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Doctors who provide abortion: their values and professional identity

Key findings

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Background and context

This research is based on detailed interviews with 14 doctors who have spent at least a decade, and in some cases most of a lengthy career, providing abortions. Most are presently, or recently retired, Consultants in Obstetrics and Gynaecology or Sexual and Reproductive Health. Some work mainly or only within the NHS, and others mainly or exclusively for Independent Sector abortion providers. The work of these doctors involves authorising abortions in line with legal requirements and making sure requisite paperwork is completed, overseeing and enabling the work of other staff involved in abortion services, performing abortion procedures, and in some cases planning the development of the service in the region where they work.

The context for the study is the aspect of the public debate about abortion whereby the *organisation and practice of abortion provision*, rather than *the morality of abortion in-and-of-itself,* is the focus for controversy. This has been very evident in recent debates, including those in Parliament, about purported problems of abortion provision including the conduct of pre-abortion counselling, 'sex selection' abortion, and 'pre signing' HSA1 forms (the forms that are returned to the Department of Health to show two doctors agree 'in good faith' that an abortion can be legally provided). These debates have included claims that some doctors who provide abortion practice unethically with a lack of requisite care for patients and scant regard for the law. Yet in academic work, although doctors are a focus for debate in this way, and despite the fact that what

doctors do is central to the provision of abortion to many thousands of women each year, their experience is curiously under-researched; there is almost no sociologically informed research about this group of doctors. The primary aim of the project, in this light, was to generate insight into the tensions between the public debate about abortion and the criticisms made about its provision, and the views and experiences of doctors most directly involved in providing abortion.

In beginning to fill this research gap, the study took as its focus the sociological question of professional identity; that is, how do doctors who work in providing abortions understand the value and contribution of their work as part of the practice of the profession of medicine to which they belong? In investigating this question, the study also sought to find evidence about the relation between legal and policy understandings of medical professionalism, and those of this group of doctors. Law and policy strongly upholds an idea of the doctor as the only 'registered medical practitioner' qualified to make 'good faith decisions' about whether an abortion can be legally provided. It requires that two doctors make such decisions and do so in line with the provisions set out in the Abortion Act 1967 (as amended), a statute that is 50 years old this year. The legal and policy context is thus one which understands the doctor and their professional responsibilities in a particular way. Set against this legal and policy framework, this study asked:

- How do doctors themselves describe the responsibilities of their work?
- How do they describe the values they hold?
- How would they like their work to be understood and organised?

Key findings

1. Abortion provision involves contradictory experiences for doctors.

The central finding of the research is evidence of a contradiction between doctors' perceptions of the work they do - its social importance, its value to women and their striving for excellence within the services which they provide - and aspects of the context for their work. This context includes misplaced perceptions evident in public debate and held by other medical professionals, and aspects of the law and policy. Overall this contradiction can be captured in the powerful words used by interviewees to describe the work they do providing abortions. Doctors spoke of their work using positive terms that included:

> *Pride, empowering, helping, inspiration, satisfaction, caring, pleasure, rewarding achievement, enjoyable, helping, challenging.*

However, when asked about areas of public debate, law and policy, and about the practical reality of meeting the needs of women they used terms such as:

Anger, disappointment, anxiety, concern, fear, discomfort, guilt, frustration, stigma, threatened, confusions.

This contradictory experience can be detailed further as follows.

2. Abortion provision is work that matters medically and morally, and is integral to good reproductive healthcare.

Those we interviewed communicated a strong and clear sense that what they do in providing abortion matters, and that most of all it matters for women. It was clear from what we were told, that interacting with women who are pregnant and who seek to access a healthcare system that seems sometimes unable to address their needs properly, generated a strong commitment on the part of doctors to: being involved with abortion provision; improving abortion provision; ensuring that a service is delivered which respects women's capacity to make significant choices; and that recognises the considerable difficulty women may experience making such a decision.

It is an incredibly important part of women's healthcare so if nobody wanted to provide infertility care maybe I would have specialised in that. I'm very happy about being involved in women's healthcare and I'm working in many different aspects of it and I like to focus on those areas that nobody else wants to deal with.

It's…caring for the problems – medical problems – of women and termination of pregnancy is a medical problem that women have and therefore it fits quite easily as far as I'm concerned with the rest of my work.

It's very rewarding…I've always thought - and it's one of the things that I always teach - that pregnancy is either the greatest or the worst thing that can happen to you. It's either really exciting and a fabulous move forward in your life and so-on and so-forth or it's a complete disaster that just pulls everything apart; relationships, you know, your planned trajectory in life, your training, your job…pregnancy's very important and not being able to become pregnant is the same tragedy as getting pregnant and I think that's important... it's a huge, central part of their life and that destroys other things which is a terrible thing…

I understand people not wanting to do abortions… I've got no moral qualms about doing abortions at all. I'm not saying it's pleasant but I have no moral qualms. I do genuinely believe it is the right thing to do for most women who ask for it.

One of the reasons that I became interested in provision of abortion care is because I feel that the mutilation or death of a woman because of pregnancy or any pregnancy-related complication is an unmitigated disaster and I've seen it all… the reality is that forcing women to have children they don't want does not make any nation richer in any form or shape… That said, it's not my decision, it shouldn't be the decision of me or that of the government or anybody for that matter, it should be the decision of the woman whether to abort or to keep the pregnancy and that is it.

I feel really strongly that abortion saves lives and I don't just mean for women who are, you know, medically compromised. This is about that, [it] can be part of it, so avoiding morbidity and mortality is part of it but it is really about making it possible for individuals to live the life that they want to live at whatever point in time they present with a pregnancy that they're not prepared to continue.

Quite often people say, "Ooh, I couldn't do your job", and it's funny because it really doesn't feel like that because, you know, it can feel incredibly rewarding to be able to help somebody around making decisions around something that is going to have such an enormous impact on their future.

I've been thinking about it since I was a medical student a lot and... I think that, I like the slogan 'trust women'. I think that's good because basically women know what's best for them and so a lot of the things that we do really get in the way of that.

3. Doctors worry about the negative impact of public debates, which reflect misunderstandings of the work they aspire to do and their motivations for providing abortion, on the recruitment and training of new abortion doctors.

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Those we interviewed emphasised different aspects of misunderstandings about abortion. Some placed stress on how some of their colleagues perceive abortion provision as unimportant or uninteresting, and how abortion is wrongly perceived as an 'added extra' to women's healthcare. Almost all of the doctors, however, drew attention to the negative effects of a response to public controversy based on enforcing greater regulation and scrutiny of their work.

....all of the negative light that's been shown on abortion, so whether it's raised by the CQC [Care Quality Commission] to see if doctors are breaking the law, harshly worded letters from the CMO [Chief Medical Office], doctors actually being prosecuted – I think those things are deterrents to junior doctors going into the field and wanting to get training and also I think it disincentivises providers in the NHS where all the training happens from developing and supporting services where junior doctors can be trained. So I think that, you know, the controversies around abortion care have a direct impact on the future workforce for individuals and because it's so heavily focussed on doctors, because doctors are still central to the law, you know, we need that workforce.

It makes doctors frightened. Apart from the fact that it's a Cinderella position anyway because it's not seen as part of normal obs and gynae and on top of that they're now also frightened because they say, "Well if we don't cross this and if we don't tick that then somebody's going to take our registration away", and it's got nothing to do with good clinical care and I'm furious about it. It's really not doctor-think.

4. The legal requirement for 'two doctors' signatures' is at odds with doctors' values regarding the doctor-patient relationship, with high quality professional care and with service improvement.

The 'two doctors' signatures' requirement was one aspect of the regulation of abortion provision that almost all of those we interviewed strongly criticised.

> *Well in short it's crap, unnecessary. Completely unnecessary … Because a woman needs to decide it and that's what she does. At the moment all the doctors in their right mind of course ask. If they've already signed a form and the woman says, "Actually I'm going to continue with the pregnancy", nobody's going to drive her into the operating theatre and say, "We've signed it, you have to have an abortion!"*

> *To me it's a procedure… but it's just completely bizarre for two doctors because it's something that you discuss with someone and informed consent is the basis of all medical interventions and that is all they should be. … I don't understand why you can't just do a consent with the clauses on it and say, you know, "You're consenting under these clauses." So to me it's a joke.*

> *The other issue is that best practice is to allow direct access from the patients so they don't have to go through a GP or another service, they can book straight in with us and, again, we'd love to be able to do that but the reality is getting that second signature is difficult so we rely on the GPs signing the first part so that most of the time we've already got one of the signatures and then the doctor in the clinic can sign the other one. If we allowed direct access it would mean for every occasion we'd have to go round the hospital trying to find someone to sign it and, again, in a big hospital that's not impossible to do but like today in clinic there were three that were unsigned it probably took me about half an hour just sort of literally walking around interrupting someone and getting them to sign it.*

5. Legal requirements appear directly to contradict the demands of acting as a responsible medical professional: the example of early medical abortion.

Interviewees were concerned – some of them very strongly so – about the effects for women of not being able to provide abortion procedures in the way they saw as best from a medical point of view. It was the provision of Early Medical Abortion that was most often discussed this way.

> *The main limiting things about the process is the blue forms and the inability to do medical abortion either off-site or for women to take medication at home….It's extraordinary that you can subject women to travelling mid-abortion* [after they have taken both drugs used to induce miscarriage and leave the clinic]. *I mean I find that unbelievable that the government can do that and why? I mean it's not morally better; it's medically more unsafe, it's logistically more difficult for women so that's another one of my absolutes, certainly the second part of abortion should be available at home. Not for everybody because some women*

are frightened and want to be somewhere where they have support or they don't have support or privacy at home but any woman should have the option to complete her abortion at home.

The big one is the requirement to give the tablets on hospital premises…. we do exactly the same thing with the patients with miscarriages so medically there is no different whatsoever between the process and the procedure but the miscarriage patients we can give them to the patients to use at home which is dramatically more convenient for them [but it] *wouldn't be legal for us to do that with the abortion patients so they're treated quite differently.*

[The law puts] restrictions on the type of care that you can provide. So the stuff around not being able to give women their medications to take away and take at their own convenience I think is incredibly important… We've just so much grown up with the way it is and not to fiddle with it because of the fear of it ending up being, you know, made worse, but … then it stops us thinking about what actually are the potentials that could have made the whole thing easier.

Further research

Further research and discussion might usefully consider the need to broaden the scope of the debate about conscience when applied to abortion provision. This study indicates that 'acting in good conscience' can be strongly applied to the actions of doctors who *do* provide and perform abortions, as well as those who, in line with legal provisions, are *not* involved on grounds of conscientious objection.

The term 'medicalised' has been used in much academic work to describe the abortion law and the system for provision to which it has given rise. This work, for example, draws attention to the way the regulations that surround abortion present doctors as powerful gatekeepers to abortion, whose role it is to make judgements about whether an abortion should be provided. The doctors who took part in this study, however, were almost all critical of what have been take as core aspects of 'the medicalisation of abortion'. This was very clear in what most said about the requirement for 'two doctors' signatures' and the arrangements for the provision of medications used for Early Medical Abortion. There were differences of opinion among those we interviewed, but overall this study suggests that doctors who are most closely involved in the provision of abortion reject aspects of its 'medicalisation'. This points to the need for sociological work to revisit this concept and its workings.

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