

## Managing a Professional Identity as Abortion Care Providers in a Time of Uncertainty

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The reversal of *Roe v. Wade* in the USA has once again brought to light the moral problem of ending a pregnancy with the Supreme Court's decision sending shock waves across the world, generating protests in many cities. The decision to reverse the constitutional right to have an abortion has been described as "an attack on women's rights everywhere" (Lavalette et al, 2022: 1) and also changes the dynamics for the medical professionals that work to provide abortions, who may now, depending on law state-by-state, no longer be permitted to do what they think is in line with the needs of women they should be caring for. Those working in the USA had previously been providing care to patients in "deeply stigmatized... [and] heavily restricted" settings in some states (Buchbinder, 2022: 1), but these same healthcare professionals can now face prosecution for simply performing this medical procedure.

The changing legal landscape of abortion because of the decision to reverse *Roe vs Wade* raises important questions on the position of healthcare providers in the USA and their future. Some states, such as Tennessee, Missouri and South Dakota have worded state law to only allow medical professionals to provide an abortion when it is medically necessary to save the life of the pregnant woman. This has been called described as a 'legal limbo' in various news articles across America because, as Simmons-Duffin (2022) explains:

*Physicians who provide abortions are in an incredibly difficult spot as they try to navigate the new legal landscape, especially in cases where a pregnant patient is sick or has complications. Intervene, and you risk violating the law and being sued, losing*

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*your medical license, even going to jail. Don't intervene and you could be risking your patient's life, and potentially being sued by the patient or family.*

Whilst it is unlikely that medical professionals who provide abortions in Britain would be sued by the patient's family, and the political context is very different (for example, with UK politicians recently voting in favour of home use of medical abortion) it is the case that the law in England and Wales places doctors in an ambiguous position where they too can find themselves in a 'difficult spot'. There have also been many attempts in England and Wales over the past 10 years to target doctors who provide abortion with accusations of law breaking and unprofessional behaviour, undermine trust in the work they do, and generate suspicion about their motives. I completed a PhD that investigated the professional identity of doctors who provide abortions in England and Wales, and in this contribution I set out some key findings. While as noted there are very significant contextual differences with the USA, I suggest that basic components of professional identity are similar, and will influence the course of developments in the USA. Abortion doctors, I suggest, are unlikely to take such a grave assault on their professional identity and wish to treat women as moral actors with autonomy and healthcare needs that should be met, without resistance.

My research used a qualitative methodological approach, whereby in-depth interviews were carried out with 47 doctors who provide abortions in England and Wales to examine their beliefs and values. Abortion is currently a medicalised problem in England and Wales (Keown, 1988; Sheldon, 1997), where the law places doctors at the centre of legal provision and puts doctors in control of who can have a legal abortion. The provision of abortion is governed by two main laws, the *1861 Offences Against the Person Act* (OAPA) and the *Abortion Act 1967*. These laws have constructed abortion doctors as gatekeepers and guardians of morality who are in control of who can have a legal abortion, creating tensions between the legal framework and the practice of abortion since 1967. Increasingly those who do provide abortion have come to act as 'doctors of conscience' and more and more work to 'normalise' abortion as part of healthcare (Lee, Sheldon and Macvarish, 2018). Doctors in England and Wales are then tasked with managing this ambiguous position and working through the tensions to provide the best possible service to their patients. This does include the possibility of imprisonment due to the background given by the 1861 OAPA, but more so a struggle with the framework of 'gatekeeper' experienced as placing unnecessary burdens on

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the best sort of care. Whilst the structure of the law in America, and especially within the states that only allow therapeutic abortions is different to that of abortion law in England and Wales there is a key similarity, medical professionals face the uncertainty on whether they can be accused of breaking the law by providing a termination of pregnancy.

In recent years the values and practices of doctors who provide abortions in England and Wales have been questioned. Doctors found themselves at the center of a series of claims that stated doctors were acting both illegally and immorally. Additionally, "British politicians have sought to intrude into issues of abortion-related clinical practice, fueling 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).

As with American abortion providers who are now expressing concern over the lack of protection by the law to allow them to provide safe and legal abortions, medical professionals who provide abortions in England and Wales also express a sense of vulnerability around the legal framework of abortion. The 'sex-selection scandal' of 2012, saw doctors facing criminal charges for agreeing to provide an abortion to an undercover journalist based on a heavily edited video footage reported in the British press. Additionally, "overt threats [were made] about prosecuting doctors were made by senior Governmental ministers" (Lee, 2017: 17). One of the consequences of the sex-selection investigations was that it "heightened the idea that providers felt quite fearful" (Lee, Sheldon and Macvarish, 2018: 31). Furthermore, it highlighted to providers 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" (Bristow, 2012: 43). As a result of this period where both, doctors were accused of acting illegally, faced with the very real threat of prosecution.

My interviewees reflected directly on the ambiguous position they find themselves in, whereby they are given the responsibility of gatekeeping legal abortion, but also find themselves experiencing a strong sense of fear of prosecution. Mark (a provider in England) drew attention to the exceptionality surrounding the regulation of doctors who provide abortion, when he explained "the only branch of medicine where if you don't get the

paperwork right, you're breaking the law." 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". A sense of vulnerability was communicated by these that doctors when thinking about the consequences of providing abortions because of the fear of prosecution.

The unique position of the abortion provider in England and Wales also increases their stigmatisation. This emerged when participants discussed their personal experiences with medical colleagues and people from the wider community. The majority of doctors I interviewed expressed a mixture of feeling both proud and stigmatised in relation to their occupation, suggesting a specific form of professional identity.

They each have their own moral story about why they chose to become an abortion provider, but one of the biggest underlying drivers for participants was a sense of moral duty to "do much better" than the services they saw being provided during their medical training. However, whilst these doctors were proud of the work they do, they also expressed a concern about who, outside of their immediate family and colleagues knew about their participation in termination of pregnancy services. One participant said, "very, very, very few doctors introduce themselves as abortion doctors or termination specialists" because "it still carries a negativity to it." This was a common theme amongst interviewees. 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". The decision not to tell people about their work in this service was reiterated by a further participant who said, "I think it's fair to say you don't readily talk about what you do".

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, 2011). Yet, unlike most other groups of doctors, those working in the abortion service work in a low-status branch of medicine. They can experience being marginalised and stigmatised for their role and they have very little control over service provision because of the legal framework. As a result, many of these doctors had adopted an identity where they were privately proud of their role in the termination of pregnancy

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services, while being cautious about who outside of their immediate family knew about their work.

Alongside the sense of pride that doctors described whilst talking about their work as a doctor who provides abortion, interviewees often told me that they were motivated to become abortion providers because of situations they had experienced where medical colleague or mentors had treated people looking for a termination of pregnancy, to their minds, unfairly. For example, one doctor, who was working in a country where abortion was illegal at the time, recalled seeing "wards that were full of septic women because they'd had illegal abortions... women die[d] from stuffing stuff in their vaginas [such as] twigs, metal instruments." Many participants had their own version of stories such as this one, whilst most of the reasons for deciding to work providing termination of pregnancies could be considered less extreme than the example above there was an overwhelming majority of participants who told me that part of their reasoning for providing abortions because they felt passionately about "bringing justice to women through health" and "to be a... positive change in peoples lives".

As a result, participants believed that it was their responsibility to provide the care that they felt their patients 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" (Dickens and Cook, 2011: 164). These doctors distanced themselves from the values of their medical colleagues and instead formed a professional identity around a strong sense of commitment to women's autonomy. These doctors told stories that portrayed themselves as moral workers fighting to protect the interests of women from other medical professionals who see them as in some way undeserving of care.

The decision to reverse *Roe v. Wade* has been described as a "direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients' rights to evidence based reproductive health services" by the President of the American Medical Association, Jack Resneck, Jr (Tanne, 2022). I suggest that this direct assault on the professional identity of doctors who have a conscientious commitment to protecting the right to choose when to have a safe and legal abortion will result in the creation of tensions

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between the medical professionals and the legal framework they are now working within. These doctors now face many tough decisions on their future as an abortion provider. News articles that have been reporting on the medical professions response to the reversal of Roe vs Wade have noted that doctors are finding new ways to work within the service. For example, the Chief Program Officer of the National Abortion Federation found that medical professionals have "started advancing and accelerating their plans to find work in other states" with "more doctors, nurses and other-front line health care workers looking for part time travel work" (Ollstein, 2022). Alternatively, some healthcare professionals are preparing for the consequences of working in post-Roe. For example, a doctor in Ohio said that she is going to stay working in Ohio because:

*There's going to be a need for aftercare for people who have managed their abortion outside the healthcare... we're still hoping that there will be exemptions for threats to the health of the mother. If someone has an emergency at 20 weeks, there are not a lot of people who know how to quickly end a pregnancy. So, I want to be here for that.*  
(Ollstein, 2022).

I believe that both examples of medical professionals looking to re-locate to provide abortion services or choosing to continue caring for patients who have complications from an unsafe abortion is a sign that these doctors will find new ways to work within the tensions created by the change in the law. These healthcare professionals will not give up or reconstruct their professional identity without resistance. Instead, like doctors working in England and Wales they will find ways to work around the legal limitations. In the form of either working within their home states providing care for women needing therapeutic abortions or through relocating to a state where they can legally provide abortions.

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