which argues that "abortion is harmful", that they are "pro-woman" as well as pro-life (Lee, 2003a: 19). As part of this claim, medical professionals were portrayed as villains (Lee, 2003a: 15) and as I go on to discuss, claims of this sort have continually remerged in different forms, including in the debates around 'sex selection abortion' which formed the impetus initially for this piece of research. Since the Lane Committee, there have been a number of policies aimed at implementing the recommendation to provide counselling for women. For example, in 1999 the Department of Health issued updated guidelines which stated, "counselling must be offered to women who request it or appear to need help in deciding on the management of pregnancy or who are having difficulty in coping emotionally" (Lee, 2011). The independent counselling debate has continued to form a large part of anti-abortion arguments to reform abortion laws as I discuss in the final section of this chapter.

Even after the Lane Committee's report was published, the medicalisation of abortion remained contested. The findings of the Lane Committee "was a disappointment to the anti-abortion groups" (Stetson, 2001: 139). Pro-life groups continued to claim that the Abortion Act was being abused by "unscrupulous private clinics and a few doctors" (Stetson, 2001: 139). The clearest example of pro-life groups contesting the medicalisation of abortion can be seen in a book published in December 1974 by Kentish and Litchfield called *Babies for Burning.* This book depicted "young girls … as haunting dark alleyways 'shopping for abortion bargains' which likened abortion clinics to butchers and abattoirs and argued that doctors had "genocidal tendencies" (Dyhouse, 2013: 190). Additionally, the book portrayed medical professionals who provide abortions as immoral and inhumane. The book:

> … contained reports of a doctor selling aborted babies alive for experiments, of a London gynaecologist selling foetuses to be made into soap, and cases of babies being aborted so late as to be taken living to the incinerator. In addition, some doctors were said to have Nazi sympathies. (Marsh and Chambers, 1981: 26-27)

While many of the claims made in this book were later disproven, it attracted much attention because the journalists claimed they had recordings of all their encounters with these medical professionals. These accusations formed the basis of many claims made by MPs who wanted to amend the Abortion Act. Between 1967 and 1992, there were sixteen Private Member's Bills (Lee, 2001). These Bills did not aim to make abortion illegal but instead aimed to amend the

1967 Abortion Act to limit access (Davies, 2004). I will now examine one of these attempts to change abortion law.

THE CORRIE BILL

The Corrie Bill (1979) has been described as "the most significant of all Parliamentary attacks on abortion provision" (bpas, 2015: 47). The Bill had four main elements which all aimed to restrict the number of abortions provided (Marsh and Chambers, 1981). Firstly, these was an attempt to decrease the time limit from 28 weeks to 20 weeks for all abortions, except if two doctors agree "in good faith that the child would be born severely handicapped" (Marsh and Chambers, 1981: 96). Secondly, the Bill aimed to tighten the grounds for having an abortion to prevent 'social abortions' and to stop doctors from using the 'statistical argument' that abortions can always be provided because, statistically, it is safer for women to terminate a pregnancy than to carry the pregnancy to term. The Corrie Bill aimed to do this by amending the law so abortion would only be legal if "the continuation of pregnancy involved (i) *grave* risk to the life of the pregnant woman" or if there was a "(ii) *substantial* risk of *serious* injury to the physical or mental health of the pregnant woman or any existing children of her family" (Marsh and Chambers, 1981: 96). Thirdly, the Bill aimed to remove the burden of proof associated with conscientious objectors as stated in the 1967 Abortion Act. Finally, the Bill wanted to "tighten up the licensing procedure for clinics and advice or referral bureaux" (Marsh and Chambers, 1981: 96).

For the purpose of this analysis, I will focus on two of the aims of the Corrie Bill that were significant to the question of who should provide abortions. Firstly, the prevention of the statistical argument that abortion is always safer than carrying a pregnancy to term. This was an important aspect of the Bill, as Corrie claimed that medical practitioners were using this argument to provide abortion on demand (Amery, 2020). Corrie's speech in the House of Commons focused "not on the character of such doctors but the difficulty of controlling them" (Amery, 2020: 88). By this Corrie meant that even if politicians did not want or intend for abortion on demand to be legalised, "the medical person sees the patient who will make the decision in the end" (Hansard, 1979: 894). This led Corrie to claim there was a risk that the medical professional would go "against the wishes of parliament [and this justified] further state intervention" (Amery, 2020: 88-89), further undermining the image of a "responsible doctor" (Amery, 2020: 89).

The Corrie Bill also focused on referrals, charities, and licences; with the aim to restrict the number of abortions being carried out outside of the NHS. The Bill made no distinction between independent sector providers and private practice providers, even though the independent sector aimed to "ensure that women could access abortion services for as low a cost as possible" (McGuinness, 2015: 291). Instead, the Corrie Bill was concerned that bpas "referred almost all the women … these agencies had simply become referral agencies for those wanting abortions" (Keown, 1988: 153). By reducing the number of abortions provided outside of NHS facilities, supporters of the Corrie Bill argued that they were trying to protect women since they "were concerned ... [women] were exploited by private clinics and faced with overwhelming remorse and depression as a result" (Stetson, 2001: 145). This Bill is relevant to the medicalisation of abortion as it outlines a distinction between the type of doctor who works in the NHS and the type of doctor who works in the independent sector.

The framing of this reform is important to the position of the abortion provider for two reasons. First, by making the conscientious objection clause of the 1967 Abortion Act easier for doctors and nurses, it is implied that some doctors and nurses were in some way forced or coerced into performing these terminations. At the same time, the Corrie Bill suggests that some doctors only provide abortions for a financial gain rather than to help women. Second, in trying to reduce the number of abortions performed in charitable organisations such as bpas, the Corrie Bill "requested the separation of referral agencies from clinics carrying out abortions" (Marsh and Chambers, 1981: 97). They believed that clinics and referral agencies needed separating in order to protect women. This separation further implies that doctors are not the best group of people to decide when an abortion should occur because medical professionals were not acting in line with professional standards. Instead of helping the women seeking an abortion, the Corrie Bill implies that doctors are self-motivated. By questioning the number of referrals, Corrie Bill supporters further suggest that the 1967 Abortion Act needs amending to ensure that women receive the best care.

To conclude, I have examined how, even in the immediate years after the 1967 Abortion Act, the medicalisation of abortion was contested, and the professional values of abortion providers were questioned. These values were questioned by the media, MPs and pro-life groups. There were many concerns that medical professionals were abusing the 'power' the 1967 Abortion Act had given them. However, it was not only those who believe abortion is wrong who

contested the medicalisation of abortion. There is evidence that members of the medical profession also expressed concerns with the role the 1967 Abortion Act had ascribed them. For example, Potts, Diggory and Peel (1977) noted that "doctors find themselves in an unsought position of power in deciding issues that ae not medical and for which they have had no special training" (p. 328). This was a concern for doctors because it meant that doctors are "open to being accused either of unreasonably withholding abortion or of practicing abortion on demand" (Potts, Diggory and Peel, 1977: 328). It showed that the apparent protection from prosecution that doctors were given by the 1967 Abortion Act was not enough for some medical professionals who were still concerned about the ambiguous position of abortion. This section has also highlighted some initial debates where the values of abortion providers ascribed by the 1967 Abortion Act were being questioned. Next, I focus on how technology has also called into question the medicalisation of abortion.

1.3.2 TECHNOLOGICAL ADVANCES AND THEIR SALIENCE FOR ABORTION PROVISION

Over the fifty years since the Abortion Act was implemented, technological advances have changed the way abortions are provided in Britain. This has led some scholars such as Amery (2020) to suggest that "access to abortion has been substantially liberalised since 1967- in practice if not in law" (p. 37). The biggest change to British abortion services, which is also a challenge to medicalisation, came with the introduction of EMA in the 1990s. EMA is a type of abortion that can be completed through a procedure where the woman takes medicine to induce her termination. There is evidence from different parts of the world that medical methods for abortion have replaced surgical abortions (Swica et al., 2011), and that the introduction of EMA has "revolutionised abortion services" (bpas, 2015).

When EMA was first introduced in England and Wales, the practice consisted of taking two sets of medication in the form of the tablets called mifepristone and misoprostol, which are taken in two phases up to nine weeks gestation. First, the woman took 600 mg of mifepristone orally, followed by 800 μg misoprostol 36-48 hours later, usually put on the end of a tampon and inserted into the woman's vagina (Wiebe et al., 2002). In 1980, French pharmaceutical company Roussel-Uclaf "identified the first anti-progesterone, a drug that occupies the progesterone receptors in the genital tract and blocks the action of progesterone" (Costa and Carrette, 2014: 62-63). The drug was called RU-486 and then formally named mifepristone.

Mifepristone operates by stopping the hormone progesterone working. Without this hormone, a pregnancy cannot continue as it detaches from the uterus. To improve efficacy, mifepristone is used in combination with prostaglandin drugs (Sheldon, 1997). Mifepristone was "introduced with a minimum of fuss" (Sheldon, 1997: 128) when it was licenced for use in Britain in 1991; however, this did not last long.

When EMA was introduced, it was described as "the pill that changes everything" (Sheldon, 2016: 283). There were numerous debates on the use of mifepristone as an abortifacient. For example, anti-abortion groups claimed that mifepristone was "chemical warfare on the unborn" (Sheldon, 1997: 130). Additionally, an American Congressman compared mifepristone with 'taking an aspirin' when he said "…with the 'death pill', the taking of a pre-born life will be as easy and as trivial as taking an aspirin" (Ricks, 1989: 92 in Sheldon, 1997: 131). For the first time, women did not need to have a surgical abortion, the side effects were minimal, and it was argued that this form of medical abortion was safer than a surgical abortion because it "avoids the risks of anaesthesia and surgical complications" (Chicoine, 1993: 83).

In addition, as Greasley (2011) notes, EMA is "usually the least emotionally distressing of the various procedural options" (p. 314). Surgical abortions are "far riskier, technically more demanding procedures" (Sheldon, 2016: 300). As women are the ones who take the drugs, by swallowing mifepristone and inserting misoprostol into their vagina, "abortion by menstrual extraction relies on women" (Sheldon, 1997: 131), and the level of technical skill from doctors, and other medical colleagues, is minimal. For this reason, Sheldon (1997) argued that "the introduction of RU-486 seems to strike at the very basis of medicalised abortion" (p. 131). A gynaecologist who was "involved with the French trials for RU-486 enthused that antiprogestins are revolutionary, as for the first time the doctor 'loses his primordial role'" (Aubeny, 1991: 33 in Sheldon, 1997). She continued that "RU-486 will lead to the disappearance of hospitalisation and any invasive procedures, and present the possibility for women to take control as it is her own action which will bring about the abortion" (Aubeny, 1991 in Sheldon, 1997: 131-132). This would suggest that EMA had the potential to change the way that abortions were provided and the role of the medical profession and women. By changing the role of the doctor, the introduction of EMA would also shape professional values of doctors who provide abortion where doctors are no longer paternalistic and instead patient-centred with women in control of ending their pregnancy.

Several concerns were raised after the introduction of EMA. In a House of Commons debate in 1990 about the future of abortion services after the introduction of EMA, Conservative MP Anne Widdecombe said that she believed "this is merely a paving measure - even if it is not intended as such - for self-administered home abortion" (Sheldon, 1997: 132). Even though pro-life groups had suggested EMA medications were seen to be as easy as 'taking an aspirin', during the House of Commons debate on EMA, it was made very clear by MPs who supported the introduction of mifepristone that EMA "would have to pass through the Abortion Act in the same way as other kinds of termination and would be subject to exactly the same level of medical control" (Sheldon, 1997: 134), meaning medical abortions are subjected to the same regulations as surgical abortions under the 1967 Abortion Act.

Practically, this meant that two doctors had to agree in good faith that the abortion meets one of the legal requirements, and any treatment must be carried out in a registered hospital or clinic. MPs were keen to highlight that "it is not abortion on request" (Sheldon, 1997: 134). Consequently, "once a woman's request for termination has been granted, she will face three visits to the hospital or clinic" (Sheldon, 1997: 136), in comparison to one visit for a surgical abortion. This further *increases* the medicalisation of abortion through EMA, where women require more visits to medical facilities and increases the involvement of the medical profession in the abortion procedure. In addition to the legal requirements of the 1967 Abortion Act, strict regulations were issued by Roussel-Uclaf and the Department of Health; these include, but are not limited to:

> Women were not to be accepted for treatment unless the staff were satisfied that she would not have to travel for more than two hours until she reached home; the client needed to stay on the premises for two hours following the administration of mifepristone; and following the administration of the prostaglandin, the woman had to have exclusive use of a bed for six hours – and not leave before that time, when a doctor had to discharge her. Furthermore, the woman's GP needed to be informed of the procedure before it took place and agree to cover her ... If the patient failed to attend her follow-up appointment after the EMA, her GP would be informed in writing. (bpas, 2011)

When EMA was first introduced, the number of abortions performed through this method did not rise substantially. Only 4% of abortions were performed medically in 1991, despite the

regime's approval (Department of Health and Social Care, 2019: 15). As a result of these restrictions, "EMA would cost at least as much as vacuum aspiration under local anaesthesia" (Paintin, 2015: 100). Interestingly, these rules set out above were implemented in addition to the existing terms of the law, "this was intended to ensure medical supervision following the termination" (Sheldon, 1997: 129).

For this reason, socio-legal literature concluded, of the initial introduction of EMA, that the "basic technical control of the abortion procedure has been tightened, despite some evidence that such a degree of control is neither medically nor legally necessary" (Sheldon, 1997: 139). Instead, "it seems likely that this very potential to demedicalise or detechnicalise abortion is responsible for the concrete increase in control" (Sheldon, 1997: 139). Similarly, as Klein et al. claimed in 1991, "in reality the RU-486/PG abortion method increased rather than decreased … the lack of women's control over the abortion experience" (1991, p. 29). Klein et al. (1991) argued that EMA is an example of "strict and prolonged medical supervision, measured by the number of doctors' visits, the duration of the time between visit one to visit three or four" (p. 29). They concluded that EMA is a "non-private extensively medicalised, and complicated method" (Klein et al., 1991: 29). The increase in EMA's medical regulations, even though the technical skill involved in this type of abortion is minimal, later becomes significant to the debates on the medicalisation of abortion as this chapter will discuss.

These strict guidelines put in place by Roussel-Uclaf and the Department of Health were lifted in 2000, and as a result, bpas, reported an increase of 151% in EMA using mifepristone. Bpas clinics performed 1,052 early medical abortions in 1999, rising to 2,644 in 2001 (Jones and Henshaw, 2002). Since these restrictions were lifted, the procedure for EMAs changed: "EMA is [now] provided up to 63-70 days" (Lee, Sheldon and Macvarish, 2018: 30). In addition to the increase to the days of gestation when EMA can be used, after a series of medical trials (Ashok et al., 1998; WHO, 2000), EMAs are now completed by taking one 200mg tablet of mifepristone followed by a single 400 μg dose of misoprostol 24-48 hours later. These shifts in the method of abortion provided in Britain is one of the most important changes to service provisions since 1967.

For the first time in history, most women do not require a lot of medical intervention to be provided with abortion. Nurses were involved in the provision of abortion for a number of years before the introduction of EMA. However, the procedure still required the involvement

of a medical practitioner.[2] In 1981, The "Department of Health and Social Security (DHSS) sent out a circular to … district nursing officers dealing with abortions by medical induction" (Sheldon, 1997: 96). In the circular the DHSS "advised that it was not necessary for a doctor personally to perform every action in the process, providing that he decided on and indicated the process and remained responsible for it throughout" (Sheldon, 1997: 96). As a result, the RCN took the DHSS to court to "test the law" (Sheldon, 1997: 96). The RCN claimed that this advice was unlawful because "nurses were not registered medical practitioners" (Sheldon, 1997: 96). After a number of appeals, it was decided in the House of Lords that on the condition that a "doctor prescribed the treatment for the termination, remained in charge and accepted responsibility throughout, and the treatment was carried out in accordance with his directions, the pregnancy was 'terminated by a registered medical practitioner'… and any person taking part in the termination was entitled to the protection afforded by Section 1(1)" (Sheldon, 1997: 97). This court ruling is important to the development of abortion services after the introduction of EMA.

There has been an increase in the number of abortions performed in the past 20 years (Department of Health and Social Care, 2020), and the large majority are performed in the first trimester. For example, in 2018, 80% of abortions were performed under ten weeks and, of these, 83% were medical abortions (Department of Health and Social Care, 2019). This means an increasing number of EMAs are performed each year. As a result, practices have been developed to "minimise physicians' involvement in medical abortion, thereby reducing staff costs and potentially the cost of the method for providers and patients" (Jones and Henshaw, 2002: 157). As explained above, for abortions provided medically, it has been suggested that doctors do not "perform or provide an abortion, as with aspiration and surgical methods" (Berer, 2020: 46). Instead, the role of the medical profession has changed. It is now a "matter of giving information, dispensing pills, monitoring process and giving support" (Berer, 2005: 31), and it is now the woman who "uses the pills- vaginally, buccally or sub-lingually [and] it is the pills that cause an abortion" (Berer, 2020: 46). This change in the type of work that doctors perform in abortion services today has changed the dynamics of the medicalisation of abortion. Doctors no longer control the abortion procedure, and the role ascribed to doctors by

[2] Nurse involvement in abortion by medical induction took place after a doctor had inserted a catheter into a woman's uterus (Sheldon, 1997). The nurses carried out "subsequent steps… [which may involve] connecting a pump to the catheter which would feed the prostaglandins into the woman and monitoring the process which could take anything up to 30 hours" (Sheldon, 1997: 187). The prostaglandins cause the termination of pregnancy.

the 1967 Abortion Act no longer reflects the values of abortion providers as they are no longer involved with most abortions. The shift in the type of work that doctors who provide abortions do today will be further discussed from a sociological perspective in Chapter Two.

The tension between the medicalisation of abortion through the 1967 Abortion Act and the practice of providing abortions, was highlighted by the work in 2007 of the House of Commons Science and Technology Committee (STC). This Committee was formed as an "attempt to sift the evidence on scientific and medical developments" in abortion provisions, since the 1990 Human Fertilisation and Embryology Act, which officially lowered the abortion limit from 28 weeks to 24 weeks (STC, 2007: 3). The Committee's Report "drew conclusions about the [scientific] and medical evidence… tells us" (STC, 2007: 3). They examined key aspects of the 1967 Abortion Act, including the requirement for two doctors' signatures, nurse involvement and the location of where an abortion can take place. I now examine how the medicalisation of abortion has changed in relation to EMA, through some of the findings of the STC. Overall, the Committee's conclusions can be considered a series of recommendations for the "loosening of medicalisation" (Amery, 2020: 131).

The first distinction between the medicalisation of abortion law and abortion practices can be seen by evaluating the current requirement for two doctors to certify the abortion. As explained above, two doctors must certify, with a signature, that they have come to the decision in good faith that the abortion meets the grounds of the 1967 Abortion Act. Currently, doctors "each sign a Department of Health HSA1 form to give notification that the abortion has been approved and on what grounds and an HSA4 form for information including patient details, the method of abortion and gestation time" (STC, 2007: 32). The Committee recognised that there were a number of reasons for this requirement, for example, they reported that this process was in place "to protect doctors from breaking the law;" as well as "to protect women"; and "to demonstrate the medico-legal concerns of Parliament, namely that the 1967 Act did not make abortion legal but conferred upon doctors a defence against illegality- the two doctors are expected to police each other" (STC, 2007: 32).

However, as Dr Vincent Argent, a Consultant Obstetrician and Gynaecologist and the former Medical Director of bpas, told the Committee that, the HSA1 form "is often considered to be just an administrative process where doctors make no attempt to form an opinion, in good faith, that the patient fulfils the grounds [for an abortion]" (STC, 2007: 32-33). This is evidence of a

clear tension between the role given to doctors by the law and the practices of abortion provision in Britain. Instead of using the HSA1 form as a record of good faith judgements, as the 1967 Abortion Act intended, doctors were:

> … signing batches of forms before patients are even seen for consultations, signing the forms with no knowledge of the particular participant and without reading the notes… signing forms after the abortions has been performed … [and using] signature stamps without consultation with the doctor. (STC, 2007: 33)

This led the Committee to conclude that this requirement "either … does not play a meaningful role in the abortion practice or the law is not being applied properly" (STC, 2007: 33). After reviewing evidence provided to them by the RCOG, BMA, RCN and service providers the Committee concluded that the requirement for two doctors' signatures "contributed to delays in access to abortion services" (Rowlands, 2013: 124). Therefore, there was no "good evidence that, at least in the first trimester, the requirement for two doctors' signatures serves to safeguard women or doctors in any meaningful way or serves any other useful purpose" (STC, 2007: 35). As they saw this part of the legislation as meaningless, they concluded: "there is a strong case for removing the requirement" (STC, 2007: 35).

Since and despite the Science and Technology Committee's recommendations, there has not been any legislative change to this part of the provision of abortion. Two doctors still have to sign the HSA1 form as proof that they have formed the opinion in good faith that the woman has met the legal requirements. This has been described by providers as "cumbersome and unnecessary [and] adds no benefit for women" (Rowlands, 2013: 124). Additionally, these findings were supported by those of a study of British gynaecologists' attitudes to the provision of abortion in 2008. As part of this study, 98 of the 152 gynaecologists that completed the questionnaire agreed that that the requirement for two doctors' signatures in the first trimester was not necessary or needed (Savage and Francome, 2011). This means that for the vast majority of abortions provided in England and Wales today, the legal requirement for doctors to 'perform' the majority of abortions has been reduced to by signing the HSA1 form and prescribing the abortion drugs while nurses are providing the majority of face-to-face patient care.

The medicalisation of abortion has also been challenged as a result of the introduction of EMA through contest over where an abortion can occur. As explained above, when the 1967 Abortion Act was introduced, all abortions were provided surgically. To control where these surgical abortions took place, it was stated in the 1967 Abortion Act that abortions must take place in a hospital or approved location. Amery (2020) has argued that in this way, "medicalisation continued to present problems" (p. 123). The law was interpreted by the Department of Health until 2018 to mean that both mifepristone and misoprostol must be prescribed and administered in the location approved under the 1967 Abortion Act. This meant that even though the majority of abortions were performed within the first ten weeks of pregnancy, women had to attend an abortion clinic multiple times to complete their procedure. Practice before 2018, in the majority of clinics, was that women could go home as soon as they had taken the misoprostol (Greasley, 2011). However, "symptoms can, and often do, start within minutes of ingesting misoprostol … it can be the case the woman experiences the beginning (and most painful) stage of abortion, and sometimes the miscarriage itself … in the street, in a car or while using public transport on her way home" (Greasley, 2011: 314-315). For this reason, the legal requirement for women to use misoprostol in a clinical setting was a highly contested part of the medicalisation of abortion up to 2018, when the Secretary of State for Health announced the new guidelines.

Before this change, many arguments had been put forward that questioned whether it was necessary for the medication to be taken within a registered clinic. Many women-centred organisations and scholars argued that women should be allowed to take the mifepristone in a clinic and then complete the procedure by inserting the misoprostol at home (Sheldon, 2016). This once again questions how the medicalisation of abortion works in practice.

The STC also reported on this part of the legal framework of abortion. The Committee evaluated evidence from countries such as the USA and Norway, where women were self-administering misoprostol at home, and concluded that there were "no particular safety concerns" with home use of misoprostol (STC, 2007: 41). They outlined a number of reasons for this decision. These include that "women already take misoprostol at home to complete natural miscarriages with no apparent safety concerns", and that medical abortions "causing unpleasant symptoms is not a reason for restricting the administration of misoprostol to a clinic" (STC, 2007: 42). The Committee finalised its conclusion on this matter by reporting that there is "no evidence relating to safety, effectiveness or patient acceptability … that should defer Parliament from amending the Act to exclude the second stage of early medical abortion

from the definition of 'carrying out a termination'" (STC, 2007: 42). However, despite these recommendations from the Committee, the Department of Health did not amend the law to allow women to take misoprostol at home.

Further to the publication of the STC report, bpas completed a study of their clients in 2010. They found their clients that "would prefer home use of misoprostol as opposed to returning to the clinic to obtain and use the medication" (Lohr et al., 2010: 21). In 2011, bpas took "legal action to make early medical abortion at home as straightforward and as safe as possible for British women" (bpas, 2011). Bpas argued that abortion law should be interpreted to allow women to be prescribed both mifepristone and misoprostol in a clinical setting but to allow women to take the misoprostol at home. However, a "high court judge ruled that both pills must be taken under medical supervision" (Amery, 2020: 123). Amery notes that "this ruling appeared to reflect the ongoing conviction that abortions must be closely observed and controlled" (p. 123). There are many reasons bpas and academic scholars have argued it is necessary to allow women to take the second set of medication at home. The most practical is that it eliminates the risk of women having the miscarriage on the journey home from the clinic (Sheldon, 2016). However, it was also seen as expensive to services and an unnecessary journey for women.

As Sheldon (2016) noted, one way medical professionals have tried to get around this aspect of the medicalisation of abortion is to provide a range of options for women as "they negotiate the tension between best interests of their patients and the regulatory framework" (p. 312). For example, some clinics offer same-day EMA where misoprostol is administered after "maximum delay compatible with regular opening hours", meaning 6-8 hours after the administration of mifepristone. This is less effective than waiting the usual 24-48 hours, with a completion rate of 96% rather than 98% (Raymond et al., 2013; Schaff et al., 2000; Wedisinghe and Elsandabesee, 2010). Similarly, an alternative method used by clinics in Britain is taking misoprostol 15 minutes after mifepristone. However, this is not as effective as when medicines are given 24 hours apart but still offer a 95% chance of complete abortion with a small chance of a greater risk of side effects (Creinin et al., 2007). By offering alternative treatments that have a lower success rate of a complete abortion, doctors are finding ways to satisfy the needs of women who use the service while staying within the regulatory framework. This further highlights the tension between the legal framework and current practices.

Through discussion of technological developments impacting abortion provision, I have outlined an existing tension between the values ascribed to doctors by the law and the values that drive doctors to change their abortion practices. I now turn to investigate the tensions between medicalisation and professionalism through some of the more recent public debates about abortion.

1.3.3 Recent controversies: Counselling, and 'sex-selection Abortion'

While there have been numerous attempts to amend the 1967 Abortion Act, since it was enacted abortion has remained "politically uncontroversial" (Bristow, 2014: 43). None of the amendments put forward were successful and as Sheldon (2016) notes, amendments were often proposed as part of "other statutes" (p. 365) which has resulted in "poor drafting" (Sheldon, 2016: 365). However, in recent years "British politicians have sought to intrude into issues of abortion-related clinical practice, fuelling concerns that abortion is unsafe and poorly regulated" (Furedi, 2014: 6). As a result of these concerns "abortion providers have faced a barrage of attacks on their businesses and reputations, and those working in the field have had to expend a great deal of time and energy fighting and defending their practices" (Bristow, 2014: 42-43).

Here I outline two key debates that have taken place in recent years that have questioned the values of abortion providers, and sought to extend the legal regulation of abortion provision. Firstly, in 2011, claims were made once again that women need to have a form of independent counselling. This was raised by MPs Nadine Dorries and Frank Field. The second debate that questioned the morality of abortion providers was the sex-selection debate. I will show that in both of these debates, arguments were formed around the principle that "abortionists are not to be trusted" (McGuinness, 2015: 300). Once again, questions were raised about the tension between the professional values ascribed to doctors by the law and current practices. Interestingly, the claims made within both debates contained some similar themes to those examined earlier in this chapter when I discussed the initial debates after 1967.

As part of the parliamentary debate to amend the Health and Social Care Bill in 2011, Dorries and Field tabled an amendment that "would have stripped abortion providers the ability to provide counselling to women seeking abortion due to perceived 'bias' in current provision of

counselling" (Amery, 2015: 551). They tried to introduce a clause to the Bill that "would require that local authorities and clinical commissioning groups must provide 'independent' counselling for all women who wished to have an abortion" (McGuiness, 2015: 300). In her speech to the House of Commons, Dorries defined 'independent' as "a private body that does not itself refer, provide or have any financial interest in providing for the termination of pregnancies or a statutory body" (Hansard, 2011). They believed independent counselling was necessary because providers like bpas and MSI have a "financial conflict of interest" (Jackson, 2011: 1). Even though these organisations are non-profit organisations with charitable aims, Dorries questioned:

> If an organisation advertises that it wants to increase the number of abortions, can we trust it to provide vulnerable women who walk through the door with the counselling that they need? ... It must be wrong that the abortion provider that is paid £60 million to carry out terminations also provides the counselling … where is the incentive to reduce them?

The claim that women need independent counselling is interesting for two reasons. Firstly, there was no evidence put forward to show any evidence that women were not given information that would enable them to make an informed decision (Jackson, 2011). Secondly, anti-abortion groups had begun to open their own counselling organisations to provide services for women seeking a termination (Lee, 2003a). These have been known as "crisis pregnancy counselling services" (Lee 2011) and promoted their anti-abortion values, under the guise of 'independent counselling'.

The argument for independent counselling as set out by Dorries and Fields is not new, and the campaign for independent counselling has been evident since 1974 with the Lane Committee's findings. Interestingly, the idea that the medicalisation of abortion is problematic because doctors are not the most appropriate group of individuals to decide when a woman should have an abortion becomes apparent. They claim that women need to be protected from medical professionals because they have a financial incentive for providing abortions. Dorries herself said in her speech that she is "pro-choice", telling fellow MPs "abortion is here to stay" and it "is absolutely not the objective" of the amendment to "reduce the number of abortions" (Hansard, 2011). By describing herself as pro-choice, Dorries implies that she is looking to protect women and that her amendment makes abortion safer.

The amendment was ultimately rejected in the House of Commons with 118 votes for the amendment and 368 votes against (Hawkes, 2011) because MPs saw it as restricting abortion and as a form of anti-abortion argument (Amery 2020). However, literature such as McGuinness (2015) has described the amendment as a "clever strategic move designed to undermine the trustworthiness of abortion providers, focused on the fact that the majority of services are delivered through independent sector providers and outside of the 'trusted' NHS system" (p. 301). Similarly, Amery (2015) noted that through the construction of women as vulnerable, the amendment to the Health and Social Care Bill follows a similar pattern of anti-abortion arguments from the 1970s, such as the Corrie Bill. This is because it targets "a key principle of the 1967 Act: the capability of doctors to make 'social' judgments and interpret the law … thus attempted to undermine the very foundation of the Act by shaking faith in the assumption that doctors can be trusted to interpret the law reasonably and in line with the wishes of Parliament" (Amery, 2015: 560).

A second recent debate, containing themes questioning the trustworthiness of doctors, was about 'sex-selection abortions'. This first began on the 22nd February 2012, when *The Daily Telegraph* published a series of articles after filming inside abortion clinics in Britain, where it was claimed that doctors were offering terminations where women had told the doctor she wanted a termination because of the gender of the foetus. Doctors were then accused of performing abortions for the reason that the women did not want to have a baby girl. The articles caused national outrage.

This anti-abortion argument is not a new in the abortion debate (Hesketh, Lu and Xing 2011; Kalantry, 2015). Sex-selection abortions have been portrayed as a problem by anti-abortion groups in America, where arguments have been made that some immigrant communities have sex-selective abortions because of the traditional preference of wanting a son. For example, Kalantry (2015) noted that in a Federal Bill aiming to ban sex-selection abortion it was argued that "evidence strongly suggests that some Americans are exercising sex-selection abortion practices… consistent with discriminatory practices common to their country of origin, or the country to which they trace their ancestry" (Kalantry, 2015: 143).

This argument directly implies that some ethnic groups have sex-selective abortions, and this is creating a problem in America that needs addressing. Even though studies such as those by

Kalantry (2015) have argued that there was not a problem of sex-selection in America, the debate opened up wider arguments on the morality of abortion providers. In 2012, the American pro-life argument that abortion should be restricted to protect girls became a central argument in the British abortion debate. As part of this claim, it was argued that it is "women (not only, or even primarily, foetuses) are the victims of abortion, while abortion doctors are persistently villainised" (Lee, 2017 in Amery, 2020: 194). By presenting doctors as villains once again, they are seen as "uncaring, self-interested, aloof from the reality of abortion, and ignorant of the value of life" (Lee, 2013: 6). The idea that female foetuses are being aborted solely because of their gender is a clear example of how pro-life groups has aligned themselves with the claim that they are trying to protect women.

"Equipped with secret cameras, reporters from the newspaper visited the clinics accompanied by actors who posed as women desiring terminations", explained Greasley (2016: 535). It was then reported in the newspaper (the *Daily Telegraph*) that during their consultations, the pregnant woman said that she had decided to have an abortion after discovering the sex of the foetus. One of the doctors was quoted to have said, "I don't ask questions. If you want a termination, you want a termination" (Newell & Watt, 2012). For this reason, the newspaper claimed that doctors were performing illegal abortions. *The Daily Telegraph*'s reports "portrayed doctors as unconstrained by regulation, failing to carry out their role as abortion gatekeepers responsibly and potentially engaging in criminal activity" (Amery, 2020: 164). This set of articles featured comments by the then Health Secretary, Andrew Lansley, who was quoted saying that doctors would "face the full force of the law" (Watt, Newell and Winnett, 2012). Lansley also wrote an opinion piece in *The Daily Telegraph,* where he said that the findings of the investigation was a "real concern [and] carrying out an abortion on the grounds of gender alone is in my view morally repugnant, it is also illegal" (Lansley, 2012). He continued:

> Whatever an individual's opinion on abortion … abortion laws in this country are decided by Parliament, not by individual doctors. If some professionals disagree with the law as it stands, they should argue their case for change. Simply flouting them in a belief that they know better is unacceptable. (Lansley, 2012)

What is interesting in the debate is that Lansley continued saying "these grounds [of the law] include considering the risk of the pregnancy to the physical and mental health of the woman

seeking a termination … these laws are absolute. They are not guidance which doctors can opt out of" (Lansley, 2012). This would imply that doctors performing the 'illegal' sex-selection abortions are not taking into consideration women's health. On the back of the investigation by *The Daily Telegraph*, claims were then made in other national newspapers that seemed to support the findings of the investigation. For example, *The Independent* also released articles with headlines claiming that sex-selection abortion in the UK has led to a reduction in "female population by between 1,500 and 4,700" according to UK census data (Connor, 2014). The sex-selection debate caused widespread "outrage" (Sheldon, 2012a).

As stated above, these articles aimed to show that doctors were acting outside of the law, and that as a result, "the 'ethicality' of doctors was called into question by claiming that they are no longer fit to act as 'gatekeepers' to abortion services, the role historically designated to them by English law" (McGuinness, 2015: 299). However, the legality of sex-selection abortions was widely debated by academics. For example, Sheldon (2012b) clarified that it was "the legal question in the case of sex-selective abortion – which is far less clear than has been assumed by many commentators" (p. 2). While the Abortion Act does not explicitly state gender as a ground for abortion, the law is open to wide interpretation. This means that legal scholars have claimed that doctors can make the case that they acted in good faith to provide an abortion if the woman's health is at risk. Just like for example, the doctor who authorises a termination on the basis of rape or incest would rely on the likely harm to the woman's health of continuing a pregnancy" (Sheldon, 2012b: 2).

One of the most important consequences of the sex-selection scandal was an inspection into all abortion clinics and hospitals in England by the Care Quality Commission (CQC).[3] In January 2012, during an inspection into a private abortion clinic, the CQC found evidence that HSA1 forms were being pre-signed by a doctor.[4] Doctors were accused of signing "batches of abortion paperwork without seeing the patient first" (Amery, 2020: 2). The CQC reported that "this is a breach of the Abortion Act, and allows the second doctor to take a solo decision to allow a termination" (CQC, 2012). However, after accusations of illegal practices through the

[3] The CQC is the independent regulator of health and social care in England who "monitor, inspect and regulate services to make sure they meet the fundamental standards of quality and safety" (CQC, 2016).
[4] Pre-signing is a process where "a discussion between a doctor and other staff members may take place, for example, by telephone, and a form that is already signed is then used" (Lee, 2017: 22).

sex-selection scandal, Lansley asked the CQC to investigate to see whether the practice was happening in abortion clinics all over England (CQC, 2012).

These inspections did not find any evidence of sex-selection abortions being performed in Britain. Instead, they found evidence that fourteen NHS hospitals were pre-signing HSA1 forms. This led to another line of argument being adopted by *The Daily Telegraph* that doctors were acting above the law and performing morally questionable abortions. Even though the CQC reported there was no evidence that "any women had poor outcomes of care" (CQC, 2012) as a result of pre-signing. *The Daily Telegraph* still suggested that doctors were acting out of self-interest. These inspections cost over £1 million (Furedi, 2014) and has been described as "an entirely disproportionate response to the scale of the practice or problem of pre-signing" (bpas 2012). For this reason, pro-choice groups, such as Abortion Rights, have described the investigation as "a politically motivated attack on abortion providers ordered by Andrew Lansley to appease a small number of Conservative backbenchers who wish to see access to abortion severely restricted" (Abortion Rights, 2012). In addition, the then Shadow Public Health Minister Diane Abbott said, "this report shows that Andrew Lansley has yet again put political interests ahead of British patient care… this report looks like a dark, sordid and politically charged campaign against care providers, doctors and British women's right to choose" (Abortion Rights, 2012).

Additionally, as part of this argument, we see claims made that pre-signing the HSA1 form is illegal. However, this is disputed by the ambiguity of abortion law. For example, in 2012, in an editorial piece in the journal *Abortion Review* it was said that "while pre-signing forms on this basis is not advisable, there appears to be nothing on the face of the statute to prohibit it" (Abortion Review, 2012: 3). The argument that pre-signing the HSA1 form was illegal is interesting to the debate in 2012, as evidence of pre-signing forms was submitted to the House of Commons Science and Technology Committee in 2007, as discussed in the previously in this chapter. Where medical professionals discussed pre-signing as a way of "improving responsiveness and reduce delays" (Rowlands, 2013: 17). However, even though doctors accused of pre-signing abortion notification forms they were doing so because they saw it as a way of speeding up abortion services. The CQC inspection "resulted in the suspension of several doctors from related duties and their referral to the GMC, despite no evidence that a single unlawful abortion has been carried out as a result of 'pre-signing'" (Furedi, 2014: 6). This further highlights the ambiguous position of the abortion provider, who is trying to negotiate

their position when the medicalisation of abortion, through the law, is seen as outdated in terms of how abortion is provided.

Another consequence of *The Daily Telegraph*'s investigation into sex-selection abortions was the criminal investigation of medical professionals. After the articles were released, the police began investigating these doctors and "the GMC had either suspended or taken action against three doctors" (Rowlands, 2013: 124). After eight months, in September 2013 the Crown Prosecution Service (CPS) decided not to prosecute the four doctors who were videoed in the initial *The Daily Telegraph* investigation because "there is insufficient evidence to prosecute" (CPS, 2013, in Lee, 2017: 23). As a result of this decision, once again, doctors were presented as villains in the media. For example, articles were written with the headline "The selective abortion of girls is a crime. Simple as. So why no criminal charges?" (Lee, 2017: 23). Additionally, *The Guardian* published a comment which said "we must be prepared to circumscribe our pro-choice position ... A girl's right to life has to be a basic tenet of any feminist position" (Gupta, 2013 in Lee, 2017: 24).

As a result of the CPS's decision not to prosecute doctors a pro-life group, Christian Legal Centre privately prosecuted the doctors who were reported in the newspapers. In 2015, the CPS halted these prosecutions on the basis that the evidence provided in the form of video footage was "heavily edited and reduced in length" (BBC, 2015). However, even though these doctors were not prosecuted, the argument that sex-selection abortion was problematic was being raised in Parliament. Pro-life MPs began to lobby for a restricted abortion law because doctors were performing abortions illegally, and the debate "ballooned into a major political issue" (Amery, 2020: 1). MPs began lobbying to record the gender of aborted foetuses and up to 100 MPs brought an amendment to the House of Commons headed by Conservative MP Fiona Bruce. However, this time it was on the basis that abortion laws needed amending and restricting because sex-selective abortions were "a form of cultural oppression of minority women in need of protection" (Anitha and Gill, 2018: 1). Abortion was once again seen as a cause for concern in the eyes of the media, politicians and the general public. This time it was claimed that sex-selection abortions are a form of discrimination and therefore doctors are discriminating against girls and women by performing abortions on the grounds of gender.

While the amendment ultimately failed to change abortion law "a great deal of damage was done to the confidence of abortion providers" (Bristow, 2012: 43). Furthermore Bristow (2012)

noted that the aftermath of the sex-selection scandal highlighted "that the government could-and in this instance, would interpret the law rather differently that it had for over a decade, leaving doctors at risk of professional investigation and criminal prosecution" (p. 43). As a result of this period where both, doctors were accused of acting illegally, faced with the very real threat of prosecution and pro-life campaigns to restrict abortion on the grounds of looking after women, the campaign to decriminalise abortion began. In 2016 with the support of the 'We Trust Women' campaign, set up by bpas, to decriminalise abortion MP Diana Johnson put forward a Bill to the House of Commons, that would abolish section 58 and 59 of the OAPA (Amery, 2020). Although the campaign is mainly framed as a "fight against equality" (Amery, 2020: 156) to place abortion into the hands of women rather than the medical professional (Amery, 2020). It would consequently change the role of the medical professional involved in abortion. Doctors would no longer be faced with the fear of prosecution under the OAPA 1861 and instead abortion, and its providers, will be regulated "like any other medical procedure" (Amery, 2020: 156). Between 2017 and 2018 a number of medical organisations including the BMA, RCOG and FSRH all voted in favour of supporting this Bill. The campaign to decriminalise abortion is a clear example where the medicalisation of abortion is contested by medical professionals.

This section of the chapter has shown how, once again, that the medicalisation of abortion has been challenged, through claims that doctors are not the best group of people to decide when an abortion can legally happen and there have been numerous claims made since 1967 which have highlighted this concern. For example, that women need independent counselling because doctors were motivated by financial incentives and that doctors were uncaring of their patients' needs. In addition, the sex-selection 'scandal' further developed the argument, that abortion providers are the villains who have very little concern for the safety of women by calling the authority of doctors into question "on the basis that it … harms women" (Lee, 2017: 17). This highlights a further tension between abortion law and practice where "abortion provision has been simultaneously accepted by the mainstream and viciously attacked by senior figures in and around the government" (Bristow, 2012: 43), highlighting the ambiguous position of abortion providers and the medicalisation of abortion.

1.4 CONCLUSION

To conclude, this chapter has firstly outlined the ambiguous nature of abortion law in England and Wales. Through outlining how abortion became medicalised through the law, which ultimately gave doctors the power to decide when an abortion can legally take place, I have shown that the medicalisation of abortion has been contested in many ways by different groups of people. In the immediate years after the 1967 Abortion Act was implemented, the initial challenges focused on the doctors who provided the abortions. There were often distinctions drawn between doctors working in the private sector and the NHS. This distinction was often based on the type of doctor who would choose to work in the private sector, and their perceived values, with the implication that these doctors could not be trusted, and regulation needed to be tightened. In addition, anti-abortion groups were keen to claim that the medicalisation of abortion was problematic because doctors were acting unethically, and women needed protecting from these providers.

Next this chapter discussed the technological advancements that have considerably changed the abortion service since 1990, focusing on the introduction of EMA and the findings of the House of Commons Science and Technology Committee in 2007. These technological advancements are important to the medicalisation of abortion as they have changed how doctors today provide abortions, even though the law remains unchanged. It is here, through reviewing the literature, we see how doctors working in abortion services are managing the tensions between the law and how the service has evolved since 1967. The work of the abortion doctor has changed substantially and for this reason, we see cases where doctors themselves begin contesting aspects of the medicalisation of abortion and have adopted a softer form of medicalisation in an attempt to manage the tensions between law and practice. However, this raises questions such as "what happens when a law rests on the idea that doctor knows best, but doctors themselves begin to disavow this authority?' [and] the current settlement for abortion regulation has become unstable" (Amery, 2020: 7).

Finally, I have laid out some of the claims made in recent years both about abortion providers and by providers in the latest debate on the ethics of abortion in Britain focusing on how the values of the medical profession were questioned by the media, MPs and anti-abortion groups during the recent debates surrounding counselling and sex-selection. Once again, the

trustworthiness of doctors who provide abortion was brought into question. It is evident that the 1967 Abortion Act did not solve the problem of abortion. The medicalisation of abortion, as laid out in the Abortion Act, was not straightforward and was often the subject of much debate and conflict. The following chapter builds on this by examining the sociological backdrop and the theoretical framework that supported the investigation.

CHAPTER 2

PROFESSIONALISM AND MEDICAL VALUES

2.1 INTRODUCTION

Chapter One outlined the unique laws which regulate abortion in England and Wales and discussed the construction of the professional identity of doctors as guardians of morality and gatekeepers to legal abortion through the 1967 Abortion Act. Chapter One also indicated that the medicalisation of abortion has been a source of tension, and changes to the abortion service have raised questions about the medicalisation of abortion and how the service should be run and organised. Sheldon, in her article *The Decriminalisation of Abortion: An Argument for Modernisation* concludes that these tensions are sufficient to mean that the framework for legal abortion "is in need of fundamental reform to modernise it in line with the clinical science and moral values of the twenty-first century" (2016, p.334).

This chapter takes further the exploration of the professional identity of abortion providers, through a broader investigation of the sociology of medicalisation. Firstly, I briefly examine the foundational sociological debate on the values of the medical profession to establish an initial conceptualisation of the problem of medicalisation. I then turn to discuss the debates on the professional identity of abortion providers in more recent literature, which has shown that the medical profession is not just one body that shares the same set of values and suggests instead we can usefully identify the presence of competing values throughout the history of legal abortion. Third, I discuss sociological theories which address the wider values of medicine and are important to a study of the professional values of doctors, including those who provide abortion. This comprises a selective review of literature on some of these debates on the general values of the medical profession, such as new professionalism and de-professionalism. Finally, I outline the conceptual framework used to develop my investigation which draws on the work of American sociologist Drew Halfmann and his exploration of medicalisation on the macro, meso and micro levels.

2.2 SOCIOLOGICAL BACKDROP

Much of the scholarship discussed so far has drawn more or less explicitly on a sociological assessment of the medical profession associated with Eliot Freidson, or more generally with the idea that abortion is 'medicalised' by assigning power over its provision to the medical profession (Macintyre, 1973; Keown, 1988). I will return to explore this theory later in the chapter. In turn, even if unstated, this Freidsonian approach rests on a foundation given by theories developed by Talcott Parsons and contests the arguments associated with Parsons. It is here that my discussion of professionalism and its values therefore starts.

Parsons first examined the role of the professions within society in 1951; he used the medical profession as an example to investigate "how values shape social action" (Turner, 1991: xiii). Parsons' (1951) use of the medical profession as the typifying example was not accidental. He believed illness was a practical problem for all societies (Pescosolido, 2013), and "medical practice… is a mechanism in a social system for coping with the illnesses of its members" (Parsons, 1951: 432). Parsons thought that "all societies create health and disease in order to have a working society" (Pescosolido, 2013: 176). It is therefore necessary for societies to create "specialised, institutionalised roles for patient and practitioner, who together, work to restore individuals to health as productive members of society" (Pescosolido, 2013: 176). The role of medical professionals was to ensure members of society return to full health and perform their role in society by being 'gatekeepers' who "officially legitimate and control the amount of illness in society" (Morgan, 2003: 58). Medical practice was in this way, for Parsons, essentially a social role that enables the functioning of the social system; medical professionals' values and the acceptance of them was his central concern.

From this perspective, the medical profession is understood as holding values that enable it to fulfil a beneficial social role, as Turner explains:

> [The] medical values [of the doctors] represent a central illustration of social action which is not dominated by utilitarian values of self-interest. A professional person is expected to be altruistic, oriented towards community service and regulated by professional ethics. (Turner, 1991: xiii)

Parsons (1951) thought that the capacities of the doctor created the possibility of this ethical role not as "a wise man … but a specialist whose superiority to his fellows is confined to the specific sphere of his technical training and expertise" (Parsons, 1951: 292). In addition, the medical profession is "expected to be objective and emotionally detached … guided by the rules of professional practice" (Morgan, 2003: 59). While treating their patients, in order to fulfil the medical profession's role, doctors must work primarily for their patient's welfare and not for any personal or financial motivation. Parsons (1951) believed these to be common values shared by medical professionals, which unite individual social actors to form the medical profession. He believed that doctors and the medical profession exist to help sick individuals and support society by helping sick members of society back into their functioning social role. This suggests the values of the medical profession are 'good' and well intentioned: they serve and uphold the moral order of society.

Freidson's (1970) arguments comprise the most systematic and detailed initial response to the Parsonian validation of the values of the medical profession, and it is Freidson's case that more or less directly influenced extensive contest over the representation of medical power as beneficent, including in the area of abortion. Freidson (1970) argued that the "foundation of medicine's control over its work is … political in character, involving the aid of the state in establishing and maintaining the professions' pre-eminence" (p.23) and he rejected the view that the power and prestige of the medical profession resulted from the expert knowledge of doctors, as Parsons (1951) suggested. Instead, Freidson (1970) believed that expert knowledge was used as ammunition by the medical profession for attaining and maintaining power. In addition, Freidson the medical profession "create illness as an official social role" and "part of being a profession [is] to be given the official power to define and … create the shape of problematic segments of social behaviour" (p.206).

In this way, Freidson (1970) suggests the medical profession is able to define non-medical problems as medical so that they can claim jurisdiction over these areas. For example, "the physician [decides] what is normal and who is sick" (Holzner, 1968 in Freidson, 1970: 206) just as a "judge determines what is legal and who is guilty, the priest what is holy and who is profane" (Holzner, 1968 in Freidson, 1970: 206). Freidson (1970) argued that the doctor is not, therefore, "merely the legitimator of one's acting sick but also the creator of the social possibility of acting sick" (Morgan, Calnan and Manning, 1985: 55). Since "the medical profession has first claim to the jurisdiction over the label of illness and anything to which it

may be attached, irrespective of its capacity to deal with it effectively' (Freidson, 1970: 251), the medical profession will claim jurisdiction over matters of everyday life, even if there is insufficient evidence that they have a medical nature. The medical profession achieves this by labelling something as an illness or disease that was not previously labelled this way.

Freidson's (1970) analysis of the medical profession thus suggests its primary focus is to extend its professional dominance by increasing the number of conditions treated in the medical sphere. Of particular relevance to the history of the criminalisation of abortion is Freidson's argument that the medical profession has, throughout history, actively tried to eliminate competition of the 'irregular' provider by bringing medicine into the field of science (Rosenberg, 1987), which is how they both gained and maintained a monopoly over diseases and illnesses.

One result of Freidson's theory of the medical professionalism is the emergence of the concept of 'medicalisation', which at its most basic it "literally means to make medical" (Conrad, 1992: 210). Medicalisation refers to the process by which non-medical problems become defined and treated as medical problems, a concept first used by sociologist Jesse Pitts in 1968. Describing social control, Pitts (1968) argued that "redefining certain aspects of deviance as an illness rather than crime … is one of the most effective means of social control" (p.390). Zola expressed a similar ideal in his widely cited 1972 paper, *'Medicine as an Institution of Social Control'*, which argues that medicine was beginning to replace religion and law as a major institution of social control (Busfield, 2017: 759). For example, Zola (1972) writes, "it is becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts" (p.187). Moreover, medicalisation is a "process whereby more and more of everyday life has come under medical dominion, influence and supervision" (Zola, 1983: 215).

Similarly to Freidson (1970), both Pitts (1968) and Zola (1972) distinguish between disease and illness: illness is socially constructed, unlike disease, which they define as a biological problem. The distinction between illness and disease, and the claim that illness is socially constructed, by definition, allows medicine to "become relevant to new areas" (Busfield, 2017: 760). These problems are redefined as medical, either in terms of an illness or disorder, and involve the problem being defined and treated, as a medical problem, through medical treatment. Since the 1970s, a large number of problems have become viewed as medical, which

previously were seen as taken-for-granted everyday problems, such as childbirth (Henley-Einion, 2003) and anxiety (Conrad, 2007).

Much of the subsequent sociological literature has been critical of the benefits of medicalisation as a social process and has focused on the "impact of medicalisation on society, medicine, patients and culture" (Conrad, 2007: 5). For example, Conrad (2007) questioned whether the medicalisation of everyday life means "that medicine is better able to identify and treat already existing problems? Or does it mean that a whole range of life's problems have now received medical diagnoses and are subject to medical treatment, despite dubious evidence of their medical nature?" (Conrad, 2007: 3). Medicalisation scholars have argued that medicine does not so much treat existing problems but instead creates those problems and defines them as medical to gain and maintain social control over people.

This view, that the medical profession as a whole seeks to increase its professional dominance, has influenced a great deal of scholarship about abortion, and its case about professional values and the provision of abortion. Research has examined the medicalisation of abortion by investigating legal history, concluding that doctors have acted as "agents of social control … to allow the 'deserving' to have abortions" (Keown, 1988: 165). As indicated previously Keown (1988) thus argues that by examining the history of abortion law reform throughout the nineteenth and twentieth centuries we find a clear example of the exercise of the medical values that Freidson (1970) believed doctors have. By investigating the law, he argued, it can be seen that the "medical men have long exerted an important influence on the determination of when abortion is 'criminal' and when it is 'therapeutic' and abortion law in Britain "appears to have been both marked and influenced" (Keown, 1988: 166) by the medical profession. Szasz (1979) further argued that just because the procedure of having an abortion is surgical, it does not make abortion a medical problem, in the same way, that "the use of an electric chair [does not] make capital punishment a problem of electrical engineering" (p.77). This, therefore, raises the question of whether because doctors provide abortions, it should mean that abortion is a medical problem, where the medical profession is looked upon to provide a solution to its moral dimensions.

An adaptation of the values of the medical profession as set out by Freidson (1970) has also been used in feminist work about abortion, developing it considerably, since Freidson's work was gender blind and did not differentiate between medical issues beyond those considered

illness and disease (Riska, 2003). Feminist literature also focuses on the medical profession as an agent of social control. According to some feminist theorists, doctors play a role in "creating, interpreting and attempting to enforce a particular role for women… which serves the needs of both men and the capitalist state" (Dale and Foster, 2013: 81). This form of control happens in two different ways, according to Dale and Foster (2013). Firstly, doctors give advice and treatment to women "which is intended to reinforce women's willingness to perform the roles of submissive wives, lovers, unpaid homemakers, childminders and carers". Secondly, doctors are able to control women by asserting control over "material resources and benefits which women need to control for themselves if they are to gain autonomy over their lives" (Dale and Foster, 2013: 81). Feminist theorists have viewed abortion as the outcome of medical tendency to seek moral and social control. Here, questions are raised about the role of doctors as gatekeepers.

As discussed previously in this chapter, Parsons' (1951) discussion defined the doctor as a gatekeeper to accessing the sick role in order to prevent too many people from claiming they were sick. By regulating the sick role, doctors decide who is ill and who is not. As Chapter One has shown, doctors have been allocated the role of gatekeeping abortion through the law. For abortion, such a gatekeeping role has been contested by feminist scholars since pregnancy is not viewed as an illness. For example, Macintyre (1973) outlines reasons why doctors may have been given the role of gatekeeper to abortion. One is the perception that "women's judgement is unsound in early pregnancy (if not all the time) and she, therefore, cannot make a rational decision" (p.130). A second argument is that "the profession is trained to make such decisions" (Macintyre, 1973: 130). Macintyre (1973) concludes that since most reasons for having an abortion are not based on "clinical medical grounds, but political, moral grounds … the medical profession has no more competence to be heard than other members of the community" (p.132).

Similarly, Boyle (1997) notes that "the abortion decision clearly involves factors beyond the medical" (p.72). Boyle also questions why doctors are given the role of decision-makers because "we do not … allow nuclear physicists to decide on the deployment of the atomic weapons about which they know so much" (p.73). Boyle recognised this is because decisions which "involve matters of value with important social and political implications and are not simply matters of technical expertise (p.73).

However, more recent literature on medicalisation (Conrad, 2007) has suggested, once a problem becomes categorised as medical, it does not only lead to medical professionals exercising social control over individuals and there are examples throughout history where the medicalisation of a problem has been viewed positively. For example, epilepsy was once considered a non-medical problem (Conrad, 2007). It is unlikely that anyone today would suggest epilepsy is not a medical problem. It raises the question of how medicalisation should be properly defined, and whether, medicalisation as defined by Zola (1972) and Freidson (1970), which has medical professionals' interests as a core part, needs expanding to account for instances where medicalisation can be viewed as beneficial and a positive contribution to society. If it is not always about doctors gaining social control, how do the doctors who seek to contest social control make sense of their role? In an attempt to answer this question, I will now explore some of the other theories of medicalisation which sociologists have used when exploring the relationship between medicalisation and professionalism.

2.3 Abortion and Competing Values within the Medical Profession

An account of abortion that emphasises the problem of its medicalisation, centred around the medical profession's role, has informed a great deal of insightful work. Yet more recent contributions question whether the role of doctors in abortion is inherently medicalising, raising points that my work extends. As Chapter One has discussed, the 1967 Abortion Act is looked upon as a solution to the moral problem of abortion by medicalising the issue. Socio-legal and historical literature has suggested that medicalising abortion is the result of the interest of the 'medical men' wanting to gain control over this aspect of women's reproductive health. However, in reality, there were many forms of tension in the medicalisation of abortion, and there are examples of competing values within the medical profession.

For example, there were tensions between components of the medical establishment where medical organisations adopted differing views on abortion law reform in 1967. The BMA, RCOG, Royal College of Nursing (RCN) and Royal College of Midwives (RCM) did not want a law that liberalised abortion. Instead, they "were prepared to accept clarification of the law" (Simms 1974: 124). In contrast, the Royal College of General Practitioners (RCGP) and Royal Medico-Psychological Association (RMPA) "were more favourably disposed towards a liberal measure" (Simms, 1974: 124). Because of these differences, abortion law reform has also been

described as a "site of significant intra-professional struggle" (McGuinness and Thomson, 2015: 188). This tension is further highlighted by Dee (2019), who argued that "a priority of the 1967 Abortion Act had been to protect doctors and license them to act in good faith yet there were still tensions, with some doctors wanting complete control over the process, and others regarding abortion as fundamentally incompatible with their practice and professional code of ethics" (p.54).

The tension is further evident in the actions of medical professionals that took place after the 1967 Abortion Act came into operation in April 1968. Once the Abortion Act was officially implemented, there was a clear lack of funding and support for a medical abortion service. This resulted in large pockets of the country where women could still not have a legal termination on the NHS. There were two reasons for this. The first, noted by McGuinness (2015), is that many conservative NHS hospital consultants were very forthcoming in expressing the opinion that they would block access to an abortion service within the NHS. For example, "as one hospital, over a six-month period, 120 of the 170 requests for terminations were refused" (Lewis, 1969: 242). The second reason is that the NHS was not prepared for a medical abortion service. For example, Munday, Francome and Savage (1989: 1231) noted:

> The Act was not backed up by any specific allocation of money for facilities or staff within the NHS. The service provided had varied from district to district, depending on the attitudes of consultants concerned.

Senior consultants were overtly stopping abortions from being practised in their hospitals, showing how medical professionals' opinions differed during the late 1960s. However, while there is evidence throughout literature that some doctors tried to prevent the introduction of abortion services, there has also been a new body of literature that has categorised some medical professionals as 'doctors of conscience', these are defined as doctors who believe it is their moral duty to provide abortions for women. This literature outlining the values of this group of doctors is discussed further below.

The conflicting values that have been outlined in more recent literature las led some legal scholars, such as McGuinness and Thomson (2015) to conclude, that from their examination of the history of the abortion law and service, the 'medical profession' is not a unified force but is, rather, fragmented and contains competing value-sets. This profession, they argue, is formed

with "complicated intra-professional rivalries", and the authors highlight "the tensions and, at times, conflicting interests for a fragmented profession" (McGuinness and Thomson, 2015:177). This is an important point since previously, theorists portrayed medicine as consisting of a unified group sharing the same values, even though different branches of medicine have different orientations and statuses.

Discussing the 1960s, McGuinness and Thomson (2015) acknowledge that during this time, while "pro-reform clinicians were (most often) motivated by concerns for women and improved social justice, establishment discourse appears predominantly concerned with promoting and protecting professional interests" (p.178). This suggests that different groups of doctors had different sets of professional values: where some groups were motivated to change the law to improve social justice, others were motivated by their professional or personal interests. McGuinness and Thomson (2015) further argue that there was "jurisdictional competition within medicine to maintain or gain control of abortion" (p.191). For example, the RCOG "took a more restrictive view" (McGuinness and Thomson, 2015: 191) of abortion law reform in the 1960s, strictly opposing any social clause put forward because they wanted to maintain clinical and professional autonomy. A report by the RCOG released in April 1966 represented the unambiguous view of gynaecologists that abortion law reform was not needed. The RCOG's report stated as a result of case law following the Bourne ruling in 1938 that the:

> Flexibility of the present legal position permits a gynaecologist, after proper consultation, to terminate a pregnancy whenever he considers it to be in the interests of a woman and her potential child; the majority of gynaecologist in the country can see no urgent need for reform of the law governing abortion. (RCOG, 1966: 852).

In comparison, other medical bodies such as the Royal Medico-Psychological Association (RMPA) openly and strongly supported the inclusion of a social clause. This created a sense of conflict where different medical groups favoured and opposed different aspects of abortion law reform, showing in turn that the medical profession should indeed not be viewed as a "united establishment" (McGuinness and Thomson, 2015: 191).

Such work suggests that the medical profession's values on abortion are not united: there are often tensions both between and within different medical groups. Even though the 1967 Abortion Act unified the medical profession and medicalised abortion by allocating doctors a

gatekeeping role in legal abortion, the above analysis rather points to a coexisting level of alternative perspectives. Authors such as Joffe (1996) refer to the idea of 'doctors of conscience' as the clearest example of an alternative value set. This term detailed most extensively in the USA and refers to doctors who perceive the provision of abortion by them and the extension of access to it for women as a positive moral act. Debates on 'conscience' and abortion have often focused on conscientious objection and medical practitioners right to refuse to provide abortions (McGuinness and Thomson, 2020). However, "there is an emerging literature that aims to reorient the debate… by focusing not just on those who wish to refuse to provide certain sorts of care but also those who are committed to providing care often at a great personal cost" (McCarthy and McGuinness, 2020: 159).

Those doctors involved in abortion law reform in Britain, who can be thought of as 'doctors of conscience', have written accounts that flesh out the meaning of this value set. For example, David Paintin, a gynaecologist who worked from the late 1960s onwards both providing abortion services and campaigning for their expansion and improvement, recalls that his reasons for providing safe abortion were that "the moral value of the foetus was small when compared with the health and wellbeing of the woman and her children" (Paintin, 2007: 9).

Doctors such as Paintin were reformers of abortion law in Britain during the 1960s; they tried to promote change to allow for legal abortion because they believed it was the right thing to do. These doctors were not medicalisers, trying to gain control over women's reproductive health, nor did they want to extend their medical authority. Instead, they wanted to reform abortion because they were motivated to help women. This arguably reflects the Parsonian notion of altruistic values, where the doctor uses his or her expertise to help and treat his or her patients, rather than the self -interested values outlined by Freidson and medicalisation scholars.

Accounts of what abortion law reformers wanted during the time the 1967 Abortion Act was being written and debated suggest that doctors campaigning for legal abortion appeared to be motivated by values different from those held by other doctors. For example, while organisations such as the RCOG and BMA adopted the position that it was essential to ensure doctors could maintain their clinical autonomy over who should have an abortion, this view

was not held by doctors most involved with agitating for law reform. Paintin (2007) thus believed that:

> [T]he unpleasantness gynaecologists associate with abortion is mainly due to the attitudes of their teachers and the aura of illegality that surrounds the subject … Reform of the law, as proposed … would reassure doctors that abortion could be performed in deserving cases with safety from prosecution. (Paintin, 2007: 21)

These comments suggest that the values of the doctors who sought to change the law were not based on wanting to extend medical dominance. They cannot be accurately described as in line with those that medicalisation theorists suggest characterised the outlook of the medical profession, suggesting that while the medical profession as a whole may have sought to extend their professional dominance, it does not mean individual doctors had a conscious motivation to do so. Instead, some doctors saw themselves as helping and being 'good doctors' by working in abortion services. These individual doctors saw providing abortions as a positive expansion of medicine and not a matter of gaining and maintaining medical control because women were being offered a choice on what to do when faced with an unwanted pregnancy.

In addition to the literature on doctors of conscience, some literature also highlights that there was no unanimous medical opinion on abortion in the 1960s, as the 1967 Abortion Act seems to imply. For example, Davis and Davidson (2006) have argued that "the state in many respected imposed medicalisation, causing noticeable resentment within the medical community" (p.48). The argument that some doctors at the time disliked the role ascribed to them by the 1967 Abortion Act was echoed by O'Neill (2019), who notes, there was a tension between the government and individual practitioners, where,

> …from the earliest days of the Act some doctors expressed concern at the responsibility that had been placed on their shoulders, believing that the Act offered confusion as well as flexibility, and potentially created difficulties for doctors and for the doctor-patient relationship (O'Neill, 2019: 72).

In addition, O'Neill (2019) noted that some doctors at the time felt that "their medical training had not prepared them for making decisions of this nature noting that the Act gave the medical profession 'considerable freedom to decide' but only 'vague criteria' to follow, meaning that

doctors were thrown into an unknown sea" (p.172). As outlined above, most of the literature on the medicalisation of abortion has suggested that doctors were instrumental in shaping the law to suit themselves and their desire to control aspects of reproduction. However, this section of the chapter has highlighted a new body of literature which has outlined some competing sets of values, which are different from those outlined by previous socio-legal scholars (Keown, 1988; Macintyre, 1973). The work of Davis and Davidson (2006) and O'Neill (2019) are examples of evidence of a differing of medical opinion on the medicalisation of abortion through the 1967 Abortion Act. One where doctors were not only didn't shape abortion laws to suit the profession's social and economic goals but openly resented the new role ascribed to them by this law.

Sociological insights developed from the debates outlined above have enabled scholars writing about the development of abortion to develop a rich and challenging account of historical developments. As those such as McGuinness and Thomson (2015) have shown, an approach drawing broadly on a Freidsonian perspective has illuminated a great deal about the medicalisation of abortion. New thinking is needed, however, in order to make further sense of the competing value sets apparent through the history of abortion provision, especially in sine the second half of the 20th Century. Those who have paid attention to the process of abortion law reform indicate that the story of abortion is one of fractured and competing value sets. It is a story of disunity and disagreement between doctors, as well as one of the dominance of a coherent form of medical power and ideology transmitted through the legal framework. There is, as this literature shows, not only one form of professional identity for doctors who provide abortion. Certainly, that ascribed by law emerges as in contrast with that developed among those doctors considered ‘doctors of conscience’. When investigating the professional identity of abortion providers, we should also look, therefore, to other sociological theories on professionalism to help guide investigation of the values of doctors.

2.4 Recent Sociological Theories on Medical Professionalism

As suggested above, literature has argued that the medical profession’s role in society has been about gaining control, where "professionalisation was intended to promote professional practitioners' own self-interests in terms of salary, status and power" (Evetts, 2011: 410), which

implies that the values of the medical profession are paternalistic and doctor-centred. However, more recent sociological literature on professionalism has suggested the values of professionals have shifted. The values of doctors are shaped "by the context in which they live and work" (Roland et al., 2011: 516); with the role of the medical profession changing, a 'new professionalism' has emerged (Irvine, 1999). New professionalism, according to Borgstrom, Cohn and Barclay (2010), suggests that the elite representation of the medical profession are no longer driven by values such as “detachment, paternalism, medical beneficence" (p.1331). Instead, there has been a shift in the priorities of the medical profession, where there is now a focus on "the importance of patient choice [and] issues of governance" (Borgstrom, Cohn and Barclay, 2010: 1331), emotional engagement, empathy, open communication with patients and patient autonomy.

Borgstrom, Cohn and Barclay (2010) identified that the NHS is actively encouraging doctors to be "less paternalistic and to actively engage with patients' preferences for treatment" (p.1331). One of the reasons for this is because, after a structural change in the NHS in 1990, a quasi-market was formed within the NHS. This created NHS trusts able to manage themselves (Lewis, 2017). This means that the hospitals had their own managers, and "they could both choose the type and mix of staff and equipment they used and also decide how much of each type of health care they would produce" (Lewis, 2017: 6), unlike previously where, since the introduction of the NHS in 1948, the "medical profession [have] enjoyed a period of unparalleled prestige, dominance and self-governance” (Harrison, 2009: 186). One consequence of this new type of structure amongst the NHS is

> Providers who produce cheap, high-quality services that are tailored to users’ needs will be financially rewarded by higher revenue… while providers who are inefficient or who are insensitive to people’s needs will suffer losses and, if they do not improve their performance, will ultimately go out of business (Lewis, 2017: 5).

In 2008, a report by the World Health Organization (WHO) concluded the way the “NHS operates was changed irrevocably by the quasi-market reforms” (Simonet, 2014: 2). The NHS became business-like, and consumer or customer satisfaction was of utmost importance to middle-level managers. This is most evident with patient care surveys that NHS patients are routinely asked to fill out. In doing so, NHS trusts can see where their consumers feel there is room for improvement. With management now being concerned about patient satisfaction and

providing a cheap but tailored care to patients, the "place of doctors in society is changing, and previously accepted claims that doctors have rights to self-regulation and autonomy are now routinely questioned" (Roland et al., 2011: 515).

New professionalism theorists argue that the NHS trust managers actively encourage doctors to be "less paternalistic and actively engage with patients' preferences for treatment" (Borgstrom, Cohn and Barclay, 2010: 1331). They suggest there has been a shift in the priorities of the medical profession, where there is now a focus on “the importance of patient choice [and] issues of governance” (Borgstrom, Cohn and Barclay, 2010: 1331).

The changing nature of the NHS impacts how doctors working in Britain provide healthcare and, therefore, how the medicalisation of a problem can occur. The development of the new professionalism theory could be used to explain a change in the professional values of the medical profession. In addition, the idea that a middle level of management runs the NHS could suggest that the values of doctors have changed from those outlined by Parsons and Freidson, because the role of the doctor in the doctor-patient interaction has changed dynamic. Where patients have an increasing role in medical decisions and the ‘doctor knows best’ attitude is not as present.

Borgstrom, Cohn and Barclay (2010) found that the rank-and-file doctors themselves are caught up in a struggle where doctors are trained with the values of the new professionalism and doctors "emphasised the importance of choice and patient-centred care" (p.1331). However, there were aspects of their rhetoric where their "values more associated with the 'old' model of professionalism such as detachment and the importance of extensive technical knowledge" (Borgstrom, Cohn and Barclay, 2010: 1331). Here a new source of tension amongst the medical profession has been identified, where on the one hand, NHS trust managers are trying to instil a set of values that they believe the medical profession should have. At the same time, individuals working within medicine are, at times, still working with 'old' values, like those identified by Freidson. The potential shift in the values of the medical profession from paternalistic to patient-centred because of a structural change in the NHS is interesting to a study on medicalisation as it could impact the day-to-day work of doctors.

The theory that the values of doctors are shifting as a result of a change in the organisation of the NHS has also been discussed in relation to reproductive health and pregnant women. For

example, in an article written by Jackson (2000) titled '*Abortion, Autonomy and Prenatal Diagnosis'* she discusses how "the principle of patient self-determination has assumed central importance in British medical law" (p.467) and she considers whether the "strong commitment to patient autonomy has any resonance for abortion law." Similarly, Sheldon (2016) also notes that notes "modern medicine has shifted fundamentally away from 'doctor knows best' paternalism: today patients are routinely trusted, and indeed expected, to make medical decisions for themselves… Contemporary abortion practices reflects this same evolution in attitude" (p.345).

The main area of tension between the values described by new-professionalism theorists and the Abortion Act 1967 is based on the premise that doctors decide when a woman can have a legal abortion. Both Jackson (2000) and Sheldon (2016) have questioned how this requirement can fit in line with the focus on patient autonomy. For example, Sheldon (2016) noted that this process has become "an entirely bureaucratic one, serving no obvious broader purpose… [and has become] redundant in terms of safeguarding women's health" (p. 345-346). Additionally, the legal requirement that gives doctors the right to decide when a legal abortion can take place has been described as a potential "breach the European Convention of Human Rights" (Sheldon, 2016: 345). Scott (2016) suggested that section 1.1 of the Abortion Act could be considered a breach of Article 8 because it can be seen as an unjustified interference with a woman's private life.

As I discussed in Chapter One, the wording of the Abortion Act has allowed doctors a degree of discretion over when a legal abortion can take place because the circumstances are not set out in the legislation. By treating the two-doctors' signatures as nothing more than a bureaucratic process doctors who provide abortions have been able to find a way to use their discretion to provide an abortion service "in line with evolutions in broader popular morality and best medical practice, interpreting the law in a way that is fully supported by concerns for women's reproductive health and patient autonomy" (Sheldon, 2016: 364). This suggests that doctors' values are patient-centred. However, this patient-centred care is somewhat different to how new professionalism theorists have discussed the shift towards patient-centred medicine Instead of being motivated by the introduction of mid-level management, as Chapter One has outlined, doctors who provide abortion have interpreted the law in different ways. These doctors are seeking to find ways to run a patient-centred abortion service even though it appears to be at odds with the 1967 Abortion Act, which clearly places the decision-making process in

the hands of medical professionals. Doctors are looking for ways to allow women to make these decisions, while maintaining their responsibility ascribed to them by the Abortion Act.

A further sociological theory that could offer new insight into a change in the values of medical professionals is corporatisation, which could explain a shift towards patient-centred medical care. Scholars investigating the sociology of professions have often been writing in the context of the USA; however, some literature has more recently been written in the context of Britain regarding changes to the NHS. For example, Siebert et al. (2018) noted that "doctors are subjects of an often deliberate strategy by managers and the state to deprive them of their professional autonomy so that a reform agenda is more easily implemented" (p. 3). Reform is happening whereby hospital managers focus on "clinical risk" (Waring and Currie, 2009: 755); as a result of this focus, there is a potential for hospital risk managers to "challenge medical autonomy through extending managerial authority over clinical knowledge" (Waring and Currie, 2009: 756). This would challenge doctor's knowledge and autonomy, two of the fundamental features of both Parsons and Freidson's analysis of the professional values of doctors.

Waring and Currie (2009) conducted 43 semi-structured interviews with hospital staff, including 25 specialist consultant level doctors who worked across five medical departments. The aim was to "explore the introduction of new hospital systems from the perspective of medical staff considering the extent of medical involvement and the impact upon medical practices" (Waring and Currie, 2009: 762). They found that while their participants "regarded patient safety as a fundamental principle of medicine" (Waring and Currie, 2009: 765), doctors disagreed with the ways to improve patient safety calling the current risk management "meaningless" and chose to refuse to share knowledge with the hospital's Risk Management department (Waring and Currie, 2009). This is an interesting insight into another possible reason for a shift in the values of the medical profession since as it shows once again a shift in the overall working of the NHS. Doctors are trying to navigate a position within this new form of management, which has been seen to take away their professional autonomy. Due to the structural change of the NHS, doctors are "losing aspects of their sociocultural professional identity and their autonomy over how work is organised and carried out" (Siebert et al., 2018: 5). Doctors are no longer left in charge of their services and patients and are now "drawn into more bureaucratic ways of acting" (Waring and Currie, 2009: 767), which doctors either try to reject or work within, shaping their professional values.

In addition to the shift in the role of the doctor due to new forms of management within the NHS, as Chapter One briefly outlined, the role of the doctor has also changed due to technological advancements in abortion services. Through the introduction of EMA doctors are now performing less abortions today than ever before. The 1981 ruling that a nurse can legally take part in terminating a pregnancy on the condition that a doctor is in charge and responsible for the procedure has been used to develop services in Britain. Most services in England and Wales are currently run with doctors prescribing the drugs and nurses administering them. This means that, in addition to the role of the doctor shifting because of structural changes within the NHS, the position of the abortion nurses and clinical support workers have also markedly changed from supporting the doctor who was providing a surgical abortion to carrying out a "significant portion of bodily tasks" (Purcell et al, 2017) so that nurses play an increasing role in abortion services.

This shift in the role of both doctors and nurses who provide abortion is evidence of tension between the medicalisation of abortion, through the 1967 Abortion Act, and how abortions are provided in practice. Rather than the doctors being looked upon as gatekeepers to safe and legal abortion and an essential part of providing a safe surgical environment, the role of the doctor has changed and now involves a softer form of medicalisation: the role of the doctor is more about overseeing the use of drugs in the majority of abortions performed today. Since it is usually the women who take the mifepristone and insert the misoprostol tablets, then there it is no medical difference between a nurse handing the tablets to the women and a doctor, leading scholars to conclude "it would be safe and practical if the prescribing doctor might delegate the supervision of the oral administration … to nursing staff". In addition, there are already nurses in Britain who are able to prescribe mifepristone for "other medical reasons" (Sheldon, 2016: 346). This develops the idea that the doctor's role has changed.

The shift in the practical role of the doctor from paternalistic gatekeepers who are given the authority to decide who can have a legal abortion to a group of professionals who now supervise abortions, raises questions about what the role of the doctor should look like. Even though nurses administer the drugs to induce a miscarriage and women are the ones that take them, doctors are still legally responsible for every termination of pregnancy in England and Wales under the 1967 Abortion Act.

This section of the chapter has evaluated some sociological theories on professionalism, which highlight general developments which may be relevant to the professional values of doctors working in England and Wales. Structural changes within the NHS towards a patient-centred and risk-averse system have led to the creation of middle-level management whereby doctors no longer have the level of professional autonomy they once had. This has led to a shift in values where doctors now have to act in accordance with a 'new' or different set of values than the ones outlined by both Parsons and Freidson. I have also outlined different sociological theories and arguments which add weight to the claim that the values of abortion doctors are not driven solely by the desire to control women's reproductive health and extend their monopoly over areas of everyday life. In contrast, they suggest the importance of recognising tensions and conflict between the role ascribed to abortion providers by the law and that given by the changes to their role since 1967. I now turn to discuss the work of Halfmann, which best provides a framework intended to capture these tensions, and which is therefore looked to, to develop an approach for the investigation of this thesis.

2.5 Rethinking Medicalisation through an Investigation into Professional Identity

The recognition that the legalisation of abortion itself entailed the development of a values orientation on the part of some doctors, forms the basis for my effort to better understand the medical professionalism of today's abortion providers. As noted at the outset, there is only minimal contemporary sociological scholarship that can directly inform this interest. However, I now turn to discuss areas of commentary regarding the values of doctors that have helped inform my investigation, drawing primarily on Halfmann's (2011, 2012) work and his efforts to re-think and investigate the 'medicalisation' of abortion. More widely, the framework I set out makes use of the conceptualisation of society as operating at the macro-, meso- and micro-levels.

Halfmann (2011, 2012) investigates the medicalisation of abortion through several works, two of which I outline here as they directly influence my study. In his 2011 book *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain and Canada*, Halfmann examined abortion policies and the "interactions between actors in civil society and the political institutions that enable and constrain their actions", suggesting these

"institutions, affected the interests and priorities that these actors constructed and shaped the meaning and salience that they attached to the abortion issue" (Halfmann, 2011: 6). Similarly, to existing socio-legal literature (Keown, 1988; Sheldon; 1997) Halfmann concluded that abortion law in Britain was focused around 'gatekeeping' and medical associations "were deeply involved in abortion making policy" (Halfmann, 2011: 68). It was also noted that in Britain after the 1967 Abortion Act, "governments and political parties successfully avoided the abortion issue … abortion policies changed infrequently and usually outside of partisan politics" (Halfmann, 2011: 202); that is, they looked to the 'medicalisation of abortion' through the gatekeeping role of doctors, to depoliticise the issue. This all suggests, in line with other scholarship, that medicalisation is a deeply entrenched and defining feature of the development of abortion law and policy in Britain.

Halfmann (2011) suggests, however, that the medicalisation of abortion is not as straightforward as some scholars have argued, instead arguing that "the medicalisation of abortion in Britain has been a valuable protection for abortion services" (p. 217). It has resulted in all attempts by those opposed to abortion to change the abortion law and restrict abortions failing, as medical opinion and medical control were looked upon as the appropriate solution to the problem of unwanted pregnancies. He investigated how organisations such as the BMA and RCOG played an important role in how the 'problem' of abortion has been shaped.

Halfmann (2012) further discusses the problem of abortion and the role of the medical profession in *'Recognising Medicalisation and Demedicalisation: Discourses, Practices and Identities*'. He introduces a new way of thinking about the medicalisation of abortion, which is important to this thesis. He recognises in his paper that medicalisation has been investigated sociologically as a negative phenomenon but that some scholars have argued it should not be seen simply as a process whereby the medical profession tries to gain and maintain social control over women.

Some scholars have taken further the idea that medicalisation should not be viewed as either 'good' or 'bad', instead arguing that it should be seen as a neutral concept that describes a process rather than a state. For example, in a paper by Conrad written in 1992, he outlines some characteristics of medicalisation. One claim he discusses is that medicalisation is "a bidirectional process" (Conrad, 1992: 224), and there is 'demedicalisation' as well as medicalisation. Demedicalisation takes place when "a problem is no longer defined in medical

terms" (Conrad, 1992: 224). The most prominent case of demedicalisation throughout literature is homosexuality. At the end of the nineteenth century, homosexuality was seen as a "pathological medical or psychological condition" (Smith, Barlett and King, 2004: 1); by contrast, homosexuality is no longer considered a medical problem in today's society.

As explained previously, the literal meaning of medicalisation is to make something medical. However, the “most prominent definitions of medicalisation define it as a process by which aspects of everyday life come under medical *jurisdiction* or [when] social problems are addressed through medical *discourse and treatments”* (Halfmann, 2019: 139). However, Halfmann (2012) elaborates on this definition of medicalisation by including "medical practices and not just treatments, the presence of individuals and collective medical actors and medical identities (Halfmann, 2019: 139). Halfmann argues that medicalisation increases when bio-medical discourses, practices or actors/identities “become more prevalent, powerful or salient in addressing social problems (Halfmann, 2012: 5-6). It is this observation about medicalised identity which is important to this thesis.

Halfmann (2012) believed that “actors medicalise not only through their involvement with a given problem but through their conformity with... bio-medical identities” (p. 188). For example, Halfmann (2012) recognises that some doctors may “reject professional associations” such as a “white lab coat” (p. 188). The acceptance or rejection of medicalisation through an exploration of identity formed the main reason for choosing to use Halfmann's exploration of medicalisation as a starting point for this thesis. Halfmann recognised that "the anti-abortion doctor identity and the monopoly of doctors over 'therapeutic' abortions increased medicalisation [and] other identities decreased it" (Halfmann, 2012: 196).

By expanding the definition of medicalisation Halfmann (2012) suggests that medicalisation is a process, suggesting it should be thought of instead as a "continuous value" (p.186) rather than a state or category. Understanding medicalisation as a continuous value creates a new way of investigating the medicalisation of a problem. Halfmann (2012) believed that by viewing medicalisation on a continuum rather than as a state or category small examples of medicalisation or demedicalisation can also be examined. Halfmann (2012) used Conrad’s (2007) explanation of the medicalisation of childbirth to explore how examples of demedicalisation can be missed. Conrad (2007) believed that even though “childbirth has changed considerably since the 1950s, often occurring in birthing rooms, often without

medicine... [and] sometimes attended by midwives rather than physicians" these changes are not examples of demedicalisation (Halfmann, 2012: 189). Instead, Conrad (2007), believed that "childbirth is only demedicalised if doctors and hospitals are completely excluded from births" (Halfmann, 2012: 189). However, by examining the medicalisation of childbirth on a continuum we can see examples of both an increase in medicalisation, "such as rising rates of electronic foetal monitoring and caesarean sections" (Halfmann, 2012: 189) and a decrease in medicalisation in other instances.

Similarly, to Conrad's view that childbirth is 'medicalised', Socio-legal literature (Keown, 1988; Grubb, 1990) has viewed abortion as being fully medicalised, where the medical profession controls who has an abortion, where they have an abortion and how their treatment is performed. Halfmann (2012) contends, however, that by conceptualising medicalisation as a category, commentary on the medicalisation of abortion has missed instances where important changes have occurred, existing accounts have "typically only examined a few aspects of its medicalisation" (p.186). Redefining medicalisation as a continuous value can change the way sociologists investigate the medicalisation of abortion. Instead of classifying a problem as either medicalised or demedicalised, Halfmann (2012) argues that the medicalisation of an everyday problem can be thought of as fluid – and this fluidity can be investigated at different levels: the macro-, meso- and micro.

The idea of analysing medicalisation on different levels is not unique to Halfmann, for example Conrad and Schneider's (1980b) typology analyses medialisation on three levels, the 'conceptual, institutional and doctor-patient interaction' level. The conceptual level refers to macro level actors such as medical researchers, journals and courts. The institutional level as outlined by Conrad and Schneider (1980b) focuses on meso level actors like "organisations such as alcohol programs" (Halfmann, 2012: 189) which do not involve involvement of medical professionals. The doctor-patient interaction level looks at mainly the micro level actors by focusing on "doctors who diagnose and treat social problems and the patients who receive those diagnoses" (Halfmann, 2012: 189). Halfmann's work builds upon the work of Conrad and Schneider (1980b) by expanding the levels by recognising that "micro level medicalisation an also occur through the identity construction of various actors" (p. 189). This thesis builds on Halfmann's concept of identity construction and examines how the professional identity of this group of doctors can be examined on each of the three levels instead of just the micro level. By examining the professional identity of doctors on each of these levels we can

see if, the macro level construction of medicalised abortion will influence, in some way, how individual doctors think and work.

Halfmann (2012) defines the macro-level as "legislation, rulings, reports, and debates of national and international organisations such as government bureaucracies, courts, legislatures…and the media" (p.190). On the meso-level, medicalisation and demedicalisation occur through "local and regional organisations such as the workplace, hospitals, medical groups, clinics" (Halfmann, 2012: 190), while the micro-level is "face-to-face interaction and the physical contract between providers and clients" (Halfmann, 2012: 190). Halfmann has used these three levels to investigate medicalisation because:

> Medical discourses are constructed, disseminated and deployed not only by macro-level actors such as universities and government bureaucracies but also by meso- and micro-level actors, such as hospital administrators, frontline medical personnel, and patients themselves … Micro-level medicalisation can also occur through the identity construction of these various actors. (Halfmann, 2012: 189)

Halfmann (2012) further argues that only examining medicalisation at one level is problematic because scholars "often miss instances of medicalisation and especially demedicalisation" (p.187). Although Halfmann (2012) was writing about the medicalisation of abortion in the USA, this insight can also be seen through discussions on the medicalisation of abortion in Britain, since here the law places doctors in a unique position of being at the centre of the medicalisation of abortion. Thus, Halfmann (2012) is suggesting that the medicalisation of an everyday problem is not neat and structured. For example, suppose you examine the law as an isolated part of the medicalisation of abortion. In that case, you may notice that, just as socio-legal scholars have argued, the 'medical man' and later doctors have been instrumental in the changes to abortion law in Britain since abortion was first criminalised in 1803. Through analysing the 1967 Abortion Act and the records of discussions with medical organisations during the process of creating this law, the 1967 Abortion Act can be seen as an example of a medicalised law created to meet the interests of the medical profession.

If the medicalisation of abortion starts with the law on paper and should be examined as a category, then what follows would be those doctors working within the abortion service have one united opinion, where they all agree with the terms of the law. This would suggest that if

we were to investigate the practice of abortion (the meso-level), doctors would all agree that they should be the gatekeepers to legal abortion. In addition, the medical profession would try to maintain the control given to them by the 1967 Act, and the medical profession would still believe that the way the Abortion Act is working in practice.

However, this chapter has outlined examples where scholars have begun to argue that the medical profession has never had a unified voice: within the profession are different sets of values, which can create tensions both amongst and within doctors' practice. Halfmann's (2012) work suggests that if we understand the meso-level as linked but somewhat separate from the macro-level, these competing value sets may become apparent. There may be instances where medical professionals do not define themselves as medicalisers, as the law on paper suggests. Instead, some doctors actively seek to engage with practices that could be seen as demedicalising, such as encouraging patient engagement (Halfmann, 2012). This can be classified as demedicalisation because it takes away an element of the medical profession's role in the provision of abortion. Through investigating the medicalisation of abortion across three broadly distinct levels, we can better analyse how doctors have constructed and re-constructed their identity as abortion providers.

Building on Halfmann's (2011, 2012) work, this thesis newly considers the medicalisation of abortion by investigating the professional identity of the doctor. The term 'professional identity' does not have one authoritative definition; many studies defined it as being "based on what professionals do; the behaviours and activities of the profession" (Fitzgerald, 2020: 3). The belief is "the stronger the identification with the behaviours and activities, the greater the professional identity" and the greater the job satisfaction (Fitzgerald, 2020: 21). Becoming a 'professional' involves a process whereby people are taught a set of "goals, values, norms and modes of interaction". This set of values then becomes internalised, resulting in "professional identities being deeply held and central to understanding how professionals behave at work" (Pratt, Rockman and Kaufmann, 2006 in Martin et al., 2020: 4). It is for this reason that professional identity is important to this thesis. As outlined in the previous section, the literature has argued that the medical profession tries to maintain its monopoly over health by increasingly medicalising problems previously considered non-medical. This would mean that medicalisation has become part of a doctor's professional identity: doctors engage with the behaviour and activities associated with 'the medical profession'. This, in turn, suggests a relation between medicalisation and identity.

Professional identity is shaped and re-shaped on each of the three levels set out by Halfmann (2012) in various ways. For example, on the macro-level, doctors' identity might be shaped by the legal framework they must work within. Abortion providers can choose, for example, to openly reject the role ascribed to them by the law. On the other hand, doctors may choose to accept certain parts or all of the law, their values on the law then shape how they practice as an abortion provider. Similarly, on the meso-level, doctors' identity may be shaped by the ways in which the abortion service has developed since 1967, including through the introduction of technological advancements, the location of abortion clinics and updated medical policy and guidelines. These may shape the way doctors' practice abortion, and, in turn, their practices shape their professional identity. On the micro-level doctors, professional identity can be considered constructed by their interactions with medical colleagues, their patients, and the wider public. Doctors create meaning in their work and their role as medical professionals by constructing their professional identity on each of these three levels. It is this meaning that is significant to the question of medicalisation, as investigated by this research.

Halfmann concludes his 2012 paper by arguing that the medicalisation of abortion allows opportunities for resistance; doctors do not always agree with medicalisation and instead can resist or disguise it through their practices. If doctors accept the medicalisation of abortion, then there are options for how doctors can deal with this, and in so doing, doctors can construct their identity in different ways. When examining what shapes the identity work of doctors, Martin et al. (2020) suggests that as part of forming their identity, doctors' question "who they are and who they are not" (p.5). As part of this, doctors "accept certain identities and reject others when constructing their roles" (p.5). The professional identity of doctors is important to the study of the medicalisation of abortion because it "refers to how professionals enact their position to provide a concept or definition of themselves" in their role (Martin et al., 2020: 4). They could explicitly resist the medicalisation of abortion. For example, doctors have provided abortion illegally; in this case, doctors form part of their identity as individuals who relentlessly contest medicalisation. On the other hand, some doctors may question part of the medicalisation of abortion while accepting other parts of the process.

2.6 CONCLUSION

This chapter has outlined some of the key sociological arguments that form the backdrop of the theoretical work behind this research. Firstly, I have evaluated the sociological background on the professional values of doctors through an exploration of the Parsons and Freidson debate. Secondly, I have then evaluated how whilst these debates have been a useful point of departure for a study on the professional identity of abortion providers there is now a growing body of literature that suggests that doctors do not always have the same set of values. At times, there have been contested value sets provided by different medical organisations and individual providers. For example, some doctors using conscience as both a reason not to provide abortions and others believing they are acting within their conscience to provide safe and legal abortions.

Thirdly, I have explored some other sociological theories that have proved insightful when investigating doctors' professional values. Shifts in the organisational structure of the NHS and the introduction of a business-like and new public management model has led some new professionalism theorists to highlight a tension between a new set of values doctors are now working within, often projected onto them by new hospital management styles and the 'old' set of values traditionally associated with the medical profession such as concerns with autonomy and discretion. This tension has led to a perception "amongst doctors that their professional status is being eroded" (Siebert et al., 2018: 25), highlighting a significant change from that of the work of both Parsons and Freidson. Finally, this chapter took forward a new way of investigating medicalisation by exploring professional identity on different levels, as discussed by Halfmann (2012). This leads to an exploration of tensions and strains in the medicalisation of abortion where a doctor's professional identity is shaped and re-shaped on each of the different levels.

In the next chapter, I focus on outlining my research questions as well as the practical issues for my work, such as the sample characteristics, recruitment methods, and ethical implications for this research. I discuss the decision to interview participants and how this has helped to investigate the meaning that doctors attach to their work. I go on to discuss the stratified sample and methods of recruitment of participants. Finally, I will explore some of the ethical implications of this research and the methods used to analyse the transcripts.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Chapter One and Two have examined the literature which inform this research project, outlining the history of abortion in England and Wales through an investigation of the medicalisation of abortion and exploring the professional identity of abortion providers through discussion of the wider sociology of medicalisation. Chapter Two also outlined the conceptual framework used to develop this investigation, drawing on the work of Halfmann and his exploration of the medicalisation of abortion on three different levels.

In this chapter, I focus on methodology and study design, detailing how I made use of Halfmann's ideas and adapted his approach. Firstly, I discuss the research questions which the research addresses, specifically considering how Halfmann's three levels have informed the approach taken, outlining in detail what is included in each of these levels. In addition, this section of the chapter examines how these levels could be used to inform an investigation into the medicalisation of abortion. By examining the medicalisation of abortion and professional value on each level this chapter will show how the three levels can be examined individually and collectively. This chapter also describes the methodological approach for this research, including the sampling characteristics of participants and recruit participants, the process of gaining ethical approval and reflections on discussions with what turns out to be an unusual group of doctors.

3.2 INTERVIEW STRUCTURE

In order to investigate the tensions and ambiguities in the medicalisation of abortion, the main research question of this thesis is: What do abortion doctors' accounts of their professional work suggest about the contemporary dynamics of the medicalisation of abortion in Britain? While this question drives the research overall, as I have explored in Chapter Two, it is important to investigate the meaning doctors give to their work, their patients and the law. To

do so, the interview schedule was split into the three levels discussed by Halfmann (2012). Each level had two questions that the interview schedule aimed to address.

The aspects of the interviews focussed on the macro-level asked two main questions:

- What do doctors view as the strengths and weaknesses of British abortion law?
- What shapes the work of an abortion provider in England and Wales?

Doctors were asked questions about the law and recent media debates about the law. Participants were directly read part of OAPA, and different sections of the 1967 Abortion Act, including the clauses about ‘good faith’ decisions, 'class of place' and conscientious objection. Participants were asked to comment on each of these aspects of the law, and this allowed doctors to discuss both their thoughts on the wording of the law and how these laws are shaped in the practice of the abortion service.

To further investigate how the medicalisation of abortion works for these doctors, directly after being asked the questions on the different parts of the law, doctors were read two headlines from *The Daily Telegraph* where abortion doctors had been accused of breaking the law. These headlines were "Abortion Investigation: Doctors filmed agreeing illegal abortions "no questions asked” Women are being granted illegal abortions by doctors based on the sex of their unborn baby" and "clinicians admitted they were prepared to falsify paperwork to arrange the abortions even though it is illegal.”

The meso-level of the interview focused on both clinical practices and the training of doctors seeking to work in the abortion service. Overall, this section of the interview addressed two questions:

- What are doctors' perceptions of the institutional frameworks for abortion provisions?
- What meaning do doctors attach to the organisation of the abortion service, including the role of the NHS?

These questions focus on the current procedures for abortions and the training interviewees received throughout their career. This allowed doctors the opportunity to discuss issues such

as complex abortions and second-trimester surgical procedures and the clinical setting of the abortion service. Another section of the interview focused on the training of abortion providers. Many studies show the number of medical students attracted to abortion provision is declining, resulting in fewer doctors willing to terminate pregnancies, which therefore directly impacts the service given to women. Additionally, by investigating the meaning that doctors have ascribed to the NHS as an organisation allowed me to further explore whether the values of this group of doctors is similar to those described in new professionalism theories.

Finally, the interview schedule focused on the micro-level by asking the doctors questions about their individual biographies and interaction with different groups. This section of the interview focused on areas such as why the interviewee became involved in the provision of abortion in Britain, and what they like and dislike about their job. Overall, this addressed two questions:

- What meaning do doctors attach to the work of terminating pregnancies, in relation to the goals of medicine?
- Do participants believe there is a stigma attached to the work of an abortion doctor?

The second question addressed here is interesting because the concept of a stigmatised doctor. Abortion stigma is discussed widely in the literature, but in relation to women and their abortion experiences. For example, research by Hoggart (2017) has suggested that women almost always experience a form of abortion stigma. However, this has been extended by some to those who work in abortion care. For example, research by O'Donnell, Weitz and Freedman (2011), applies the notion of 'dirty work' to abortion providers in the United States of America. Similarly, MacDonald (2003) suggests that nurses caring for women are also stigmatised, and it was this aspect of the existing research that I sought to engage and develop, as part of a consideration of professional identity.

As discussed in Chapter One, the law on abortion would not suggest that doctors are stigmatised since it places them in a powerful position within the abortion service. However, if doctors are reporting in their accounts of working in the abortion service that they are seen as 'dirty workers', this could be one example of how the medicalisation of abortion is fluid. The first question is a broader question that links their experiences as a doctor to the work they do providing abortions. For example, do doctors see themselves as working in a highly contested

area of medicine completing dirty work, or do they believe they are helping their patients, just as they would as doctors working in another area of medicine?

I have outlined above the research questions which drive this thesis and how these are linked to the structure of the interview. The next section of this chapter will go on to examine the methods I adopted to investigate the research questions. In the discussion, I focus on practical issues for my work, such as the sample characteristics, methods of recruitment and ethical implications for this research. I discuss the decision to interview participants and how this has helped to investigate the meaning that doctors attach to their work. I go on to discuss the stratified sample and methods of recruitment of participants. Finally, I will explore some of the ethical implications for conducting this research and the methods used to analyse the transcripts.

3.3 STUDY DESIGN AND METHODOLOGY

The use of questionnaires was one method initially considered but not taken forwards as an appropriate method for the research. Firstly, there is currently no register of doctors who provide abortions in England and Wales. Instead, doctors who work within the abortion service work within two specialities of medicine, Obstetrics and Gynaecology and Sexual and Reproductive Healthcare (SRH). Therefore, to complete a questionnaire to access doctors who provide abortion, a questionnaire would have to be sent out to all members of the RCOG and Faculty of Sexual and Reproductive Healthcare (FSRH), regardless of whether they have ever provided abortions. As the number of doctors who provide abortion is relatively small in comparison to members of these specialities, it would have meant that a large number of doctors receiving a questionnaire that they would be ineligible to complete.

In addition, while questionnaires are useful in providing a large sample, doctors do not always respond to questionnaires, and an acceptable response rate can only be attained with repeated mailing and follow ups. For example, in 2011, Savage and Francome completed a study on '*British Gynaecologists' Attitudes in 2008 to the Provision of Legal Abortion'*. This study used a postal questionnaire sent to one in six gynaecologists on the RCOG register and asked similar questions to that of a study they had conducted in 1992. The sample size for this study was 217 participants, and overall, the questionnaire had a response rate of 70% but only after

mailing the questionnaire three times (Savage and Francome, 2011), suggesting a need to send out multiple questionnaires to potential participants before having a large enough sample.

A better response rate may be achieved when the study is conducted by a member of the cohort being researched. It may be that doctors are more likely to respond to a survey sent by a doctor, medical student or individual(s) from their institution. For example, a study by Gleeson et al. (2008) *'Medical Students' attitudes towards abortion: A UK Study*' had an overall response rate of 300 out of 500 questionnaires sent after receiving 170 questionnaires back incomplete. However, researchers sent the questionnaire out to medical students at the University of Birmingham, where the research was being carried out, which may have impacted the response rate.

Semi-structured interviewing was decided on, as the best approach. One reason was to encourage doctors to discuss their experiences in depth, alongside the meaning they ascribe to different elements of the abortion services. Quantitative research would not have allowed me to gain this insight into the work of the doctors as most quantitative research involves a set of standardised close-ended questions that fall into pre-set categories and "fails to provide insight into the participants' individual or personal experiences" (Yilmaz, 2013: 313). As I am interested in exploring how medicalisation operates for this group of doctors, it is important to allow them to discuss any area they feel is appropriate.

By allowing doctors to openly discuss their values, motivations, career and experiences, alongside asking participants questions regarding their beliefs about specific aspects of the law on abortion and their current practices, this approach to data collection allowed me to gain more of a complete picture into the values of doctors and their reasoning for working in such a contested speciality of medicine. As Kendall (2008) notes, more than any other research method, interviews allow for the "exploration of meaning … constructed by the research participants regarding a topic or setting of interest" (p.133-134). In the next section I outline the sampling criteria for this research.

3.4 SAMPLING

Semi-structured interviews were, in the end, conducted with forty-seven doctors who provide abortions in England and Wales. After designing the interview schedule and before conducting my fieldwork, the interview schedule was tested in two pilot interviews, which then influenced the approach I took to designing an ideal sample, and recruitment to the study. The discussions in the pilot interviews also guided me in revising parts of the interview schedule.

Both pilot interviews were conducted with retired abortion providers who had worked within the service for a substantial part of their medical careers. The purpose of these interviews was to examine the feasibility of the questions used in the interview schedule before conducting interviews with participants. In addition, the two pilot interviews gave me the opportunity to ask providers what they thought of the interview and whether there were any other areas they believed should be on the interview schedule. These interviews were extremely helpful to this research for two reasons. Firstly, from a practical perspective as it gave me an opportunity to practice the role of the interviewer as I did not have any previous experience having not conducted any primary research before starting this thesis. Secondly the pilot interviews were helpful because they gave me the opportunity to add some follow-up questions to the interview schedule to ensure that doctors had the opportunity to discuss different aspects of the service. I changed the wording of some of the questions on the current provision of later abortions, in the light of what was said.

Through reviewing the literature, attending academic conferences, discussions with my academic supervisors and completing the two pilot interviews, it was decided that a purposive sample should be created taking into consideration some potentially important socio-demographic characteristics, namely, age, gender and location of the workplace. The pilot interviews were helpful for deciding my purposive sample characteristics as during these interviews the interviewees were very open in telling me that they believed gender, age and the country where the doctor was trained could all cause different responses to interview questions, based on their experiences working with different doctors. This chapter will now outline the potential significance of these characteristics and highlight how the pilot interviews drew attention to issues to consider, and so shaped the approach taken to study design.

3.4.1 AGE

Age is potentially a characteristic where the fluidity of the medicalisation of abortion can be seen, since doctors of different ages will have experienced the medicalisation of abortion in different ways. For example, as Savage and Francome (2011) noted that by 2008 "unless they had been working in the developing world, there are no [doctors] practising in the NHS with any experiences of the horrors of illegal abortion in Britain before the Act" (p.322). In addition, the age of participants was also raised when one of the pilot interviewees said that she believed "young doctors had felt very anti-abortion". She believed many younger doctors are anti-abortion because they had never seen the consequences of illegal abortion, and medical students do not see abortion consultation or treatment in routine medical placements. This could have an impact on how some doctors view the medicalisation of abortion as older doctors who had recently retired were those campaigning for changes in the law to prevent the consequences of illegal abortion, and younger doctors who have not been working in the abortion sector when abortion was illegal will only know the provision of abortion since it has been medicalised. If doctors working in the abortion service today have always provided abortions in this way, then they may have different opinions on the role of the doctor in providing this service to patients.

3.4.2 GENDER

Gynaecology has been described as "an area of healthcare that is essentially a women's world … women in a women's job carrying out women's work" (Porter, 1992: 510) and where there is a "shared understanding amongst women" (Bolton, 2005: 170). This is different from the medicalisation literature, which often discusses doctors as men who aim to control women's reproductive health as a broader method of social control. If Porter (1992) and Bolton (2005) are correct that there is an understanding amongst women and that abortion is part of 'a women's world', then this would suggest that male and female doctors would have differing beliefs about the medicalisation of abortion. For example, female doctors would have more understanding of their patients than their male counterparts.

Possible differences in beliefs and accounts because of the gender of the doctor were also raised in one of the pilot interviews. The interviewee was asked: 'how do you think medical colleagues within obstetrics and gynaecology that do not provide abortion view your work?'. The

interviewee responded that: "women were more pro than anti and there are a lot of two-faced men that will do abortion for foetal abnormality but won't have anything to do with any other kind of abortion". Once again, this categorises female doctors as more compassionate and caring to women than male doctors involved in providing abortions. Therefore, it is important to investigate whether in today's abortion provision, male doctors are more likely to support the medicalisation of abortion in comparison to their female colleagues.

3.4.3 LOCATION OF WORKPLACE

The location of the doctors' place of work has been taken into account as a characteristic of the sample in order to capture any similarities or differences in values surrounding two recent debates. These are about home use of EMA, and current provision of abortions performed in the second and third trimester of pregnancy. The location of the clinic could influence the values that inform the work of doctors providing abortions, as the patient population is different for each clinic. Different patient populations may highlight some constraints that doctors face in their work as abortion providers which could impact the way they view the medicalisation of abortion.

For example, different patient populations may have an impact on doctors' views on issues such as EMA. Numerous pieces of medical research (Fiala et al, 2004; Swica et al, 2015; Gatter, Cleland and Nucatola, 2015) from all over the world have concluded that mifepristone and misoprostol are safe for women to take at home, and that it is better for women if they can complete their abortion at home without the fear of miscarrying on the journey home. It could follow that doctors working in clinics based outside of metropolitan towns would prefer this form of abortion provision where their patients often providers, their participants who worked in rural areas raised the issue of the distance women had to travel to attend appointments in at their location. However, these cases may not appear to be so apparent in clinics that see patients from a local proximity, as they do not have as far to travel before they are home after taking the EMA medication.

3.5 RECRUITMENT

Participants were recruited in three ways. Firstly, I recruited through a closed forum for members of the British Society of Abortion Care Providers (BSACP). When I began recruitment for this study in February 2018, there were sixty-five members of BSACP, primarily health care professionals working within the abortion service. After discussions with bpas representatives and my academic supervisors, it was decided that this is the most effective route of recruitment since it allows me to interact with abortion providers across Britain directly. This form of recruitment was somewhat successful and resulted in twenty potential participants volunteering. Unfortunately, out of these twenty doctors, five were ruled out as they either worked in Scotland or Ireland and therefore do not match the participant criteria.

The second method was through emails sent out from representatives of bpas and Doctors for Choice who emailed doctors on my behalf. Bpas emailed doctors working for them explaining details of my study and asking doctors if they wanted to participate. The organisation Doctors for Choice also sent an email to their mailing list with information of my study, similar to that published by myself on the BSACP closed forum. This form of recruitment proved very useful, and seventeen participants were recruited through this method.

During the beginning stages of my recruitment, one of my participants also sent out an email to the Doctors for Choice mailing list explaining that she had taken part in the interview and that it was very informative and a useful piece of research. This was extremely helpful in my recruitment stage, and many doctors contacted me after this email (confirming an observation made earlier about how recruitment to a study with doctors can be encouraged). At the beginning of my recruitment stage, I was advised by a doctor that works in the abortion service that I may face challenges in researching abortion doctors because there was a sense of fear amongst these doctors after the sex-selection scandal that those with pro-life interests were targeting doctors. As a result, I believe this way of recruiting participants was successful as it gave doctors a sense of security that my research would be impartial, that I was not aiming to cause any distress or harm to them. Finally, the remaining participants were recruited through snowballing.

The aim was to recruit 50 participants based on the sample characteristics addressed above through the techniques outlined here. A breakdown in the characteristics can be seen here in Figure 2, below. This figure also shows the characteristics of the actual number of participants interviewed. The most important is the number of male doctors interviewed. The number of male doctors interviewed was significantly lower than the number of males outlined in the proposed sample. This could either be attributed to (1) the proportion of women working within the abortion service or (2) whether male doctors chose not to participate in this research. It is important to note that although there is a difference in the number of male participants, the overall sample recruited was close to that which was intended. Additionally, this table also highlights where the doctor also completed their medical training. As with age, the location of where the doctor attended medical school could also impact their beliefs about the medicalisation of abortion. However, due to the small number of participants who I interviewed who studied abroad and to ensure that the participants were not identifiable it is not possible to provide specific location information.

Age	***40 and below***	***41-65***	***Retired***	
Predicted	20	20	10	
Actual	18	22	7	
Gender	***Male***	***Female***		
Predicted	25	25		
Actual	15	32		
Location of clinic	***Urban***	***Rural***		
Predicted	35	15		
Actual	31	16		
Location of training	***In Britain***	***Europe***	***Asia***	***Africa***
Actual	42	1	2	2

Figure 2: Table of overall participants' characteristics

All interviews took place between February and December 2018 at various locations. Thirty-one were completed face-to-face in an office at the doctor's workplace. Two interviews took place in a public location chosen by the participant, three interviews were conducted at the interviewee's place of residence, one interview took place via skype and ten interviews were completed over the telephone. The eleven interviews that took place via telephone or skype

were requested by the participant and were doctors whose work schedule was hectic or doctors who lived far away and preferred to speak over the telephone rather than face to face. All interviews were recorded through a secure recording device and transferred to a secure computer immediately, and the interview recordings were stored on a password-protected hard drive. The interviews were transcribed as soon as possible through NVIVO 11 (and then later NVIVO 12 after a software update) and fully anonymised to ensure the participants identity was never compromised. Figure 3 below outlines the characteristics of each participant based on the sampling characteristics outlined above.

	Name	Gender	Age	Location	Setting
1	Abigail	F	Retired	Urban	both
2	Amy	F	>41	Urban	NHS
3	Ben	M	>41	Urban	NHS
4	Bridget	F	41-65	Rural	Both
5	Charles	M	41-65	Urban	NHS
6	Chloe	F	>41	Urban	both
7	Christine	F	41-65	Urban	both
8	Clare	F	41-65	Urban	NHS
9	Daisy	F	>41	Rural	NHS
10	Daniel	M	41-65	Urban	Independent Sector
11	David	M	>41	Urban	Both
12	Doreen	F	>41	Urban	NHS
13	Elizabeth	F	41-65	Urban	NHS
14	Emily	F	41-65	Urban	NHS
15	Eva	F	>41	Rural	NHS
16	Faith	F	Retired	Urban	NHS
17	Georgia	F	41-65	Urban	NHS
18	Harry	M	>41	Urban	Independent Sector
19	Jack	M	>41	Rural	both
20	James	M	Retired	Urban	both
21	Janet	F	41-65	Urban	Both
22	Jessica	F	41-65	Urban	NHS
23	John	M	>41	Urban	NHS
24	Joshua	M	>41	Urban	Both
25	Judy	F	Retired	Urban	both
26	Karen	F	41-65	Rural	NHS
27	Kelly	F	>41	Urban	Both
28	Lauren	F	>41	Rural	NHS
29	Liam	M	Retired	Urban	NHS
30	Lilly	F	41-65	Urban	Independent Sector
31	Lisa	F	41-65	Rural	Independent Sector
32	Lola	F	41-65	Rural	NHS
33	Maria	F	>41	Urban	Independent Sector
34	Mark	M	Retired	Rural	NHS
35	Mary	F	41-65	Rural	NHS
36	Melissa	F	Retired	Urban	NHS
37	Michael	M	41-65	Rural	NHS
38	Michelle	F	41-65	Urban	NHS
39	Nathan	M	41-65	Urban	NHS
40	Nicholas	M	41-65	Urban	Independent Sector
41	Paul	M	41-65	Rural	Both
42	Rebecca	F	>41	Rural	both
43	Samantha	F	>41	Urban	both
44	Sophia	F	41-65	Rural	Independent Sector
45	Vanessa	F	>41	Urban	NHS
46	Yasmin	F	41-65	Rural	both
47	Zoe	F	>41	Rural	Both

Figure 3: Table of participants based on sampling characteristics.

3.5.1 ETHICAL CONSIDERATIONS

Aware of the ethical implications this research posed, and sensitive to the aim of having a discussion with doctors about their work in the abortion service, I addressed the potential ethical issues during the design stages in my research. Ethics applications were submitted to the Faculty of Social Science and Ethics Committee at the University of Kent, the NHS Health Research Authority (HRA) and bpas Research and Ethics Committee.

The nature of the topic is considered sensitive. Therefore, it is important that the study was designed with participants in mind, to ensure that participants did not feel any distress or harm. One way to ensure participants do not feel distressed is to seek informed consent from all potential participants. As part of seeking informed consent, all potential participants were given an information sheet (see: Appendix 2) and two copies of the consent form (see: Appendix 3) before starting the interview, where they were given the opportunity to ask any questions about the research and the researcher before the interview began. In addition, the email address of one of my academic supervisors was included in the information sheet so potential participants have a further contact should they feel it necessary to speak with a member of staff at the University of Kent.

As I will discuss later in my reflection of conducting the interviews, there was an element of uncertainty amongst some doctors of the aims of my research and therefore by having information available on the aims, the potential positive impact and the risks of participation, participants were able to make an informed decision on whether they would like to take part. The most significant ethical issue I faced was that participants would potentially disclose information on lawbreaking throughout the interview, especially when asking questions on opinions of the law and recent headlines implying abortion doctors are breaking the law. This meant it was important to exercise sensitivity and be aware of any possible discomfort that may arise from the interview questions.

Semi-structured interviews allow for a degree of flexibility in the questions asked, the focus of the interview can be changed if there is any distress to the participant. There were three interviews with doctors where suggestions were made that they 'could have' broken the law by either providing abortion drugs abroad, inaccurately estimating the gestational age of

pregnancy or, as one doctor told me, they had given women a dose of an EMA tablet to take at home in case the first one failed to bring on a termination of pregnancy, not realising that this was against the law. Each of these doctors were careful with the information they disclosed to me.

On a few occasions, participants became emotional when recalling their accounts with groups who did not approve of their work, and law enforcement agencies, especially doctors involved in the pre-signing scandal. At this time, participants were reminded that the interview could move on from the question asked, they could pause the interview or that it could be stopped at any point if they wished. All participants were comfortable to continue with the interview and wanted to discuss their experiences. However, where appropriate during this section of the interview, the interviewee was allowed to recall their experiences without being recorded, though all participants asked declined.

Overwhelmingly, the ethical question that concerned participants was confidentiality. Confidentiality in research involves making sure that any data identifying participants is not reported in any way, and therefore precautions need to be taken to protect the privacy of participants. Confidentiality is one of the most significant ethical issues specific to this thesis for two reasons.

Firstly, the number of doctors who provide abortions in England and Wales is small in comparison to the number of doctors who work within Obstetrics and Gynaecology and the FSRH. The number of doctors who perform later term abortions decreases drastically; for example, Friend (2017) found only seven hospitals in England and Wales performing abortions at nineteen weeks. This may mean it could be possible for fellow participants to identify other participants from quotations used in this research. To overcome the problem of identifiability, I informed participants that if I were to use quotations from interviews that pose any possibility of the participant being identified, specific consent for the inclusion of these quotations in any documents published would be sought. This was to ensure that participants were informed of any quotes that will form part of this thesis which may make them identifiable. Participants were made aware in both the information sheet and the consent form that they would be able to decline if they do not wish that quote be used in the research. I did not have to ask for specific consent to any quotes being used while completing this research as I did not use any quotes which I believe could be identifiable to other participants.

I sought ethics approval from both the Research and Ethics Committee at the University of Kent and the bpas Research and Ethics Committee. Firstly, an ethics approval application was sent to the Faculty of Social Sciences Research and Ethics Committee. The application explained the purpose and aims of the research, gave a detailed account of the recruitment strategies, interview questions, the aims of the research and outlined the inclusion/exclusion criteria, (see: Appendix 4). Due to the research focusing on doctors who work within England and Wales, it was not anticipated that any of the participants would be considered vulnerable- for example, being unable to offer informed consent. It took approximately four weeks to receive approval in July 2017 and full ethical clearance was granted from these bodies.

In addition, an ethical application was submitted to the bpas Research and Ethics Committee. This application was necessary in order to gain access to participants who work for this organisation, within the independent sector. This application was similar to the application submitted to the University of Kent. One of the main points to note about this application is that the consent form which was amended. As a result of this thesis being funded by the ESRC, there is an expectation that anonymised transcripts of the interviews will be passed onto the ESRC Data Service. This service will allow fellow researchers funded by the ESRC to access transcripts for research in the future. The consent form was amended to ask for specific consent from participants to passing on their transcripts to this service.

In addition to the ethics applications submitted and approved by the University of Kent and bpas, I was also advised that I would need to complete an application to the NHS HRA as I was aiming to interview doctors working in the NHS and the interviews would take place in NHS settings. This form was submitted in June 2017, and it was decided in January 2018 that as the interviews focused solely on the doctor's experiences and beliefs rather than questioning them on the NHS it was not necessary to have HRA approval for this research.

3.6 CONDUCTING THE INTERVIEWS

On reflection, the interviews were insightful, interviewees were positive in response to the questions and my role as a researcher. Power imbalances could have occurred between me as a student researcher and the doctors participating in this research due to the professional nature

of 'the doctor'. This imbalance was not apparent during any of the interviews since participants were almost always keen to help with this research in any way possible.

At the beginning stages of recruitment very few doctors came forward volunteering to participate, this was surprising to me as I had previously been told this topic was something that doctors wanted to speak about and have their opinions heard. The recruitment process was in fact quite long in the beginning, and sometimes interviews were cancelled at the last minute because of changes in the workplace or time constraints.

To work around this problem and to offer doctors the chance to participate in this research, I started to complete telephone interviews. This proved very helpful, and there were a couple of doctors that I interviewed via telephone on their journey to/from work as it was the only time they were able to talk to me. While I would have preferred to interview doctors face-to-face, as recruitment went on, I realised it was not that doctors did not want to participate, it was that they did not have time in their working day to sit down with me for an hour while the interview was taking place. Completing telephone interviews gave participants more opportunity to take part in my study.

Doctors often used medical terminology throughout the interviews when discussing procedures and their career. Approximately fifteen doctors made a conscious effort to either explain key terminology or ask if I understood certain concepts and procedures. This was extremely helpful for allowing me to question their career further, especially when doctors were talking about aspects of their career outside the abortion service.

Overall, the majority of the interviewees were very positive, with participants being very open to answering my questions and often told me stories about their experiences and how working in an abortion service has impacted their lives. However, I did experience a few issues in a couple of the interviews I conducted. For example, in one interview which was conducted in an abortion clinic which had previously been found to pre-sign abortion forms one of the doctors was quite defensive when asked about the headlines in the *Daily Telegraph* around sex-selection and pre-signing. This was one of the first interviews I conducted and as a result of this experience when conducting the interviews, I made sure I set out that I was going to ask the participant question on the law and some recent headlines before asking these questions. As discussed in the previous section of the chapter, there were some interviewees who

discussed law-breaking during their interviews. One of the biggest challenges that I faced as an interviewer during these interviews was knowing how far to press these issues in the interviews. This was an important skill to learn so that I could balance being able to understand the motivations and values of these doctors, while trying to remain impartial, to ensure that my opinions and beliefs did not interfere with how participants responded to questions. All while ensuring that participants were always aware, and felt comfortable enough, to skip any questions that they did not want to answer.

3.7 PROCESS OF ANALYSIS

There are different approaches to analysing qualitative data; I have chosen an iterative approach for the purpose of this research. An iterative approach is where "the researcher considers emergent findings in light of pre-understanding and contextualises findings within the relevant literature" (Roulston 2014: 302). This process involves "reviewing the literature reflecting on data and making assertions and revising prior understandings of topics" (Roulston, 2014: 302). This was the most appropriate analytical method because the extant literature had already identified key issues outlined as important to abortion providers.

The literature has primarily focused on law and macro-level problems. For example, existing research has suggested that 'two doctors' signatures' is an outdated part of the law and those involved in the abortion services at all levels would like this part of the law to change. Similarly, abortion providers and medical organisations have actively campaigned for a change in legislation to allow women to take the second EMA drug at home instead of travelling to a clinic for a second visit. Before designing the empirical work for the thesis, I knew that these topics would be necessary to discuss, and for this reason participants were asked questions on these issues. However, even though the interview included specific questions on these topics, the interview schedule was also designed to be open, asking participants questions on a wide range of issues to identify unexpected themes that might emerge.

After conducting the interviews, I began the process of analysis through the software NVIVO. This process was two-fold. To develop a coding framework through an iterative process, a researcher must "make connections between ideas, collapse codes into larger ideas … called themes, and begin to develop assertions" (Roulston, 2014: 302). When beginning analysing the

interview material, I started by separating participants accounts by each of these broad themes. For example, I categorised all beliefs about two doctors' signatures together. I then broke these down into positive and negative responses. Once I had categorised the initial responses into positive and negative, the next step was to categorise these responses into further themes; for example, one theme was outdatedness. These were then broken down into further sub-themes.

The second stage of the analysis focused more on identifying patterns in themes that came up from the interviews with participants. Themes, as defined by Taylor and Bogdan (2015), are "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk saying and proverbs" (p. 171). These themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985: 60). Using this idea of what a theme is, I began to look for similarities in the transcripts. These were first identified through reading the transcripts numerous times.

Initially, I read the transcripts to gain an understanding of the interviewees' stories. Then I re-read the transcripts and wrote down a list of topics which seemed important to each of the interviewees while highlighting key terms, emotive words and interesting comments, looking for patterns and themes that were prominent in multiple interviews. I went through each transcript individually and counted the number of participants who discussed broader issues and put the information in tables to get a clear idea of how many doctors addressed these issues. After identifying themes, I began a process of more in-depth thematic analysis.

Once I had the basis for the themes on NVIVO, I printed all of the comments made on each topic and created a Microsoft Word document, beginning to highlight each one on paper. Going back to paper copies of the data allowed me to analyse the quotes in-depth. Highlighting and annotating the sub-themes on paper allowed me to see how each of the quotes were similar and different, which I then used throughout Chapters Four, Five and Six. In addition to identifying themes, I also added the participants by 'classifications' set out in the stratified sample. Doctors were categorised by age, gender and location of the workplace. This was helpful in later allowing me to determine whether there were any differences in accounts by the sample characteristics.

Overall, participants' accounts were coded into macro-, meso- and micro categories, as I will discuss below. However, when doing this, it became possible to see the fluidity of each of these

levels where topics could overlap between more than one level. For example, parts of the discussion on EMA was placed within the macro-level since participants discussed this in relation to two doctors' signatures and class of place, but it could also be placed in the meso-level where doctors discussed the clinical practice and the way the service should be provided. In addition, themes such as stigma were evident throughout each of the levels. When talking about the macro-level and recent attempts to prosecute doctors, some doctors addressed the stigma that doctors faced during this time from the public and the media. In addition, on the meso-level, doctors discussed the stigma they face from other medical professionals and because of the sector they work in. Furthermore, stigma was presented on the micro-level when talking about the positive and negative attributes of their work. This made splitting the themes into the three levels challenging, clarifying how fluid the levels of medicalisation of abortion are.

3.7.1 MACRO-LEVEL

As set out in Chapter One, the macro-level focuses its attention on the laws that govern abortion in England and Wales, and as a result, the themes set out are based on aspects of the legal framework. Themes set out on the macro-level were based mainly on those set out in existing literature, for example (Sheldon, 1997 and Keown 1988) have both discussed critical aspects of the legal framework on abortion. As Figure 4 below shows, The OAPA of 1861 was split into two key themes – criminalisation and sex-selection – with comments made from participants then being divided into positive and negative reactions to these elements of the law. The Abortion Act was split into three topics: two doctors' signatures, class of place and conscientious objection. These are all areas of interest which have been raised in the extant literature and form the basis of the macro-level. I then categorised responses into two categories: positive and negative reactions on NVIVO. After this stage, I printed all comments onto a Microsoft Word document. I began to highlight interesting comments and phrases, annotating specific parts of commentary to see if there were any similarities or differences in the doctor's language. As Chapter Four will show, key themes emerged as a result of this process, including nurses' involvement in the abortion service, the ways the law works in practice and how doctors view the role of women.

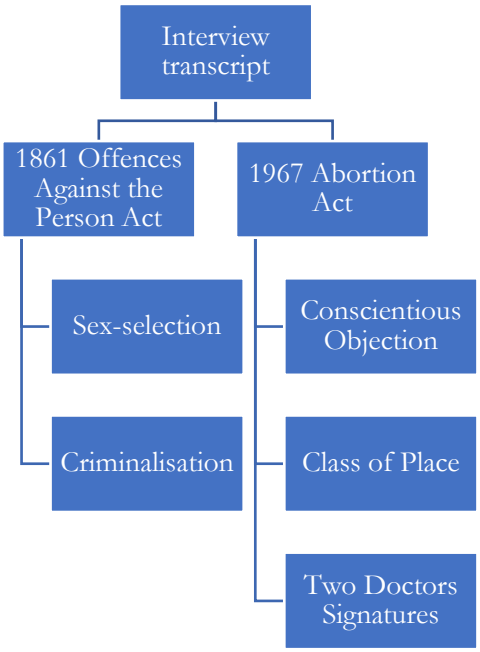

Figure 4: Process of analysing the transcripts for the macro-level

3.7.2 MESO-LEVEL

The process of analysis for the meso-level was very similar to that outlined in the macro-level section above. The main difference is that the themes from this level came out of the interviews with participants, rather than existing literature. As Chapter Two set out, this could include discussions about policy on EMA, clinical guidelines doctors work within or doctors' views of the procedures currently practised by doctors. The interview schedule was designed to elicit discussion about these topics to determine which are significant to the work of doctors and in what ways.

As discussed previously, recruitment to the study was purposive, on the basis that existing research pointed to the possibility that age, gender and location of the clinic might shape accounts, and I also generated a sample that included doctors working in NHS and independent sector clinics. As I analysed the interview data, it becomes apparent that the setting where the abortion takes place was a prominent theme. During the process of analysing the transcripts, I noticed that many participants often spontaneously brought up the differences between the independent sector services and the NHS in various ways. For this reason, I opted to give priority to this theme in writing about the meso-level.

Once I had identified this repetition in interviews discussing the two sectors, I began to investigate further by analysing all of the participants' comments about the NHS and the independent sector in a similar way as I had done with the macro-level commentary. On reading and re-reading the transcripts, I identified three common themes which occurred in multiple interviews. Firstly, I split general comments made by doctors on the two different sectors into a category and then further divided them into further sub-categories of 'positive comments on the independent sector', 'negative comments on the independent sector', 'positive comments on the NHS', and 'negative comments on the NHS'. These four categories were useful in helping me to gain an overall picture of participants feelings about the history of the abortion service and the relationship between the two different sectors. Secondly, many participants discussed the abortion service in relation to women who have complex medical cases this was then identified as a theme, and I set out all responses on complex cases into a category on NVIVO. The third thing that became apparent when reading the transcripts was the number of doctors that expressed concern with the way that second-trimester abortions are currently being performed in England and Wales.

Thirty-nine doctors expressed an opinion on second-trimester surgical abortions even though they were not directly asked a question about this topic. The fact that a large number of doctors discussed this type of abortion suggested to me that this area needed further investigation. Once again, similar to the other themes I had identified, I began to place all responses on second-trimester abortion into a category on NVIVO and these were then divided into positive and negative responses for each sector as Figure 5 below shows. When doctors were discussing training and opinions on the future of the abortion service, the different sectors were also raised as an issue. For this reason, training was also included in meso-level analysis.

Doctors raised and discussed issues on complex medical cases, second-trimester surgical abortion and training in various ways as Chapter Five will discuss in detail. Key ideas emerged from these discussions, including a concern with the current procedures in the independent sector and the NHS as a 'better' organisation for providing abortions in.

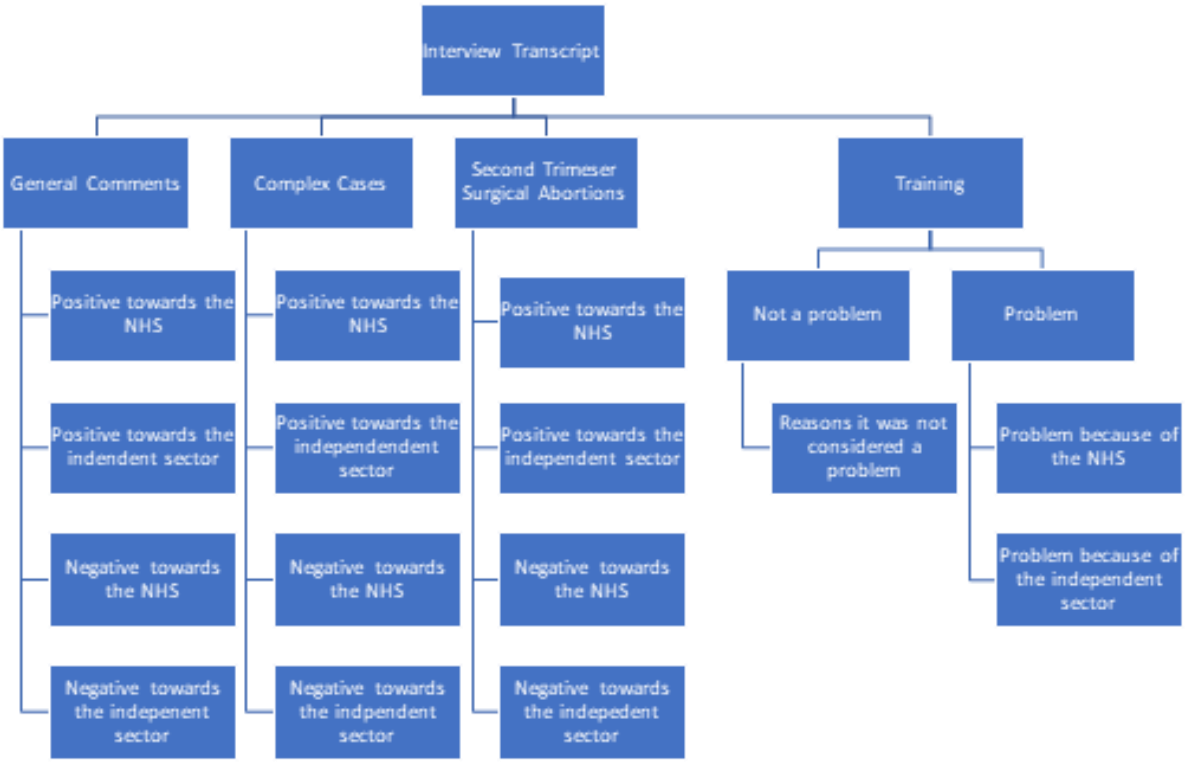

Figure 5: Process of analysing the transcripts for the meso-level

3.7.3 MICRO-LEVEL

The micro-level was the most challenging level in terms of how to analyse the transcripts, mainly because unlike for the macro- and meso-levels, on the micro-level there were no major themes that have been explored in the existing literature already. As discussed in Chapter Two, Halfmann (2012) has suggested that the micro-level is important in terms of the medicalisation of abortion, since that is where doctors construct their identity. As a result, it was therefore important to see how doctors have constructed their individual identities as a doctor providing abortions.

Doctors have traditionally been seen as having high levels of discretion as the medical profession self-regulate. Self-regulation has been an important aspect of medicine and self-regulation of the medical profession is linked closely with the belief that the profession is altruistic (Collier, 2012) and is, or was, trusted. However, the provision of abortion is not self-regulated, as Chapter One has shown. In contrast, doctors working in the provision of abortion are subjected to an extensive legal and policy framework in addition to the regulations that

govern other medical professionals. This has created a unique position for abortion doctors, where they can face life imprisonment for providing medical treatment.

In the course of analysing the interview data it became clear that participants constructed their professional identity on the micro-level through comments and stories about their relationships and interactions with patients, medical colleagues and the wider community. Firstly, doctors used stories to explain why they became involved in abortion services. These were categorised into two main themes. As Chapter Six will show, the majority of doctors made a conscious decision to work in the abortion service for one of four reasons. Participants described being motivated to work in the abortion service because they had either seen women having illegal abortions, had experience of seeing women being treated unfairly, because they believed it was a women's right to control their own reproductive health or as the result of having a pro-choice mentor as a trainee doctor. Thirteen doctors also discussed working in the abortion service either through a pragmatic account or as part of the role they 'stumbled' into. These categories were useful in helping me to gain an overall picture of how doctors constructed their identity in the form of who they are and who they want to be as a doctor.

Furthermore, stories were used on the micro-level to show how doctors have constructed their professional identity by making reference especially to pride and stigma. If medicalisation is, as the literature suggests, a way of the medical profession asserting their authority over members of society, then it does not follow that doctors would describe themselves as stigmatised. However, the ambiguous position of the abortion doctor has meant that thirty-nine participants talked about themselves as stigmatised, and discussed the management of a 'spoilt identity'. In order to develop the micro-level chapter through looking at identity, stigma and pride, Chapter Six draws directly on the work of Goffman (1963) and the associated literature to explore how these doctors manage the stigma of being associated to abortion. This is important to how these doctors have given their job meaning when being faced with criticism and disapproval because of the area of medicine they work within.

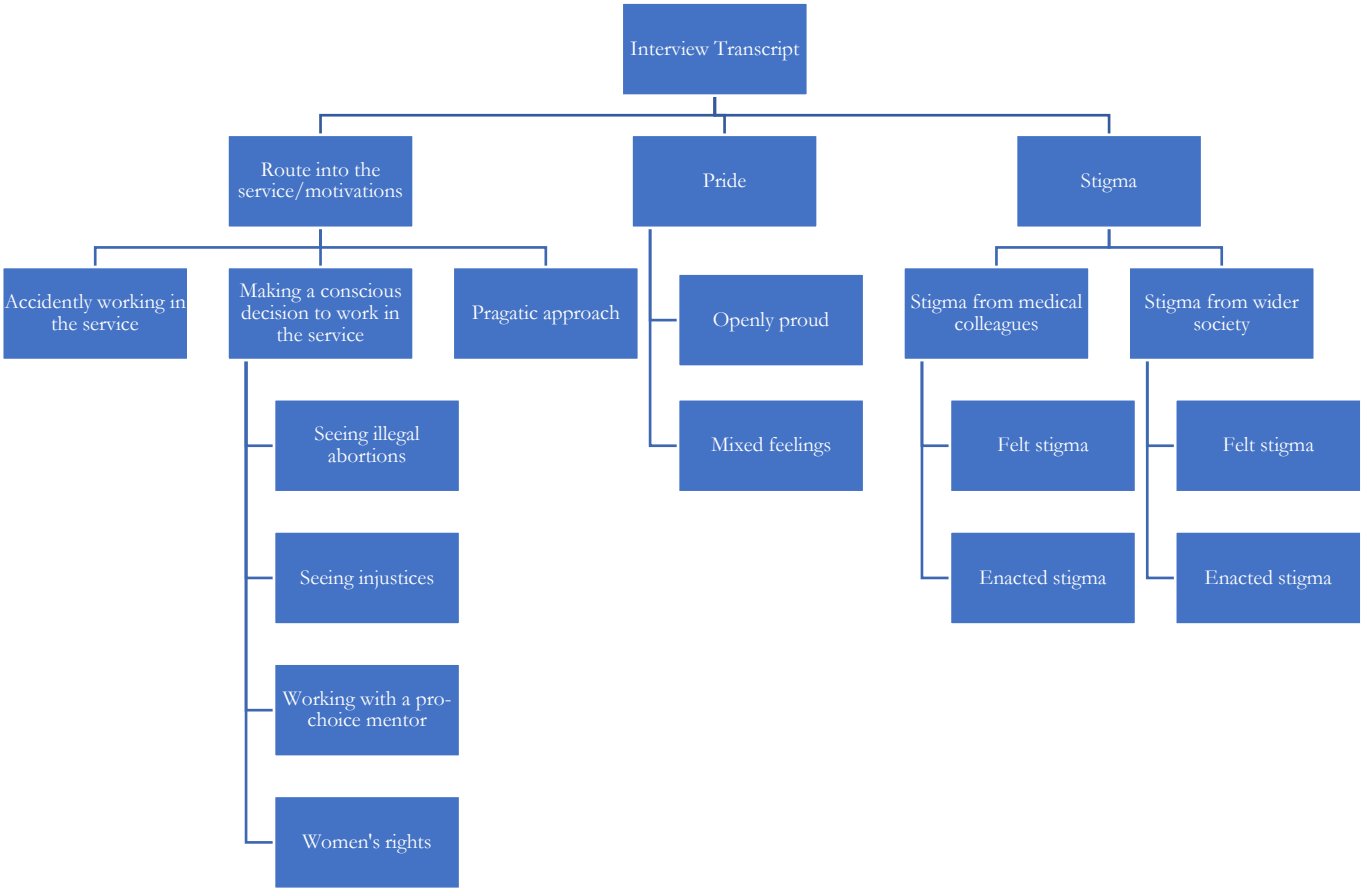

Figure 6: Process of analysing the transcripts for the micro-level

3.8 Conclusion

This chapter has firstly outlined the research questions which have informed this piece of research, discussing how Halfmann's three levels informed the research and outlining in more detail what is included in each level and how these levels could be used to inform an investigation into the medicalisation of abortion.

I outlined how the macro level has focused on the law and some more recent debates which have questioned the values of abortion providers by suggesting that this group of doctors are motivated by money and control rather than helping their patients. Then this chapter has outlined how on the meso level, when exploring the perceptions of the institutional frameworks for abortion and the meaning that doctors have attached to the organisation of abortion services,

the setting of where an abortion takes place became a predominant feature throughout the majority of interviews, and for this reason this theme became a key feature in the investigation into the professional values of abortion doctors on the meso level.
This chapter then outlined how, when investigating the professional identity of abortion providers on the micro level, participants were asked questions on the meaning they have attached to terminating pregnancies in relation to the goals of wider medicine and the potential stigma that they face because they have chosen to work in a stigmatised area of medicine.

I have then explored the study design, including how the pilot interviews helped me to decide my sampling considering the sampling strategies used, the recruitment techniques used to find doctors who perform abortions in England and Wales, the ethical implications, I then reflect on the interviews considering both the logistics of recruitment and the issues that arose during the interviews. Finally, this chapter has explored how the data was analysed. The next chapter is the first of three which focuses on the results from the analysis of these data starting with the values that inform the work that doctors do in relation to the macro-level.

CHAPTER 4

THE MACRO-LEVEL: RESISTERS OF MEDICALISATION

4.1 INTRODUCTION

This chapter begins my discussion of the interviews with participants. I begin by considering participants' beliefs about what I set out in the previous chapter as the macro-level. As explained there, for the purpose of this investigation, I define the macro-level as constituting the legal framework that governs abortion. The interviews I conducted focused on asking participants about two parts of that legal framework: the 1967 Abortion Act and the 1861 OAPA. During the interviews, it became apparent that doctors were more opinionated about the former piece of legislation. For this reason, the chapter opens with an account of what they had to say about that Act.

Overall, the main claims made by those I interviewed were that their values differ from what they consider to be the assumptions inherent in the law. This sense of differentiation between how my participants perceived the work they do, the technologies they use, and the women they interact with, as compared to the ways they thought the law understands these components of abortion, were all aspects of our discussions. Interviewees' commentaries covered: the medical needs of patients, the practicalities of how they provide abortion, and more explicitly value-oriented claims about why they think abortion matters and what the role of those doctors who provide it should be. In what follows, I discuss these variations in how the doctors communicated their disagreements with the law.

4.2 LEGAL ABORTION

As discussed in previous chapters, the background work that lay behind deciding what to discuss with my participants emerged from reviewing relevant literature about abortion law, attending academic conferences with doctors, participating in events organised for and by abortion providers, and discussing the issues with my academic supervisors. As I have set out, certain aspects of the 1967 Abortion Act have become subject to contestation, meaning that although the law remains the same on paper, in practice its interpretation and meaning have

modified considerably. The interviews I conducted focused on aspects of the law that appeared the most important, where the practice of abortion, and the tensions and concerns of abortion providers themselves, were continually raised. These areas, as indicated in Chapter One are: 'two doctors' signatures', the 'class of place clause' and the 'conscientious objection'. I turn now to discuss my analysis of the participants' commentary on each of these aspects of the law.

4.2.1 Two Doctors' Signatures

Of all the areas discussed with participants concerning what I have defined as the macro-, meso- or micro-levels, response to questions about two doctors' signatures was the most uniform. All participants believed that the need to sign paperwork to give authority for an abortion to take place negatively affected their ability to be a 'good doctor'.

Overall, therefore, my research, in line with that conducted by Lee, Sheldon and Macvarish. (2018), confirms that the legal demand for abortion to require doctors' authorisation – beyond the usual process of a patient consenting to the provision of medical care – is perceived as antithetical to the value set this group of doctors hold. The most general view across my participants was of a difference between those values or ideas that influenced thinking and organisation of the regulation of abortion in the 1960s, and the present time.

The view was that the values of a good doctor today were not the same as what they may have been in the 1960s, a perception expressed this way by Amy:

> A good piece of legislation when it was passed in the 1960s … but it was passed as a public health issue. It was passed to protect women … it did the job that it set out to do which was to stop backstreet and self-induced abortions, so in that respect in the 1960s, amazing. However, it is outdated, so my choice would be to start with a blank slate and then to regulate abortion as healthcare – as a health care issue.

While not all of my interviewees concurred strongly with Amy's description of the 1967 Act as 'amazing', the idea that this law is 'outdated' did seem to capture the view of all of those I spoke to. However, how doctors expressed this sense of outdatedness and what they highlighted

as the key components of the contradiction between their value set and this aspect of the law on paper varied.

Amy continued her discussion on the problem of the outdatedness of the law by telling me that it "prevents good clinical practice". This idea, of what is necessary if doctors are going to act as 'good doctors', is defined as working in line with best practice guidelines or general standards of clinical excellence, was raised by many other interviewees. Christine told me that "the law is really functioning as a barrier to an ordinary service". This use of the term 'ordinary' appeared to suggest that Christine considered that, as a doctor providing abortion, she should be able to do her work in the same way as if she were providing any other sort of medical care. For Christine, the main issue preventing her from providing the care she wants to arose from the demand of abortion law, she said, "there were a few times where I really had to scramble around and spend a lot of time chasing signatures just so people could have their procedures".

The contradiction between the workings of an 'ordinary service' and what happens in practice because of the two doctors' signatures requirement goes beyond a concern with impeding timely patient care. My participants also communicated a sense of being placed in a position of having to behave unprofessionally because the law gave them no choice. More or less explicitly, they suggested that they acted to meet the terms of the legislation formally, knowing they neither believed in it nor felt it meaningful.

Christine said that it was a matter of 'pragmatism vs theory': the legal requirement for two signatures rested on a theory she had negotiated pragmatically. "Women come", she said, "they ask for an abortion, somehow or other we get two signatures, and they have it". The belief that doctors will find signatures even though they believe it of no value was also highlighted by Lauren. She told me that "everyone is skirting around it", concluding, "it should be dumped". Lauren also used the words "with every legal means possible" to describe the skirting around that she said abortion doctors do. I discuss this aspect of doctors' discontent with the demands placed upon them later in this chapter where I report my participants' comments on so-called "pre-signing". The demand on doctors from the abortion law was also addressed by Nicolas, who told me the current abortion law "delays the service … because sometimes it's not been always easy to get two doctors there to sign and process the forms".

Interviewees' objections to the outdated legal requirements and their impact on their ability to provide the best care also took the form of discussions about a nurse-led future of the abortion service. Compared to the 1960s, doctors were keen to draw attention to the transformation in the role of the nurse as part of abortion provision. In turn, they stressed the significance of professional values oriented towards collaboration between professional groupings and giving due recognition to the skills and contribution to those other than doctors. Doctors' talk about a nurse-led future could be taken to signify a very marked value shift from the idea that doctors are necessary and always in a position of authority compared to other professional groupings.

The ubiquitous view among interviewees was that the growing role of the nurse was positive, it should be taken further through training nurses to do almost everything that doctors do currently. Faith told me it was already the case that "a lot of providers are now delegating most of that [EMA work] to nurses so that doctors are doing far fewer than they used to". Joshua was categorical in his positive assessment that: "the movement towards nurse care is good". He emphasized that, on this basis the outdatedness of the current law, "the cumbersome requirement for two doctors' signatures, both of whom are unlikely to have seen the patient because it's going to be in most cases a nurse-led service, seems archaic".

Three doctors drew attention to the similarities between the work of the doctor and the nurse. Amy said that nurses "are more than capable of doing everything else that I do; they just can't sign the forms and prescribe the drugs that I can prescribe". Amy clearly communicated an equality between her and her nursing colleagues that should be recognised and valued, with the inference that the continuing legal requirement was making an artificial distinction that doctors sign forms. She said, "that's the difference between me and my nursing colleagues is that I can sign the forms". Other doctors similarly spoke very highly of the nurses who work within their service. Emily, who worked within SRH, described one of the nurses that worked within her service as "very specialised … very highly trained probably more highly trained than me … because they've been doing it longer and it's their only field of specialism … so the fact that they medically can make very good decisions, but then legally can't sign the form, it doesn't really make sense". Karen also indicated that the law is creating an unnecessary and artificial division that current medical values would oppose. She said:

> There is no medical or safety reason why a nurse couldn't also be a prescriber of medications or why they couldn't also do some of the procedures … we have nurses

> here in the department that do Manual Vacuum Aspirations (MVA) for miscarriage management, so obviously if the law changed then overnight, she would be able to also be providing surgical abortions.

Some participants also made their value orientation toward equality with nurses clear in their comments about the problems with the present service. Mary told me, in a concerned way, about a nurse she worked with who had been "inadvertently dispensing" the medicine required to perform an EMA. Under the 1967 Abortion Act, it is not legal for nurses to prescribe these drugs, and therefore this nurse was unintentionally breaking the law. Mary clearly felt that the punishment of this nurse, although legally required, was wrong. She described the process as "really a big deal" and told me that "I really felt for her because in a clinic of twenty patients it's quite possible that you could overlook that and there can be no malice intended". Sociological studies of the medical profession have highlighted how the medical profession have historically "emphasised [their] professionals' capacity to preserve monopoly over specialised knowledge … to create boundaries that protect the status and role of doctors in society" (Denis and van Gestel, 2016: 46). However, the abortion service in England and Wales does not reflect this traditional view of the doctor, since those doctors interviewed believed most of the abortion service could and should be run by nurses who have specialist training.

A third way doctors discussed the outdatedness of the law appeared more explicitly as a question of values, understood as a moral question focused on autonomy and decision-making. The issue was not whether doctors were able to do their job well by providing good and timely patient care. Instead, the issues raised were more substantively about what the role of the doctor was in abortion and in what ways doctors should influence abortion decisions based on what might be considered right or wrong. As others have commented on the basis of their research with doctors (Lee, Sheldon and Macvarish, 2018), the power and strength of the terminology used by some doctors who provide abortion on this question is striking.

Doctors discussed the outdatedness of the law by saying what they thought the law implies about the role of women. Georgia, for example, said she believed that the law "kind of implies that women are stupid". It was quite clear that she considered her values as a doctor to be at odds with what she took to be the moral presumptions of the law. She told me that the problem with the law is that it works as though women "don't know whether they want to continue with the pregnancy or not". Yasmin used language which similarly presented an apparent counter-

position between her sense of how women requesting an abortion should be perceived in contrast to how she thought the law viewed them. "If women can go to the moon, how can they not choose to have or not have a child?" was her rhetorical question in response to me asking her what she thought of the law requiring two doctors' signatures.

The belief that the values of participants were at odds with those ascribed to them by the 1967 Abortion Act was also discussed by Lauren, who said the requirement for two doctors' signatures constitutes an expression of "women's best interest" was "a joke". Rebecca suggested the idea that the values of the law are at odds with those of doctors was a shared view, telling me that doctors "now know", presumably as compared to the past, "that it's your own body and it's your own decision". Faith also communicated that the view of doctors, in general, was different from how it used to be. Doctors "do listen to women now" she told me, and she said "they realise that actually, it's up to the woman to decide. The vast majority of them anyway". She concluded, "so, it's time we took that paternalism away", indicating a quite clear sense that the values of the past were 'paternalistic', whereas those held by her and other doctors, in contrast, upheld the significance of the individual making her own decision.

Zoe directly contested the legal presumption that the doctor is well placed to judge whether an abortion should be provided. She said that she was "in no position to judge whether she should or shouldn't do this", and she told me, "the only reason I will not sign is if I believe she is being coerced. Other than that, if she says I am not going to go on with this pregnancy, I couldn't possibly say well you must".

Practically speaking, the most frequently discussed alternative to the present arrangement was that the provision of abortion should simply require patient consent to treatment. Vanessa, who seemed outraged this is not the case, said "it's ridiculous we have two signatures". She told me, "it should be a consent procedure … the same type of consent from whether you're having your appendix out or fixing your leg or having an abortion". Michelle took a similar view in her comment that "it's like any other medical condition, so why would you want two doctors to actually sign? One doctor's more than enough to give consent".

Overall, the clear response from my participants to the legal requirement that they make the decision about whether an abortion can happen, and sign a form accordingly, was that this is in direct contradiction to present medical values. However, this did not mean my participants

considered there to be no role for a healthcare professional in abortion decision-making. There seemed to be a distinction made between the role of a doctor in legally validating a decision, and the role of a doctor or other healthcare provider in 'helping'. Janet, for example, discussed the role of the professional as involving an obligation to help women decide. She told me, "I feel that is what I owe women", with the use of the term 'owe' indicating a sense of moral obligation. Janet thought this obligation was, "not to help make their decision, but to make sure it's clear in their mind and they have thought about the options [they have regarding the pregnancy]".

This section of the chapter has brought to light the distinction between the values of doctors, whereby they reject the legal oversight that the current legal framework provides. The interviews identified a clear consensus against two doctors' signatures and strong support for women simply consenting to an abortion themselves. However, I have also indicated the presence in some sense that doctors consider it their role to help women with abortion decision-making. I return to this area later in the thesis. I now turn to discuss class of place, an area which continues my exploration of the participants' sense of a value conflict between their own definitions of a good doctor and those of the past. This draws attention to the importance of the expansion of the use of EMA, and the associated shifts in how abortion is provided, as one of the drivers for the perceived values tensions.

4.2.2 Class of Place Clause

The idea that the class of place clause is outdated came across in participants' accounts during the interviews in different ways. Some presented a specific legal requirement about the location for the provision of abortion procedures as reflecting particular values. Melissa, for example, told me the class of place clause is a "load of nonsense as there is a very nasty, sexist, misogynistic underpinning", where the arguments for restricting location "end up being women are untrustworthy". However, twenty-eight participants posed the problem as one of legal overreach, whereby their clinical perspective based on current knowledge is overridden. As Lauren told me, "where the abortion goes on should be a clinical judgement, not a legal one, so it is a load of bollocks".

Paul also discussed this problem of the law by recalling that his NHS service was, "actually unknowingly breaking the law a few years ago". During this time, a second dose of misoprostol was given to women to take at home if the first "had not proved effective". For Paul and his colleagues, it seemed apparent that EMA could, and should, be available this way, based on what made sense from a clinical point of view. Yet this left them in breach of demands of the law, and potentially subject to prosecution as a result. As I go on to discuss, it was this concern about the overriding of clinical judgement that was developed in participants' comments on 'home use' as part of the provision of EMA when they discussed how they perceived the possible developments and improvement of the abortion service.

To begin with, however, I discuss what participants had to say about their efforts to provide abortion in a way they considered best, in the context of those legal restrictions in place when I interviewed them. It is important to note that during the time I carried out the fieldwork for this thesis, health policy changed, firstly in Scotland, then in Wales and England. The policy was changed to allow women to take the second stage of treatment for EMA at home. While this policy did not come into effect until after all of my interviews were completed, it meant that some participants discussed the law while this policy amendment was being discussed amongst doctors, the media and politicians.

SIMULTANEOUS ABORTIONS

Interviewees told me about an approach to providing abortion they have tried to develop to overcome the problem of the class of place, referred to as 'simultaneous abortions' by doctors. Simultaneous abortions are the process whereby women have both the mifepristone and misoprostol on the same day. This has a slightly reduced success rate of completing a termination of pregnancy.

Doctors still provided abortion this way, despite the reduced success rate, because as Georgia told me, women "seem to prefer it". Georgia believed the fact women prefer to have a simultaneous abortion "shows that women want something easier to access". This was also expressed by Bridget, who said in her independent sector clinic that "most are done simultaneously". James also told me, "we have adopted a process if women want … even though we do not feel it is best for them to have just simultaneous, because we know that it's better if you wait". About a quarter of doctors provided EMA simultaneously. All doctors who

spoke about simultaneous abortions discussed the procedure as a way of working around the class of place clause until the law allowed for a different interpretation. Joshua believed:

> Women very soon should be able to have the mifepristone here and then be able to take the misoprostol away and have it 24 hours later at home, which will work better than simultaneous and will be more convenient than the alternative of coming back the next day for the misoprostol.

All doctors, regardless of whether they provided a simultaneous procedure, believed it was essential to allow women to take the misoprostol at home. There was a shared belief that the best service would be one where women are legally allowed to have their abortion without an increased risk of incomplete abortion, and without having to return to the clinic or hospital numerous times. The problem of women needing to attend the clinic or hospital on more than one occasion was one of the reasons doctors were keen to see a change in the interpretation of the law. Doctors wanted an amendment that would allow women to take the second part of the EMA at home, which is discussed in more detail in the next section of this chapter.

WELCOMING HOME USE

As explained in the previous section on simultaneous abortions, the values of the doctors differ from what they consider to be the assumption of the law. I discussed one way doctors tried to overcome this difference: by providing a service which works within the current interpretation of the law. However, doctors did not believe this to be the most appropriate service for women. For example, Maria told me that she thought all doctors working in the abortion service would "prefer to provide" a service where "the woman is able to take these drugs on unlicensed premises". She described this ideal service as one where women "come for a consultation and then are given a pack with the mifepristone, instructions on when to take it and instructions on when and how to take the misoprostol".

The idea that the law constitutes a barrier to a service that doctors believe is the best for their patients was raised by most of my interviewees. Doctors spoke about the inconvenience of women attending more than one appointment to complete their EMA. Samantha told me that, "for an early medical abortion, she probably has three visits… but if it was legal to give her the second part, we could do that and it would be one visit, but it isn't so it's the way we have to do

it". Rebecca also recognised that in some cases, women would have to go to the hospital or clinic three times because women must take abortion pills on licenced premises. She said:

> We do see people that really struggle to get to the appointment … all types of women, [some] struggle because they haven't physically got the capacity to get to the clinic if they don't drive, or they haven't got the money for the bus fare. They just often haven't got the money to get back enough times to the appointments they need, it adds an extra layer of difficulty on.

This concern for patients due to the current interpretation of the legal framework was also expressed by Georgia. She described the class of place clause as her "biggest bugbear" because of the circumstances of patients, who need to "juggle their childcare, and they're juggling so many things". This was one way that doctors expressed their belief that the law is outdated and needs to change to allow them to be 'good doctors'.

As part of Jessica's discussion on the negative impact of the law, she expressed her disgust that it is "not breaking the law if you give them the misoprostol, and then they travel home and risk of miscarriage on the way home". This was also expressed in Melissa's interview when she told me "I think it's [home use of EMA is] much better than people aborting on a train". The impact multiple clinic visits have on women, as well as ensuring women did not complete their abortion in public, were central reasons for doctors wanting home use of EMA to be legal in England and Wales.

As I have noted, the law's outdatedness was discussed primarily through contrasting its terms with current clinical understanding. Jessica believed that the current legal framework is "beyond ridiculous" because home use is "clearly medically safe and clearly wanted by women". Jessica continued that the class of place clause "is one of the things that is completely unbelievable, the way the law works … when it is quite clearly medical unanimously throughout medical literature that home abortion is safe and much easier for women". Here Jessica made it clear that her values as a doctor are at odds with those of the law. She believes that there is a distinction between the values of the medical profession and the presumptions of the law. Jessica explained that the law prevents good clinical care because of the "way that a few thinks, in trying to make abortion difficult". Jessica's belief that the law does not fit in line with medical literature and knowledge was also expressed by Emily, who said:

> It doesn't really make sense because we don't do that with any other treatments really, even controlled medicine like morphine, GPs or whoever are allowed to make the decision that patients can have it at home … so if they're safe and they're deemed safe medically to have at home, I don't see why they shouldn't really.

The comment here raised by Emily is an example of how advancements have been made in other areas of medicine, where patients are now allowed to have treatments in their homes for medical reasons. However, as Jessica told me, even though there is medical literature which shows that home use of EMA is safe, women still have to have their abortions in licenced practices because of the existing legal framework. Once again, this is a clear example of how doctors believe that their values conflict with those they ascribe to the law and lawmakers, who are "trying to make abortion difficult". Doctors also believe that the law on abortion is outdated, in comparison to other areas of medicine where doctors can decide if patients should have their treatment at home.

As I have noted, government policy in Scotland, Wales and finally England changed in the course of my research. Elizabeth welcomed the news from the government that women will be allowed to take the second part of the treatment for EMA at home as "great … a big step forward". Nathan also believed that allowing women to take the drugs at home would "make the, you know, life easier, system easier for a woman". Amy said that her "main concern with [the abortion service] at the moment is that it prevents women from taking medical abortion pills at a place that is convenient for them … women should be allowed to take the pills in their own home with back up support where needed, and good information". Doctors who were interviewed after the announcement of the change in interpretation of the abortion legislation were overwhelmingly positive about the change. They saw it as a victory for the service and its service users as they saw this as a 'modernising' move to a service where the medical profession was able to provide in the way they believed was best for their patients.

CONCERNS ABOUT HOME USE

As discussed previously, all participants saw law reform as a positive step forward. However, what would be best for women attracted different beliefs, one example is discussed here.

Doctors believed that the home use of EMA would make a positive contribution to the abortion service; however, some doctors interviewed raised concerns about this type of abortion. Doctors interviewed were well aware of the safety of the mifepristone and misoprostol combination used to produce an EMA, and that complications are rare. However, some doctors – specifically those working in the NHS – were still uncomfortable with EMA being provided without the current level of medical supervision. They presented their concerns though using the term 'safety'. As I go on to discuss, this seemed to be a concern not about the clinical safety of the drugs used in EMA, but rather about taking EMA out of the medical sphere. Those doctors supporting EMA at home were, on this basis, very clear that they still believed that medical professionals should be involved in the process the running of the abortion service, and they were cautious about the merits of 'demedicalisation' understood as a disappearance of their involvement.

Discussions with these doctors focused on what they believed to be a vital medical intervention to ensure the safety of women. For example, there appeared to be concern about women being able to buy abortion pills over the internet or as an over-the-counter drug. Emma explained that she did not feel "it is safe for them" because she believed "they need an NHS input or a doctors' input to actually scan them … they should have some point of contact with some clinician". There was a concern that allowing women to buy EMA drugs over the counter or online would be, as Kelly put it, "moving a bit towards that kind of unsafe abortion scenario that we had before". This would suggest that proving an abortion service where women can access the abortion pills without the intervention of a clinician is a step too far for some doctors. Kelly also felt that "there needs to be some kind of regulation" although went on to say she "doesn't know what form" she thinks it should take but she "didn't think it needs to come under criminal law … maybe medical regulation". This is an example of how doctors reject current legal oversight but still value regulation that gives them clear guidance.

Joshua put this idea differently saying, "mifepristone obviously is something that you don't want to have washing around in the community in an unregulated way". To make sure it is not unregulated, he believed "it makes sense that, if women are having to be seen for a consultation, it should either be a GP surgery or licensed premises that are providing the treatment". While Joshua says he believes women should not take abortion pills without medical supervision, he frames his reason as a public health concern. He suggests that mifepristone "washing around in the community" is a bad thing, which is why women have to be seen by a medical

professional. For Joshua, the issue is not whether women are reverting back to the backstreets by taking the tablets without medical interaction, as Kelly suggests above, but instead he is concerned about the safety of having the drugs available in the community. Furthermore, Joshua suggests that a woman can be seen in a GP surgery. This is yet another example – as with nurses discussed earlier – where doctors working in the abortion service are not trying to distinguish their role and that of other healthcare professionals.

The concern over the safety of their patients was a driving factor in forming the claim that women should be seen by a medical professional when seeking an EMA. Doctors expressed that the majority of women seeking an abortion in the first trimester did not, however, need to be seen by a doctor, but instead could be seen and examined by a nurse with sufficient training. Furthermore, it is clear that doctors did want to demedicalise abortion. They wish to see a change to the abortion service to allow women to take the necessary medication on their own, but with the additional support of medical professionals such as nurses. Once again, this does not reflect the traditional view of the doctor as a professional trying to gain and maintain social control over an area of healthcare. Instead, doctors were very clear that their values are at odds with those of the law by not allowing other healthcare professionals to be involved with more aspects of the abortion service.

The idea that doctors are agents of social control was raised explicitly during the interview with Kelly when she discussed her reservations about home use of EMA, which does not require any medical intervention. She said, "I guess to a degree I'm not totally opposed to that, but then I do have some reservations about it. And I think that those reservations are motivated by care for women as opposed to social control of women". This comment from Kelly was intriguing, since she felt that she had to justify that her motivations for wanting women to see a medical professional were about a genuine concern for her patients' safety and not wanting to maintain 'social control of women'. Kelly's discussion on social control is another clear example of how she believes that her values as a doctor are not the same as those of the doctors who were working during the times the laws were written.

In direct comparison to the belief that women should have an EMA once they have been seen by a healthcare professional, Mary, a consultant in SRH, said:

> I wonder if the law is changed and we stop making it feel like a load of hurdles to get through to get what you want, why don't we just make a little box of mifepristone and misoprostol, costs 20 quid and you go in and buy it from Boots? And if you can't afford it or if you've got any health problems then you have to come through a service like mine [laughs]. I mean what would be wrong with that?

Mary's belief that there is a potential for EMA to be available over the counter without specifically involving the medical profession shows that some doctors can see a future where the drugs used to perform an abortion before ten weeks are provided without doctors' or nurses' involvement. This future would be a clear demedicalisation of abortion, where women can freely purchase the medication needed without medical involvement. However, Mary was the only participant who believed women should be able to access these drugs without the intervention of a medical professional.

This section has brought to light a further distinction between the values of doctors and those of the current legal framework. Similar to discussions on 'two doctors' signatures', the interviews identified a clear consensus that the class of place clause is outdated. Doctors discussed ways in which they have tried to get around the legal restrictions they face while trying to provide the service that women want. Doctors also discussed how these procedures do not go far enough in allowing them to treat their patients in a way they believe medically best for women. However, this chapter has shown there are differences in beliefs on how far home use of EMA should be taken. The majority of doctors are not keen for women to have an EMA without medical surveillance,

The next section of the chapter will go on to discuss a third aspect of the 1967 Abortion Act, a subject of much contestation amongst those working within the abortion service: conscientious objection. This section will discuss how this area continues my exploration of my participants' sense of a value conflict between their own definition of a good doctor compared to those of the past.

4.3 CONSCIENTIOUS OBJECTION

In line with the general theme that featured in commentaries about the macro-level, the law was discussed as 'outdated' or presented by participants as in some way inadequate or unhelpful. In this respect, what they told me appeared to fit with the discussion reported so far concerning the gap between the apparent presumptions of the law and the realities for those who provide abortion. Participants generally did not go so far as to entirely dismiss the idea there could be a legitimate 'conscientious objection' to abortion. Indeed, some made it clear they considered such an objection could be 'genuine' or 'deeply held'. Others expressed a view that conscientious objection should be given respect in some way. Few considered conscientious objection to abortion to be entirely morally untenable or to lie entirely outside the concerns of how abortion is provided and regulated. However, there was a strong perception that how the objection is currently understood or recognised creates problems for those who do, and want to, provide abortion.

These problems were discussed most obviously as practical ones, concerning how to organise an abortion service. In part, commentaries seemed to relate conscientious objection to a lack of recognition of abortion provision itself as an act of conscience, connected to an idea of being a 'good doctor' in a moral rather than a technical sense. My interpretation is that this has led to a view that conscientious objection should be in some way reassessed, given less weight and status. I now discuss this point about perceptions of abortion and 'conscience' through an account of participants' discussion of the macro-level. I first consider what participants had to say about the law 'on paper', and then about conscientious objection in practice, including where some did think the exercise of a right to object should be restricted.

4.3.1 CONSCIENTIOUS OBJECTION 'ON PAPER': A MATTER FOR GUIDELINES NOT LAW

The idea that the conscientious objection clause is outdated was notably apparent throughout the interviews. All participants said they believed that conscientious objection should not be written into the law. Instead, it should be taken out of the legal framework for abortion and dealt with differently, through medical guidelines. Overall, my participants seemed to be arguing for an approach that would, relatively, downgrade objection to abortion on the grounds

of conscience, and place greater emphasis on addressing the problems experienced by those who provide abortion. I suggest that making a case for addressing conscience through guidelines, not law, was one way this shift in emphasis was argued for.

Some doctors were concerned about the idea of abolishing conscientious objection to abortion entirely. As Lily put it, "it's important to recognise, yes, you are terminating a life, so I do understand the conscientious objection". Similarly, Daisy told me she believed that "doctors who do not feel able to sign the form should not be made to do so, for example, people with moral, religious or ethical objections to abortion do not have any part of it". However, while no-one I interviewed made a case against all and any formal recognition of conscientious objection, the most common case was to change how that recognition is enacted and what it might mean.

The most common way doctors discussed these issues was to indicate they wanted to in some way recognise that conscientious objection is important, but not so important as to warrant legal recognition. Mary thus said she believed that: "the guidance that's put out by the General Medical Council (GMC) is perfectly clear and it sort of copes with conscientious objection generally, so in my view, it would be much better if it wasn't in the law itself". Amy told me she also didn't think "it's necessary to be in the law". Like Mary, she told me other guidelines can address what needs to be addressed better:

> I do think it needs to be in comparable codes of practice, which it is. I mean one could argue that it needs to be a bit more meaningful in codes of practice, I think health care professionals do need to be able to opt-out of doing abortions if they have strong moral objections to it.

Indeed, Amy continued to make a positive case for the impact of a professional code for professional practice, rather than law. She said, "actually there are a whole series of things that doctors need to think about and health care professionals all need to engage more with the issue of conscientious objection in a practical way rather than in a legal and moral way".

Emily said she thought, "it is sort of understandable because although it's a medical treatment and I would like it to be treated like that, I know that it does come into many people's religious or moral or ethical or whatever beliefs". She continued, however, that the conscientious

objection clause, "probably doesn't need to be written into law, but maybe we need to have just a professional sort [of rule]". Elizabeth said: "I don't think it needs to be there in law because we have GMC guidance, and it's in GMC guidance", and Faith that she did not believe, "we should keep the conscience clause". Kelly also suggested that she did not "think [conscientious objection] necessarily has to be depicted in law; it could just be medical guidance".

Overall, then, there was a perception that conscientious abortion should be addressed through meso-level measures, not through legal recognition. In the interviews, I pursued discussion with participants about this aspect of the law further by talking with them about their experiences in their day-to-day work. I now turn to discuss what they had to say, emphasising how stronger arguments seemed to emerge from some participants about the need to downgrade the validation of objection for those working in abortion provision, and especially in obstetrics and gynaecology.

4.3.2 Conscientious Objection and the Practice of Abortion Provision

As I have noted so far, no-one interviewed made a general case that conscientious objection to abortion is merely invalid within the medical profession as a whole. However, as I now discuss through an account of participants' comments about their work, its validation was weak. Insofar as the legitimacy of conscientious objection was upheld by participants, it was to validate the need for good care for women. Doctors who agreed conscientious objection was a necessary part of the law believed this was the case to stop women seeing doctors who disagreed with abortion. There were also strong arguments made against its validity by some, with a case pressed that the approach that does invalidate objection to abortion should pervade areas of medical care that directly include abortion.

Some discussed their position as abortion providers in relation to doctors who will not provide abortions on the grounds of conscience. Faith said she did not think it is "good for women to be treated by doctors who have a conscientious objection to doing so". Georgia told me: "what you don't want to do is have people who do object against it being forced into a discussion with the woman where they are going to be very biased and try and lead them down the route of keeping it. That's not helpful to anybody".

These doctors seemed to be discussing what it means for them to be a 'good doctor'. Working in the abortion service was, for them, an essential part of being a good doctor. Having doctors provide abortion when they do not feel the same would be detrimental to women. As Kelly explained, "I think if we force people to take part in things that they have a moral objection to, then they won't do it to the best of their ability, and then women will just have poor care". Conscientious objection was in this way validated, but negatively, as a means to maintain the exclusion of those who will not be good doctors for women from their care.

Some also recalled times when their abortion service was affected because other healthcare professionals did not want to work on abortion lists. Those who discussed their experience this way strongly expressed a view that it is not acceptable. During Abigail's interview, for example, she stated "it does become difficult with theatre staff, you know, they don't have to do the abortion list". She continued by explaining that staff refusing to work in the abortion service, "encourages people to make judgments about other people, it encourages stigma" because "you know they're not doing the abortion". For this reason, Abigail told me, she has in the past told staffing nurses: you can't provide me with that member of the team, fine, we'll make do. I'll mop the floor in between. People don't like that, if the surgeon says that.

Abigail's suggestion that she would "mop floors" acts to draw a moral line between those committed to providing the service for their patients, as she believed a doctor should be, and those who refuse to participate. Melissa similarly contrasted the moral outlook of those who provide and those who refuse:

> The way nurses used to say, "I don't want to look after that woman," that's not good enough, you know, because that's abandoning a patient and a woman in need and I think that's really bad, and there's a lot of that going on all over the NHS of people, you know, being able to be morally in judgment of patients.

The discussions of conscientious objection as a problem for providers and the service was also expressed by doctors recalling times when it affected other medical staff who also work on abortion lists. There was a concern that staff were not aware that the law states someone with conscientious objection must legally perform an abortion if the women's life is at immediate risk. Mary expressed concern for obstetricians and gynaecologists refusing to help a woman

who needed urgent medical attention as the result of a complication while having an abortion. Mary recalled a time where:

> Seven or eight years ago … a woman who was bleeding very heavily and I needed help in the day surgery unit, and so the on-call gynaecologist was called to come and assist me, and he put his head around the door and said, "I don't do this kind of work".

This caused frustration for Mary, who believed she was providing a safe service for women who had unfortunately experienced a medical complication that needed resolving as soon as possible. Once again Mary made a distinction between her job and other doctors who do not work within the abortion service and would refuse to provide a service for women, discussing her work as part of the reason she is a good doctor.

This discussion of the morality of abortion provision and what objection should mean in practice took one particularly notable form: where participants discussed the role of doctors who work within obstetrics and gynaecology. In this case, the strongest argument was made by doctors who work within this specialty that conscientious objection had no place within any specialties centred around reproductive health, and therefore should not be validated. Beliefs about whether doctors working within these two specialities should be able to conscientiously object was divided by which specialty the doctor worked in, with those participants working in SRH believing that all doctors should be allowed to conscientiously object. These participants were more likely to believe that doctors should be able to work within obstetrics and gynaecology and not provide abortions. Doctors who work in SRH considered abortion work to be a small part of obstetrics and gynaecology and that there were many other aspects of the specialty that doctors could be involved in which are just as important.

However, doctors who worked in obstetrics and gynaecology believed that choosing to work in an area of medicine directly linked to women's reproductive healthcare, like obstetrics and gynaecology, should mean that all doctors provide abortions. For example, Abigail said that she would find it difficult working as a Prison Officer because she "might not like the way prisoners are treated, and that is a matter of conscience for me". She continued, that she "can't decide to go and work in prison and then say I really don't like it, but can I still be paid to sit around and moan about it". She compared this analogy to doctors working in obstetrics and gynaecology who do not provide abortions on the grounds of conscientious objection: "we

make choices, and I think if it's part of the job and you don't like it then go and get another job really".

Abigail's point that doctors who conscientiously object and work within either specialty should 'go and get another job' was reiterated by Faith and Rebecca. They explain that they believe doctors who specialise in obstetrics and gynaecology or SRH should re-evaluate the speciality they work in. For Faith, "there is an argument that if you want to do obstetrics and gynaecology, you are probably not fitted for it if you don't see that a woman needs an abortion to control her fertility". Rebecca questioned, "why you have chosen that specialty if you are not happy to be involved in every part of termination care". However, Rebecca realised this was a complex issue. She suggested that not all doctors need to be involved in all aspects of termination of pregnancy care and that actually, "I don't necessarily think everyone should operate up to 24 weeks". Rebecca continued that she felt "if you're not willing to be actively involved in directly providing or care of women that are undergoing termination" then those doctors should not work within either specialty.

Overall, conversations with doctors about conscientious objection suggest the current legal framework is a problem for them, they welcome change that would recognise some of the practical difficulties of providing abortions. The conscientious objection clause was almost always discussed negatively by participants who believed the only reason the clause is helpful is to ensure women are not being seen and treated by doctors who have a negative opinion on abortion. Doctors expressed a feeling of helplessness and frustration when discussing the impact this clause has on their work, especially when recalling conversations they have had with medical professionals who have refused to participate in emergency surgeries or those who have refused to be in the theatre while an abortion is taking place.

This chapter will now focus on a second law which affects the work of abortion doctors today and is considered a source of tension. I set out in Chapter One the aspects of the criminal law that have been subject to contest, which the next part of this chapter now addresses.

4.4 CRIMINALITY OF ABORTION

In my interviews with doctors, one part of the interview schedule focused on the criminality of abortion. I read out the following text from the 1861 Offences Against the Person Act: "whoever unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour". Later in the interview, I turned to discuss how claims had been made that focus on criminal law should be brought to bear as a result of the recent media campaigns on sex-selection. In what follows, I discuss my participants comments about OAPA as part of the abortion law, and about the recent events associated with it, through the efforts to bring prosecutions against doctors.

4.4.1 ARCHAIC LAWS

As noted previously, those I interviewed had most to say about the 1967 Abortion Act. The comments about OAPA were less extensive. Indeed, some seemed to have only a vague understanding of this part of the law, with participants not knowing that the law even exists today. Daisy, for example, asked "is that a current one?" when asked her opinion on OAPA. Kelly seemed to think that this law might already have been repealed when she asked me "I think things have changed haven't they?". The dominant overall theme, however, was of the gulf between present needs and what the content of medical care should be, and nineteenth century law.

Two doctors believed that the OAPA was a necessary law to help protect women from non-medical professionals but wrongly believed that the law did not apply to medical practitioners. For example, Chloe thought that this law was a good piece of legislation as "there should be something legally that's not about medical professionals, that is about people who are assaulting others".

However, the majority of participants believed this aspect of the law was no longer necessary for example, Christine said, "We are a long way from the 1800s". Samantha told me the precepts of the criminal law were "in conflict with human rights". Samantha talked of the law as not allowing "women the choice of what happens to their body". She continued "I think that in general, we believe that women should have the right to determine their own reproductive decisions, so I think therefore it shouldn't be a criminal offence". Kelly said there is a

contradiction between the criminal law and present norms since "we live in a society big on autonomy", so the "law needs to be changed".

Jessica commented that by reforming British abortion law to repeal the 1861 OAPA, abortion "would become part of routine healthcare". Repealing section 58 and 59 of OAPA has formed part of a campaign to decriminalise abortion. A sub-set of interviewees were actively involved in campaigning for the decriminalisation of abortion, and they were very keen for abortion to be taken out of criminal law and placed under medical guidelines. For example, Lauren believed "decriminalising abortion should be the way forward". Abigail hoped that changing abortion from criminal law and placing it within medical guidelines "is going to bring a bit more common sense … some legal obstacles which take longer to get around" and she was hoping that "those things will be addressed rather than just sticking to what is known already". This was reiterated by Jessica, who said "it would be better if this was decriminalised and the main concern for doctors was about woman's safety rather than the legal aspects".

The idea about outdated values was also communicated specifically in participants' discussion of doctors and the medical profession. Some participants at least, notably, connected the 1861 Act with patriarchal and self-interested values. Christine described the law as being "male-centric … not in women's best interest" and continued discussing the outdatedness of the law, explaining that she believed laws "in those days were written by men to protect interests of professional money-making men … protecting doctors and protecting doctors' businesses". Some made comments about the way in which the positioning of abortion as part of the criminal law had important consequences for present-day practices. It was not simply that an outdated piece of legislation regulates abortion, but that this form of law influenced doctors work in important ways, where doctors are also vulnerable to the threat of criminal prosecution, as discussed in the next section of this chapter.

Mark drew attention to the exceptionality surrounding the regulation of doctors who provide abortion as a result. It is, "the only branch of medicine where if you don't get the paperwork right, you're breaking the law" he said. Mary was very concerned when she told me that doctors "are humans" and continued that "they do make mistakes. So as long as abortion is in criminal law, we are going to have that, unfortunately". Here Mark and Mary discuss a sense of vulnerability that doctors working in the abortion service today feel when thinking about the consequences of providing abortions. On the one hand, doctors are perceived as powerful

because of the law on abortion, but here doctors are showing that in fact there is a sense of fear that a genuine mistake can result in them facing criminal prosecution.

The 1861 OAPA is not, for doctors working in the abortion service today, an example of the medical profession intervening in people's lives as a "quest for monopoly rights over the body" (Arnold, 1989 in McGuinness and Thomson, 2015: 180) as much of the socio-legal literature has previously suggested. Instead, the interviews with participants fits in line with Lee, Sheldon and Macvarish (2018) research that doctors working today view OAPA as a source of "fear and uncertainty" (p. 31). The experiences of fear and uncertainty that doctors working in the abortion service today felt will further be addressed through discussions on the sex-selection debate in the next section of the chapter. Although my participants' comments on the 1861 Act simply as a piece of legislation were relatively limited, they had a great deal more to say about events surrounding the discussion of how the OAPA impacts the service and the threats associated with the sex-selection debate as I now discuss.

4.4.2 Sex-Selection and its Aftermath

During the interviews I showed participants two national newspaper headlines, as follows.

> Abortion investigation: doctors filmed agreeing to abortions' no questions asked' women are being granted abortions based on the sex of their unborn baby.
>
> Doctors admitted they were prepared to falsify paperwork to arrange the abortion even though it was illegal.

These headlines were taken from *The Daily Telegraph* (February 2012) after a media investigation, where an undercover reporter entered abortion clinics and secretly recorded the consultation with doctors. As Chapter Two has shown, as part of the consultation, the pregnant woman discussed the gender of the foetus with the doctors. Journalists then reported certain parts of the consultations in the newspaper. The newspaper articles sparked debate on the use of sex-selection abortion in Britain, where three doctors were accused of providing illegal abortions to women. The second headline outlined above focuses on a claim which was made

in national newspapers, where doctors were accused of breaking the law by pre-signing HSA1 forms, after an investigation by the CQC.

I now discuss each of these aspects and my participants' responses, starting with a discussion on sex-selection and then pre-signing. The discussion about these headlines ranged across doctors' views about the media reporting the ensuing scandal and doctors caught up in it about the ethics of sex-selection abortion itself and them onto a subsequent episode of investigation of the abortion service which focused on the CQC investigating the paperwork used by abortion clinics as part of their processes for authorising abortion. As I discuss below, this focused specifically on the question of so-called "pre-signing abortion" forms. I now discuss each of these aspects and my participants' responses in turn.

Responses to Sex-Selection

Participants' responses to the sex-selection debate were very divided, with some doctors expressing sympathy for doctors caught in the scandal. In contrast, other doctors condemned abortions on the grounds of foetal gender. All participants were discussing sex-selection in relation to what it means to be a good doctor. Discussions on sex-selection are linked to the macro-level as doctors were accused of breaking the conditions of the 1967 Abortion Act. Doctors were asked their beliefs on the issue of lawbreaking. In line with the theme of comments on the macro-level, sex-selection was yet another way some participants presented the law as inadequate and outdated. Some doctors believed that abortion on the grounds of foetal gender was illegal under the 1967 Abortion Act while other participants told me that the law does not prohibit abortion on these grounds.

Opinion Differentiation on the Sex-Selection Episode

Even though doctors had divided beliefs on the debate, all of them described the sex-selection debate as a problem. As this section will show participants responses to the sex-selection claims were presented as a moral problem and a legal problem.

The sex-selection scandal was described as "life-changing" by Amy because until this incident, she "thought the Abortion Act worked well for doctors and women". She continued, it was only after the articles were published that she realised, "while abortion is still in the criminal code

this kind of thing can always happen". Similarly, Eva said the sex-selection debate: "really woke me up politically to the issue about the legality, you know, abortion being a criminal offence and a weapon that gives anti-choice people to beat doctors with". Both Amy and Eva described the sex-selection debate as "eye-opening" – and while not all of my interviewees communicated such a strong response, the discussions were linked to the values of doctors.

Participants' responses to questions on sex-selection varied most strongly around opinions on whether abortion on the grounds of gender were right or wrong. Some doctors had strong beliefs about whether abortion on the grounds of gender is illegal, and doctors who provide abortions for these reasons are working outside of the law. For example, Mary did not "think that is the spirit of the law that was intended really". Nicholas also expressed a negative opinion of doctors who he believed had provided abortions for these reasons, saying: "I think that's absolutely horrible. I thought that was really shocking … it is forbidden to do the gender diagnosis in the services I've worked, and I think that should not be happening". Through comparing his experiences with that of doctors accused of a crime in *The Daily Telegraph*, Nicholas suggested that not revealing the gender of the foetus is the right thing to do, providing abortion on the grounds of foetal gender is morally wrong. Samantha also spoke about "feeling very uncomfortable" after hearing about the reports of the sex-selection in the media. This was because she believed "termination purely on the basis of sex-selection is, you know, is wrong", though she told me that she had never "personally encountered" someone requesting an abortion on the basis of the gender of the foetus. The belief that sex-selection abortions are wrong was also echoed by Joshua, who told me "I personally would feel uncomfortable about termination of pregnancy on the grounds of sex". The fact that some doctors find providing abortions on the grounds of sex-selection 'uncomfortable' and believe the law does not allow for abortions on the grounds of foetal gender, indicates that the current abortion law is open to interpretation by doctors, where doctors can use their judgement to decide which abortions should be considered legal and illegal.

For some doctors, questioning the morality of sex-selective abortions went beyond feeling uncomfortable. Two doctors expressed a concern that amending abortion law could potentially mean that abortions on the grounds of gender could be legal, which they did not want to happen. For example, Mary believed "it should be a criminal activity to try and limit sex-selection really, and it should not be included in any development in the abortion law" because as she continued "that's one step too far". This was also expressed by Zoe, who said she didn't think

sex-selection "should be a reason in any way". The claims made by these doctors that abortions on this ground is morally wrong and should be kept in some form of criminal law is interesting, as when discussing different elements of the 1967 Abortion Act there was an overwhelming belief that the current law was outdated and a barrier for doctors. However, when talking about these specific headlines, doctors were not comfortable with providing abortions they felt were wrong; some were keen to ensure this type of abortion remained criminal. This implies that some doctors do still hold a moral judgement on which abortions should be allowed to take place legally.

Other doctors believed that it is not so straightforward to say that sex-selection is wrong and therefore should be illegal. For example, Bridget said, "anyone who's been involved in any kind of abortion care knows that there is never a decision made on one fact alone". This was reiterated by Karen who told me that from her understanding: "most people who are requesting an abortion where gender may come into it, it's actually not the sole factor, actually, if women are requesting it, then the woman is actually at risk of honour-based violence".

Other doctors also addressed Karen's belief that most patients' decisions were not taken on one factor alone. Chloe said that while she personally doesn't "approve of any of that" when asked about sex-selection and said she would "find it very difficult" if she was asked to provide an abortion for this reason. However, she questioned what she would do if she "had a patient in front of me saying 'I don't want a girl, and I don't want a girl because my husband will beat me up'".

Some doctors discussed sex-selection with regard to the law. For example, Rebecca told me that she "wouldn't personally feel comfortable with that" when discussing sex-selection abortions, but "the way that the 1967 Act and the HSA1 is worded, actually if it would cause a woman distress to have a baby of a certain sex, then that would be allowable under the 1967 Act because it's so open to interpretation". In addition, Jessica told me that "it doesn't really matter" a woman wants to have an abortion because "clause c says that continuation of pregnancy would cause more harm to the woman than abortion". This was her way of justifying providing a termination of pregnancy on these grounds. Jessica recognised that "there are concerns about sex-selection", but she saw these as no different to people who "don't have babies because they don't like their partner or because they don't want another baby erm I don't think I think that's such a red herring". In addition, Bridget told me that she does "not see an

issue with" sex-selection as long as she is "satisfied that it's going to affect that woman in some way".

PRE-SIGNING ABORTION NOTIFICATION FORMS

As explained in Chapter Two, since the Abortion Act was introduced doctors have been adapting "their administrative procedures" (Rowlands, 2013: 124) in order to provide "safer and higher quality services with better access" (Rowlands, 2013: 124). One of the adaptations providers have made has been to allow for a "degree of flexibility in signing the HSA1 form" to reduce waiting times and improve the safety and quality of the service (Rowlands, 2013: 124). As Chapter Two outlined after the sex-selection scandal, the Secretary of State for Health ordered the CQC to inspect abortion clinics and, in March 2012 the CQC were ordered to inspect "all 249 English abortion services" with the aim of focusing on the use of HSA1 forms (Rowlands, 2013: 124).

As all abortion services were inspected, all participants had first-hand experience of the CQC inspections, meaning that unlike with the responses to the questions asked regarding sex-selection, where some doctors appeared not to know the events that took place, participants were all discussing their experiences. Four of my participants were working within trusts that were using pre-signed forms at the time of the inspection. The GMC investigated these doctors for two years. During this investigation, the threat of losing their medical licence and fear of criminal prosecution was very real for these doctors. Mary was one of the doctors who was found to have pre-signed the abortion notification forms. She described the process in a way that rationalised the reasoning behind this decision:

> we'd sign a bunch of forms, so that was an equal number of everybody's signature and then, you know, the other--, the doctor in the clinic would provide the other signature … We were just going on the --, you know, relying on our colleague who did see the patient to make sure that they were vetting things properly.

Karen was also accused of pre-signing HSA1 forms. She explained that pre-signing in her service was a "way of working around" the fact that "there were no doctors [laughs nervously]

who wanted to work in the service". Karen continued that doctors working in her clinic "felt that we were doing the right thing" and were not aware that it was "inappropriate or wrong". Participants often expressed sympathy towards doctors caught in the middle of the pre-signing scandal. Doctors were sympathetic because they believed doctors were trying to run an "effective service". For example, Lauren said, the doctors accused of pre-signing HSA1 forms were "just people desperately trying to run an efficient service for women". She continued that she believed "it's a completely reasonable thing to do". The idea that pre-signing is 'reasonable' was also addressed by Christine, who told me that it is especially challenging to run a service when a doctor is away because their other colleagues will not sign HSA1 forms:

> You can't actually run your service with one signature, and if you know that the doctor, your colleague assesses people properly then personally I would have no problem with leaving some pre-signed forms for a trusted colleague to put her signature when she has seen that person.

Pre-signing forms as a means to overcome a practical problem was also raised by Mark, who said he thinks the doctors had been "caught out by the complexities of the system". He believed doctors were only pre-signing because of the "pressures of the system" and not because they were trying to flaunt the law. Lilly also spoke to me about the pressure signing the HSA1 form places on doctors by saying "all that paperwork makes an already stretched service unsustainable".

Another way participants expressed sympathy for those caught in the investigation was by suggesting that those doctors were acting within the law. For example, Samantha believed doctors were acting within the law because they "felt that they were acting in good faith". She believed they were acting in good faith, as the law requires because it was "their colleagues who would see women", colleagues who she believed "they trusted implicitly to provide what was within the law". This point was reiterated by Clare, who said she believed "most doctors who were pre-signing it were based on good faith". She believed that doctors were signing the HSA1 forms in good faith because they trusted their colleagues and believed that "when seen in clinic they would only be put forward for an abortion if they, you know, met the criteria". Amy told me that the "doctors who did it, they did not know that they were breaking the law, they weren't breaking the law, and they did it in good faith because when doctors pre-signed you trusted your colleagues, you didn't just pre-sign for anyone".

Elizabeth recalled times where she "often provides second signatures" even though "she has not seen the patient". She said that she is given "a stack of forms to sign at the end of clinic [and she] signs the forms in good faith, knowing full well that [her] conscience is clear as to why [she's] signing that form". Elizabeth believed that she is right to sign these forms without seeing them because she knows "the process they've been through…how they've come to be there, who they've seen already".

All four doctors interviewed who were accused of breaking the law by pre-signing HSA1 forms believed that the current legal framework was outdated and not in line with the values of doctors today. Chloe explained that she believed "the regulations around the Abortion Act are quite hidden; they aren't really that clear". She continued that the findings of the 2007 Science and Technology Committee "made it clear that lots and lots of services were doing what we were doing". This put her in what she called "a false sense of security" that "if we were doing it, and lots of other people are doing it, then it can't be wrong". There was a period of over two years from when Karen was reported to the GMC for pre-signing HSA1 forms to being notified that she will not face a Fitness to Practice enquiry. If she was subjected to this enquiry, she could have been "struck off" and lost her license to practice medicine. This was an extremely stressful and traumatic experience for abortion providers that were just trying to run an effective and efficient service that did "not compromise the patient safety". The very real threat of prosecution that doctors faced through the pre-signing scandal and the CQC inspections was once again another reason doctors working in the service today felt the current legal framework was outdated and not in line with the values of doctors working in the abortion service today.

4.5 Discussion: Doctors as resisters of medicalisation?

There is a rejection of what have been taken as key dimensions of the medicalisation of abortion, primarily the formality of needing two signatures to authorise a decision that an abortion can take place. However, this rejection of medicalisation is not without ambiguities. The professional identity of this group of doctors is formed, in part, around rejecting this medical power and oversight of abortion decision making, and sometimes this is presented explicitly as a contrasting value set to that given to the medical profession by the law. It is very important to note that the most common theme in the interviews was the identification of the authority given to doctors by law as a problem, since it is considered a barrier to being a good

doctor. As part of this claim doctors often discussed making abortion ‘like any other medical procedure,’ a phrase often used by participants to justify ‘normalising’ abortion by allowing women to give consent to a procedure. The idea of normalising abortion by allowing women to give consent to a procedure instead of two doctors agreeing an abortion can legally take place is interesting when investigating the medicalisation of abortion, as it would suggest that participants want to give up an element of medical control that they have been assigned by the 1967 Abortion Act. As evident from my research, the most prominent reason doctors rejected medicalisation on the macro-level was because of the conflict between bodily autonomy and the legal framework. This is a remarkable shift and would suggest that on the macro level doctors valued patient autonomy and are less paternalistic than traditional socio-legal scholars have argued. This would indicate that the values of these medical professionals fit more in line with those described by new professionalism theorists, as outlined in Chapter Two. However, this research has found a significant difference between where the patient-centred value originated. New professionalism theorists believe that the reason for the change in values from authoritative to patient-centred is because of the changing role of the NHS, through the introduction of NHS trusts and managers, who are encouraging doctors to change their values to become more patient-centred. Instead, these doctors did not want to change the service because the way that the NHS operates has changed, because, more often than not these doctors are working outside of NHS settings. Instead of being guided by middle level management these doctors now see themselves as drivers of change, where they are creating legal methods to work within the law, while providing a service they believe women want.

The parity given to nurses and doctors in regard to technical skill and role in provision of most abortions is also striking, and at odds with some ideas from existing literature about medical power. These doctors were very keen to express their discontent with nurses being unable to provide EMA's to women because of a legal formality rather than because of any clinical reason. This legal restriction has resulted in these doctors trying to find a way to navigate the tension between the law and what they considered to be best practice. Doctors still being responsible for the abortion procedure, even though they are not the health professional who sees the woman was a major source of tension for these participants reflecting, Lee, Sheldon and Macvarish (2018) conclusion that the law "undermines their medical professionalism" (Lee, Sheldon and Macvarish, 2018: 29).

Yet the role of the doctor was not simply rejected and presented as no longer necessary. Instead, there was evidence of a redefinition of the role of the doctor, what might be called informal medicalisation. The most explicit split in opinion about the law was around the issues raised by sex-selection. Here there was evidence of some participants wanting to exert control over access to abortion and raised questions about the acceptance of the criminalisation of both doctors and women, in cases of 'morally unacceptable' abortions. For example, some participants openly said they felt a sense of discomfort at the thought of providing an abortion on the grounds of gender. Suggesting that there are some cases where providing abortion needs to have more than a simple patient consent form, and doctors should use their judgement before a pregnancy can be terminated. This indicates that the values of doctors who provide abortion are complex and sometimes seemingly contradictory. However, this supports Halfmann's contention of medicalisation as a bi-directional process, whereby some of the values of doctors on the macro level support the medicalisation of abortion, whereas at other times the values of doctors who provide abortion seem to be in opposition to the medicalisation of abortion.

Additionally, we can see aspects in the macro level where doctors quite strongly advocate for their involvement in services. Some participants presented the doctor role as important for a positive experience of abortion, and importance attached to ways of recognising the conscientious act of working as an abortion provider. For example, when discussing conscientious objection some participants believed their involvement in the service was vital because they were providing a standard of care to women that other doctors may not.

Overall, the participants in my study expressed concern for the role that the law has ascribed doctors and expressed this concern by telling me that their values are different from those working in the 1960s when the law was enacted. This is also in line with the evidence from research by Lee, Sheldon and Macvarish (2018) who argued that the law "was presented as a force that hampers the exercise of clinical judgement, and the ability to act as a 'good doctor'" (p.29). By rejecting this role, doctors also reject the form of medicalisation where they have been given the power to make decisions on behalf of their patients. While this rejection of medical power was guided by discussions on patient-centred care, the drive to normalise abortion can be seen as an attempt to further medicalise abortion, through a drive to 'make abortion like any other medical procedure.'

4.6 CONCLUSION

To conclude, this chapter has considered the commentaries from participants which relate to the macro-level, particularly the legal framework which covers abortion practice. Overall, the main claims made throughout discussions on each of the aspects outlined in this chapter are that doctors working in the abortion service today have different values from those doctors working during the times the laws were written. This chapter has discussed the ways in which doctors working today now consider these laws to be outdated and have argued that abortion laws need amending. It has evaluated how doctors expressed a concern that the current legislation is getting in the way and leaving them unable to provide an abortion service they believe is best. This fits in line with the existing literature discussed throughout Chapter Two which has evaluated some of the tensions between the medicalisation of abortion, through the 1967 Abortion Act, and the development in the practice of providing abortions.

Throughout this chapter we can see how participants have given meaning to their work through discussions on the limitations of abortion law, and their belief that their values as doctors have changed since the legalisation of abortion in the 1960s. Participants discussed this change in values through conversations which were framed about how the law is affecting a patient's medical needs, what it means to be a 'good doctor' working in the abortion service today and as a practical problem where doctors have causing participants to argue strongly for reform. Doctors interviewed believed abortion should be treated like 'any other area of healthcare' and the current legislation prevents this by separating abortion from mainstream healthcare. Participants were unanimous in believing that abolishing the 1861 OAPA and the Abortion Act of 1967 would ultimately normalise abortion services and in doing so this would partially demedicalise abortion so that they no longer have the decisional powers ascribed to them by the legislation.

However, this chapter has shown that there is also a tension between the belief that doctors should not be involved in the decision-making process when they are faced with cases they believe are 'unethical'. Discussions on sex-selection have shown that when doctors are responding to accusations of unethical practices, they can also look upon the law as a protection. For example, as Lauren said "on the whole, it has served us well for a long time. It has been very well-phrased in terms of allowing a degree of flexibility as to why you do it".

This would suggest that the medicalisation of abortion is a complex issue and even when there are very clear examples of doctors wanting to partially demedicalise abortion. Through amending the law to diminish their role in making decisions, there are instances of the bi-directionality of medicalisation. Where doctors are also using the legislative framework, and the medicalisation of abortion, as a way of protecting themselves. The next chapter continues the discussion on the bi-directionality of the medicalisation of abortion through an investigation of what it means to normalise abortion in practice and how tensions appear when discussing normalising abortion in relation to where abortions should be provided.

CHAPTER 5

THE MESO-LEVEL: NORMALISING MEDICALISATION

5.1 INTRODUCTION

This chapter continues to explore tensions in the medicalisation of abortion suggested by the conflicted or ambiguous aspects of the interviews discussed so far, focusing on the meso-level. As previous chapters outlined, the meso-level describes how the provision of abortion has been shaped since law reform in 1967. Chapter One discussed ongoing debates that influence how the service is run. I then outlined in Chapter Three, how – of all these areas of debate and policymaking – it was the setting of services, that is, where a doctor works providing abortions, that emerged as the most dominant theme from my analysis of the interview data. The current chapter turns to highlight the bi-directionality of medicalisation as it carries on the discussion from Chapter Four. Chapter Four showed that all participants agree abortion laws are outdated and need to change. The legal framework makes abortion procedure and service 'abnormal' in terms of the wider areas of medicine. Abortion is explicitly different from other areas of medicine because of the additional legal framework, and consequently participants openly resist the role ascribed to them by the law.

This chapter investigates the medicalisation of abortion by evaluating possible tensions around the meaning attached to the 'normalisation of abortion'. Purcell et al. (2020) note that "a shift towards normalising abortion is evident in a nationwide, multi-organisation campaign for full decriminalisation of abortion" (p. 1349). Literature (Millar, 2020) also associates normalising abortion with one way of reducing the stigma service users feel is associated with having an abortion. Purcell et al. (2020) discuss the impact of normalising abortion in Britain through the lens of the language used by service users. However, literature such as Maxwell et al. (2021) argues that "health professionals can play a key role in normalising abortion, through the ways in which they frame their work and present abortion to women they treat" (p. 32).

When analysing interview data on the meso-level, a common theme emerged from participants' discussion of aspects of clinical practice and how they saw the future running of the service. This emerged during conversations about where doctors thought abortions should be performed. Participants often formed meaning for their work through discussions about where

abortion services should be provided. The normalising of abortion, as discussed by participants, was referred to in conversations about wanting to make abortion 'like any other medical procedure'. However, as this chapter will show, a tension emerged when doctors began to discuss the practical side of the abortion service. This tension was evident through discussions about the extent to which doctors discussed the merits and demerits of abortion provision in non-NHS settings.

The abortion setting was, in this way, a prominent element in discussions among doctors as influencing their work and their assessment of how the service should work; it is therefore the focus of this chapter. The abortion setting made the relationship between the NHS and the independent sector a theme of considerable significance; more than I initially anticipated. This chapter continues to explore the bi-directionality of medicalisation, showing that doctors expressed concerns about forms of demedicalisation in a practical sense, often mentioned in conversations about what it means to 'normalise' abortion services.

When discussing the legal framework for abortion, doctors were keen to demedicalise abortion through distancing themselves from the values ascribed to them by the law, whereas, when discussing the service provision on the meso-level, normalising abortion was seen as at odds with demedicalisation. This concern stems from a belief that the NHS has better facilities and services for women and that, as part of normalising abortion, services should be provided within NHS settings, as this chapter will show.

As I have explained, the interview schedule was standardised: the same questions were asked to all participants regardless of whether they worked in an NHS or a non-NHS setting. As part of the interview, participants were never directly asked about their views or judgements about any sector. Instead, participants were asked questions on services they provide, their perceptions of these services and the future of the abortion service as a whole. All comments made by participants on the running of NHS and independent sector termination of pregnancy services were spontaneous as opposed to prompted. Through analysing the interview data, four themes emerged as key points of discussion when the sector became a dominant topic for participants, and I discuss these now in turn.

The first section of the chapter discusses some general comments made by doctors, where twenty-eight doctors appeared to give meaning to the setting in which an abortion takes place

through discussions on how they perceived the role of the independent sector and the NHS. The second and third section of this chapter examines two key issues raised by participants as important to clinical practice. The first was framed as a problem by thirty-two participants who considered the roles of the NHS and the independent sector through a conversation on the management of medically complex abortion cases. The second aspect of clinical practice raised by thirty-three participants as a problem was concern about the process of women having second-trimester surgical abortions. Finally, the chapter discusses the training of abortion providers. During the interview, thirty-nine participants expressed their belief that there is a problem with how training on abortion is managed and run. The leading cause for this concern was the number of abortions presently performed outside of NHS settings, which was discussed as a problem for the 'normalisation of abortion' since there is a lack of opportunity for students to receive training.

Throughout this chapter, I draw attention to a new way of exploring the medicalisation of abortion: through the lens of what doctors suggest it means to normalise abortion. Overall, claims made by participants on complex cases, second-trimester surgical abortion and the training were predominantly building on an argument that to normalise abortion, services should be provided within NHS settings by NHS providers. However, as this chapter will show, tensions appear when participants begin to discuss the practicality of having all abortions provided within NHS settings.

5.2 Perceptions of the Independent Sector

How the independent sector is perceived is important to understanding the normalisation of abortion. As this section will show, doctors who work within the NHS – either solely or partially – often discussed the independent sector in relation to how the service was commissioned outside of the NHS. Their accounts can be considered as existing on a spectrum: general comments on how the abortion service progressed in the independent sector are at one end, whereas at the other end are negative criticisms, often using language associated with anti-abortion groups, that describe a difference in values between doctors who work in each sector.

5.2.1 General Commentary on the Role of the Independent Sector

The most general view held by participants was best outlined by Joshua when he told me that "there has been a progressive move of abortion care out of the NHS". Joshua is referring to the history of how the abortion service grew once it was legalised in 1967. The history of the service was also brought up in the interview with Kelly, who told me: "the independent sector jumped in quite early to try and deal with the demand, which patently the NHS wasn't coping with". While both participants' comments can be considered as general statements about the independent sector, they are formed in a specific way: they imply the NHS was not given the time and opportunity to provide the service within an NHS setting.

Kelly continued by telling me that the independent sector was established too soon and that "setting up these big organisations and doing more than half the abortions … has serious issues". Chapter One reviewed how the independent sector was created to provide an accessible service for women when the NHS were unable to provide a service. However, it appears that Kelly was unaware of this historical aim of the service, she felt the problems the service faces today result from the split between the independent sector and the NHS service in the 1960s.

Participants almost always described the split of the services out of the NHS in a negative way. For example, Vanessa told me that abortion provision has "all but disappeared" in the NHS. Vanessa believed the reason the abortion service is not provided in NHS settings is that "it's been farmed out to the independent provider sector". The language used by Vanessa has a negative tone, it implies the NHS should provide the work being undertaken in the independent sector. 'Farming out' abortion provision was also discussed in Faith's interview, where she told me there are implications "if you start farming this out in this way" when referring to the independent sector. While Faith thought it was "wonderful that the private sector has virtually disappeared as far as abortion was concerned", she expressed a growing concern for the number of abortions performed outside of an NHS setting. Faith continued by telling me that she thought the independent sector "works pretty well" but that "it's gone too far". Faith appears to acknowledge there is no clinical concern with the standard of care provided by non-NHS settings. Instead, what appeared to surface was a concern about maintaining medical oversight: the belief that providing abortions in the independent sector harms the service purely because abortions are not provided within NHS settings.

Other doctors shared Faith's view about the number of abortions performed outside of the NHS. For example, Rebecca said: "it's a difficult situation at the moment because there really isn't a role for you to work in termination as a doctor unless you leave the NHS and work for an independent service provider". Continuing the discussion, she told me that "even though you're a SRH consultant, you can't do it [provide abortions] in most areas". She believed this needed to change "urgently" and would "ideally like to do it as part of her consultant role". The inability to provide abortions within NHS settings was also discussed by Christine, who told me she had "about four or five colleagues who used to do terminations". When I asked a follow-up question on why these colleagues no longer work providing abortions, she said: "it was tendered out and taken away from the hospital and given to [the independent sector]". Unlike her, these colleagues work full-time in the NHS. As a result, she explained: "it's not that they have chosen not to [provide abortions] but the service has been taken away from them as providers".

The language used by both Rebecca and Christine is similar to that described above, where participants seem to suggest there is an inability to provide a service within the NHS. Yet some doctors would provide an abortion service within the NHS if they were given the opportunity. Still, they are currently unable to because it has been "given" to outside organisations. It is here we find a way that doctors have formed an argument to bring abortion into the NHS setting, as a way of normalising the abortion service. These conversations highlighted the belief that abortion should be normalised through the setting in which abortions are provided was not based on a clinical concern for patients. Instead, it was to afford NHS doctors a greater role in the abortion service.

The idea of NHS doctors playing a larger role in the service is striking when investigating the fluidity of the medicalisation of abortion: participants argue for an increasingly medicalised abortion service where women would be required to travel to NHS hospitals for treatment. The idea of NHS doctors having a larger role in the service is noteworthy when compared to comments made by doctors when discussing the macro-level. Doctors often discussed the laws governing abortion as outdated because they restricted women's choices. As explained in Chapter Four, doctors were determined to instigate changes to demedicalise abortion in terms of the decisional power that doctors have, through allowing women to be the decision-makers and to decide where their abortion should take place.

However, when abortion is discussed on a practical level through conversations on clinical practice, the argument to demedicalise abortion was not presented clearly, as in the previous chapter. Instead, Rebecca and Christine here imply the service would be better if NHS doctors provided abortion in an NHS setting for reasons that are not clinical. The differences between the two sectors were also described by Eva, who when comparing her experiences of working in both the independent sector and NHS said: "it is a bizarre setup … the way we currently run the service in the UK whereby its NHS funded but not in NHS hospitals is negative".
The idea that women should be seen in the NHS is interesting, as during her interview Eva compared her personal experiences of providing abortions in the independent sector and the NHS. She told me that one differences is "in the clinic, it is an accepted and essential role of the service … and abortion is still considered a central function of the system". In direct comparison, Eva told me that from her experiences, "in the hospital … it definitely feels like it's a different service and it's maybe at odds sometimes with the service we provide". She concluded her comparison by telling me that "in the clinic, it feels more integral and part of our role, and in the hospital, it feels like something that we're being asked to do additionally". Eva believed it was better for women to be seen in the NHS, even though from her own experiences she felt like her work providing terminations in NHS hospitals was "at odds" with her other work there. She spoke positively about the work in the independent sector and the service they provide. However, still, she told me the current relationship between the NHS and independent sector providers is 'bizarre' and 'negative'.

The reasoning behind providing abortion within the NHS rather than in any other setting was to normalise abortion services through maintaining medical oversight of the services. However, even though doctors who work within the NHS try to gain more influence over abortion by placing it within an NHS setting, they are not motivated by wanting to gain further control over abortion as literature by Zola (1972), and Freidson (1970) argues.

Instead, doctors like Rebecca and Christine believe that providing abortions in an NHS setting is important to the future of the service because: "if it was something that was available in every hospital that has a gynaecology unit, then it will be accepted that it is part of any women's reproductive life course". I found that doctors embraced the NHS as a significant part in the normalisation of abortion and for this reason appeared to provide further meaning to the provision of NHS services. Participants expressed this through a range of general comments

on how they saw the interaction between the setup of the two sectors. By placing abortion into the NHS, doctors would be increasingly medicalising abortion in Britain.

However, as this section of the chapter has shown, the motivation behind this form of medicalisation was a drive to improve the service for its users. This is in line with the dynamic view of medicalisation taken by Halfmann (2012), that medicalisation is a complex process. Medical professionals can sometimes "disguise the degree of medicalisation" (Halfmann, 2012: 202), so it should not be considered as always motivated by a drive for medial control and the expansion of their activities. I now continue to explore perceptions of the independent sector through conversations that highlight a difference in values between the independent sector and the NHS.

5.2.2 Different Values between the Independent Sector and the NHS

Throughout the part of the interview on clinical practice, I found doctors used the opportunity to express a difference in how they saw the values of the independent sector and the NHS as part of their claim that abortion services should be provided within the NHS. One way participants communicated this idea was through the language they used to describe and discuss the independent sector.

Some doctors used language usually associated with anti-abortion groups to describe the independent sector. Seven participants described the independent sector as a 'private sector', implying that these doctors are working for profit, even though such organisations are charities. It is important to recognise this point and outline such differences, since the claim forms part of an explanation of why doctors working within the NHS are critical of the independent sector. It is also noteworthy that the majority of doctors did not differentiate between the two leading independent sector providers, BPAS and MSI Reproductive Choices, which were often spoken about as one collective group. Labelling the independent sector, as the 'private sector' further divides the two sectors.

Existing literature such as Humphrey and Russell (2004) note an assumption that doctors who work as salaried employees of the NHS are guided by their clinical practice by professional values that encourage them to put their interests first (p. 1241). In comparison, there is a

suspicion that doctors who work in the UK private sector "are motivated by self-interest, with commitment to their patients compromised by consideration for their purse" (Humphrey and Russell, 2004: 1241). I now turn to consider how the language used by participants was used to express a difference in the values participants associated with the NHS and those of the independent sector.

The independent sector has historically provided a charitable abortion service 'at cost' to meet the demands the NHS could not maintain. However, seven doctors referred to the independent sector as if it were part of a private healthcare system, rather than a contracted NHS provision. For example, Lisa told me that the "private sector provides most abortions today". Samantha also spoke about the independent sector as private in relation to the number of abortions that are being performed in the NHS, because the "NHS is providing … less and less year on year … so there's plenty of demand out there, but it's not within the NHS, so women have to go to the private sector". Doreen also referred to the independent sector as private and suggested that "for all those women that are not seen in the private clinic we need to be able to have a good--a good service within the NHS". Comments that referred to the independent sector as private were very general and often used in conversation as a way of describing or defining the service; however, characterising the independent sector this way suggests that the independent sector providers have different values from the NHS.

Another example of doctors using language usually associated with anti-abortion groups can be seen in Melissa's interview. Melissa worked in the NHS and described a time when she visited an independent clinic during her interview. When she recalled her observation of the clinic, she described it as "factory-like". She continued that for patients, it is a matter of "take off your clothes, put them in this bag or bucket … you walk on to the table … the abortion is done then you get put into the next room". Melissa implies the independent sector works like a conveyor belt, in comparison to the service she works in, the NHS. She expressed shock at the number of abortions doctors provide, saying "they would get through twenty in a list". She continued that what she observed was "extraordinary".

Melissa's description alludes to independent sector clinics as "factory-like". It implies a clear difference between the work she completes in the NHS and that of doctors in the independent sector. The kind of language she uses to describe an abortion provider is similar to that of pro-life groups. The 'factory' feel Melissa describes implies a production line of women coming in

with unwanted pregnancies and leaving once their procedure is completed, rather than in a hospital where the doctors are primarily concerned with the health of their patients. Comparing the independent sector with an industry similar to factories distinguishes between the 'legitimate' medical care provided in NHS hospitals and that provided in the independent sector.

In the same way as the participants who discussed general comments above, Melissa is not specifically questioning the standard of care provided in the independent sector and did not express concern with any clinical or practical problem with the service. Instead, she describes the layout of the clinic with negative undertones, suggesting that how the clinic is set up makes the independent sector different from the NHS. Through her language, Melissa compares her observations at the clinic to her working environment at an NHS hospital, implying that her setting is a better place to provide an abortion service because of the way the clinic and service works. This would imply that Melissa believes the abortion service should be placed within the NHS and not in the 'factory-like' independent sector.

In direct comparison, Bridget, who works in the independent sector proving the abortions that Melissa has described above, told me that as part of her job she would "do twenty, thirty a day". However, these two conversations highlighted a difference in how doctors give meaning to their work. For example, while Melissa thought it was "extraordinary" that independent sector providers are performing abortions on what she saw as a large number of patients Bridget believed that this contributed to her work and made her a good doctor, and her work was "very rewarding". She said, "everyone is here because they want to help the women and there is sometimes pressure to help so many, but there's always waiting lists, and they're telling people to keep waiting".

Melissa and Bridget's descriptions of the independent sector are different. Instead of feeling like she worked in a 'factory', Bridget acknowledged the abortion procedure as quick, but ultimately believed that she was helping women and making a difference to their lives. Bridget described the pressure doctors working in the independent clinic are under because of the number of women seeking to have an abortion, but attributes this to a lack of services, rather than a negative part of her role as a doctor. Instead of feeling as if she worked in a factory-like setting, Bridget viewed her work as the same as that which she had previously provided in the NHS. This is a direct comparison between two participants who have quite different views on how the service should run. Melissa's claims about the independent sector form part of her

argument that abortion should be placed within the NHS and run by NHS staff to normalise the service.

In comparison, Bridget does not believe it is necessary for the abortion service to be placed within the NHS for it to be considered part of healthcare. She believes she is making an important contribution to the service by helping women, so they are not made to 'keep waiting'. Melissa and Bridget both recognise issues with the way the service is currently run. However, there is a difference in how these participants believe it could be improved. Melissa suggests that providing abortions within NHS facilities is the best way to provide a service for women. Bridget implies that for her, the location where abortion takes place does not make a difference: the issue with the service is the amount of time women must wait to have their procedure.

Judy reflected on the belief that the independent sector had different values from the NHS when she discussed the commissioning of abortion services throughout her interview. She told me that she believed the independent sector "is shunting people around the country". Judy was, in this context, discussing the process of medical and surgical abortions of all gestations. The reason women are being 'shunted around the country' according to Judy is that local clinics "say they are full". Women must then travel beyond the vicinity of their local independent sector clinic to have an abortion. Judy addressed this problem because she believed that on one level, it looks as if the service is running smoothly. After all, the independent sector provider has "ticked the box; they have seen the woman and offered her an abortion within two weeks. They have done everything right". But, if you look beyond the tick-boxing, Judy told me that women could not get to appointments offered by independent clinics because they have to travel long distances. She described this as a problem because as far as "the commissioners are concerned everyone is being seen in two weeks, so what is the problem?". The problem, as she identified, is women are being asked to travel around the country for all abortions, not just for later gestation surgical abortions. Finally, she told me that she would "put money that some independent clinics aren't coping".

Although this claim is formed in a different way to those discussed above, it is once again used as part of a wider argument that abortion services would be better if they were provided within the NHS. As Judy implies that this service is not running efficiently because the independent sector cannot cope with the number of patients requesting their services. In addition, she believes that the independent sector providers are not getting the help needed to make the

service effective, because to outsiders commissioning the service it looks like it is running smoothly. Judy continued this discussion by telling me that in her view, if these services were not be being commissioned out to independent sector providers, "NHS trusts would have more knowledge of what is happening in their local community".

The argument for the normalisation of abortion appears to surface throughout Judy's discussion on the management of abortion services as she advocates for abortion services to be placed and managed within mainstream NHS settings. This argument indicates the primary goal of doctors is to treat abortion like other areas of mainstream healthcare rather than abortion being commissioned outside of the NHS, as it is currently provided. Providing all abortions within NHS settings could be viewed as an extension to the medicalisation of abortion. Instead of women being able to visit an independent clinic, women would be required to attend an appointment in a hospital or NHS service to have their abortion procedure.

However, here Judy is not motivated by self-interest; she wants to bring abortion within the NHS as a way of improving services for women. This supports the claim by Halfmann (2012) that there are examples where medicalisation could be viewed as a positive contribution to the service. The next section of this chapter continues the exploration of the bi-directionality of medicalisation through the claims made around the 'normalisation' of abortion with regard to a key aspect of clinical practice raised by participants.

5.3 Complex Cases

This section of the chapter continues to explore the meaning doctors give to the normalisation of abortion, investigating how it fits with the medicalisation of abortion through a conversation with participants on the management of medically complex cases. Some women are categorised as medically complex because they have a comorbidity. Medically complex cases were often seen as problematic during the interviews and were discussed by thirty-two participants. The management of complex cases was often used as a justification for providing all abortions within NHS settings because independent sector clinics are unable to manage these cases. This commentary was similar to those outlined above, where doctors discussed the independent sector negatively.

However, while thirty-two participants believed complex cases were a problem, there was a tension in how participants thought the problem should be resolved. Discussions on complex cases were formed around the best ways to solve the existing issues participants saw as a problem. Firstly, this section of the chapter will outline how participants framed the problem through conversations about the problem of the independent sector. Once again, conversations were based on the assumption that normalising abortion means providing abortion inside NHS facilities. However, I found that participants also discussed inadequacies within the NHS services. These stories indicate participants' muddled thinking about what they mean in practical terms when they say abortion should be treated like any other medical procedure.
The main claim made about complex cases is that abortion services should be placed within the NHS because the independent sector is unable to manage medically complex cases safely. Claims about the negativity of the independent sector provision were based around two central arguments, as this section of the chapter will discuss. First was a concern in a practical sense for what doctors saw as a lack of facilities in the independent sector; second was a concern for how abortion is perceived with regard to tensions that arise when the two sectors collaborate to manage complex cases.

Samantha told me that medically complex abortions should be provided in the NHS because the independent sector is providing a 'limited' service. She told me the independent sector's inability to manage complex patients meant they were providing a "very very limited provision" because: "they're not based in hospitals. They don't have all the backup … they don't have ICU, HCU. They don't have blood products or all the pathology services that are needed to manage [these patients] safely". Samantha continued that this means some of "the highest risk women and those whose need is greatest are those that are getting the poorest service of all". She said: "because, you know, the independent sector can't safely manage women who are high risk with comorbidities … so, unfortunately, those women struggle to get any service at all".

This argument was also put forward by Rebecca, who believed the independent sector's role was limited. She told me that although she believed the "independent service providers have done a very good job, they are limited in what they can do", and because of these limitations "it really stigmatises termination". This further indicates that doctors are motivated to normalise abortion as a way of reducing the stigma associated with abortion. The link between stigma and abortion is further discussed in the next chapter on the micro-level. However, the

perception that the independent sector stigmatises abortion appears to surface through this account. Rebecca is not suggesting that the independent sector stigmatises abortion because of any clinical problems or because of the way patients are treated in these clinics. Instead, her discussion implies the opposite. Rebecca suggests that the fact non-NHS clinics are unable to provide care because it is medically complex is a negative thing.

Once again, this line of argument suggests that abortion services should be placed within the NHS to bring them in line with other areas of healthcare. Both Rebecca and Samantha claim the independent sector is 'bad' because it cannot complete the higher risk procedures that require hospital services. Other doctors shared the same view. For example, Liam told me that "hiving it [abortion] off to the private sector has created this problem" when discussing the lack of NHS services for women with complex medical cases.

This view that the current split between the two sectors makes the work of NHS providers harder was also expressed by Melissa, who told me that "actually the hospitals don't get involved very much, but when they are involved, it's always, always difficult". Here Melissa refers to the complex cases that are passed to her service by the independent sector. She believed these abortions were 'difficult' because, as she continued, "either the women have got medical problems, heart disease, lung disease, something like that or they're very late or they've got foetal abnormalities". She went on to tell me how she saw the relationship between independent sector providers and the NHS, that the NHS is "picking them [abortions] up from the private sector". This is a negative representation of the independent sector. Melissa suggests that her role in the NHS as a provider makes her a better doctor because she is concerned with patient welfare, unlike those working in the independent sector where doctors "abandon people".

Jessica, a doctor who has worked in the NHS for over 35 years, also expressed a negative perspective about the independent sector's inability to perform complex abortions. She told me it was a "big palaver" for the NHS when women are referred from the independent sector, this was one way she validated the claim that abortion should take place within NHS facilities. Once again, she was not critical of the care currently provided in non-NHS settings. Instead, she expressed her belief about what she considered a flaw in the service: its inability to provide complex care. One way to overcome this flaw would be to provide abortions in NHS settings. Jessica continued her conversation by telling me that there were issues she had to overcome

"for a woman with very serious cardiac disease … [to] get on a gynaecology list". These issues caused a 'big palaver' because she would "have to find an anaesthetist, and we'd have to find a surgeon". This caused more pressure for her as a doctor. If these abortions were performed within an NHS setting, then these staff would already be in the hospital with those patients with a complex medical history. Therefore, there would be no need for any interaction between the two services.

Although Jessica's point of view is unique compared to other participants, her claims are part of a larger argument that abortion should be placed within the NHS. She expresses a negative judgement on the independent sector due to her experiences of the interaction between her NHS service and the independent sector providers, where not having abortions provided within mainstream healthcare has made her job more challenging.

The portrayal of the independent sector as problematic because women need facilities associated with treatment in the NHS suggests that doctors appear to give greater importance to the work they perform in the NHS. However, interestingly it seems as though the independent sector is being blamed within an argument about how NHS services are unable to cope with the service demands.

5.3.1 Inadequacies in the NHS

During my discussions with doctors on the problems they associate with medically complex cases, the role of the NHS in the management of complex cases became apparent. I found a tension between the idea of normalising abortion services and what participants saw as the inadequacies of the existing NHS provision of abortion. It is important to note this is not a systematic investigation into the inadequacy participants associated with the NHS, but instead is based around the perceptions of the participants in relation to complex medical cases. Their comments centred around two key issues that participants saw as a cause for concern: first, about the organisation of NHS services, and second, about the outlook of staff working within the NHS.

As explained in the previous section, doctors discussed the role of the independent sector in the management of complex cases negatively. Their main reason was the inability to provide

these terminations further stigmatises the service, while bringing abortion into the NHS would normalise abortion and make it 'like other areas of medicine'. However, as this section of the chapter will show, participants were also sceptical about how the organisation of the NHS would cope if all abortions were performed in the NHS. For example, Charles, an NHS doctor, described its provision as an "incredible postcode lottery", whereby whether you have access to services depends on where you live. Charles refers to the number of NHS services that provide abortions after being referred by the independent sector.

Bpas have reported that they were able to refer women to thirty-five NHS services in England; however, the number of services decreased as the gestation of the pregnancy increased (bpas, 2018). As a result, women with comorbidities often face increasing waiting times and have to travel further for their treatment, even at an early gestational stage. For example, bpas reported in 2018 that they had cases where a woman who presented at nine weeks gestation waited forty-five days before she was first contacted for treatment after being referred to an NHS service (bpas, 2018). In addition, because hospitals decide their gestational limit and the type of abortion they perform, some women were unable to have their preferred method of treatment for their abortion. These were considered the major limitations in the NHS abortion service by participants.

Underlying the argument for normalising abortion was a concern for how normalisation would align with the current provision of abortion within the NHS. The belief that the NHS provision of abortion in Britain is currently not good enough was reiterated by Samantha, who has worked in the NHS for over twenty-five years. Samantha described the provision of abortion as "Cinderella" because she believed "it's a very poor service in the NHS". These conversations highlight that even though on the one hand, participants were critical of the independent sector, they were also aware that the current service provided in the NHS was far from adequate. This was presented as a tension between what they saw as the normalisation of abortion and how it would work on a practical level.

During my interview with Doreen, she also highlighted that in the NHS, "we need to do better". She was concerned that some patients were unable to have an abortion within the NHS before the legal time limit has passed because of a lack of availability, meaning some women have to continue their pregnancies even though they would like to have a termination. This indicates that doctors were aware of existing problems on how the NHS services are organised.

This creates a tension: doctors are making claims that they want to normalise abortion by bringing services into the NHS, while acknowledging the flaws of the current service. This tension was also expressed through a concern with how the NHS manages cases where women present complex medical histories. For example, Vanessa also indicated that there was a problem with how medically complex cases are managed in the NHS. She told me in her NHS service there were times where they had a five-week waiting list for an abortion. This is potentially going to increase because in their service they "have more and more women with more and more medical complexity that can't be accommodated [in the independent sector] but there's nothing available" in the NHS.

She continued by telling me that women who need to be seen in the NHS because of their comorbidities:

> Are either forced to go elsewhere and seek unsafe alternative methods or to undergo medical abortion which is maybe what they don't want to have at that time, and it's proven that surgical abortion is safer and more effective, but it's just not a service that we can offer as the NHS as a whole.

The implication that women seek to terminate their pregnancies through unsafe methods because they are unable to have a safe abortion in the NHS acts as evidence of a tension between what the concept of the normalisation of abortion means, and what it would look like in reality. Another way that inadequacies within the NHS service were presented was through discussions about the outlook of staff not currently working in the abortion service. One consequence of normalising abortion services would be that only doctors employed by the NHS would be able to terminate a pregnancy.

The findings in Chapter Four presented the lack of NHS staff willing to work within a termination of pregnancy service as one of many practical difficulties caused by the current legal framework. Doctors often discussed feelings of frustration and helplessness because of the impact the conscientious objection clause has on their work. Yet, when discussing the normalisation of abortion, the same doctors call for services to be provided inside the NHS.
I found that when speaking to doctors about the inadequacies of the NHS in managing complex cases, similar claims were made about doctors who do not provide abortions that were made

about these doctors when discussing aspects of the legal framework in the previous chapter. The issue of the outlook of NHS staff was mentioned by Michelle, who works solely in the NHS: "no anaesthetic department within any hospital in the NHS now wants to put somebody to sleep who they're worried might be at risk of dying because it doesn't look well when you have to write the reports about the maternal death". She continued that "madness that everyone is so risk-averse" where the NHS doctors will not "do the right thing and facilitate an abortion for someone … because they're a bit tricky".

Michelle was outraged by the NHS's inability to provide safe abortions for medically complex women because, as she told me "these cases are going to be ever so much more tricky by the time they get near the end of the pregnancy if they survive that long". She considered the problem with complex cases to be "getting the anaesthetist to do their bloody job". This line of argument put forward by doctors such as Michelle further highlights a tension within the way doctors discuss the NHS where the NHS is simultaneously valued through an argument to normalise abortion and presented as unable to provide abortion services in a way it is needed to.

It was not only anaesthetists who participants saw as a problem when discussing issues associated with the management of complex cases. The claim that the NHS is unable to provide the service needed was also expressed through a concern about the number of doctors who choose not to be involved in this service. For example, Nicholas, who works solely in the independent sector, said "I've got lots of friends who are gynaecologists working for the NHS. Many of them are just like it's a separate thing, and it has to be a separate sort of specialty completely". He continued that the abortion service has "moved slightly away from gynaecology", and instead, it has become "like a specific direction for the doctors who want to go that way". This is yet another example of the tension between normalising abortion and what that means in practice.

This is further linked to discussions about the conscientious objections outlined in the previous chapter, where doctors told me that they believed that some doctors identified as conscientious objectors to avoid providing terminations. The idea that doctors must actively choose to work in the abortion service rather than it being a natural progression in medicine will also be explored later in this chapter through discussions with participants about training. The fact that abortion provision has 'moved away' from the NHS because doctors do not want to provide

terminations is interesting when compared to the claim that abortion will be normalised by being placed inside NHS settings.

When discussing the practical side of providing abortions, doctors discuss the NHS service as extremely limited because doctors do not want to provide these services. If, as discussed in Chapter Four, and as Nicholas has outlined above, abortion is seen as a separate service within the NHS then placing abortion into the NHS setting does not mean that the service will be normalised as doctors often discussed. Similarly, Rebecca, who works primarily in the NHS and part-time in the independent sector, also stated that some doctors she works with do not want to provide abortions. She said in the NHS trust she worked in, "they had the choice many years ago to stop delivering terminations". She believed the reason for this is "it's quite convenient for most obstetricians and gynaecologist consultants that they don't have to be involved". Similarly, during the interview with James, who like Rebecca also works in both the NHS and independent sector, said, "you'll notice I didn't talk about the NHS … local gynaecologists are saying that they won't do any abortions at any gestation". Clare told me she felt "gynaecologists over the years have probably tried to push it out a little bit". I found that doctors often discussed the issue of attitudes of NHS staff when telling me about the management of complex cases. However, comments were actually being made about how the NHS services are run generally.

The belief that doctors working in the NHS do not want to provide abortions was also addressed by Yasmin, who worked in both the NHS and the independent sector. She said, "the people in my NHS work don't really like me talking about it … they're quite happy to dole out contraception and then not sort the women out if it fails". She continued by telling me that there is a SRH consultant who she works alongside in the NHS who "had to do abortions as part of her training, but she wouldn't do them now". This has detrimental to the NHS service, according to Yasmin, as now "no one within the department plays an active role in abortion".

Yasmin is discussing what she thinks it means to be a good doctor, she compares herself to a colleague who could provide abortions but chooses not to. Yasmin has decided to provide abortions, which she believes makes her a good doctor. However, she also addresses the complexity of having all abortion services provided within NHS settings since there are not enough staff willing to provide abortions, even if they have been trained to provide them. The next part of this chapter addresses another set of claims, made by participants on the

management of complex cases, where doctors have argued that the two sectors should work together in order to provide the best service or women.

5.3.2 Collaboration between Services

Not all doctors agreed with the assessment that the independent sector is limited because of its inability to provide complex procedures, therefore services should be provided inside the NHS. Instead, of the seven doctors interviewed who work solely in the independent sector, five believed that the NHS is a useful service that should work alongside their service. They felt as if the current split between the services was an appropriate way to provide the most effective abortion service. This is an entirely different interpretation from those outlined above, who believed the best way to provide a service is to normalise abortion by bringing it into the NHS. Instead of seeing the independent sector service as limiting, they believed that the two sectors should work alongside each other, providing the services needed for women to receive the best care.

For example, Lilly told me that part of her role as a doctor who works in the independent sector was to "check through their medical histories to check they're okay" because: "those who are sort of unwell, you know, or have other complex medical problems get referred to the NHS. Now there's going to be like a super network of centres who deal with, you know, very complex patients in gestations".

Lilly implied that part of her role as a good doctor was to ensure women with complex medical backgrounds are passed onto the NHS in a timely manner so they can have the best care. She does not feel the service she provided in the independent sector is compromised because she is unable to offer women with complex medical histories the procedure in her clinic. Lilly's assessment of the work she does as part of the service run outside of the NHS is different from that of doctors who either work primarily or solely in the NHS. In comparison to the claims made in the previous section by doctors who were highly critical of the independent sector, who believed the only way for abortion to be considered a standard part of healthcare was to provide it within an NHS setting. Lilly did not see that being unable to perform abortions that they cannot manage medically harms the service. Instead, she believed that the independent

sector should work alongside the NHS, providing the best care for patients, and this division of services provides the best care for women.

Nicholas, who works exclusively for an independent sector provider, outlined a similar interpretation of the situation. He told me "if we are not happy with something, we can request more information and sometimes we might have to refer the patient to the hospital ... and if everything is fine in the end" and "the correct paperwork has been filled in then they will provide the treatment for the woman". This resonates with the point raised by Lilly that doctors working for an independent sector provider refer patients to the NHS when they believe there may be a complication with the pregnancy or the health of the woman. They see this as a positive, practical step to providing exemplary clinical care, in contrast with the belief outlined by some NHS doctors, as discussed earlier, where the complex cases have been described as a limitation to the service.

In addition to the independent providers who described their sector as working in collaboration with the NHS, there were some doctors working in the NHS also believed the best service for women is when both sectors work collaboratively to provide a service accessible to all women. However, working collaboratively was not described as simple or straightforward, and the idea that complex cases are hard work did resonate with these doctors. I found that these participants did not believe normalising abortion services through NHS provision was the best way to provide an abortion service. For example, Janet who is also a doctor who worked in the NHS for a significant part of her career, told me "when a complex case comes up, they are time-consuming, and you do need a really good network who will pull their fingers out and get on with it". Janet recognises that complex cases are challenging in comparison to those without any co-morbidities. However, she did not see this as a drawback of the independent sector. Instead, she saw it as part of the provision of abortion the NHS had to accommodate for women to have their abortion safely. This illustrates a tension in how providers see the future of the service, where doctors have differing opinions on what is considered the 'best way' to run the abortion services.

This tension was also addressed through the interview with Joshua, who told me, "obviously if there are women who fall outside of the treatment criteria for bpas, then they need to be cared for in a non-judgemental supportive environment in the NHS". Joshua echoed the point made by Janet that there are cases where the independent sector cannot provide the abortion, and

patients need to be treated within the NHS. Both Janet and Joshua are examples of NHS doctors who collaborate well with the independent sector and believed that the best service should consist of the two sectors working simultaneously to achieve the best service for women.

Christine also raised the idea of collaboration between the two sectors. She told me, "it is really important that the independent sector works together with the NHS because they each have things to offer, and if they combine them, they can offer almost everything". She believed "that working closely with the NHS is the only way forward for a good service". Similarly, Lauren told me she thinks "it is really important that the NHS works alongside independent sector".

This section of the chapter has highlighted a tension between what doctors say in regard to normalising abortion and how such normalisation works in practice. When discussing the management of complex cases within the independent sector, doctors often once again made negative comments that continue to form part of an argument to bring abortion services into the NHS. When making general statements about the role of the independent sector, the main concern for NHS doctors was finding a way of normalising the abortion sector in relation to the rest of healthcare and maintaining medical oversight becomes important for doctors.

However, there is more ambiguity when discussing specific service provisions such as the management of complex cases, as doctors are also aware that the NHS is unable to provide a normalised abortion service because abortion is viewed as different to other areas of medicine. This also highlights a tension between the demedicalisation of abortion which was expressed on the macro-level, in the previous chapter, and the drive to normalise abortion services where doctors expressed concern for maintaining medical oversight through providing abortions within the NHS. The next section of the chapter continues the investigation of the tensions in the medicalisation of abortion through a second key issue raised by participants when discussing clinical practice: second-trimester surgical abortions.

5.4 Second Trimester Surgical Abortions

This section of the chapter is based on another aspect of clinical practice raised by participants during the interview. The issue of second-trimester abortions was not an explicit part of the interview. Instead, it became apparent through analysing the data that commentary on the issue

was important to doctors. As this section of the chapter will show, most of the comments were once again focused on the normalisation of abortion through a conversation on the role of the independent sector. Participants made claims about both the safety and morality of providing abortions outside NHS facilities. This section of the chapter then explores the claims that have been made about the challenges of providing a second-trimester surgical abortion sector in the NHS. This section further highlights the tension between the arguments for normalising abortion and what this means in practice.

5.4.1 A Medical or a Moral Problem with Independent Sector Provision?

Doctors reflected on how they saw the future of the abortion service through the claims they made about the safety of women who had second-trimester surgical abortions in the independent sector. The argument that the independent sector should not provide second-trimester surgical abortions can be best examined through Nathan's comment. Nathan, who now works solely in the NHS, but still has close links to the independent clinic in his area, believed that the independent sector "do provide a marvellous service … but …" he continued, "if my daughter were having a 22-week surgical termination of pregnancy I don't know I'd be happy for her to have it in non-NHS service". His reasoning behind this was similar to that expressed when doctors discussed the role of the independent sector in complex medical cases. He told me that "complications can occur," and in the NHS facilities, they are equipped to deal with these complications unlike in the independent sector. Kelly also raised concern that the independent sector "don't have all the backup" which meant that women "can't basically be managed by those services, and they struggle to get any service at all".

This argument is similar to that explored above through discussions on medically complex cases, that abortion services should be placed into NHS settings because they have better infrastructure and facilities to manage these abortions. However, unlike above, where doctors claimed the independent sector increases the stigmatisation of abortion by not providing treatment for women with complex medical histories. While discussing second-trimester abortions, doctors expressed concern for the abortions that were actually being performed in the independent sector. Doctors framed the argument that it is important for women to have their treatment within the NHS through claims that the independent sector is disadvantaged

because they are unable to manage complications that arise in their clinics, while patients have their procedures, and this was a concern for safety for participants like Nathan and Kelly.

Three doctors who work in the NHS also reiterated the claim that the independent sector is stigmatising abortion through framing the argument that second-trimester surgical abortions have become seen as 'dangerous' by some medical professionals. It is important to note that these participants were not actually suggesting that these abortions were dangerous, but instead, that they can be perceived as dangerous by medical professionals. The perception that it is a dangerous procedure was enough for them to suggest that providing abortion in an NHS setting is best for the future of the service.

As Chapter One has outlined, the law states that if the life of the pregnant woman is in immediate risk, then all doctors have a duty of care to save her, regardless of whether they are conscientious objectors. Many NHS hospitals do not provide any abortion treatments, so many doctors do not routinely see patients who have a surgical abortion. However, if there is a complication during a second-trimester surgical abortion being performed in an independent sector clinic, then in that case, the patient will be transferred to a hospital where they must be treated.

Joshua was concerned that doctors who are not routinely involved with any abortion services would only see the patients who arrive at the hospital after complications of surgery. He explained that "hospitals that are physically in the vicinity of an independent sector provider will see the complications as they arise", and he continued telling me that these hospitals "receive patients who've bled or who have a trauma as a result of surgical termination". As these doctors only see a small number of patients who have had complications from a surgical abortion, they have the opinion that this type of abortion performed is not safe. These medical professionals then believed that the independent sector has "unsafe procedures" because the women who have been transferred to the NHS may "require a hysterectomy or even worse ends up a maternal death in hospital, which gives doctors the assumption that it is an unsafe practice". This was also addressed by Sophia who said, "these are seen as dangerous" by doctors who do not provide abortions because "all they see are women bleeding out", and this gives the perception that second-trimester abortions and the independent sector are unsafe.

Once again, this suggests that participants believed there to be an associative stigma attached to the independent sector, which further stigmatises abortion; the way to eliminate this stigma is to provide abortions within an NHS. While this claim was partly about a concern for medical safety, this is also a way of expressing a morally-driven point on what happens to women who are seen outside of NHS facilities, alongside a sense of unease about what they see as a disregard for women and the care they need from the medical profession if they have a second-trimester surgical abortion in the independent sector. If these abortions are being routinely provided in NHS hospitals, then doctors working in those hospitals will not only see the complicated procedures, so their experiences will not tarnish their opinion of the service.

The concern that complications are unable to be managed in the independent sector is of interest, as in 2017 there were 303 cases reported complications with the abortion procedure in England and Wales of the 197,533 abortions performed[5]; this is a rate of 1 in 637 abortions[6]. The likelihood of a woman experiencing a complication increases as the gestation of the pregnancy increases; however, the rate is still low, and surgical abortions are still considered a very safe procedure. The low complication rates of surgical abortions would suggest that the doctors who expressed this concern are apprehensive about abortions being performed in the independent sector 'just in case' complications arise. At the same time, there is little evidence of any problems or complications with second-trimester surgical abortions that are performed in the independent sector those that work in the NHS present arguments raising complication rates as a concern. Through doing so, doctors are further arguing that abortion should be normalised through a provision in the NHS services, even though there is no evidence this would make the service better for patients. This could be, to a greater extent, a concern for maintaining medical oversight where doctors working within the mainstream health care setting believe they have better infrastructure and facilities to deal with any complications which could arise. I now turn to discuss doctors remarks that focused on the challenges that have risen from NHS services and the provision of second-trimester surgical abortions.

[5]One hundred ninety-two thousand nine hundred abortions were for women who are residents in England and Wales.
[6] This rate is an overall statistic for all abortions performed- irrespective of gestation and method.

5.4.2 Challenges in an NHS Service

Doctors reflected on the challenges they face when trying to run an abortion service in the NHS. These challenges were presented in doctors' answers to questions on clinical practice in many ways. Two doctors presented the NHS as problematic. For example, Judy, who works in the NHS, reiterated the point that providing surgical abortions in the NHS is not straightforward when she told me "we know we are under capacity for second-trimester surgical abortion". She continued if you speak to NHS providers or the independent sector providers "they all say they are turning people away because they don't have the capacity" for complex and non-complex cases. She continued that surgical abortion "is disappearing altogether in the UK … as there is a lack of capacity for late surgical abortions" in the NHS. She concluded that the reason:

> We are under capacity as the NHS is not prepared to pay for it … I think if the NHS can get by with what we've got, and we'll screw it down to the absolute bare minimum, and if that seems to be working, then that is good enough. Good enough or almost good enough is enough.

This point, that NHS services are problematic, was also outlined by Paul, who said the NHS "just aren't doing enough to provide this type of service … there are too few hospitals willing to provide them". Doctors' comments on the lack of abortion service available within NHS settings are interesting in relation to the opinion of doctors in the independent sector.

NHS doctors were highly critical of the independent sector's inability to provide terminations to all women. This was considered a significant weakness in their provision of abortion services. One driving force to normalise abortion was through "arguing that positioning it as routine healthcare is essential to countering stigma and inequity" (Maxwell et al., 2021: 33). However, when discussing the role of the NHS in the provision of abortion, we can see that some doctors working in the NHS are also highly critical of the care currently provided within the NHS. These claims made by Judy and Paul do not suggest that placing abortion into NHS services will counter this form of stigma or inequity because, according to them, the NHS services are not able to manage to provide all abortions efficiently.

The most common way doctors reflected on the challenges they face through providing second-trimester surgical abortions within the NHS was through discussions about the attitudes of their medical colleagues. For example, Melissa told me that doctors in the NHS "make the distinction between the sort of the deserving and the undeserving". Melissa distinguishes between the 'deserving' women in need of a second-trimester surgical abortion because of a foetal abnormality, and the 'undeserving' woman who seeks a second-trimester surgical abortion for any other reason. She told me that part of working in an NHS abortion service mean doctors are "looking after these poor women who have got these terrible complications [because of a foetal abnormality]". In comparison, she believed that most doctors working in the NHS are "kind of distancing themselves from the mass of abortions which are unwanted pregnancies and the 'feckless'". Even though there are regional foetal medicine units that "do all the foeticides in the over 20 or 24 weeks" these doctors do not want to provide abortions to people they consider 'feckless'. As Melissa explained:

> There's a lot of "no, I'm not going to do that". I don't want to do a termination on, you know, the great unwashed, you know, a woman who has got no money, drugs, alcohol, mental health, who knows what happened to her when she was under five and, why she's selling her body or how she's turned up at 22 weeks with an unwanted pregnancy? I don't care …

Melissa discusses how she struggles to provide abortions in the NHS because as she described, "we have got much less awareness of the importance of safe abortion". This is an interesting point, since when discussing the independent sector doctors were critical of the abortion service because it was provided outside of the NHS. However, when discussing the NHS provision, doctors were aware there were also many problems within the service, and that there is only a limited number of medical professionals willing to be involved in providing the service.

Other doctors shared the same view as Melissa. For example, Mary told me that "foetal medicine doctors who've got some of the skills for the later stuff want to separate themselves from social abortion" because "there's a lot of that going on all over the NHS, you know, being able to be morally in judgement of patients". Throughout my interview with Samantha, she also told me she finds "quite a few of my colleagues quite judgmental actually, and that is unfortunately quite endemic within the NHS". Once again, these claims made by participants do not suggest that placing abortion into NHS settings, in a drive to normalise abortion, would

reduce the inequity around abortion. In comparison, these doctors are implying the opposite: they suggest that women are not treated fairly by NHS staff because they judge them due to their decision to terminate a pregnancy.

As explained briefly above, if a woman experiences a complication during a surgical abortion, then all doctors must work to save the life of the woman regardless of whether they have a conscientious objection or not. However, three doctors who work within the NHS, either solely or partially, discussed the problems they have faced with doctors who have initially refused to provide treatment for women who experienced a complication while undergoing a surgical termination. For example, Nathan told me "if a woman half-way through a medical procedure suddenly has a complication, to me that then is a medical emergency". However, he experienced a time where he needed assistance. A colleague had been reluctant to assist. In addition, Karen believed "there is not enough understanding of what happens in the independent sector by staff in the NHS". When things occasionally go wrong in the independent sector, and complications happen, and patients are transferred to the NHS, she has "seen people behave really badly". She believed that is down to "a poor lack of understanding".

A further participant discussed her experiences of NHS doctors not being willing to help assist in surgeries once a complication has happened. For example, Abigail, who works for both the independent sector and the NHS, recalled a time where she had a "woman who was bleeding very heavily". She needed assistance from a colleague and he "put his head around the door and said, 'I don't do this kind of work'". She described this encounter as "really difficult" because she "had to leave the operating theatre to have a confidential discussion with him and to remind him that it was his responsibility".

This section has once again highlighted a tension between the argument to normalise abortion and what that would mean in practice. Where on the one hand doctors are explicitly hostile towards the independent sector and use this as a justification for normalising abortion through providing it within NHS facilities. On the other hand, when discussing what this would mean in practice, doctors often discussed issues of inadequate provision within NHS services. This has further highlighted a tension between normalising abortion and demedicalisation, where the two are considered at odds with each other because normalising abortion increases medical oversight.

When discussing the management of second-trimester surgical abortions, doctors often discussed the role of the independent sector negatively as part of their argument that abortion should be provided within an NHS setting. However, similarly to when participants discussed the management of complex medical care, there was a tension between how doctors believed the service should be provided within the NHS and the current service being offered. Some doctors acknowledged that the NHS was currently running a service that meant they are unable to provide the required number of second-trimester abortions. The next section of this chapter continues the investigation of the tensions in medicalisation through analysing participants answers to questions about how they see the future of the service in relation to the training of doctors.

5.5 TRAINING

As part of the interview, doctors were invited to discuss the training they received at different stages of their medical degree. They were asked 'do you think enough doctors are working in the abortion service?' and 'what attracts medical students to working in the abortion service?' In this part of the chapter, I will discuss the general claims made about the training and how these were used as part of an argument to normalise abortion through placing services within the NHS. Participants often made claims that blamed the independent sector for a lack of doctors working within the abortion services. When doctors were asked, 'do you think enough doctors are working in the abortion service?' the majority answered 'no', with twenty-nine doctors saying they did not believe enough doctors were working within the service. In addition, some twelve doctors told me they did not feel as if they were able to answer the question because they did not know enough about the sector as a whole.

5.5.1 A TIME OF CRISIS

The general belief amongst participants was typified by Rebecca, who told me "there is not a huge queue of people wanting to work in the service, doctors or nurses". Zoe also reiterated this point that she believed there were not enough doctors working in the service and she replied "Christ, no, no I mean, we're at a crisis. We're at a huge crisis". She continued by telling me that even though doctors have a "very minimal role" there is a lack of doctors for even "reviewing notes and signing HSA1 forms, we struggle for staff. Just keeping that going is

difficult". Interestingly, doctors once again shaped their claims around the premise that abortions should be provided in NHS settings and the way services are currently run is problematic.

The majority of doctors who work in the NHS, either partially or fully, raised the argument that abortion needs to be taking place within the NHS in order to improve the number of doctors working in the abortion service. For example, Michael believed "because NHS gynaecology departments have largely opted out of the provision of abortion" the majority of abortion services are providing outside of the NHS. One of the consequences of an outside provision is that there were no longer opportunities for medical students to have training.

This point was further reiterated by Emily, who said there are not enough "opportunities to train them, like the jobs, are not done in the NHS premises anymore, so then it's difficult for people to go and get training". This resonated with most of the participants I interviewed who believed the reason doctors did not work in the service was that there is a lack of opportunities for medical students to train within an abortion service. For example, Elizabeth told me that abortion is "not taught in medical schools properly, so I guess students don't see it as a viable option". She went on to tell me that another reason she believed there would be a crisis is: "a lot of abortions are now done in independent providers like bpas, which is great in a lot of ways. But also, you're not exposed to that as part of your normal NHS kind of training".

This was also discussed by Amy, who recognised that for some doctors not providing abortion is a moral issue but told me, "there are many doctors where it's not an issue, and the reason they don't do it is for practical reasons". She believed "if training were more flexible, then we would have more doctors. I know many junior doctors who would want to do abortions as part of their future clinical work". Once again, this draws back to the argument providing abortion outside of an NHS setting has detrimental consequences for the future of the service. While abortion is not considered to be a part of 'normal' healthcare, doctors will be unable to access training. Abortion providers overwhelmingly believe the best solution would be to provide it within the NHS where medical students would frequently see abortions as part of their standard training.

The tension between the number of abortions provided outside of the NHS, and opportunities to train medical students, was described by Joshua, who works in both the independent sector

and the NHS. He told me, 'it's a "catch 22 situation, at the moment where within the NHS, there is little exposure, so little chances of getting training" but until abortions are provided in the NHS, this will not change. The training was described as a problem because, in England and Wales, all medical students perform rotations around NHS hospitals. This means that because the majority of abortions are performed in the independent sector, as Abigail said, "it's difficult for people to go and get training". The inability for medical students to access training for abortion services was discussed as a significant drawback to the normalisation of abortion as it directly impacts the future of the service.

Three doctors made very adverse claims towards the independent sector when discussing the training of medical students. For example, the most striking comment about the training of medical students was made by Melissa, who once again referred to the independent sector as "factories". She began discussing training and what she considered to be "potential dangers" because "the private providers aren't paid to be doing all the education". She continued her conversation by saying:

> Goodness, you know, there's so much knowledge in, you know, these factories, you know, BPAS and MSI are doing tens of thousands between them…Those are tens of thousands of teachable moments and teaching opportunities which are being missed. That's what I think is a shame really.

Referring to the independent sector clinics as 'factories' once again shows how she is comparing the work of abortion providers in the independent sector to factory workers. Quite clearly, this indicates that she does not believe they have the same values as NHS doctors and sees her role as a doctor working in the NHS as different from those who work in the independent sector.

This tension between the training of medical students and the way the service is currently provided outside the NHS was further highlighted by Vanessa, who works in the NHS, she told me, "the fact that it's all been farmed into the independent provider sector who don't offer any kind of training for NHS students or people in training" is a problem. She saw this as a problem because "if the NHS provided more of this service, there were more jobs in the NHS doing the job, then of course then it's [the training] something which people are going to need". There is the misconception that independent sectors do not provide abortions as some independent provider organisations do currently provide training opportunities for medical students in the

form of 'externships' and student placements to medical students. Even though the independent sector offers these opportunities, there was a belief that the only training medical students get on abortion is within the NHS. This would mean that if the NHS setting you are training in does not provide abortions, then you will not be able to receive training in abortion care.

These claims have been framed differently from those being discussed in the previous sections of this chapter, as they are not expressing any negative assessment of the independent sector provision. However, doctors are once again suggesting that abortions being provided outside of an NHS setting is bad for the future of the service. To 'normalise' the abortion service and to make sure medical students actively choose to work in abortion services in the future, the abortion service must be provided within NHS settings where doctors can be trained. Exposure to abortion became a central part in conversations with participants when discussing the future of the abortion service, and they did not believe it would be possible to have the level of exposure needed to sustain the service through independent sector provision. I found this claim by doctors, that abortions must be performed inside of NHS facilities to allow more doctors to train in the service to be interesting as when discussing NHS provision in terms of the clinical practice of the management of complex cases and second-trimester surgical abortions doctors were often discussing their accounts of negative experiences they have with NHS staff in trying to provide abortions. Doctors told me they had experienced judgmental NHS staff refusing to provide services where a women's lives were in danger, a lack of services within NHS facilities causing women to be forced to continue their pregnancy to term because they do not have the capacity to provide abortions within the legal timeframe and NHS doctors trying to distance themselves and their work away from abortion. Yet, when discussing the training of abortion doctors, they believe abortion should be placed within NHS facilities so medical students can be exposed to abortion while training. This would once again suggest there is a tension between the claim that abortion should be normalised through providing it within NHS settings and how this would work on a practical level.

Overall, accounts about the training of future medical students were quite uniform, with many participants expressing concern with the number of abortions being provided outside of an NHS setting. Participants believed that this was having serious consequences for the future of abortion in England and Wales with some describing the service as heading for a "crisis". The main reason they saw as the cause of the crisis was that abortion services were not in the NHS. As a result, the best way to overcome this problem would be to place abortion into mainstream

healthcare services where doctors and medical students would not see abortion as separate from other areas of medicine. Claims made about training, as outlined here, inform the broader debate on the medicalisation of abortion as they imply that doctors want to medicalise abortion further to help validate or legitimate the services. This highlights a tension between what doctors believe a 'normal' abortion service should resemble and how this fits with claims made to demedicalise abortion.

5.6 Discission: Bio-medical identity and normalising abortion

In Chapter Four we saw how doctors began to construct their identity as drivers of change and resisting aspects of the medialisation of abortion. This chapter continued the investigation into the construction of the professional identity of the abortion provider. On the meso level we have seen how doctors working in the abortion service today have re-constructed their identity as abortion care providers. Even though participants rejected the role of medicalisers given to doctors on the macro-level, participants saw a critical role for them in the abortion service. Instead, they re-constructed their identity to show their role is vital to the abortion service because of their skills and knowledge. This came in the form of expressing a concern for demedicalising abortion on a practical level, predominately, through discussions of the distinction between the independent sector and the NHS. In the previous chapter participants explored the possibility of ‘normalising’ abortion services by abolishing the gatekeeping role given to them by the law. In doing so, doctors argued that demedicalising abortion was best for their patients, However, this chapter has shown that there is a tension between the demedicalisation of abortion and what doctors considered to be providing a 'normal' abortion service.

This tension was evident when doctors discussed the practices of abortion where there is a belief that to normalise abortion services in England and Wales, they must be provided within an NHS setting. Doctors were increasingly aware that the role of the abortion doctor is changing and becoming less prominent due to the changing nature of how abortions are provided. However, as with the macro level, this does not mean that doctors are suggesting that their role in the service is redundant. Instead, their argument appears to re-medicalise complex and surgical abortions by suggesting these abortions should be provided within mainstream healthcare facilities. This perspective was evident in previous research as Lee, Sheldon and Macvarish (2018) found "some interviewees identified [their specific contribution] as arising

not from any special insight into whether abortion is 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" (p. 29).

The conversation about the role of the NHS and its relationship with the independent sector can be categorised into two different types. Firstly, when discussing how services should be based in the NHS, participants who work either solely or partially in this organisation often described the NHS in terms of a set of ideals such as s a medical service where all patients can be seen in a timely manner and in a location within close proximity to their home. With this type of discussion came concerns from my participants about the physical separation of clinics from NHS hospitals and how this increases the stigma surrounding abortion. This concern was not because they believe the independent sector's service is inadequate or ineffective but because they did not have access to the same equipment, staff and facilities as the NHS.

However, there was also another type of conversation I had with participants about the NHS, and these were based on the realities of providing an abortion service within this organisational setting. During these conversations, both participants who work in the independent sector and the NHS, were very critical of the current NHS service. During this type of conversation, participants often discussed the realities of having an abortion service provided in the NHS. In addition, because of the inconsistencies within the current NHS services, these participants also described what they saw as a negative impact on patients and the future of the service if all abortions were provided within NHS settings. For example, participants often discussed limitations on the current NHS services being over-stretched and understaffed, which would only be accelerated by providing all abortions in the NHS.

These two different types of conversations created an internal tension for some participants where they discussed both the outsourcing of the service and the running of NHS services negatively while constantly telling me that the services should be placed within mainstream health settings to de-stigmatise services. This highlights a tension between demedicalisation and what they saw as 'normalising abortion' and stemmed from the belief that abortion should be placed inside a formal healthcare system to de-stigmatise abortion. This relates to the wider debate on medicalisation, since doctors suggest they want to medicalise abortion to improve women's services. This line of argument informs broader insights into the medicalisation of a non-medical problem, as the motives for medicalising the abortion service are different from

how medicalisation theorists have portrayed them. These doctors argued that abortion should be further medicalised by placing it within NHS settings, even though they were aware that women are forced to carry on the pregnancy. After all, the NHS is currently unable to cope with the number of terminations currently being requested that cannot be performed in the independent sector.

5.7 CONCLUSION

To conclude, this chapter has considered doctors accounts of the meso-level, focusing on doctors' claims about how to normalise abortion services. The argument for abolishing the independent sector not only featured as part of the argument to normalise abortion but was also presented as a way doctors give meaning to their work in the NHS. This chapter has explored the issues raised by participants on clinical practice throughout their interviews. This chapter has shown a tension between the demedicalisation of abortion on a practical level when participants discussed clinical issues such as complex cases and second trimester surgical abortions and providing a 'normal' abortion service. This tension is highlighted by the strong belief by participants that in order to normalise abortion services in England and Wales, they must be provided within an NHS setting.

Doctors often made negative comments about the independent sector to form part of this argument that abortion should be placed in mainstream healthcare settings. Doing so can be considered a form of medicalisation on a practical level, since abortion care is placed inside a formal healthcare system that increases the amount of medical oversight. This is interesting in regard to the broader debate on the medicalisation of abortion, as here doctors want to medicalise abortion further so it can be de-stigmatised and normalised within wider healthcare.

In comparison, when doctors discussed the legal framework on the macro-level, a form of demedicalising abortion was considered as one of the most appropriate ways to normalise the abortion service, showing how medicalisation should be viewed as a continuum rather than a state or category. The discussion on how doctors give meaning to their work continues throughout the next chapter, where pride and stigma are themes explored in detail through an investigation of how doctors have shaped and managed their professional identity around their everyday interactions with medical colleagues and the wider public.

CHAPTER 6
THE MICRO-LEVEL: A PROUD PROVIDER AND STIGMATISED INDIVIDUAL

6.1 INTRODUCTION

Previous chapters have discussed that participants believed a demedicalised abortion service is needed to *(i)* allow women to have bodily autonomy, and *(ii)* change the role of the doctor from that of a decision-maker to a medical professional who assists their patients. Such a form of demedicalised service was discussed throughout Chapter Five, which highlighted a tension between what doctors considered a normalised abortion service, which meant for many providing abortion as part of the NHS, in the wider context of a medical service where health care professionals still play an important role. In this chapter, discussion turns to doctors' concerns about the demedicalisation of abortion, especially when considering complex abortions and second-trimester surgical abortions. Such concerns often took the form of arguing that abortion should be placed within NHS settings to ensure they are considered part of 'normal' healthcare. By normalising the abortion service, the interviewees argued that on a practical level they would run more efficiently, while doctors would be able to provide a service for their patients. This chapter builds on my account so far, moving to the micro-level.

As Chapter Three outlined, for the purpose of this investigation, the micro-level focuses on the 'abortion doctor' in relation to their patients, medical colleagues and the wider community. My account of the micro-level is therefore built out of accounts that mainly concern doctors' relationships and interactions with others, including medical professionals and members of the wider community. In particular, the chapter focuses on the identity work that participants do to construct their identity. Sveningsson and Alvesson (2003) have defined identity work as a process where people are: engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness. (p. 1165)

Sveningsson and Alvesson (2003) thus define identity work as a process through which an individual tries to make sense of who they are. Vignoles et al. (2006) add that "the process of identity construction" is guided by "pressures towards certain identity states and away from

others" (p. 309). This chapter focuses on the stories doctors have told that show how they create their professional identity as a doctor who provides abortions. I focus here on the different ways doctors engage in identity work through an investigation of how participants discuss their relationships and interactions, both with medical colleagues and the wider community, and how these have impacted their values as an 'abortion provider'. I examine the accounts of participants who compare themselves to others, then use these comparisons and experiences as justifications for their values and how their values impact their practices.

This is, in turn, important to the medicalisation of abortion: as Halfmann (2012) has argued, medicalisation can occur on the micro-level through identity construction and identity work. As briefly discussed in Chapter Three, abortion has been described as 'dirty work'; it is not considered a high-status area of medicine. During the course of analysing the interview data, it became clear that the questions on identity and how participants construct their identity were being answered through discussions about the pride and stigma that doctors feel. Both pride and stigma were important to how participants had constructed their identity as a 'good doctor'. Hence, as part of this analysis, I drew upon Goffman (1963) and the associated literature that recognises the significance of the making of identity as a part of professional experience. For example, Wilkinson, Hislop and Coupland (2016) have suggested that forming a professional identity is part of a process where individuals construct an image of the "self when finding ways to contribute meaningfully to society" (p. 12).

This chapter will, therefore, examine how doctors construct their identity as medical professionals, working in what they experience as a stigmatised area of medicine. This chapter also considers how these individuals manage the tensions in the medicalisation of abortion, carrying on the conversation from Chapters Four and Five. This chapter begins with an investigation into the motivations of those doctors who provide abortions. The second section of this chapter then continues the discussion on how doctors have created and shaped their professional identity by examining the feeling of pride and fear that they expressed during the interviews. I then turn to discuss how doctors have made sense of these different emotions through building a new collective identity as a medical professional working in a stigmatised area of medicine. This chapter explores how doctors manage their professional identity through the ways they discuss their contribution to the abortion service.

6.2 BECOMING AN ABORTION PROVIDER

To investigate how doctors construct their professional identity, it is important to explore the individuals' motives for working within this sub-specialty, this is where the current chapter begins. As part of the interview, doctors were asked a series of questions that allowed them to discuss their reasons for wanting to work within an abortion service. For example, in part of the interview schedule participants were asked 'how did you get into that role?' Doctors were never explicitly asked why they decided to work within an abortion service to allow them to tell their story without being influenced by the interviewer's agenda.

Doctors gave many reasons for working in the abortion service. I have interpreted their accounts of their professional lives in relation to the extent to which they used language that prioritised an idea of morality or in some way doing good. As this section of the chapter will show, doctors each had their own moral story to tell about why they became an abortion provider.

However, participants expressed different degrees of morality in their stories. Participants' accounts can therefore be thought of as existing on a spectrum where, for example, 'conversations with anti-abortion doctors' is at one end (this being the sort of account where the moral dimensions of becoming an abortion provider were most explicit) and 'work-life balance' on the other (this being a more pragmatic type of account, in which being a doctor of this sort appears motivated by considerations unconnected to the morality of abortion). The reason for choosing these as the two ends of the 'moral spectrum' is that when doctors discussed their reasons for working in abortion services, they were also talking about ways in which they were 'doing good' by providing these services to patients. Such accounts often functioned as a justification for doctors' involvement in abortion services.

In comparison, I found that doctors who reported a more pragmatic approach in their motivation for working in the abortion services were less patient-centred when discussing this aspect of their decision-making. As the following discussion illustrates, most participants discussed their careers in a way that included explicitly moral dimensions. Broadly speaking, this is broken down into how they viewed the women seeking abortions and how they saw their role as a medical professional assisting their patients.

6.2.1 IDENTITY MOTIVES

This section first explores the observations of doctors, which can all be categorised as being motivated by past experiences. It is important to note that each of the doctors interviewed told their own unique story about why they decided to become an abortion provider. However, what I investigate here is the common themes that appeared in these stories and that led doctors to create and shape their professional identities.

For example, Bridget told me the reason she decided to work in an abortion service developed out of her experience as a medical student training in a strict Catholic country. She had encountered one woman who "was brought to our ward who had a septic abortion" and who had kidney failure. When the patient was being discharged, Bridget asked the consultant to sign a prescription for a contraceptive pill, but the consultant refused because "he basically said she's a tart. She's just having sex when she shouldn't be having sex so I'm not giving it to her". Bridget told me that this motivated her: she "thought well if you can be that horrible to women, I have to do the opposite, so I have been overly nice to women all my life. There I am 40 years later still doing it". Bridget thus suggests she has a moral responsibility to do her job to counter-act the attitude she encountered in her medical colleague.

Amy also discussed the idea that doctors work in the abortion service because they have a moral duty to provide a service which is better than that seen as part of their medical training. She discussed a time when she witnessed a doctor-patient consultation and thought: "I can do much better than this", and that gave her "the kick to say right you can do this". The sense of moral responsibility that Bridget and Amy discuss is interesting, since these doctors are not only working to provide a good service. Instead, they are engaging in identity work by constructing their professional identity in discussing who they were and wanted to be.

As Lepisto, Crosina and Pratt (2015) note, to investigate professional identity, it is important to investigate identity motives. This is defined as the "underlying drivers" (p.17) that lead individuals to build their identity in a specific way. Using this definition, participants such as Bridget and Amy construct their identity as doctors who are 'different' from those who they have previously worked with, and this is what motivates them to provide abortions. By working to provide abortions, then, these doctors are doing a type of identity work. They illustrate what

they believe is an important type of identity work by distancing themselves and their practices from those of their medical colleagues.

Charles also expressed the idea that participants work in this sub-specialty because they feel a moral responsibility to provide abortions. He reported having a similar experience to Amy when he was a junior doctor. Charles told me he had "always been interested in termination of pregnancy from the first job I ever did". His interest in the area was sparked when he worked with a mentor in obstetrics and gynaecology. Charles said the professor would do his "operating list from 8:30 in the morning till four o'clock" every Wednesday. He continued telling me that "between four o'clock and five o'clock myself and the other Senior House Officer would do four terminations of pregnancy". What struck Charles was that the Professor and his team treated these patients as if they "were beneath them". Charles thought this "was incredibly wrong". He felt that "these women deserved the same level of treatment as anybody else and that's what spurred me".

What becomes apparent from these stories is the impact doctors' experiences have had on their reflections of their behaviour and what they believe makes them a 'good doctor'. These doctors were motivated to become abortion providers because they had experienced situations where medical colleagues or mentors had treated women, to their minds, unfairly. As a result, they believed it was their responsibility to provide the care they felt women deserved. Existing literature, such as by Dickens and Cook (2011), suggests that this "conscientious commitment to undertake procedures to protect women's health often arises in response to other practitioners' failures or refusals to provide care" (p. 164).

These doctors actively sought to distance themselves from the values of their medical colleagues, they formed their professional identity in such a way as to challenge certain values they had encountered. Doctors' stories were thus about becoming involved in the provision of abortion as a way of rejecting a particular form of professional identity, a rejection of the values certain medical colleagues were teaching them. Instead, they re-constructed their professional identity to become a provider of a service they believed both important and necessary.

Through constructing their identity in this way, doctors are not suggesting that they should be the ones that make decisions on who can have a safe and legal abortions, but rather consider their role in a different light. These doctors tell stories that portray themselves as moral workers

fighting to protect the interests of women from other medical professionals who see women as in some way undeserving of care. In doing so, these participants giving meaning to their work as doctors who provide abortions.

In addition to doctors whose past experiences with their colleagues were motivating influences, twelve doctors decided to work in the abortion service because they had first-hand experience while working abroad of seeing women who were unable to have a safe termination. Judy told me that she knew someone who had to travel halfway across Australia to have an abortion because there was no local service. She was motivated to provide abortions by this experience. Maria told me that when she worked in the Middle East, she "came across people that were coming in with miscarriages and they clearly were not" but she "just put them through as an incomplete miscarriage. No more said". This made her realise that legal abortion was important and providing them "was an important thing to do". She told me that abortion work is "a job that needed to be done".

Similarly, Faith had worked in a 'bush hospital' in an African country where abortion is illegal, and she saw women die from illegal and unsafe abortions. She described her experiences as "quite horrifying really". She told me that "they were young women, and they took native medicine and all their organs shut down and there was nothing we could do". Faith carried on by telling me she discovered that one of the medical professionals was "doing illegal abortions, and every night there were about fifteen women who came in with complications from an illegal abortion and so it was obvious that there needed to be a service". It was after this time in her career that she "decided that one needed to work in the service because women needed access to safe legal abortion". The decision to provide abortions described by Faith is one influence on the formation of her professional identity. Recognising the consequences of not having a legal service provided by medical professionals, she has dedicated her career to ensuring women in England never have to face these consequences.

Joshua also told me that he had "first-hand become aware of the problems that lack of safe abortion care poses for girls and women". He had gained this experience as he worked in "countries where the law is very restrictive and where people are very judgemental". As with Maria, this was a contributing factor to explaining why Joshua decided to work in the abortion service to provide a safe and legal service for women.

Jack also discussed his past experiences as motivating factors for working within the termination of pregnancy services. He spent time in an African country where abortion was illegal for religious reasons, after becoming a doctor, and described experiences where he "watched disasters" because he saw women that could not have a termination. He recalls seeing "wards that were full of septic women because they'd had illegal abortions". In particular, he had seen:

> Women die from stuffing stuff in their vaginas, twigs, metal instruments, lacerations to the vagina. I saw one 16-year-old girl who I will never forget. Someone stuck a knife up her vagina. It was horrendous.

For these doctors, engaging in identity work to construct their identity goes beyond the experiences of seeing women being treated unfairly by medical professionals. These identities are constructed based upon the idea that they must do the work they do because, without doctors like them, women's lives would worsen and sometimes catastrophically so. Their identity eschews the construction of the doctor as a decision-maker responding to a woman's request: it is instead built around the story of a moral worker fighting daily to enable women in their reproductive health.

The past experiences of doctors discussed above show a form of identity work where participants focus on shaping their professional identity by rejecting certain values. For example, doctors reject the values of medical colleagues who treat women unfairly and also reject the values of a society without a legal abortion service. However, past positive experiences can also cause individuals to accept and retain existing values. Ten doctors discussed being inspired by a mentor who performed abortions, they constructed their professional identities around wanting to be like these individuals. For example, Christine told me that when she was a medical student, she had a "black and white theoretical view that stopping life is the wrong thing to do and perpetuating it is the right thing to do". She worked alongside a consultant who provided terminations but she "didn't like him very much" so she just "carried on her stance without questioning it" because she did not want to contribute to abortion care. However, her attitude changed when she worked with a consultant that she "did like", who said to her: "you don't have to do the abortions, but would you mind seeing them in the clinic and doing the pre-assessments?". She told me that she thought to herself "because I liked her and respected her very much, I thought well for you I will give it a go". It was after

this experience that she told me that she "began to see that life was greyer". She continued by drawing on a direct comparison between her work and that of a soldier in the army. She told me that although it is always wrong to kill someone:

> As you grow older, you realise that yes you could join the army and earn from killing because life gets more complicated than 'you must never ever kill anyone, or your life is over and ruined'. That's such an immature way of looking at things, and a pragmatic approach is to do the least harm.

However, she had previously "kept away from those kinds of thing" because they challenged her opinions and beliefs on the role of the doctor as being someone who prevents death. She told me that this changed when she began working with the second consultant because, before that, she had not met anyone whom she would consider "as a role model that I could say is a good person". Working alongside a doctor she respected who provided abortions changed her way of thinking about the service.

Christine's account of how she became involved in the abortion service is illuminating. She discussed how during her career she was continually engaging with identity work. Part of her journey involved a powerful moral conversion which led to her to re-evaluate her beliefs about life, death and abortion. This was the result of certain interactions she had with medical colleagues and how she had perceived them. When Christine worked under a doctor she respected, she began to re-shape her professional identity and found a new commitment to providing abortion care.

Karen told me a story similar to Christine's, where she was inspired by a medical colleague. During the early stages of her career, she said, she encountered a colleague who wore a Christian symbol as a badge on her uniform and who worked in an abortion clinic. Karen asked her colleague how she could be "a committed Christian" and have a job working in abortion care. Her colleague replied: "Well, I think these women need compassionate care". Unlike Christine who was Christian, Karen was not, but they both shared the same belief that the role of doctors was to prevent death and that terminating a pregnancy went against this core principle. However, the discussion with her colleague helped her "to mature and think about things in a more pragmatic and nuanced way".

Both Christine and Karen were engaging in identity work by abandoning the unwanted identity that abortion was wrong because it went against the core principle of doctors to save lives. They outlined their reasons for working in the abortion service by discussing stories that had great moral significance to them, and that were part of a re-shaping of their professional identities as workers on a moral mission.

Lauren also told me a story where she considered herself a moral worker. She had a mentor who was a well-respected doctor known for working in the abortion service. After working alongside and talking to this particular doctor, she decided "yes this is something I want to do". A sense of moral responsibility and moral purpose was further mentioned by Emily, who said that when choosing a career for "the rest of my life, I want it to be something that I enjoy, but also that I feel benefits people". Eva discussed 'helping people' during her interview; she was interested in "trying to reach the most vulnerable people". But more than that, she wanted to "look at the crossroads between health and people's social experiences and kind of try to be an agent of change, positive change in people's lives".

The idea of making a difference to the lives of women also resonated with Georgia, who told me that she was "always interested in it from university, always pro-women's choice". As she went through medical school and "junior houseman jobs" she decided that she wanted "to be part of improving, changing and enabling women to access that service". Similarly, Elizabeth said it was "the only area of medicine that I really, really identified with, probably partly because of my feminist beliefs … a lot about sexual and reproductive rights and women's rights and things like that". Melissa also told me that part of her reasoning for working in the abortion service was because she was "quite a feminist activist at university" and that she "felt very passionately about women's access to safe abortion". The reason she began working in this sub-speciality was that she "feels very passionately about the fact that women used to die, and in fact in some parts of the world women still do die from unsafe abortion". So, she decided to provide abortions because she believed it was important to make sure women could access safe and legal abortions. In addition, Abigail also identified herself as a feminist and described her "approach to medicine" as "bringing justice to women through health". In these accounts, abortion provision is presented as a variant of activism.

The accounts examined above concern doctors who made a conscious decision to work in the abortion service. Many participants told stories of how they were either always motivated to

provide abortions or had been motivated by past experiences. Regardless of their motivations, they all expressed themselves as constructing and shaping their identity as a form of moral work where their interactions with others had shaped their values. As a result, doctors discussed how their journeys help to explain their values. For example, some participants considered abortion work a form of activism; other considered it as life-saving; while some identified an opportunity to reject the values of other medical professionals.

However, not all participants reported a conscious decision to work in the abortion service: some doctors discussed how they began working in the abortion service accidentally. Not all doctors who worked in the abortion service were doing so because they felt a moral responsibility to women to provide a service. For example, Vanessa told me when she was a speciality trainee, she "was the only registrar who didn't conscientiously object to being part of that, so not by design but by default I ended up doing a lot of it". She continued by telling me that she "can't put my hand on my heart and say it was why I got into obstetrics and gynaecology. It wasn't what I set out to do in my career, it was one of the things that came along … and it's very rewarding". Michael also told me that he "stumbled upon" his work after taking a job early in his career in a hospital where abortions are provided. Yasmin shared a similar story to Michael, saying she "took a temporary job working in sexual health and from there just stayed in it because I really enjoyed it".

These doctors were not motivated to provide abortions because of a sense of moral duty, but rather that they became involved in abortion services by chance. However, what is significant here is that they also describe how, once they became part of the abortion service, they began to feel attached to a similar set of values that other doctors have described. They found the job rewarding and became moral workers once they started working in the abortion service. This goes beyond doing a better job by providing a good service; working in the abortion service became a mission, whereby they form their identity around the idea of making a difference to the lives of women.

Some doctors were not morally motivated to work within the service. Instead, seven doctors spoke about working in the field because it allows for a work-life balance in comparison to other specialities in medicine, which was their primary motivation. For example, Daisy informed me that the reason she chose to work in the abortion service was that she "needed something with a decent work-life balance 'cause I had my children already". This also

resonated with Kelly, who acknowledged that she "doesn't want to work nights or weekends, and it's not as onerous as working in A&E or on a labour ward which I used to do". Lisa also told me that her time spent training abroad "wouldn't count" so she would "have to start all over again and you were doing nights". She did not want to do that because she "had three children at home, and a husband" and this impacted her decision to start "looking for work that was in the daytime". Faith also mentioned during her interview that she decided to work in Family Planning because she could not do the "extra night on-call with four children". Mary told me that working in the abortion service meant she has "a reasonable work life balance".

We can identify two different ends of the spectrum to participants' accounts of why they work in the abortion service. On the one end of the spectrum, participants use their past experiences as a justification for medical involvement in abortion services through claims that without doctors like them, women would not be able to access safe and judgement-free services. On the other end, as discussed in the last paragraph, some doctors took a pragmatic approach in their accounts with reasonings less patient-centred then their colleagues. While all participants discussed different identity motives for why they chose to work in the abortion service, and each participant had their own personal journey and route into the service, the vast majority believed they have a moral responsibility to do their job and this is what guided them to their current role as abortion providers. The next section of this chapter evaluates how doctors have constructed their identity beyond their motives through discussing the feelings of pride and fear they experience due to working in the abortion service.

6.3 Emotion Stories: Pride and Fear

This section examines how doctors engage with identity work beyond identity motives through investigating doctors' experiences. It analyses references in the interviews to feeling pride as a way of investigating how doctors view the role of the medical profession in providing an abortion service, and to explore how they attribute positive meaning to actions they take as professionals. As we have seen from the first section of this chapter, doctors were particularly motivated to provide abortions because of a moral belief that women should be able to access safe and legal abortions, and that their role was to help provide this service. As part of the interview, doctors were asked 'are you proud of the work that you do as a [insert job title]?'. It is my analysis of the answers to this question that I discuss first. The other emotion discussed

when interviewees talked about their work was fear. Unlike pride, conversations about the sense of fear participants felt were spontaneous, and often developed as part of their reply to the question about pride. The stories participants shared about these emotions are important to analyse since they are part of how these doctors have shaped their identity.

Doctors engage in identity work through discussions on their interactions with other people. Berger and Luckmann (1996) suggest that once identity is formed "it is maintained, modified or even re-shaped by social relations" (p. 194). Through examining how participants give meaning to their identity as an abortion provider, this section explores how interactions have influenced participants values and shaped how they see their identity.

6.3.1 PRIDE

In a way similar to participants' accounts of their motivations for working in the abortion service, doctors discussed pride when they told stories of how their emotions and experiences have shaped the work they do. As their pride affects how they provide abortions it is therefore linked to how they view the medicalisation of abortion. Even though almost all participants (forty-three) described themselves as being proud of their work, doctors described the pride they feel in different ways. The majority of doctors were personally proud of their role but often did not disclose it to people outside the abortion services. This distinction relates to the question of stigma, which I discuss later. Once again, participant remarks can be considered as falling on a spectrum: at one end, doctors described themselves as openly proud of their work; on the other, doctors reported battling a range of conflicting emotions that affected how they saw and discussed their role as abortion providers.

Several doctors told me they were openly proud of their work; however, there were various reasons for this overt sense of pride. Five doctors were proud of their work because they believed providing an abortion service is an essential part of healthcare, and that they were working to provide this. Michelle said:

> It's my conscience that tells me that I'm doing the right thing. I'm proud to be a doctor, I'm proud to be a gynaecologist, and I'm proud to be an abortion doctor. I don't see

> anything wrong with that because I applied to be a gynaecologist and it's all part of gynae[cology] isn't it?

Michelle's portrayal of her sense of pride in her job and her role providing abortions is in line with the case made by Dickens (2008). Dickens (2008) argued that some healthcare professionals working within reproductive health are conscientiously committed to providing services. Medical professionals who are conscientiously committed, according to Dickens (2008), to act "against … medical orthodoxy following the honourable medical ethic of placing patients' interests above their own" (p. 1241). Michelle has a strong sense of pride in her work and believes that she does the morally right thing by providing abortions. By begging the question that abortion is part of healthcare, she compares herself to other doctors working as gynaecologists who do not provide abortions and believes she is a good doctor because of the work she does. She draws a direct comparison here with doctors who do not provide abortions, implying she is conscientiously committed to providing abortions because abortion care is not different from other areas of gynaecology. She is proud of her involvement because, without doctors like her who see abortion as like other areas of medicine, women would not have access to the service.

A strong sense of pride was also apparent in the interview with Bridget, who said "I've always been very proud to be an abortionist. I'm really okay with it". What is interesting about both Michelle and Bridget's comments is that both conclude that they are either 'okay' with their decision to provide abortions or believe it the 'right' thing to do. This would imply that both doctors have made a conscious decision that providing abortions is what makes them good doctors, they have taken on the role of moral workers. Through telling stories of their conscientious commitment, they also communicated the belief that they work in an area of medicine that is still morally contested and felt they must justify their decision to work in the service. The idea that these doctors were telling stories to justify their choices in the speciality relates to the broader debate about the role of the medical profession as it would imply that the values of these doctors are not self-serving. Instead, they are formed by the belief that they are in some way helping and doing what is morally right.

Doctors told stories about pride in conversations where they suggested abortion should be treated like other areas of healthcare. However, some comments made suggested they thought of abortion as in some way different to other medical procedures. For example, Daisy told me

that working in an abortion service is "one of the most important aspects of my job". Similarly, Chloe believed "everything I do is essential so it's quite easy to justify getting out of bed in the morning". These comments can be interpreted as suggesting that abortion has been thought of as an ethical or moral dilemma. Doctors' wording once again suggests that they are moral workers who see themselves as part of the solution to an ethical problem. This is relevant to the broader debate on the medicalisation of abortion: it suggests that some doctors see their role as moral workers and not as paternalistic doctors concerned with maintaining medical autonomy. This suggests that instead of a tension between the self-interest of medical professionals and altruism (Cruess, Cruess and Johnston, 1999), the values of these participants are altruistic since they are motivated to help their patients.

When discussing the macro-level, doctors were keen for abortion to be seen and treated as 'like any other medical procedure', yet when discussing their sense of pride, these doctors were aware of a difference between providing abortions and other areas of medicine. For those doctors who saw providing abortions as a moral or ethical decision, they concluded that they provided abortions to do the right thing by their patients.

Another reason doctors spoke explicitly about being proud of their work in the abortion service was because of their interactions with patients. For example, Rebecca told me that she is "really proud" because she thinks that she "makes a big difference to a lot of women". She told me that she felt this way about "all doctors who work in the service, and nurses" that she believed it was a "real privilege to work in that service". Similarly, Abigail said, "ah, I think that I can make a difference to people's lives". Through discussing making a difference, doctors are expressing a value set they have in response to the interaction they have with patients. Doctors here act as advocates for their patients and believe this makes them good doctors.

Patient interaction was also expressed as a reason for feeling proud by Lisa, who told me that "generally speaking they are the most grateful patients you can ever have". Georgia also discussed the personal gratification she feels from working with her patients. She told me, "I'm proud to be able to help the women at that time, give them the right advice, point them in the right direction". She told me that:

> Particularly with the more vulnerable people, young patients, you know, we're involved with the police in some circumstance. Child safeguarding and all those sorts of things

> come into it and to be able to try and take someone--, you can come in and think on the face of it, it's just a woman having an abortion, we're now digging deeper and looking into what is actually going on for that person sitting in front of you. And some of the things that come out are so shocking, and hopefully, through that work, we can take them from one path and move them onto a slightly different path and improve things for them in the future, and that is something I'm proud to be involved in.

Georgia describes forming her identity around helping and doing good, these are the factors that explain her values. However, Georgia's explanation of working with young and vulnerable people is different from how the role of the doctor has been portrayed in the previous two chapters. Throughout Chapter Four, the role of the doctor in the abortion service was to provide a service in which they play a minimal role. On the macro-level, doctors were very motivated to provide an abortion service that is partially demedicalised in terms of decisional power, so doctors play no role either as decision-makers or in making moral judgements.

However, here Georgia suggests the doctor's role goes beyond that outlined on the macro-level. This description of a good doctor goes beyond the belief that the role of the doctor is to use their expert skills and knowledge to perform medical procedures. The role of a good doctor includes working with the police and other organisations to move patients "onto a slightly different path".

Overall, doctors constructed their identity partially through discussing feelings of pride. Their discussions centred on what they saw as behaving in ways that are both good and important to them, as doctors. The stories told by participants endows the medical role with positive attributes. However, the feeling of pride exists in an ambiguous relation with demedicalisation because here participants give value to the medical role when it is enacted in a way they deem most appropriate. The ambiguity between demedicalisation and pride is clearest throughout discussions about vulnerable women, as outlined above, where participants made the case that these women need a doctor like them to be involved in the abortion process.

While participants discussed feeling a sense of pride because they work in the abortion service, they were also aware that other people do not view abortion this way. For example, Eva discussed her work in the abortion service compared to her work outside of the service: "no one's [medical colleagues] going to come and give me a pat on the back for being involved in

a termination, but I am proud of the work, really proud". Eva is acknowledging that her work in an abortion service is viewed as different from other areas of medicine. Even though some people do not like her work, she believes that she is doing the right thing by providing abortions to women. She thus is describing herself as a moral worker, providing abortions to help women, and it is for this reason that she is proud of her role in the abortion service.

The idea that doctors who provide abortions are different from other doctors was also raised by Clare. She told me during the interview that she was proud of her role working in the abortion service "in general, yes, yeah", but she also recognised that the role of a doctor working in the abortion service is different from that of other doctors. She described part of their role as "not saving lives necessarily, but we make a massive important and difference to people's quality of life, help them make positive choices". Again, here Clare talks about how her role is to make a difference to women's lives, and she has formed her identity around helping people who she believes are vulnerable. This relates to how doctors discussed their overall role in the decision-making process as outlined in Chapter Four, where doctors claimed their role was to provide assistance rather than to help women make choices.

As Chapter Four has shown, doctors were highly motivated to perform their role in a partially demedicalised abortion service in order to allow women to enjoy more bodily autonomy and to be the decision-makers. Doctors were clear that they believed the medical profession should not have a role in the decision-making process: women should be the sole decision-makers. The role of the medical profession is to assist women and provide guidance when women request it.

However, above Clare values her ability to help the women she sees to make those decisions. This would suggest she believes the role of the doctor is to assist women in the decision-making process. This is one example of a tension in the values of the abortion provider between the macro- and micro-levels, where when discussing the law, doctors clearly expressed the argument that the law should not place doctors at the heart of decision-making. However, on the micro-level, some doctors were proud of being able to help women make their decisions. It is important to note that Clare is not suggesting that doctors have a right to decide on behalf of their patients, which was ascribed to doctors through the 1967 Abortion Act.

6.3.2 Mixed Feelings: Worry, Fear and Keeping Abortion Work a Secret

Pride was not always at the forefront of how doctors discussed their work. Twenty-three doctors discussed feeling proud of their role in the abortion services; however, they also told me they were cautious about telling people about their involvement with abortion provision. As Martin et al. (2020) note, when professionals face insecurity it can threaten their identity. As a result, doctors "draw on 'retaining' identity work … to provide a continued sense of meaning or purpose" (p. 10). I now explore how doctors are continually shaping and reshaping their identity when they discuss negative emotions, such as fear and worry, because of their job. As the last two sections of the chapter show, doctors who provide abortions have a strong sense of identity built on the premise that they are helping people and doing good. However, this section of the chapter will illustrate a tension between how doctors see themselves and how doctors believe others see them.

Christine told me she was proud of her work, "but with abortion care, you have to be careful whom you discuss it with because some people just don't understand, and don't want to understand". In addition, the common phrase used by ten participants was 'you wouldn't mention it at a dinner party'. For example, Lilly believed that bringing up her work as an abortion provider is "not dinner party conversation". This shared phrase used by a number of participants is interesting as it suggests a collective identity these doctors have built. A collective identity is formed when individual values are connected with a wider practice or community. There is a shared emotion that these doctors express where there was a concern that telling people you provide abortions can have a negative effect on them and their work. This would suggest that abortion doctors have formed a collective identity around the idea that they are part of an embattled group of professionals. Rebecca also mentioned the idea that abortion doctors are part of a disparaged group of medical professionals, telling me that she is "very careful about whom I tell. I don't tell many people that I work in a termination service". Samantha said, "I think it's fair to say you don't readily talk about what you do".

This collective identity where doctors are cautious about who knows they provide abortions was also discussed with Lola, who told me that while she is proud of her work, she does not think she is "particularly good at being very outspoken about it". For example, on her "LinkedIn profile, I didn't write huge amounts about abortion". Similarly, Eva said she was "definitely

proud yeah" but she "doesn't like posting on Facebook very much". She used this as an example of how she describes her pride because she had recently posted on her Facebook page about an experience of attending a birth on a labour ward where it was a special moment for her. She told me that she felt "really moved" by her experience, which is why she spoke about it on Facebook, and she had received "a lot of positive responses" because of it. However, she "instantly felt like that was only half the story" because "a huge part of my job is to support the women who make the really hard, hard decision to have a termination". She continued, telling me "they don't get anything. They don't get special praises, and they don't get special Facebook posts" because she is worried about the reaction she might receive.

Some accounts suggested interviewees were deliberating how they felt about their role in the abortion service through accounts of mixed feelings. Kelly discussed feeling proud of her job on a 'private level'. She initially suggested that she is proud of her role in the service, but after some further reflection, she also spoke about an "element of fear". This, she said, impacts how "outspoken" she is about her role in the service. As a result, Kelly described herself as proud on a "kind of private level", in order to avoid "exposing" herself to "any kind of risk to my family". Some doctors seemed in this way to be managing a conflict between taking pride in their role in the service and responding to a perceived risk about anti-abortion individuals knowing about their role.

Doreen, who works in the abortion service while completing her Community Sexual and Reproductive Health training, also had a complicated view. Her work involved "some specialist contraception clinics, some abortion clinics and surgical abortion lists" amongst other areas of sexual health. As part of her response, she considered her role as a doctor and her personal experiences. She told me that she had done some "soul searching" because although she "believes in women's choice" her friends and family do not know that her work involves abortion care. "It's something that I don't tend to mention out socially, in public, when people say what kind of doctor are you, I don't tend to mention it". This led Doreen to conclude that she is not proud of it because "if I were proud of it, I would be definitely talking about it". However, even though Doreen told me that she was not proud of her role in the abortion service, she was "absolutely sure" that she is "doing something that is needed and is right" because of this she did not "question my ethical stance or my morality". But she did question "whether it's socially appropriate to bring it up, whether it's just going to cause awkwardness and unnecessary … because it's such a controversial topic". She continued that she believes: "it's

right, and I'm proud that I've done what I believe is right, but I'm not proud of what I do … and I'm not proud of the service as it is at the moment … as I have experienced it in the UK".

Doreen's description of the sense of pride she feels is interesting as, like Kelly, both doctors discuss the different and somewhat conflicting emotions they experience. Where on the one hand, they believe what they are doing is right, on the other, both worry about how others would perceive them were they to find out their role in providing abortions. Doreen is conflicted between the "immediate pride" she feels when she receives feedback from women, which reminds her of why she is working in abortion care but also the fact she does not "openly talk about it". Kelly described a similar conflict but defined this as pride on a 'private level', whereas Doreen told me that she is not "openly proud" of her role in the abortion service. While these doctors had different reasons for not defining themselves as proud of their work in the termination of pregnancy services, they both believed they were doing the right thing by providing the service for the women they saw. However, doctors used this tension in how they see their work as an abortion provider to explain how they give meaning to their work and why they believe abortion work is important.

One doctor interviewed suggested that even though he was proud of his role in the abortion service, he recognised a difference between the pride he felt as a doctor working within an abortion service in England and that of doctors who work in the termination of pregnancy services in other countries. Nathan noted that "very, very, very few doctors introduce themselves as abortion doctors or termination specialists" because "it still carries a negativity to it". This implies that even though many doctors who work in the service are proud of their job and their role in the abortion service, these doctors are aware that working in the abortion service "carries a negativity to it".

In comparison, after attending a conference in Amsterdam in the early 2000s, Nathan recalls that "abortion surgeons have a very high status and introduced themselves as abortion specialists". He said one of the doctors "had a chauffeur driven car that was provided by the clinic" and that doctor was "being paid extremely well". During the interview with Nathan, he suggested the reason for this is because, in Holland, the attitude towards abortion is "a lot better". He told me that this is because he believes:

> The British haven't got much beyond Carry On films really, you know what I mean? [laughter] … whereas in Holland, I can never imagine that that sensationalism around--, around these issues exists really, people seem to be a lot more mature about the issue.

Even though he did not see British society as valuing his work as they would do in Holland, he was still "very proud of what we do". Nathan implies there is a tension between his feeling of pride for working in the abortion service and the feeling that medical professionals are stigmatised for their role because the values of British society have not changed much since the 1970s. However, doctors such as Nathan still believe the attitudes of the public towards them and their work have not changed, and they are still feeling stigmatised because of the sub-speciality they have decided to work within. Nathan, like the other participants who said during the interview that it is not 'dinner party conversation', are navigating a tension where they are both proud of their work but aware of the stigma associated with abortion. This tension places doctors who work within the abortion service in a unique position in relation to the wider values of the medical profession.

This section of the chapter has investigated the sense of pride that doctors working in the abortion service express about their work, and the ambiguities that entails. While doctors often spoke about a sense of pride they feel because they believe they are doing what is right by providing women with a safe and legal abortion service, they were also scared and worried about the effects of being open about their work, in a way that seems unusual for a medical professional to feel the need to keep their work a secret. I now develop a discussion of this aspect of the constitution of professional identity through a consideration of stigma.

6.4 Stigma: Making Sense of Mixed Feelings

As the previous section of the chapter has shown, doctors manage a range of emotions when shaping and re-shaping their professional identity. There were times during interviews when doctors constructed themselves as proud providers doing a job, they believe important. There were other times where doctors told stories about feeling powerless in the face of criticism from both the wider public and their medical colleagues, due to working as abortion providers. The section explores how these doctors make sense of this tension they face and how it impacts their professional identity. Thirty-nine doctors – the majority – mentioned the word stigma at

different points during interviews. The interview schedule did not include questions that directly used this word; rather, it spontaneously came up repeatedly.

Stigma is a term doctors used to describe the position and wider environment they felt themselves in. Goffman (1963) defines stigma as "the situation of individual who is disqualified from full social acceptance" (p. 5). He suggests that the stigmatised individual is someone who fails to meet the expectations of what is considered 'normal' and 'good' in society. This broad concept, originally outlined by Goffman, has been adapted and discussed throughout many different fields of sociology. Still, stigma is "typically a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group" (Scambler, 2009: 441). These are not characteristics usually associated with the professional. Instead, stigma is usually associated with patients in the doctor-patient interactions, with medical professionals being the stigmatisers. For example, studies on stigma and mental health have shown that "mental health professionals are known to treat clients disrespectfully or to ignore clients' stated needs and preferences" (Horsfall, Cleary and Hunt, 2010: 452), which exacerbates the stigma that their patients feel. In addition, Link and Phelan (2001) argue that for stigmatisation to occur "power must be exercised" (p.363).

However, as this chapter will discuss, thirty-nine doctors who work in the abortion sector have in some way classified themselves as 'stigmatised', suggesting they do not consider themselves as being in the group exercising their 'power'. They instead imply the opposite by suggesting they are the ones who are viewed as failing to meet the expectations of what is considered 'normal' behaviour and values. This relates to the broader debate on the medicalisation of abortion: as Chapter Three outlined, the literature on medicalisation has not portrayed doctors as feeling powerless – instead, medicalisation literature such as Freidson, (1970) has argued that a key value of the medical profession is asserting their power and control over their patients.

According to Goffman (1963), stigma is managed through being assigned a 'spoiled identity'. A person society views as stigmatised is "insulated by his alienations, protected by identity beliefs of his own, he feels that he is a fully-fledged normal human being, and that we are the ones who are not quite human" (Goffman, 1963: 16). The stigmatised individual is hence

someone who believes they are the "normal person [because]… the stigmatised individual tends to hold the same beliefs about identity that we do" (Goffman, 1963: 16). However, unlike in Goffman's (1963) work, which argues the individual does not know they have a spoiled identity because they believe it 'normal', my participants were aware that they had a 'spoiled identity' and even spoke about themselves as having a stigmatising identity.

This section of the chapter investigates how participants suggest they are stigmatised, using Scambler's (1998) terms enacted stigma and felt stigma. According to Scambler, enacted stigma is when an individual experiences unfair treatment in comparison to others. Felt stigma refers to "the shame and expectation of discrimination that prevents people from talking about their experiences" (Scrambler, 1998 in Gray, 2002: 72). These two forms of stigma were both described by participants; however, when discussing their experiences of stigma, doctors interviewed often spoke about stigmatisation from two different groups of people.

6.4.1 Stigma from the Wider Public

During the interviews, nineteen participants mentioned feeling stigmatised by the wider public because they work providing abortions. This was discussed in several ways and often given as a justification for doctors keeping their abortion work a secret. However, doctors also recalled times where they have experienced enacted stigma. This section of the chapter investigates how doctors working in the abortion service discuss their perception of stigma and how they explain their spoiled identity.

As discussed in the previous section of the chapter, many doctors were reluctant to tell people that they provide abortions. Doctors suggested the reason was the felt stigma they experienced. Stigma was described by participants even if they had never encountered someone who objected to their job. For example, Lisa mentioned that stigma takes the "edge off" the pride these doctors feel. As she said, "you can't really say, 'oh yeah, this is great, look, you know, we perform fantastic abortions'". In addition, Mary also said that "I don't talk about that part of work. So, there is a stigma attached to it". She continued "I think it does take the edge off it". In addition, Clare believed the abortion service to be "quite a stigmatised area … I certainly don't talk to the school mums about what I'm doing on my Friday theatre list. I say I operate, but I don't tell them I do abortions every Friday morning. I worry I might, yeah, upset

someone". Clare does not discuss her job with her wider community because she is worried about their reactions and the impact it may have on her and her family.

The felt stigma and fear of threats associated with abortion still plays a role in how doctors act and whom they discuss their work with. Therefore, the spoiled identity of these participants directly affects how they act. For example, Elizabeth explained, "sometimes you might think twice about saying, "oh, I provide abortions". She believed that not explicitly discussing the area of her work "is a form of stigma because another doctor who works in heart surgery wouldn't ever think twice about saying that that's what they do". Elizabeth told me that she does not tell people about her work even though she had "never personally felt it [stigmatised] from anyone".

Abigail further highlighted this and reported that "maybe" she has "become a bit paranoid about everything but you kind of spend the whole-time sort of second-guessing yourself and wondering whether to tell people what you do and that sort of stuff". As a result, if people ask Abigail what area of medicine she works in, she tells them she works "in a sexual health clinic" rather than as a Lead for an abortion clinic. The reason she tells people that she works in sexual health is that "it covers everything".

What was interesting is that Abigail also said that she doesn't "really get a sense that in the UK there is the kind of anti-abortion, pro-life protest type stuff that would actually present any risk". Once again, doctors are engaging with identity work, through trying to make sense of who they are and their role as a medical professional working in an area of medicine they describe as stigmatised. The feeling of paranoia due to their role as a medical professional in the abortion service was also mentioned by Sophia, who said that "maybe I am just totally paranoid, but yeah it's in the way people deal with you".

These doctors discuss a form of felt stigma they have experienced. The stigmatisation of their work as abortion providers was often given as the reason for doctors not wanting to disclose information about their work. Their experiences of felt stigma, which they have used to shape their professional identity, have resulted in a set of values where doctors are cautious about who they discuss their work in abortion with. They have instead built a set of values based upon worry and fear of interacting with people who believe their work is morally wrong.

The fear of being stigmatised because they are not sure how others will respond and react is interesting to the wider debate on the medicalisation of abortion. Doctors are traditionally seen as building their values on the premise that they want to both have and maintain medical autonomy over lay members of society. However, this account given by doctors, that they feel vulnerable about disclosing this information, does not fit with the extant literature of medicalisation. Instead of doctors being seen as agents of social control, these doctors are trying to navigate and find meaning for their work. They find themselves in an ambiguous position: they are given power from the law but experience discrimination due to being abortion providers.

In addition to the felt stigma doctors described, they also told me stories of enacted stigma where they had experiences of being treated differently because of their work. For example, Chloe mentioned how her work in the abortion service had a direct link to how she and her family were treated because of her role as an abortion provider. Chloe lives and works in a very Catholic area and provides abortions one morning per week. She believes that because the community has quite strong religious beliefs "whether it's at work or outside work there is something, erm, taboo, there's a stigma about it". She told me about experiences where she was directly impacted because she works in the abortion service. Firstly, she discussed a time where a parent at her children's school who was "quite an observant Catholic specifically contacts me every year at Lent to say that she is part of a protest and that she is praying for me". Chloe's experience here is a form of enacted stigma where members of her wider community treat her differently because of her work.

When discussing pride and stigma, James also mentioned experiences of enacted stigma. He explained that when he first started providing abortions, he "used to get hate mail, lots of hate mail". He continued: "some of them were written in blood, it's quite nasty". In addition, John told me he also had received "hate mail and death threats" because he publicly discussed his role as a medical professional working in the abortion service. A further example of enacted stigma was set out by Janet, who told me that after public appearances where she discussed abortion, she gets "the occasion poison letters". One participant discussed a time where they had an experience where the Home Office came to their house to "teach me how to deal with a terrorist while driving" in case they were stuck in a traffic jam and encountered an anti-abortion demonstrator.

For these doctors, the threat to their safety was a very real experience likening their experiences with doctors working in the United States of America. For example, James told me that:

> The undercurrent of hate against abortion is rife in this country. Again, in a similar way to the States where there is a consciousness to it, so you're more likely to die doing terminations than you are having a termination if you look at the statistics.

While the majority of reports on anti-abortion extremism is linked to the situation in the USA, the experiences shared by participants suggest that incidents are not isolated to the USA. Doctors who openly work as abortion providers in Britain may face the same threat of violence as their international colleagues. These incidents suggest the wider community, or some sections of the community, heavily stigmatises doctors who work in the abortion service if they are publicly known to provide abortions. Doctors providing abortion have needed to re-construct their professional identity around this culture of hostility.

One doctor described another way that abortion stigma operates for her. Chloe also recalled that when her children were younger, three families told their children "not to play with my children" because she provides terminations. As a result, she had instructed her children "not to say outright that their mother does abortions". This is a different way that stigma operates and is an example of courtesy stigma. Courtesy stigma involves "public disapproval [which is] evoked as a consequence of associating with a stigmatised individual or group" (Phillips et al., 2012: 681). Members of the public have overtly stigmatised Chloe because of her role in the abortion service. As a result, her immediate family are facing being ostracised by those who believe abortion is morally wrong. In this example, it is not only Chloe's identity which has been re-constructed as a result of this form of stigma but those of her family as well, in particular her children.

Participants' discussions about the stigma they feel as providers further highlight- why abortion providers are keen to 'normalise' the abortion service. On the meso-level, doctors were not explicitly arguing that abortion should be placed inside NHS services in order to combat the stigma associated with the existing provision of abortion. As this section of the chapter has shown, pride and stigma affect every aspect of the doctors' lives. From the analysis of the macro-level, doctors were fearful of their position as medical professionals because of the criminality of abortion in Britain today.

However, Karen told me when discussing the stigma that "most people aren't really worried about the legal thing". Instead, she believed that the biggest worry for providers is "how people react from their own personal and moral stance" and this causes many providers to feel a "sense of shame about it" which often they internalise. By internalising this sense of shame, participants are engaging in identity work to find ways of giving their work meaning. The sense of shame that doctors feel affects their behaviour outside of the workplace, and these interactions shape their values.

However, it is not just stigma from the public that doctors working in the abortion service face today. Many doctors discussed feeling stigmatised by their medical colleagues, as this chapter will now explore. This form of stigma abortion doctors feel is a form of associative stigma. Associative stigma is the stigma that "health professionals experience because they are associated with persons who belong to a stigmatised category in society" (Verhaeghe and Bracke, 2012: 18). Recent years have seen a focus on the associative stigma medical professionals working in mental health services experience (Verhaeghe and Bracke, 2012; Yanos et al, 2017 and Yanos et al, 2020). The next section of the chapter investigates how doctors working in abortion services are also stigmatised by their medical colleagues because of their association with abortion.

6.4.2 Stigma from Medical Colleagues

The stigma that doctors working in the abortion service felt from their medical colleagues was briefly discussed throughout Chapter Four through attitudes to conscientious objection; it will be examined in more detail here. Once again, a range of comments had been made by medical professionals which led participants to feel stigmatised by their colleagues. These range from some subtle remarks, where the professional status of the doctor was being questioned, to quite morally explicit examples of abortion being stigmatised, and doctors felt stigma by association. This section will firstly explore how participants discussed their experiences of stigma through interactions with medical colleagues about their professional status.

Most commonly, participants discussed comments made to them by other doctors about why they decided to work in the abortion services. These comments did not concern any moral or

ethical standpoint on abortion but were based on how they viewed the status of these doctors. For example, Chloe said that some of her colleagues "think that if you're doing abortion work you've got the short straw… that you're not up to doing more tricky things surgically". Kelly also raised the belief that doctors involved with abortion work are only there because they are unable to work in other areas of medicine. She said there is a "sort of perception that it's not real gynaecology… that all the people who run it are failed gynaecologists and we couldn't cut it in real surgery". This attitude was also mentioned by Lauren, who said that abortion work "is seen as the second- or third-class work [because] it's not technically particularly difficult". Karen also who told me that gynaecologists think that providing contraception and reproductive healthcare is "very easy" and if you work in those areas then you "weren't someone that was trying very hard".

The belief that abortion providers are stigmatised because other medical professionals see their work as 'low grade' was mentioned in a different way by five participants, who told me that there was the perception their personal lives were the main reason for working within the abortion service. For example, during Samantha's interview, she revealed that some colleagues had said to her: "I'm guessing you left obstetrics and gynaecology to do that because you wanted to have a family". In addition, Maria recalled an encounter when she told a fellow colleague that she worked within the provision of abortion and her colleague replied, "so do you have children then?". Once again, these comments suggest that doctors who work in abortion services are not doing so because they are motivated to. Instead, there is a belief that doctors who work in the abortion service have either sacrificed their career because they are either unable to work in a high-pressured area of medicine or because they have decided to start a family.

As a result of these comments, it seemed that those I interviewed thought of themselves in relation to a type of collective identity constructed to refute the identity given to them by other doctors and support other abortion providers. For example, as I have discussed, participants commonly suggested they have made a conscious decision to work in the service of providing terminations for moral reasons. In this way, they refuted the idea that the work involved in abortion care is less complex than other areas of medicine. However, throughout the macro- and meso-level, when discussing EMA and nurse involvement, participants themselves also recognised that a doctor's input in most abortion cases is unnecessary. These are some central ambiguities identified through this research, to which I return in the final chapter.

The idea that doctors who do not provide abortions look down on abortion providers was also mentioned during the interview with Liam. However, he spoke about his interaction with doctors in a different way to those outlined above, this time suggesting that doctors who do not provide abortion are talking about abortion in a moral sense when discussing what they thought of the service. Liam told me that from his experiences, some medical colleagues "look down on the work and they either look down on it as being not important, or they look down upon it as being, that sort of the whole area of dirty work and stigma". Liam's comment suggests that doctors have a problem with abortion services, this stigma is then passed onto the doctors who work to provide these services. Doctors are stigmatised because of their association with the service. This is a different form of stigma to what was discussed above, where it was suggested that abortion work is easy.

By using the term 'dirty work' to describe how others view abortion, Liam portrays a form of collective identity shared with his colleagues who also provide abortions: they are morally responsible for this type of work because, without them, there would be no abortion service because those not involved consider it beneath them. He went on to describe the "frustrating" feeling he has when he "has to deal with other doctors and nurses" who openly "look down on you" but unfortunately, as he told me, "you just have to deal with it and get on with your work really".

Liam's comment reiterates the point that doctors working in abortion services all over England and Wales feel stigmatised because of the career they have chosen and the area of medicine in which they decided to work. This reiterates the point made by many participants that abortion is seen as different from other areas of medicine because it is considered a moral or ethical issue for most people. Due to the distinction between abortion services and other areas of medicine, participants have needed to shape and re-shape their identity to give meaning to their work in relation to how abortion fits in with wider medicine.

A further claim that participants made about the stigma they have experienced from medical professionals was that they believed medical colleagues stigmatised abortion because they saw abortion as 'taking a life'. For example, Daisy said "doctors feel that it's a disapproved of area of care from a sort of moral and ethical framework"; she believed this because as she told me "people don't like the idea of ending a life". The idea that doctors stigmatise abortion because

it does not fit with the core principles of medicine is thought-provoking because abortion doctors see their job in a completely different light. Abortion providers face accusations of going against the core principles of their profession by their colleagues, and they form a professional identity around these interactions.

Lilly also expressed the sense that medical professionals still view abortion as a serious problem because it is taking a life. She said there is a belief that "it's a dirty job, you are killing babies, you're killing life basically and it doesn't matter whether it's six weeks to thirty-two weeks, you're still ending a life and that is what people find hard". In addition, Christine said that she knows a couple of obstetricians and "there's no way they would be comfortable with abortion because they're trying to deliver babies … they're trying to keep these babies alive in utero". Once again, the idea that abortion providers are seen as life-takers is another example of how abortion is seen as a separate part of medicine, and the medical professionals choosing to work in this sub-speciality are different from other doctors.

Interestingly, the belief these doctors are different because they provide abortions was also mentioned by participants themselves. However, these doctors interpreted the difference oppositely: they believed that providing abortions made them good doctors and more often than not discussed colleagues who did not provide abortions negatively. The belief that abortion providers are different was best outlined by Daisy who said, "you have to be somebody who really believes that it's the woman's choice or necessary for her mental or physical health for the pregnancy to end". While medical professionals who do not provide abortions see abortion providers as working outside of the main ethics of medicine, these doctors actually build a collective identity around refuting this identity ascribed to them. They have constructed their identity based on the premise that they are doing what is morally right by giving women the ability to access a safe and legal abortion service.

Three doctors explicitly mentioned experiences of encountering medical professionals who had explicitly moralised abortion stigma. These doctors each had an experience where they were either being called or made to feel like 'baby killers'. For example, Faith recalled a time when "there was an Ears Nose and Throat Surgeon who was a Catholic and he used to wander in and say, "Oh, killing babies again are you?" Faith laughed at this remark as she was now friends with that surgeon, but during the interview, she used this example of how she felt stigmatised by her fellow medical colleagues. She told me that at the time it was not "a very helpful thing

to say". Doreen was the second interviewee who explicitly mentioned feeling like a baby killer, suggesting that working in an abortion service is:

> The place where, at some point, if you train in abortion in an NHS hospital you will be made to feel like you're a baby killer and--, and people do that in lots of ways … I've had a student come up to me saying I'm meant to be in this theatre next door. They're doing something radiological, can I come in yours? And I say yeah, it's a termination list and--, and she goes oh, er, no, no thanks then. You know, just all the time, just a no thank you.

In addition to the comments made by Doreen and Faith, Lilly also mentioned having to overcome the personal thought that maybe working within the abortion service is emotionally challenging and at points, during her career, she felt as if she was not proud of her work in the abortion service and "so for one, actually, I just wanted to give it up because I was a bit like, this is not making me happy. It's a bad job. I'm killing babies". Lilly's belief that she was doing a bad job because she's 'killing babies' is another example of how abortion is still seen as more than a standard medical procedure. Some doctors working within the service personally debate whether they are doing the right thing by providing this service.

Five doctors spoke about encountering colleagues who have been very anti-abortion and openly disagreed with their work but "they're the first to come running" as Chloe put it. In addition, Mark told me that "every abortion provider knows at least one colleague who is always very anti-abortion until it's their daughter, or sister, or cousin" then they have the belief that "this is a different situation". These participants used this example to show how they believe abortion stigma is "deeply engrained" in medical colleagues, and this affects how they are treated as doctors. This type of claim is interesting to the argument that medical professionals who stigmatise abortion providers are doing so for a moral or ethical reason. Abortion doctors experience stigma from their medical colleagues until they face a time when someone they know needs an abortion. They then turn to the doctors they stigmatised to help solve the problem of an unwanted pregnancy.

This section of the chapter has outlined how doctors have responded to the stigmatisation of abortion. Doctors' commentary on stigma are used as part of stories as a way of discussing how they have become the type of doctor they are. As the next section of this chapter will show,

even though doctors reported experiencing stigmatisation because they are working as an abortion provider, these doctors continue to provide what they believe to be a good and right service. These doctors believe that women have the right to a safe and legal abortion which is the main reason why they became providers during their medical training and early career and continue to provide a termination of pregnancy service even when faced with very real threats to themselves and their families.

6.5 Doctors' Contribution to the Service: Identity Work and the Management of Professional Identity

Doctors are tasked with managing the stigma they face from both medical colleagues and the wider public through doing identity work. Through investigating doctors' narratives about their contribution to the service and to women's rights and health, we can see how their values shape the work they do. During the interviews, doctors were asked 'what is the most important contribution doctors have to the abortion service?'. This question was asked as a way of understanding what doctors believe their role in the service to be and what the role of the doctor should be. The interpretation of their remarks here is developed as a way of considering how participants manage stigma and address the problem of spoiled identity through an investigation of how they find meaning in their work.

There were very similar answers amongst doctors; comments clustered around the four main themes: 'to give women choices'; 'advocating for women'; 'patient satisfaction'; and 'not judging women'. This suggests, once again, that doctors have built a collective identity where they have similar beliefs about what a doctor's contribution to the abortion service is. The majority of abortion services are nurse-led services, as previous chapters have detailed, and the involvement of doctors in a large number of cases has been reduced to a virtual signature. It is, therefore, important to investigate how doctors for whom providing abortion is central to their professional work give meaning to what they do. On the one hand, through the macro-level doctors present abortions as a simple procedure, that can be completed by women, outside of a clinical setting through telemedicine, where a doctor does not see them. Still, those I interviewed, as I have discussed, also present their work as necessary and important. They give meaning to their work in ways this chapter will now discuss, and in so doing, manage the stigma that forms their identity. When asked about their biggest contribution to the service,

twenty-three doctors said that their most significant contribution made by merit of the type of service they provide. However, this was portrayed in different ways, and I close this chapter with a discussion of them.

Some doctors discussed 'choices' as a way of giving meaning to their work. Vanessa believed her most important contribution is the fact that she gives "women choices in the end". She continued that "it's a woman's choice about a single straightforward medical intervention, so it's about giving women a choice about how they manage their lives and their bodies". Georgia told me that doctors' main contribution to the abortion service was to let patients "know what their options are and enable them to make choices that are right for them". The idea that a doctor's role in the service is to provide women choices reflects some of the values described previously in this chapter. As explained above some doctors were motivated to provide abortions because of what they have seen or experienced. Doctors were then motivated to provide abortions and proud of their work as providers because they believed without them, there would be no safe abortion service in Britain. Vanessa and Georgia are therefore not discussing their contribution to the service as other specialists may; for example, it's unlikely a cardiologist would describe their contribution in relation to giving their patients choices. However, they believe their biggest contribution to the service is allowing women to make her own choice about when she wants to start a family. Here is an example of how doctors have attempted to manage their spoiled identity through a discussion on the ways to manage the stigma of abortion. Through describing their contribution to the service as giving women choices, they are suggesting that even though they are stigmatised because of their association with abortion, they believe they are doing the right thing because they are helping women, and this is how they justify and give meaning to their work.

Another way participants discussed their contribution was through providing 'a good service'. Jessica said that "having open access service and being somebody who can just give them their procedure" is their biggest contribution. The belief that a doctor's role is to provide women with a good service was also mentioned by Bridget, who said her role is to provide a "better service". These doctors suggest that their biggest contribution is ensuring a service can exist in a way they believe most appropriate. Four doctors specified it is the type of care that is provided which is their biggest contribution to the service. Michelle said it's to have a "non-judgemental approach" because "it's such a common condition, and it's such a common reason why women

request medical attention". As termination of a pregnancy is such a common medical procedure, she believed "it should be not be given a separate entity or status or stigmatised".

Michelle's comments present a doctor's contribution to the service in terms of normalising abortion, which is why she discusses providing a judgement-free service in relation to a separate entity. The idea of a judgement-free service was also mentioned by Samantha, who said that she thinks a doctor's biggest contribution is "providing high-quality, safe care and not being judgemental". Elizabeth said "it's important for doctors not to be judgemental to allow that space for women to be able to, you know, have an open discussion. Not to feel judged". In this way, participants discussed different reasons that explain why the role of the doctor is important to the abortion service. They suggest that their role is mainly not a technical one because, in general, abortion is a common and straightforward medical procedure. Hence, they find different ways of emphasising the role of the doctor in regard to the welfare of women.

Doctors give their work meaning, and respond to stigma, by constructing the work of the abortion doctors as important because they provide a service where women are not judged. In this way, responding to the stigma of abortion and the stigma surrounding women who end pregnancies this way, becomes the means through which the doctors manage their own identity. They are allowing women to decide when to end their pregnancy because, without them, there would be no access to legal abortion.

This is interesting to the wider debate on the medicalisation of abortion. As we can see from Chapter One when discussing the development of the legal framework for abortion in the 1960s, the medical profession was very reluctant to give women the freedom to make their own decisions about her reproductive health; they did not want to be viewed as 'technicians' providing abortions at a woman's request. However, when asked about their biggest contribution to the service, today participants almost always discussed their role as being to assist women when they want an abortion.

Doctors also discussed abortion as more than just a medical procedure. Some began talking about the morality of abortion when asked about their contribution. Melissa said that she thinks "the most important contribution is just standing up for it". This was reiterated by Georgia, who said that she is "interested in trying to promote [abortion] and give women access to the care that they deserve". Paul told me that he believed a doctor's contribution "is creating the culture

where it is entirely reasonable and right that women should have easy access to an abortion service that runs efficiently". Zoe said the most important thing for doctors is to make it safe for women to "disclose any concerns or issues they might have, or any, you know, coercion or any safeguarding problems to come out" and Joshua told me that he believed "advocating for women and for choice over reproductive health is an important part of the job". However, Joshua also told me that "doctors are leading in advocacy and developing the quality of the service".

The idea that doctors are improving the service was also mentioned by Christine who said their most important contribution is that "it hasn't been delegated to people who are not committed to always looking for better ways of doing things and making use of technology and medical advances". This direct comparison that Christine draws on is an example of how abortion doctors give meaning to their work by comparing themselves to doctors who do not provide. They find meaning in their work based on the interaction they have had with doctors who do not have the same values as they do. Christine continued:

> You know you don't want to over medicalise anything, but at the same time if you can give something top-level leadership it just keeps it… should keep it in a safer and more dignified place.

Christine specifically told me that she doesn't want to 'over medicalise' the service but she believes the role of the doctor is an important one and needed to ensure the service is run safely. The concern about 'over medicalising' abortion could suggest Christine is aware that the role of the abortion doctor is different from that of other doctors.

There is a fine distinction between doctors providing a good standard of care because they provide women with access to a 'good abortion service', and an abortion service where the need for medical oversight is overstated. The claim that a doctor's contribution to the service is to create a safe and judgement-free service is interesting for the wider arguments on the medicalisation of abortion, as these doctors are suggesting that they are working in the service for their patients. They are not, as some literature has suggested, trying to gain control over abortion, but instead believe that by having a role in the abortion service, they are ensuring women have access to safe and legal terminations. They do not view their work as in any way an attempt to control women's reproductive health; they believe they are doing the opposite,

and by working in the service, they are increasing women's control over their reproductive lives; that is empowering women.

These doctors give meaning to their work in response to criticisms and stigma they have experienced. Doctors discussed abortion as a moral and ethical dilemma for most people, both inside and outside the medical profession. They have faced accusations from other medical professionals that they work outside the values of the medicine. When discussing their contribution, they retaliate to these claims by saying that their work is important. They have a meaningful professional identity because they are providing a service which women need.

A further way doctors gave meaning to their work was through discussing their medical contribution. Three doctors specifically mentioned that maintaining the "gold standard" was important. Karen believed that it's their knowledge that is their biggest contribution. She said, "we only really need to be involved in probably a small minority of cases". She continued that "it can be really hard talking to somebody if they have got a foetal anomaly so things where there is specific medical training through understanding of disease and diagnoses". Eva also mentioned the specific knowledge that doctors have and said, "the knowledge of the doctor is very important, the doctors have to be able to assess the risk and offer the best treatment for the patient". She continued, that for women with comorbidities "it's impossible to achieve … great care without a doctor's expertise and knowledge". These comments suggest that the role of the doctor is more than just providing safe and judgement-free care as other participants have suggested but actually that doctors training and expertise are essential for the running of abortion service.

The contribution of expert knowledge and skills was also mentioned by Emily, who said, "I know legally we have to fill the paperwork in, but I don't think that that's the most important thing from a patient aspect". Instead, she believed that a doctor's biggest contribution to the service is to ensure that "patients are medically suitable for whichever procedure they're having". She told me that doctors do this by "making sure that we do any investigations". These investigations involve "checking the medical history" and being able to understand these "in perhaps more depth than other members of the team". Clare said "I think our contribution is largely medically led. The sort of liaison with specialists, and formulating management plans for those women, erm, and children sometimes". John also discussed liaising with other

professionals, specifically discussing cases of "women whose partners don't know that they're seeking termination or even, say, young girls whose mothers' don't know".

This discussion of doctors' contribution goes beyond just providing a 'good service' as doctors had previously mentioned. Instead, these doctors give meaning to their work by saying that they use technical knowledge and skills that other medical professionals do not have. This was also reiterated by Lilly, who said that that you can look at their contribution from a medical angle. She believed this involved "keeping complication rates low and reducing infection rates".

When discussing doctors' contributions to the abortion service, thirteen doctors mentioned the role of the medical profession, which has been given to them by the law. Clare said, "Well, the big thing is that at present doctors have to do the legal bit". By 'legal bit' she is referring to "the decision-making about whether the woman is eligible for an abortion". This was also mentioned in the interview with Mark, who said "Well, I think a doctor's role is very important. I think it is essential because everything starts on the law in this country where two doctors have to sign for an abortion to take place at all". Here, the doctor's role is considered from a very pragmatic perspective, through an explanation of the 1967 Abortion Act, which has ascribed the role of the decision-maker to doctors. As Abigail said, "we are the only ones that perform them … so the important contribution is we perform the abortions". She continued "doctors are uniquely placed because of our ability to prescribe and to operate and under the law". As a result, even if doctors delegate tasks within the abortion service, it is, according to the Abortion Act, "still something which is meant to be led by and directed by doctors and we are therefore responsible for it". Here Abigail mentions the involvement of nurses in the provision of abortion.

Interestingly, nurse involvement was also raised by three more participants when discussing their contribution to the abortion service. Daisy directly compared her work with that of her nursing colleagues, saying that the "service cannot run without doctors". She told me this is because even though the majority of consultations are with nurses, "actually patients have to have input by doctors to sign the legal forms". She also compared the role of a doctor and a nurse: "we have to prescribe the drugs ourselves; nurses can't prescribe even if they're nurse prescribers with adequate training". Doctors here suggest their contribution to the service is

important because they are the only group of medical professionals able to provide legal care to women through prescribing and performing the abortions.

Rebecca also mentioned the role of nurses in her explanation of a doctor's biggest contribution to the service. She said, "Well, nurses can't operate at the moment, so from that point of view, you need a doctor". However, unlike other participants, she told me that she believed "doctors and nurses are different beasts". By this, she means that "nurses are limited in what they can do". Rebecca informed me that she has worked with "some excellent nurses and some consultant nurses who work at an extremely high level. But suppose you're talking nursing body overall. In that case, I think it is both unrealistic and unfair to expect nurses to work as mini doctors". The reason why she believed it was unfair to treat nurses as 'mini doctors' was that women are scanned by a sonographer who reads and interprets the scans. Although she has "no issues with it being a nurse. Still, it should be a clinician that is appropriately trained to interpret that scan, along with the patient's medical history and examination". She believed nurses are not trained to "interpret scans, take appropriate medical history or do examinations" and so the best group of medical professionals to do this is doctors. Because of this, she thinks that "our practice is wanting".

Rebecca's explanation of her contribution is interesting in relation to the medicalisation of abortion as she is suggesting that doctors are needed to provide the service that is safe and legal for women. Even if nurses had the training, they would still need to have doctors input to ensure the service is run effectively, this would suggest that nurses are not seen as appropriate substitutes for doctors.

6.6 Discission: A Proud Provider and Stigmatised Individual

As I have shown throughout Chapter Four and Five, doctors have tried to construct their identity through conversations about their work and practices on the macro and meso level. In doing so, doctors discussed aspects of the medicalisation of abortion either explicitly or implicitly. At the micro-level, we can see how doctors manage the complexity of their position in relation to the macro- and meso-level in their everyday activities and practices. In this chapter, we can see how participants make sense of their role as an abortion provider, on a very

practical level through how they discussed their interaction with medical colleagues, patients and members of the wider community.

Doctors have expressed a sense of pride as an abortion provider. However, doctors also discussed feeling stigmatised because of the service they provide. This theme was also highlighted in the work of Maxwell et al. (2021) who have noted, that "a common theme which emerged from the analysis was health professionals having encountered resistance or hostility from others within SRH/gynaecology" (p. 33). Participants often discussed a sense of fear they felt from other people knowing they were involved in the provision of abortion. Many doctors had adopted an identity where they were privately proud of their role in the termination of pregnancy services, while being cautious about who outside of their immediate family knew about their work. This identity as a proud provider but stigmatised individual brings together the sense of meaning they give their work based upon the professional values they have due to the macro- and meso-levels. For example, both the law and abortion practices shape how they interact with women, medical colleagues and the wider community.

As a result, one way to resist this stigma is by "reframing their work in ways which emphasise its greater good" (Maxwell et al., 2021: 33). This can be seen through participants' discussion of their contribution to the service. Doctors made sense of their contribution to the service by suggesting their clinical expertise and knowledge is essential for providing a service where women can access safe and legal abortion. On the micro-level, doctors discussed their biggest contribution to the service as providing 'top-level leadership' to run abortion services that they believe women wanted and needed. These doctors suggested they were fighting for a good cause and working in this area of medicine to help women have access to a service that would not be available if they were not part of the provision. Once again, this is a clear example of doctors valuing different aspects of medicalisation and demedicalisation that they believe fits in line with their values as an abortion provider. This would suggest that on the micro-level doctors values are more complex than those outlined by Freidson and medicalisation theorists. Instead of using medicalisation as a method of social control to exercise a sense of power over their patients these doctors are using aspects of medicalisation they believe will help their patients obtain access to a better service. This would also suggest that the values of doctors are more like those outlined by Parsons as a professional who is altruistic and oriented towards the community they work with. However, there is one significant difference between the values outlined by Parsons and this group of doctors, that doctors are objective and emotionally

detached. Instead, these doctors are emotionally driven to provide a service they believe is best for their patients.

Doctors who work in the abortion service find themselves in an ambiguous position because they work in a highly skilled profession traditionally seen as having high social status with high control levels (Jones, 2012). Yet, they are unlike most other groups of doctors working in Britain. Doctors working in the abortion service work in a low-status branch of medicine where they are often marginalised and stigmatised for their role and they have very little control over service provision because of the legal framework. Therefore, doctors on the micro level create meaning in their work based on what they believe it means to be a good doctor. One of the ways that participants have tried to make sense of their position, as a stigmatised doctor is through discussion of strategies about how to normalise abortion services. This finding is similar to Maxwell et al. (2021), who found that doctors "said they viewed their work as part of routine, essential SRH" (p.35). However, as evident from the previous discussion about the other levels, participants suggested that normalising the abortion service towards what they considered mainstream healthcare would be beneficial for both themselves and their patients.

This analysis of the micro level has shown how doctors have tried to make sense of the tension between the law and current practices. As Chapter Five have shown, doctors try to manage the abortion service within the law, which acts as a constraint against the 'gold standard' of care for abortion. As a result, these doctors have discussed ways of normalising abortion, all of which usually involve bringing abortion in line with mainstream medicine. The idea that mainstreaming certain areas of medicine to decrease the stigma attached to them is not specific to abortion doctors working in England and Wales. For example, Thompson (2015) who investigated the professional identity of public health doctors in New Zealand argued that there "have been a variety of attempts to reduce the marginalisation of public health and… the marginalisation of public health physicians… by attempting to mainstream public health teaching rather than having it remain separate from clinical medicine" (p.91). In addition, Thompson argues that "both the value systems and the 'doctor' identity" (p.92) is challenged in public health medicine, just as we can see these challenges that abortion providers face. This suggests that when facing stigma associated with working in areas of medicine not considered high-status, doctors form a professional identity that aims to mainstream that service to establish their values as a medical professional. They reject the identity given to them, instead, looking for ways to create a new professional identity which fits with their belief they are

providing an important service. By creating a new identity, based on their values, participants have chosen to align themselves with certain aspects of the medicalisation of abortion that they believe are important and reject others they believe go against their beliefs on what it means to be a good doctor.

6.7 CONCLUSION

This chapter has shown that on the micro-level, doctors have shaped their professional identity around the interactions they have had with patients, medical professionals and members of their community. Through engaging in identity work doctors have found meaning for their work and have discussed why they believe their role is important. As this chapter has discussed, doctors are very proud of their role in working in a termination of pregnancy service. However, there is also a sense of fear from doctors about the consequences of people knowing they work in the abortion service. This sense of fear has made doctors cautious about when and where they discuss their work. Doctors have tried to make sense of the mixed emotions they feel about their work by forming a collective identity as a group of stigmatised doctors. Doctors discuss experiences of working in a stigmatised service in a number of ways as outlined in this chapter. When discussing examples of stigma with doctors, they were very aware that other groups of medical professionals saw them as working outside of the main principles of medicine and there was a strong moral argument put forward by other medical professionals as to why abortion is different from other areas of medicine.

This chapter then evaluated how doctors answered questions about their biggest contribution to the abortion service. This helped to understand how doctors made sense of the tension they see between being a proud provider and working in a stigmatised service. Overwhelmingly, these doctors believe their biggest contribution to the service is providing a safe and legal service that women can access. This fits in line with the beliefs that doctors portrayed when discussing the legal framework and would suggest that when doctors discuss both the law and their personal experiences, they are motivated to partially demedicalise abortion. As Chapter Four has shown, doctors wanted to normalise abortion to fit in line with other areas of medicine and doctors believed the way to do this is to partially demedicalise abortion so that they no longer have the power that the 1967 Abortion Act has ascribed to these doctors. However, when doctors discussed the practice of abortion, and especially, complex and second trimester

surgical abortions, doctors believed the best way to normalise abortion would be to further medicalise abortion by placing services within the NHS.

This chapter has contributed to the debate on the bi-directionality of medicalisation by investigating the identity work that doctors have done. Through looking at the interactions doctors have on the micro-level, we can see that once again the argument to normalise abortion services appears. Doctors do not discuss their contribution to the service as being any particular technical skill. Instead, they give meaning to their work through the belief that if they were not there to provide the service women would not have access to legal abortions. Therefore, they find meaning in their work by giving women choices over their reproductive health and through giving women bodily autonomy. This would suggest that doctors believe that abortion should be demedicalised in terms of the power that is attributed to those involved, in elements such as who should be the one to decide when a woman can have an abortion. However, when this is thought about in practice, doctors believe that the best way to provide abortions is through a medicalised service. The next chapter brings together the evidence from all three of these data chapters and the existing literature on medicalisation in the form of a discussion about how the medicalisation of abortion can be viewed as bi-directional.

CHAPTER 7
DISCUSSION

7.1 INTRODUCTION

In this final chapter, I discuss key themes that have emerged from this research. Overall, the discussion has explored developments in the medicalisation of abortion by examining how the doctors I interviewed see their professional identity. Following Halfmann, I designed my research as an investigation considering three levels: the macro- meso- and micro. As discussed in Chapter Three, the main question this thesis addresses is: What do abortion doctors' accounts of their professional work suggest about the contemporary dynamics of the medicalisation of abortion in Britain?

Using Halfmann's (2012) theories as the basis for the organisation of the study, I extended his explanation of medicalisation on each level. Using the three levels as a tool was, as I discuss further below, useful for collecting data and allowing me to gain a broader picture of these doctors' work. By exploring doctors' accounts at each of the three levels, I determined that doctors' values were contested, and that doctors' professional identity is not unified, thus building and extending insights raised in recent literature.

The chapter begins with a summary of the main ideas identified from the existing literature I have drawn on, from the sociology of medical professionalism and about the concept of medicalisation. I then reflect on the key sociological contribution this investigation has made, through its exploration of the tensions in the medicalisation of abortion and the related question of professional values. I then analyse the key issues raised by participants on the continuum of the medicalisation of abortion, to demonstrate the fluidity of medicalisation. One of the key findings of this research is that the values of participants were almost always linked to what they believed was needed to normalise abortion services and bring them in line with other areas of healthcare. Therefore, the next section of the chapter evaluates how the professional values of participants are linked to the normalisation of abortion services. Following on, I examine the practical strengths and weaknesses of the research methods used and then make some recommendations for future research into the medicalisation of abortion. Finally, this chapter makes some concluding comments on the medicalisation of abortion and the values of abortion providers.

7.2 THE SOCIO-LEGAL CONTEXT AND TENSIONS IN THE MEDICALISATION OF ABORTION

Through the literature reviewed in Chapter One I briefly highlighted how socio-legal literature has explored the medicalisation of abortion, showing that abortion laws throughout British history have been shaped by the opinion and values of the medical profession at different points in time. The provision of abortion, it is argued, has been shaped by a group of professionals who are motivated by a desire to gain and maintain control over areas of reproductive health. However, various bodies of literature have begun to argue that the values of the medical profession have historically been fractured, and the same value set has been not always been shared by medical professionals collectively. I began my study of the professional identity of abortion providers against this background, looking at how values of this particular group of doctors shapes their work and what this suggests about the medicalisation of abortion.

Chapter Two focuses on the theoretical backdrop for this thesis through an exploration of sociological theories on the values of the medical profession, initially set out by Parsons (1951) and Freidson (1970). This chapter then outlined some of the more recent theories of medicalisation which have argued that the values of medical professionals are not unified. I next consider the importance of investigating the tensions that appear between the role ascribed to doctors by the law, and the values associated with the medical profession, according to theories such as new professionalism and de-professionalisation. In Chapter Two I lastly outline the basis for my investigation, through an exploration of the work of sociologist Drew Halfmann. Halfmann suggests that by viewing medicalisation as a state, aspects of demedicalisation are often missed, and instead we should consider medicalisation a on a continuum rather than as a state or category.

As early parts of this thesis explored, research about this tension into medicalisation processes has already raised questions about the values held by medical professionals working within the abortion service today. I build on and extend this research. Lee, Sheldon and Macvarish (2018), for example, concluded that there is a "shifting meaning of medical authority and medical professionalism" (p.31). This shift has changed the way that many medical professionals discuss abortion law and practice and has led to medical support for and leadership of campaigns to decriminalise abortion and change the legal framework to reflect the changes in

the provision of abortion. Maxwell et al. (2021) argues that the 21st century campaign for the decriminalisation of abortion "is underpinned by a drive to normalise abortion," explaining that "positioning it as routine healthcare is essential to countering stigma and inequity" (p. 22). However, this does not mean that decriminalisation would automatically mean deregulation. Instead, decriminalisation "would need to be part of a managed programme of reform" (Dyer, 2017: 1). This implies that there would still be a form of medicalisation of abortion, to the extent that it would be 'normalised' as 'routine healthcare'; an area that Chapter Five explored and which I consider again further, below. The rules about abortion provision would be different to those within the existing legal framework, reflecting the professional values of the doctors who work in these services today.

I argue that it is important to think about the medicalisation and demedicalisation of abortion against a backdrop of possibilities for abortion provision. For example, a fully demedicalised abortion service might be dangerous, since it could ultimately lead to women being once again treated in a backstreet style abortion; women having surgical abortions outside of a clinical setting could be thought of as 'demedicalised'. However, for the purpose of this research, I am suggesting that a demedicalised abortion service is best defined as a system where women self-manage their abortion but are supported by a healthcare service. For example, for an EMA, women would be able to purchase abortion pills from either a pharmacy or obtain them through a prescription. There are no restrictions on the type of medical professional who can prescribe the drugs needed to have an EMA. In addition, in a fully demedicalised service, women would have their EMA in a location that suits their needs, whether at home or another private location. In addition, in a demedicalised service women decide when, where and how to have their abortion.

In comparison, a fully medicalised abortion service involves a specific set of medical professionals deciding when an abortion can occur, having a specific criterion for where that abortion may take place, what procedure is needed and being fully involved in clinical decisions and procedures. As examined through Chapter One, the Abortion Act fully medicalised abortion by regulating when, why and how an abortion can legally occur. The interviews I conducted portrayed an insightful and detailed picture about how and why the doctors I talked to sought to place abortion in a particular position on this continuum of medicalisation. The interviews explored this in many different ways, generating a picture of some areas of clarity and consensus, and others where the picture was cloudy and contested. I

now turn to discuss these areas in more detail and highlight the key areas that emerged from my research overall.

7.3 MEDICALISATION AND PROFESSIONAL IDENTITY

This section of the chapter will examine some of the theories outlined in Chapter Two which have explored the professional values of the medical profession and consider then in the light of the issues raised by my interviews with abortion providers. As I discuss further below, these are a unique set of doctors who are trying to create a professional identity. As explained previously, existing literature on the medicalisation of abortion has suggested that doctors have built their professional identity on the basis of wanting to gain medical power over their patients. However, this research has shown that doctors working in abortion services in England and Wales today are searching for an identity, as part of a reaction against the professional identity given to them by the law. As explained throughout this thesis, the abortion service has changed extensively since abortion was legalised in 1967. However, sociological literature has not investigated whether the professional identity of these doctors has remained the same and as how the law and socio-legal literature has portrayed this group of medical professionals.

A key finding of this research is that this search for a de-medicalised identity that rejects medical power as given by law, exists in tension with other components of doctors' professional identity. This tension was evident throughout all three levels explored in this thesis. On the macro level there was a rejection of key aspects of the medicalisation of abortion. Instead of wanting to be gatekeepers to legal abortion these participants had a patient-centred approach towards who they thought should make the decision on whether to have an abortion. However, this aspect of professional identity co-exists with others apparent at the meso and micro levels, which do not validate the case for the demedicalisation of abortion, as described previously. Rather, this research detected a version of professional identity that sustains the significance of and need for doctor involvement, and for a medicalised setting for abortion provision.

7.4 IMPLICATIONS FOR THE SOCIOLOGY OF MEDICALISATION

The themes that run across the three levels investigated through the research are relevant to the broader study of the sociology of medicalisation. This analysis suggests that doctors' values today differ from those discussed in much sociological literature. The value of Halfmann's (2012) work on the medicalisation of abortion was evident, in that my findings resonate with the proposition that instead of medicalisation being viewed as a category or state, medicalisation should be considered to be bi-directional. However, this thesis has extended the work of Halfmann (2012) by exploring the bi-directionality of medicalisation through a study of doctors' professional identity, showing how medical professionals reject, but also use and need medicalisation. They accept that certain aspects of medicalisation are reflective of their values.

By investigating the medicalisation of abortion on the three different levels, this research has shown both medicalisation and demedicalisation are salient at each level. This suggests the medicalisation of abortion is complex, and not as unidirectional as some socio-legal literature has suggested. For example, Keown (1988) has argued that the medical profession has medicalised abortion to control this aspect of women's reproductive health. However, through examining medicalisation as a continuum rather than a state we see examples of doctors' professional identity which highly values both aspects of medicalisation and demedicalisation. Parsons (1951), Freidson (1970) and other medicalisation scholars have suggested that doctors' values tend to be shared and uniform with medical professionals working as one collective group. However, when exploring the dynamics of medicalisation through doctors' accounts, we can see that this is not the case. There are many instances where doctors do not agree with each other, and times when their values seem to be contradictory, suggesting that the medicalisation of abortion is not neatly packaged; doctors who provide abortions have fragmented values, which often appear in contest with the values they described on each of the three levels.

Medicalisation can take different forms. Two main forms of medicalisation were identified from the analysis of the interviews were medicalisation in terms of *decisions*, and the medicalisation of *practices*. Participants discussed these forms of medicalisation differently. When discussing aspects of abortion on the macro level, such as who should decide if a woman has an abortion and the idea that the law dictates the location of where an abortion can take

place, participants were very clear in their belief that women should be allowed to decide if they want to end a pregnancy, and they believed that women should be allowed to take EMA pills at home, if they wanted to, provided it is clinically safe to do so. This is a clear form of demedicalisation, where doctors reject the role of gatekeeper in favour of a patient-centred approach. Doctors working today are choosing to give up this element of medical control, which was a core principle for medical organisations, such as the RCOG in the 1960s. Medical organisations at that time were concerned that by allowing women to decide when they want to have an abortion doctors would become technicians, providing abortions at the request of women. This was considered a major problem during the 1960s when abortion law reform was being debated, and as Chapter One has shown, even in 1990s during the debates on the introduction of EMA the thought of doctors providing an abortion service 'on demand' was considered a moral problem. Instead, my research has shown that doctors working in abortion services today are actively trying to remove this element of medical oversight from abortion services.

In comparison, when discussing services on the meso level, we see examples of values that tend to support medicalising abortion, through a drive to normalise abortion by bringing services into NHS settings. Participants who work in the NHS, either solely or partially, often told me that the service would be better for women if abortions were all provided in NHS facilities, justifying this set of beliefs in terms of the potential implications for when complications arise, or of the independent sectors inability to provide care for patients who have a complex medical history. By arguing that services should be placed into the NHS, doctors inevitably support continued medical oversight for all abortions. This would suggest a distinction between abortion decisions and abortion practices, where on the one hand doctors are willing to give up an element of control over who decides if a woman can have an abortion, while on the other hand seek to maintain or expand medical influence over the practices of providing an abortion service.

In addition to a distinction between these two types of medicalisation discussed by participants, there were also examples of this sample of doctors having competing values. Doctors saw the future of the service differently, depending on the sector in which they work. A small number of doctors called for a more collective approach to building a service where the independent sector and the NHS work in unison both in providing abortions but also in t training medical

students. Other doctors argued that for the future of abortion services, it is best to abolish independent sector clinics and have doctors trained within the NHS.

One of the most interesting aspects of the argument put forward by some participants was that the future of the service should be within the NHS, even though they would also point to the failings of the current NHS services. Doctors would often tell me of instances where women needing to be seen in NHS services faced increasing waiting times and were having to travel further to reach an NHS facility that performed a termination of pregnancy, while also advocating for all abortion services to be placed within the NHS. This draws out a further distinction, about how doctors value the NHS as an organisation. There were times throughout the interviews where the NHS was highly valued by participants and was seen to be the 'gold standard' of care, and other times when the NHS was seen to be failing both patients and providers.

The distinction between the types of medicalisation, and the differing opinions on how the service should be run in the future, can both be characterised as a form of partial medicalisation. Doctors use aspects of medicalisation and demedicalisation to express their concerns and interests. As a result, we can see that the medical professionals' values are not always uniform and collective as described by both Parsons (1951) and Freidson (1970).

Aspects of the approaches of both Parsons (1951) and Freidson (1970) are, however, evident in these doctors' values. Parsons believed that doctors are altruistic and work for the welfare of their patients rather than being self-interested. Participants in this study were guided by values which benefit women, which can be interpreted as in line with Parsonian altruism. However, Parsons suggested that doctors are specialists who are expected to be emotionally detached from their work, guided solely by professional standards and practices. This research has shown that doctors who work in the abortion service have clearly rejected the medical power and control given to them by the 1967 Abortion Act but still have a strong sense of professional identity as an abortion provider. The micro-level has shown that doctors are not emotionally detached from the service or their patients. This finding is supported by Maxwell et al. (2021), whose participants used language to defend and justify their work. However, while doctors are not emotionally detached, they also believe their role as an abortion doctor is important and gives meaning to their work because of their technical skills and knowledge.

Freidson (1970) characterised a doctor's role primarily in terms of the pursuit and maintenance of professional power and control. A central claim in the case for the normalisation of abortion is that doctors would play a more limited role in most abortions. By removing the legal requirements from the 1967 Abortion Act, doctors would no longer have a role in most abortions, which would then be managed by nurses and other healthcare professionals. However, as Chapter Five outlined, doctors have not suggested they have no role in abortion services. Instead, they have shifted the way they see themselves, from gatekeepers of legal abortion to medical experts using their skills and knowledge for complex and difficult abortions. This once again draws a distinction between the medicalisation of *decisions* and the medicalisation of *practices.* Where doctors value some aspects of medicalisation while rejecting aspects that they no longer believe is in line with what it means to be a 'good doctor.'

One aspect of Freidson's (1970) argument is that a key element of medical power is professional medical autonomy. But, as this research has shown, the professional autonomy of abortion doctors is limited. Chapter Four highlighted the significance of legal restrictions that impact and limit doctors' control over how to provide abortions. Chapter Six outlined ways in which the medical power of doctors who provide abortion is limited because they are both marginalised by other medical professionals and stigmatised by members of the wider community. This has resulted in most abortion doctors trying to counter the stigma they encounter by keeping their work in abortion services secret from anyone outside of their immediate network.

Overall, the implications of this research confirm Halfmann's argument, that by investigating medicalisation as a concept or state there are examples of medicalisation and demedicalisation which can be missed. Rather, medicalisation appears as a process and a continuum, which can be explored at each of the three levels. Instances of medicalisation and demedicalisation can be identified, in the formation of the professional identity of the doctors interviewed.

7.5 STRENGTHS AND WEAKNESSES OF METHODS

Using Halfmann's (2012) three levels as a tool for analysing the medicalisation of a problem was beneficial for two reasons. Firstly, from a conceptual framework perspective, using the three levels as a tool for analysing participants values was useful as s Chapter One outlined,

there are many different factors which influence the work of abortion doctors today. For this reason, it was important to differentiate between the levels to see how these influences might impact the values of abortion providers. Additionally, Halfmann noted that by only exploring one of the levels independently of the others, aspects of medicalisation and demedicalisation have previously be missed by medicalisation theorists. Secondly, breaking down the interview schedule following macro, meso and micro levels proved useful for structuring the interview. It allowed doctors to tell their story of how they began to work in the abortion service. The interview was often completed with discussions on how they would like the service to run in the future. This ensured that doctors could discuss any issues they felt salient and relevant throughout the interviews.

Conducting interviews, was crucial to gaining an in-depth understanding of doctors' experiences and values. The interviews gave doctors the opportunity to discuss issues and themes they thought important. As a result, the interviews raised new and interesting themes and insights that I had not anticipated or expected. This was exemplified by the discussions about the social stigma associated with the abortion service and abortion providers, and the importance of the organisational setting where an abortion takes place and its relationship with normalisation.

Applying for ethics through IRAS was a time-consuming process which took six months, and I later discovered it was not needed for the scope of this research. This meant I started my fieldwork six months later than initially planned. The disadvantage of going through the process was the delay that meant I could not be more selective in my sampling. Additionally, I initially contacted some doctors who expressed an interest in participating in the study; however, they later did not ultimately choose to participate. These doctors did not give a reason for not participating, and usually they stopped replying to emails. If I could have started the fieldwork six months earlier, I would have had time to allow for this which also meant that I could not be more selective in my sampling. However, overall, once doctors were able to participate, they were welcoming and keen to support my research.

The diverse sample was useful for capturing many of the wider debates that doctors discussed. For example, I managed to interview some doctors who were well known as abortion providers (as active campaigners) as well as doctors who were not involved in abortion activism. As explained in Chapter Three the number of male doctors recruited was smaller than originally

intended. If I was able to start my fieldwork earlier, I may have been able to recruit more male doctors. This could have been an important factor, as during one of the pilot interviews gender was put forward as a potential source for different sets of values amongst doctors. However, I did not find this from the male participants that I interviewed. As a result if I were given the opportunity to recreate this study, I would also try to interview more male doctors to investigate if there were any differences not captured by my current sample.

It is not possible to know if this study included representative sample because, as explained in Chapter Three, there was no national registration of doctors working in England and Wales who provide abortions, making it impossible to determine the characteristics of abortion providers. Therefore, I cannot establish whether the number of male participants reflects the split of medical professionals working within the service, or whether male doctors were less likely to participate in my research. To see if my research is transferable and generalisable, a mixed-methods study may have been useful. By sending out a questionnaire or a survey asking doctors if they provide abortions and questions on the key debates surrounding abortion as well as conducting in-depth interviews, I may have been able to have a clearer picture on the type of medical professional who works in a termination of pregnancy service.

7.5.1 Recommendations for future research

To extend the work of this thesis, it would be interesting to investigate some of the themes in the findings which were unexpected. One of the most surprising findings of the study was at the micro level, where doctors discussed the mixed emotions associated with providing abortions. Participants explored how these mixed feelings affect the day-to-day work of providers and this thesis has examined how these doctors then try to manage their identity. This research has found that doctors have tried to manage the stigma they face as an abortion provider, by finding meaning in their work by describing their work as important and necessary, as a way to address the problem of having a spoiled identity. Doctors considered themselves stigmatised by the public and medical colleagues because of their role in abortion services. It would be interesting to further explore how doctors make sense of this role they find themselves playing, as both a stigmatised individual but proud provider.

The strength of opinion regarding the setting, where an abortion should take place was also a finding which I had not anticipated. This should be further investigate this distinction and how the setting of services influence medical professionals' values. One way this could be done is by interviewing other healthcare professionals to further assess the significance of setting for the formation of professional values. As explained throughout this thesis, nurses have an increasing role in working in all aspects of the service, from patient consultations to physical examinations and follow-up queries. One of the noteworthy points raised through the interviews with participants was that, if the legal framework changes, nurses, who have specialist training can perform the majority of abortions in England and Wales through both second trimester surgical procedures and EMA. With the increasing presence of nurses being involved in abortion service but still restrained by the legal framework, it would be interesting to explore what nurses believe and whether their formulation of the relation between normalising abortion and provision in the NHS is similar to that identified in this study.

Lastly, the research could be developed through considering the professional identity of doctors who work within obstetrics and gynaecology or SRH but do not provide abortions and have never provided abortions. This would enable research to assess whether the tensions in values discussed through this thesis are specific to those working within the abortion service, or common to larger fields of medical practice in which abortion provision is situated. This would further add to the sociology of medical professionalism literature.

7.6 CONCLUSION

Overall, the main contribution of this research is the development of insight into how medicalisation manifests itself in doctors' values and practices. This thesis has shown that medicalisation is bi-directional, and at the different levels there are aspects of medicalisation and demedicalisation. There is a common concern to normalise abortion. On the macro-level, normalising abortion services would involve demedicalising abortion in the law to mainstream abortion services. Doctors would no longer act as gatekeepers, and decision-makers, who control access to abortion services. On the meso-level, it was found that some doctors believe that demedicalising abortion is counter-productive to normalising abortion services. The best way to normalise abortion is, they believe, to provide services within NHS settings. Finally, on the micro-level, doctors once again make claims for demedicalisation of abortion through

expressing the belief that the role of the doctor and their work are both are necessary for women to have access to safe and legal abortion services. At the same time, on the micro level, doctors argued that on a practical level the best way to provide an abortion service is through a medicalised service. This would reduce the stigma that both, they face, being associated with abortion and reduce the stigma that women feel when trying to access services. Overall, the main claim that doctors have made is that they want to normalise abortion services, and the way they believe this is most effective is to decriminalise abortion, bring it into NHS settings and de-stigmatise the service for women and for themselves.

A further example of the complexity of the medicalisation of abortion can be seen through the changes to abortion procedures due to the COVID-19 pandemic. The pandemic has unintentionally shifted and accelerated the process of demedicalisation by allowing medical professionals to prescribe "both abortion medications by video link, telephone, or any other electronic means" (Romanis, Parsons and Hodson, 2020: 8) and allowing women to "take both medications in their homes" (Romanis, Parsons and Hodson, 2020: 8). The decision to allow home-administered EMA is salient to doctors' values and highlights the complexity of medicalisation, since in March 2020 as a result of COVID-19 the Department of Health wrote "comprehensive regulations on permitting telemedicine for early medical abortion" on the advice of the RCOG, FSRH, and RCM (amongst other healthcare bodies) (bpas, 2020). This development in the way abortions are provided is central to the wider debate on the values of abortion doctors. Participants in this research, on the one hand wanted women-centred abortion services, when home use of EMA was discussed on the macro-level. However, doctors overwhelmingly wanted to maintain a form of bio-clinical control. This would be through nurses, so that women could have an ultrasound and be seen by a medical professional, who would prescribe the abortion drugs before the woman was allowed to go home to complete her termination. However, as a result of COVID-19, there has been a further shift in the values of abortion providers, where they are now arguing that women should be allowed to have the complete EMA (by taking both the mifepristone and misoprostol) at home without ever seeing a medical professional in person.

This thesis has contributed to the sociology of medicalisation. It suggests that the medicalisation of abortion is different from how previous sociological literature has portrayed medicalisation, and this group of doctors are not motivated by self-interest. Instead, this thesis has shown that by examining medicalisation based on doctors' accounts of their professional

work and identity, doctors choose to engage with, and reject, different dimensions of medicalisation. This has created a situation where medicalisation, and demedicalisation, are both looked upon to be a solution to what this group of doctors believe are the current problems with the abortion service in England and Wales today.

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APPENDICES

APPENDIX 1. INTERVIEW SCHEDULE

Economic and Social Research Council
Shaping Society

Interview Schedule for doctors that provide abortions

The Professional Identity of Doctors Who Provide Abortions: A Sociological Investigation

Participant information

Job title:

1. About you and your career:

- How did you become to be an [Insert job title]
- What does your work as an [insert job title] involve?
- What are the positive and negative things about your job?
- What do you consider to be the most important contribution of the work you do as a [insert job title]
    - Prompt- Specifically about doctors contribution to the abortion service.
- Are you proud of the work that you do?
- How do you think medical colleagues who are not involved with the abortion service perceive you and the work you do?
    - Prompt- Their position in relation to the rest of obstetrics and gynaecology and medicine?

2. Clinical practice

- How are early medical abortions provided in your clinic?
    - Prompt- Do you think it works as well as it could?
- Has the availability of early medical abortion changed the work you do?
    - Sub-question- If so, how and why?
- Up to how many weeks in pregnancy do you provide abortions?

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- Sub-question- Why?

❖ Tell me a bit more about what you think about the provision of later term abortions?
  - Prompt- Where do the women that need late term abortions in your area go? Do they go to your clinic or another clinic.

❖ Are there any other aspects of clinical practice or providing abortions you would like to talk about?

3. Training of an abortion doctor

❖ What abortion training did you receive at undergraduate level?
  - Prompt- How was [answer from previous question] taught?

❖ What abortion training did you receive after undergraduate studies?
  - Prompt- How was [answer from previous question] taught?

❖ What do you think of the training that you received?
  - Prompt- Could it be improved? If so Have you been involved in changing the way abortion is taught in medical schools.

❖ Do you think enough doctors are going into abortion care?
  - Prompt- If no, why? What do they think can be changed?

❖ What attracts medical students to abortion service?

4. Law and policy

I would like to ask you about the law, specifically the 1861 Offences Against the Person Act

❖ The Law says: "whoever... unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor" What do you think about this?

I would like to ask you specifically about the 1967 Abortion Act

❖ The Law says: "A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners if two registered medical practitioners are of the opinion, formed in good faith" What do you think about this?

❖ The law says: "Any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of state... or a hospital vested in a NHS service trust or NHS foundation trust" What are your opinion of this?

❖ Section 4 of the 1967 Abortion Act states: "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: Provided that in any

legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it." What are your opinions on this aspect of the law?

- Prompt- Do they think it is still necessary?

I now want to now ask you about fairly recent events where some have argued for the prosecution of doctors

- In 2012 the Daily Telegraph released an article that was headlined 'Abortion Investigation: Doctors filmed agreeing illegal abortions "no questions asked" Women are being granted illegal abortions by doctors based on the sex of their unborn baby." What are your opinions on this?
- The Daily Telegraph also reported that 'clinicians admitted they were prepared to falsify paperwork to arrange the abortions even though it is illegal" referring to doctors pre-signing the HSA1 form. What do you think of this?
- How do you find the regulations of your work? What do you think about them on a scale of 1-5. Where 1 is not helpful at all and 5 is very helpful
- Are there any other aspects of the provision of abortion you wish to discuss?

Age: Gender:

APPENDIX 2. INFORMATION SHEET

Economic and Social Research Council
Shaping Society

Information about the research

The Professional Identity of Doctors That Provide Abortions: A Sociological Investigation

I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve. I will go through the information sheet with you and answer any questions that you have. Please ask me if anything is unclear.

Part one

Information about the study

This study is being carried out as part of a Doctorate of Philosophy by a student at the University of Kent funded by the Economic and Social Research Council. This study involves a set of interviews doctors working in Obstetrics and Gynaecology or Sexual and Reproductive Health.

The purpose of the study

The purpose of this study is to find out how doctors view their job in relation to recent debates about abortion, doctors opinions on the current legal framework for abortion in Britain, the challenges doctors face in their work and the values that inform their work.

Why you have been invited

To participate in the study you need to be a doctor in England and Wales that specialises in either Obstetrics and Gynaecology or Sexual and Reproductive Healthcare.

Do I have to take part?

You can decide whether to join this study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will it involve?

Your participation will involve taking part in a confidential, face-to-face interview at a venue convenient with you. The interview will last approximately 60 minutes and would be

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recorded (with your permission) so that your responses can be transcribed for inclusion in the analysis

Content of the interview

Some of the themes we would like to ask you about in the interview: 1) Your work as a doctor; 2) Opinions on abortion law; and 3) Perceptions of recent debates about abortion provision in Britain.

The interview recordings will be transcribed and then analysed using qualitative analysis.

Possible benefits to taking part

This study provides you with the opportunity to express your opinions on the work that abortion providers do in Britain, an area that is currently under-researched.

Possible risks to taking part

As part of the interview a discussion on recent case of law breaking may arise, you should only disclose what they feel comfortable discussing. I will also seek specific consent from you if the quotation poses any risk to the participant (for more information on specific consent please see 'Use of Quotation'. All information disclosed during the interview will be analysed after data collection.

The number of doctors involved in some areas of abortion provision (for example, performing abortions at later gestational stages) is quite small, and this is especially the case for senior personnel. This means that it is possible participants could be identifiable from quotations used in reports/papers based on this research. In the event of it being the case that quotation I want to use poses this risk I will contact you to ask for specific consent/ approval for its use, making it clear that the quotation in question will only be used subject to permission.

Part two

Confidentiality and ethical considerations

Your responses will be totally confidential, and everything possible will be done to assure anonymity for all participants and all study sites. The transcript of the interview will be coded and anonymised so that neither you nor your clinic will be identifiable. The digital recordings of the interviews will be transferred to a password-protected computer.

Use of Quotations

Where I would like to use quotations from interviews that pose any possibility of you being identified, specific consent for inclusion of this quotation in documents to be published will be sought, and quotations will only be used where this is obtained.

Who is organizing and funding the research?

The Economic Social Research Council (ESRC) funds this PhD. Interviews will be conducted by Hannah Pereira from the School of Social Policy, Sociology and Social Research at the University of Kent.

Storage of data

The personal data will be stored for 3 years for the duration of the PhD. This is a necessity in order to complete the PhD, therefore the researcher must keep all data needed until the Thesis is submitted and approved. The storage of any personal data after the research is complete will be up to 3 months. After the three months, any personal information will be destroyed. During this time, the Data will be stored on an encrypted computer and hard drive secured by the researcher. After completion of the PhD the data that has been anonymised will be donated to the UK Data archive in agreement with the ESRC scholarship funding.

Further information and contact details

Hannah Pereira,

Dr Ellie Lee (PhD Supervisor)

APPENDIX 3. CONSENT FORM

Economic and Social Research Council
Shaping Society

Consent form

The Professional Identity of Doctors That Provide Abortions: A Sociological Investigation

Please tick the boxes below to show that you understand and agree with each statement. ☐

I confirm that I have read and understood the information sheet for the above study and have the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my legal rights being affected. ☐

I understand that any personal information that I provide to the researchers will be kept strictly confidential. ☐

I understand that I will be asked to give specific consent for use of potentially identifying quotations and quotes that pose any risk to me and quotations will only be used where this is obtained. ☐

I agree/disagree to the interview being audio recorded.

I agree to/disagree to an anonymised transcript of the interview will be passed onto the ESRC Data Service.
(Please delete as appropriate)

I agree to take part in the above study ☐

Name of participant: .....

Signature: ..... Date: .....

Name of Person taking consent: .....

Signature: ..... Date: .....

APPENDIX 4. ETHICS APPLICATIONS

UNIVERSITY OF KENT ETHICS APPLICATION

ETHICS REVIEW CHECKLIST FOR RESEARCH WITH HUMAN PARTICIPANTS – FACULTY OF SOCIAL SCIENCES

University of Kent

A checklist should be completed for every research project in order to identify whether a full application for ethics approval needs to be submitted. The principal investigator or, where the principal investigator is a student, the supervisor, is responsible for exercising appropriate professional judgement in this review.

This checklist must be completed before potential participants are approached to take part in any research. All forms must be signed by the School's Research Ethics Advisory Group representative.

Section I: Project details		
Project title:	'Caring for women' or 'taking unborn life'? A sociological investigation of the professional identity of the abortion doctor.	
Planned start date: 01/09/2016		Planned end date: 01/09/2019
Funder:	ESRC	

Section II: Applicant details		
Applicant name:	Hannah Pereira	
Department:	SSPSSR	
Email:		Telephone number:
Contact address:		

Applicant signature:	Hpereira	**Date**	05/06/2017

Section III: Students only				
Supervisor:	Dr Ellie Lee, Dr Michael Calnan			
Undergrad. ☐	Postgrad ☐	Masters ☐	Doctorate ■	Other (please specify)

Supervisor signature:	E. Lee	**Date**	05/06/2017

School REAG rep signature:	S. Cotter	**Date**	06/06/2017

If all questions in the checklist are answered as 'no', **send the completed and signed form to the Faculties Support Office.**

If any question in Section IV(A) are answered 'yes':

1. **Contact Nicole Palmer** (University Research Ethics & Governance Officer) for advice
2. Send a copy of ethical approval to the Faculties Support Office, once received

If any questions in Section IV(B) are answered 'yes':

1. **Complete full application form**
2. **Send to the Faculties Support Office** for review by the Research Ethics Advisory Group (REAG)

Declaration: Please note that it is your responsibility to follow, and to ensure that, all researchers involved with your project follow accepted ethical practice and appropriate professional ethical guidelines in the conduct of your study. You must take all reasonable steps to protect the dignity, rights, safety and well-being of participants. This includes providing participants with appropriate information sheets, ensuring informed consent and ensuring confidentiality in the storage and use of data.

Section IV: Research Checklist

Please answer all questions by ticking the appropriate box:

A) Research that may need to be reviewed by an NHS Research Ethics	YES	**NO**

ETHICS REVIEW CHECKLIST FOR RESEARCH WITH HUMAN PARTICIPANTS – FACULTY OF SOCIAL SCIENCES

University of Kent

Section IV: Research Checklist

Please answer all questions by ticking the appropriate box:

A) Research that may need to be reviewed by an NHS Research Ethics Committee, the Social Care Research Ethics Committee (SCREC) or other external ethics committee (if *yes*, please give brief details as an annex)	YES	**NO**
Will the study involve recruitment of patients through the NHS or the use of NHS patient data or samples?	☐	■
Will the study involve the collection of tissue samples (including blood, saliva, urine, etc.) from participants or the use of existing samples?	☐	■
Will the study involve participants, or their data, from adult social care, including home care, or residents from a residential or nursing care home?	☐	■
Will the study involve research participants identified because of their status as relatives or carers of past or present users of these services?	☐	■
Does the study involve participants aged 16 or over who are unable to give informed consent (e.g. people with learning disabilities or dementia)?	☐	■
Is the research a social care study funded by the Department of Health?	☐	■
Is the research a health-related study involving prisoners?	☐	■
Is the research a clinical investigation of a non-CE Marked medical device, or a medical device which has been modified or is being used outside its CE Mark intended purpose, conducted by or with the support of the manufacturer or another commercial company to provide data for CE marking purposes? (a CE mark signifies compliance with European safety standards)	☐	■
Is the research a clinical trial of an investigational medicinal product or a medical device?	☐	■

If the answer to any questions in Section IV A is 'yes', please contact the Research Ethics & Governance Officer for further advice and assistance.

B) Research that may need full review by the Social Sciences REAG	**YES**	**NO**
Does the research involve other vulnerable groups: children; those with cognitive impairment; or those in unequal relationships, e.g. your own students?	☐	■
Does the project involve the collection of material that could be considered of a sensitive, personal, biographical, medical, psychological, social or physiological nature.	■	☐
Will the study require the cooperation of a gatekeeper for initial access to the groups or individuals to be recruited (e.g. headmaster at a School; group leader of a self-help group)?	■	☐
Will it be necessary for participants to take part in the study without their knowledge and consent at the time? (e.g. covert observation of people in non-public places?)	☐	■
Will the study involve discussion of sensitive topics (e.g. sexual activity; drug use; criminal activity)?	☐	■
Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	■
Is pain or more than mild discomfort likely to result from the study?	☐	■
Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	☐	■
Will the study involve prolonged or repetitive testing?	☐	■
Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?	☐	■
Is there a possibility that the safety of the researcher may be in question (e.g. international research; locally employed research assistants)?	☐	■
Does the research involve participants carrying out any of the research activities themselves (i.e. acting as researchers as opposed to just being participants)?	☐	■
Will the research take place outside the UK?	☐	■

ETHICS REVIEW CHECKLIST FOR RESEARCH WITH HUMAN PARTICIPANTS – FACULTY OF SOCIAL SCIENCES

University of Kent

Will the outcome of the research allow respondents to be identified either directly or indirectly (e.g. through aggregating separate data sources gathered from the internet)?	☐	☐
Will research involve the sharing of data or confidential information beyond the initial consent given?	☐	☐
Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	☐
Will the proposed findings be controversial or are there any conflicts of interest?	☐	☐

BPAS APPLICATION FOR ETHICAL APPROVAL OF RESEARCH

Application for Ethical Approval of Research

bpas Reference Number:

Instructions for applicants

Parts 1 and 4 of this form must be fully completed by **all** investigators wishing to carry out research at **bpas**. All applications that involve use of fetal tissue must also complete Part 2. Part 3 must be completed by all applicants with the exception of those applicants who have already received NRES approval. A copy of the full NRES application (available http://www.nres.npsa.nhs.uk/) with the approval letter may be submitted in lieu of Part 3.

In addition to the **bpas** Application form, **all** submissions must also include:

- A full research protocol including a detailed summary, project time chart showing milestones, and flow chart of procedures
- Proposed client information leaflets, consent forms, instruments, interview guides and questionnaires to be used in the research, with dates and version numbers
- If applicable, a letter of approval from a NHS REC, and letters of support from additional sites

Please return all application materials to:

by email to: research@bpas.org

by regular mail to:

Electronic submissions are preferred.

For any queries, email **research@bpas.org** or call 0845 365 5050

Consideration of research proposals to bpas

The Research & Ethics Committee gives advice on and approval for research work involving clients, staff or client data to be carried and considers requests for research information and data from **bpas**. The Committee is concerned with the aim of the proposed research, the method employed, the projected outcome and how it may be used. In some cases, the Committee will identify a named individual as responsible for a research project. This person

will be a staff member(s) of **bpas** who will act as a contact for queries about the research and its progress. It is suggested that the contact person may be invited to co-author any published articles derived from the research work, provided their contribution to the work satisfies the requirements of the journal concerned and merits inclusion as an author. Suitable acknowledgement of **bpas** in articles for publication should be cleared first.

PART 1

1.1 Title of Project
A Sociological Investigation of the Professional Identity of the Abortion Doctor
1.2 Date of Application
13/08/2017
1.3 Principal Investigator/Supervisor
Hannah Pereira, Supervisors- Dr Elle Lee and Dr Michael Calnan
1.4 Position or Appointment
PhD student
1.5 Co-investigators and/or Collaborators
1.6 Has external funding been sought? Yes X No ☐
This PhD is being funded by the Economic and Social Research Council (ESRC)
1.7 Has internal funding been sought? Yes ☐ No X
If Yes please give details
1.8 Type of Approval Requested **Exempt ☐ Expedited ☐ Full x Full and Board ☐**
1.9 Contact Information
Mailing address: Telephone number: Extension: Fax number: Email:
1.10 Name and site of the institution at which you intend to carry out the project
This study is part of a PhD by Hannah Pereira who is a University of Kent student funded by the ESRC. The interviews will be carried out at various locations, including bpas premises as appropriate.
1.11 Relevant qualifications and research experience of Investigators
I have completed a PCert in Methods of Social Research at the University of Kent. I have also written an undergraduate dissertation and masters dissertation on the 2012 'sex-selection' debate.

1.12 Proposed study dates and duration	
Start date:	**September 2017**
End date:	**September 2018**
Duration:	1 Years 0 Months

1.13 Primary purpose of the research (Tick as appropriate)

☐ Commercial product development and/or licensing
☐ Publicly funded trial or scientific investigation
X Educational qualification
☐ Establishing a database/data storage
☐ Other (describe):

1.14 Implications for bpas

Please describe the role of bpas in this research, clearly explaining the implications for bpas staff time and use of facilities that will be required

I would like to interview approximately 50 doctors that are involved with the provision of abortion in Britain as part of this study, given bpas is the main provider for abortion this would include doctors that work for bpas as part of the sample. I would like to make it as easy as possible for bpas staff (ie those who work in clinics that provide abortion) to participate and so would like to be able to conduct the interviews at the most appropriate time for the interviewee and at the clinic where those who participate work, if this is most convenient. I expect interviews to last approximately 60 minutes.

1.15 What use could the results be to the public, to bpas clients and for bpas policy?

This study aims to consider how doctors think about their work and their contribution to medicine, when abortion provision is situated ambiguously in relation to ethical and organisational frameworks for reproductive health care and the practice of medicine. The results of this study could be useful for the future of the abortion service in Britain as the results will be discussed with those involved in the service provision and the relevant policy circles.

1.16 What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, bpas clients of staff for negligent harm?

No special arrangements as no medical intervention is involved.

1.17 What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, bpas clients or staff for non-negligent harm?

No special arrangements as no medical intervention is involved

PART 2

This section is to be completed where the proposed research involves a request for the supply of fetal tissue.

2.1 Please estimate the amount and integrity of tissue needed (e.g. gestational age, viability, intactness, freedom from chemical contamination).

2.2 Please indicate the process of proposed disposal of the fetal tissue at the end of the project.
2.3 Please describe the experience of Principal and Co-investigators in handling and disposal of fetal tissue.

Please attach:

1. A detailed synopsis or diagram (flow chart) detailing the proposed operational procedure(s) for obtaining specimens at the **bpas** Treatment Unit, including transport of the tissue.

2. The Material Transfer Agreement.

3. The Human Tissue License.

PART 3

3.1 What is the principal research question/objective?

1) The work of the abortion doctor as part of medicine
2) Opinions about the law and current policy
3) Perceptions of recent debates on abortion provision in Britain

3.2 What are the secondary research questions/objectives (if applicable)

3.3 Abstract of the proposed research

Maximum 300 words in lay terms; (including the purpose of the research, and a short summary of the theoretical framework, methodology, design, outcome measures and analytical methods that will be used to achieve the objectives, the role of **bpas**, and the potential benefits, if any, to **bpas** and its clients).

This study consists of a set of detailed interviews with doctors that authorise and/or perform abortions. The main focus for this study is the professional identity of doctors that perform abortions in England and Wales focusing specifically on the criticisms that doctors have faced recently, their perceptions of the law and institutional frameworks, and the values doctors that provide abortions place on their work. This study is contextualised through an assessment of the 'abortion doctor' historically, in relation to law, medicine and health service provision, based on a literature review. It will recognise that present debates are the contemporary expression of the historically liminal and ambiguous position of 'the abortionist' in relation to the medical profession, medical law and ethics, and the organisation of healthcare through the NHS in Britain. Participants for this study will be recruited through the British Society for Abortion Care Providers (BSACP) and with the help of the bpas Medical Director Patricia Lohr.

1 in 3 women living in England and Wales estimated to have at least one abortion (Sheldon, 2015). The majority of abortions completed in England and Wales are done before 12 weeks gestation, through early medical procedures, rather than surgical abortions meaning the method now used to terminate pregnancies has drastically changed since 1967, and abortion is now safer than ever before. However, while the abortion procedure has become much safer and the risk of complications to women has decreased, abortion law remains the same. As a result the arguments produced by those who oppose abortion reform have shifted in recent years to focus on those that provide legal abortions and have called into question the practices of abortion providers and as a result it is important to investigate the 'lived experience' of abortion providers.

3.4 Background and significance with supporting literature

The study is contextualised by particular, contradictory features in the legal institutional and cultural context for abortion provision. One of the most significant consequences of the 1967 Abortion Act is it gave doctors the medical autonomy to decide when an abortion can take place (under regulation). However, historically the position of the medical profession has not always been supportive of legal abortion, for example as Kirstin Luker (1984) described the medical profession in the United States of America as "probably the single most important influence in bringing out nineteenth century anti-abortion laws" (1984: 16). Similarly John Keown noted in Britain the "important influence [of the medical profession in]… the determination of when abortion is 'criminal' and when it is 'therapeutic'" (Keown, 1988: 166). Keown, suggests that a "central… concern of the [medical] profession … has been self- interest" (1988: 159). The position of the medical profession is significant to this

thesis as it is essential to examine how the people that have played and continue to play a role in the women's experience of terminating a pregnancy have been addressed.

Throughout the nineteenth century and the early twentieth century individuals that provided abortions had been criminalised in an effort by the 'medical man' to claim their authority over the ultimate question 'when does life begin?'. However this position as the 'medical man' slowly began to change with the 1929 Infant Life Preservation Act, the Birkett Committee and the Bourne ruling in 1938 when the construction of the 'abortionist' changed from a mysterious figure harming women to the ordinary doctor looking to save the psychological and physical health of women. As a result of this construction the medical professionals were looked upon to provide a solution to the social problem of abortion through the 1967 Abortion Act. Exploring the history of the law on abortion and the development of abortion practice and provision post 1967 are both essential for exploring the problems that medical professionals face in providing abortion today as the current practice of abortion has been formed around these laws.

This thesis is significant as while there has been a research on the women's experience of abortion in Britain there is a small amount of research that focuses on the experience of the individuals that provide the abortions to women. The law has been constructed that would give the impression that the social problem of abortion has been resolved by the 1967 Abortion Act, however as McGuinness and Thomson (2015) notes the opinion of the medical profession on abortion was not 'uniform' after the 1967 Abortion Act and the 1967 Abortion Act created tensions that were not resolved.

3.5 Will any intervention or procedure, which would normally be considered a part of routine care, be withheld from the research participants?

☐ **Yes** ☐ **No** X

If yes give details and justification:

3.6 Will the research participants receive any clinical intervention(s) or procedure(s) including taking samples of human biological material over and above that which would normally be considered a part of routine clinical care?

Describe the additional intervention	Average number of interventions per patient		Average time taken (minutes/hours/days)	Details of additional intervention of procedure, who will undertake it, and what training they have received
	Routine Care	Research		

Additional rows may be added to the table above as needed.

In addition, attach a detailed flow chart or research plan

3.7 Will the research participant be subject to any non-clinical research related intervention(s) or procedure(s) (includes use of interviews, non clinical observations and use of questionnaires)?

☐ **Yes x** ☐ **No**

If yes, attach any interview tools, and questionnaires. Include a flow chart or research plan which describes the research procedure or intervention. Detail who will undertake it and what training they will receive.

The interview schedule is attached. Hannah Pereira will conduct the interviews and will attend a workshop 'Conducting Interviews' run by the Graduate School at the University of Kent that aims to raise awareness of what to expect when conducting interviews.

3.8 Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during the interviews/group discussions, or use of screening tests for drugs)?

☐ **Yes** ☐ **No x**

If yes provide details of procedures in place to manage these issues:

3.9 What is the expected total duration of participation in the study for each participant?

a) during treatment: N/A

b) pre or post-treatment: N/A

3.10 What is the potential for, and likelihood of, risk and burden for the participants (e.g. withholding medications, devices, ionising radiation, pain, discomfort, emotional distress, inconveniences, or changes in lifestyle)? How will you minimise these?

Each of the interviews will be arranged for a time and location most convenient with the doctor, this is to ensure minimal inconvenience is caused to the doctor. As part of the interview discussions concerning recent cases where allegations of law breaking have been pressed e.g. in media reporting and it will be made clear to all participants that they should only disclose what they feel comfortable discussing. In addition, specific consent will also be required from participants if the quotation poses any risk to the participant.

3.11 Is follow up support available (e.g. medical care, counselling) for participants if research uncovers underlying unresolved issues?

N/A

3.12 What is the potential for benefit if any to research participants?

This study has the potential to benefit research participants as the participants will have the opportunity to raise and explain problems they consider influence their work.

3.13 What are potential risks to the researchers themselves? (If any)

The potential risk to researchers are minimal due to the professional nature of those being interviewed. However, as part of the interview a discussion on recent case of law breaking may arise and it will be made clear to all participants that they should only disclose what they feel comfortable discussing. I will also seek specific consent from participants if the quotation poses any risk to the participant.

3.14 How will potential participants, records or samples be:

a) identified: Doctors will be identified through the British Society of Abortion Care Providers (BSACP), through myself attending conferences and talks with Patricia Lohr.

b) recruited or obtained: Participants will primarily be recruited through the BSCAP and then snowballing.

3.15 How many participants will be recruited and by whom? How many of these participants will be in a control group? If randomised please give the method of randomisation.

This study aims to interview between 50 individuals recruited primarily through BSCAP by Hannah Pereira and then snowballing sample.

3.16 Inclusion and exclusion criteria

Participants must be doctors that are currently/have been involved in the provision of abortion in England or Wales. Doctors included are those that authorise and/or doctors that perform abortions.

3.17 Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?

x **Yes** ☐ **No** ☐ **Not Known**

If yes, give details and justify their inclusion. If not known, what steps will you take to find out?

Some of the participants may have been involved in a study produced by my PhD supervisor Dr Ellie Lee.

3.18 Will valid consent be obtained from the research participants?

x **Yes** ☐ **No**

If yes, give details of who will take consent and how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material. Supply copies of the consent and information sheets.

Participants will be asked to sign a written consent form which will be signed at the time of interviews and will be given an information sheet on the study prior to any interviews.

3.19 Will the participants be from any of the following groups?

☐ Children under 16
☐ Adults with learning disabilities
☐ Adults who are unconscious or very severely ill
☐ Adults in emergency situations
☐ Adults with mental illness (particularly if detained under Mental Health Legislation)
☐ Adults suffering from dementia
☐ Prisoners
☐ Young Offenders
☐ Other vulnerable groups (please specify)

3.20 If participants are to be recruited from any of the potentially vulnerable groups listed in 3.19, say how you will ensure that consent is voluntary and fully informed. Where applicable, describe the procedure for ensuring willingness to participate in participants where consent is provided by a legal representative.

N/A

3.21 If consent is not to be obtained, please explain why not.

N/A

3.22 How long will the participant have to decide whether to take part in the research? What arrangements are in place to answer any questions they may have during this period?

A request to participate will be made via BSACP forum or email, and participants will be given at least two weeks to decide whether they would like to be interviewed or not. Potential participants will be able to call and/or email Hannah Pereira. Participants will also be given the email address for my main PhD supervisor in case they have any queries.

3.23 What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters).

N/A

3.24 Will individual research participants receive any payments, reimbursement of expenses or any incentives or benefits for taking part in the research?

☐ **Yes x No**

If yes, indicate how much and on what basis this has been decided:

3.25 What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for negligent harm?

Please also attach copies of the relevant documents.

N/A

3.26 What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for non-negligent harm?

Please also attach copies of the relevant documents.

3.27 How will the results of research be made available to research participants and communities from which they are drawn? How will this be done and within what time frame?

I am hoping to attend conferences to discuss my research throughout the second and third year of the PhD and final results of this PhD study will be disseminated once the PhD is completed.

3.28 What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or any other anonymisation procedures have been used and what stage.

Data will be stored in accordance with the University of Kent's data management policy: https://www.kent.ac.uk/library/research/data-management/index.html

Anonymised interview transcripts will be stored on a password protected PC for use of the researcher. If any identifiable data is collected by the researcher this is will occur during

the recruitment stage of the research, this data will be the following: name, age, location, email address and telephone number. This will be kept on an excel spreadsheet under a password protected folder on the encrypted hard drive. This spreadsheet will be saved until the end of the project.

All identifying details will be changed in transcripts and write-ups so that none of the participants involved are recognisable throughout the study. However, the number of doctors involved in some areas of abortion provision (for example, performing abortions at later gestational stages) is quite small, and this is especially the case for senior personnel. This does mean that it is possible participants could be identifiable from quotations used in reports/papers based on the research. In the event of it being the case that quotation the researcher want to use poses this risk I will contact the participant concerned to ask for specific consent/ approval for its use, making it clear that the quotation in question will only be used subject to permission.

3.29 Where will the analysis of the data from the study take place and who will undertake it?

The University of Kent, Hannah Pereira

3.00 Who will have control of and act as the custodian for the data generated by the study?

Hannah Pereira

3.31 Who will have access to the participant's personal data and other data generated by the study?

Hannah Pereira

3.32 How long will data from the study be stored? At what point will it be destroyed, by whom and how? Please supply rationale.

The personal data will be stored for 3 years for the duration of the PhD. This is a necessity in order to complete the PhD, therefore the researcher must keep all data needed until the Thesis is submitted and approved. The storage of any personal data after the research is complete will be up to 3 months. After the three months any personal information will be destroyed. During this time the Data will be stored on a encrypted computer and hard drive secured by the researcher. After completion of the PhD the data that has been anonymised will be donated to the UK Data archive in agreement with the ESRC scholarship funding.

3.33 How has the scientific quality of the research been assessed? Please include any available critiques and /or assessments.

The proposal was assessed by the ESRC and the University of Kent. This study has also received approval from the university of Kent's Faculty of Social Sciences Research Ethics Advisory Group, this review also considers the scientific quality. I am aware that this is a separate ethics and documents can be further amended. It is also possible to go back to the University of Kent's Faculty of Social Sciences Research Ethics Advisory Group with any further amendments put forward as a result of this review.

3.34 Has the size of the study been informed by a formal statistical power calculation?

☐ **Yes** X **No**

If yes, indicate the basis upon which this was done, giving sufficient information to allow the replication of the calculation. If no, how was the size of the sample decided?

3.35 Has a statistician given an opinion about the statistical aspects of the research?
☐ **Yes** x **No**
If yes, give a brief summary of advice offered and attach a copy of comments if available:
3.36 What arrangements are in place for monitoring and auditing the conduct of the research?
Monthly meetings with PhD supervisors and progression checks throughout the PhD
3.37Will a data monitoring committee (DMC) be convened?
☐ **Yes x No**
If yes, give details of the membership of the DMC and its standard operating procedures. Forward summary interim analyses to **bpas** REC.
3.38 What are the criteria for electively stopping the trial or other research prematurely?
This study would only stop if it were not possible to find people to interview
3. 39 How will any incidental findings be reported and addressed?
Through reporting of the findings of the study
3.40 Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?
☐ **Yes** x **No**
If yes, give details including: Name of Research Ethics Committee or regulatory authority Decision and date taken Research Ethics Committee reference number If no, please provide the letter of approval as an appendix.

Part 4

Declaration by Principal Investigator(s)

In compliance with the policies established by bpas Research and Ethics Committee, the Principal Investigator(s) agree that:

1. The information in this form is accurate to the best of my (our) knowledge and I (we) take full responsibility for it.

2. I (we) undertake to comply with the ethical principles of the current Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the application is approved, I (we) undertake to adhere to the study protocol.

4. Approval will be obtained from **bpas** prior to instituting any change in this research project.

5. Development of any unexpected events will be immediately reported to **bpas** Research and Ethics Committee.

6. An annual review and progress report will be completed and submitted.

7. Signed valid consents and all research documents will be kept for the duration of the project and for at least three years thereafter at a location approved by **bpas** REC.

8. *For projects involving fetal tissue only*. I have considered the feasibility of achieving the purpose of the project by means not involving fetal tissues, and in my opinion no such alternatives exist. I undertake responsibility for the management of the project and that it will be carried out in accordance with any guidance from the Department of Health including the recommendations of the Polkinghorne Report, the Human Tissue Act and the Associated Code of Practice.

9. *For projects where a Data Management Committee has been convened only.* I undertake to forward summary interim data analyses to bpas REC.

10. I undertake responsibility for the management of the project and that it will be carried out in an ethical manner.

11. I understand that the lay summary of this study may be published on **bpas** website

SIGNATURES

ALL SIGNATURES MUST BE ORIGINAL. Type the name of each individual above the appropriate signature line.

Principal Investigator: Hannah Pereira

Signature: Hpereira **Date: 15/09/2017**

Co-Principal Investigator: _____

Signature: _____ **Date:** _____

Student Adviser (if any): _____Dr Ellie Lee

Signature: _____  **_____ Date: ____17/09/2017_____**