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

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ABSTRACT

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

1. Introduction

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

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

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

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

Macintyre's claim then, was that doctors, including those supportive of abortion being legally available on 'health' grounds, laid claim to having their views 'recognised' on the basis of their 'professional status'. She questioned the validity of that claim, suggesting that doctors, arguably, had no more insight about 'wider aspects of abortion', that is whether it should be provided and to whom, that anyone else. In this paper, we reconsider Macintyre's assessment in the light of our own interviews with doctors who have spent lengthy careers providing legal abortions and in leading service development. Before detailing our findings, we first discuss the context for our research and outline the design of our study.

2. Background to the research

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

This gap in the literature may partly reflect changes to abortion provision, whereby health professionals other than doctors play a growing role. While there is limited research exploring any kind of health professionals' experience of working in abortion services (Lindström et al., 2011) some has been published. Lipp reviewed 25 studies which investigated experiences across a wide range of professional groupings, using data from different countries (2008). Other studies have been published since; for example, recent qualitative research carried out with 'health professionals' in Scotland generated interesting insights about attitudes, including about age, class and motherhood in professionals' descriptions of women who have abortions (Beynon-Jones, 2012); their conceptualisations of abortion at later gestational stages (Beynon-Jones, 2011); and the extent of a focus on women's rights and needs in providers' accounts (Purcell et al., 2017). This work overall reflects a context of the growing use of miscarriage-inducing pills at early gestational stages (Early Medical Abortion, EMA). The pills are usually provided to women by nurses or midwives with the involvement of doctors increasingly confined to medically complex cases. Our findings reflect, in part, this changed landscape of abortion provision.

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

The ethical orientation of doctors most closely involved in abortion provision after 1967 has also been noted in socio-legal scholarship investigating the relationship between abortion, the law, and the medical profession. Most notably, McGuiness and Thomson explore 'how the competing interests of different specialisms played out in abortion law reform from the early twentieth-century, through to the enactment of the Abortion Act 1967, and the formation of the structures of abortion provision in the early 1970s' (2015, p.178). Of particular interest for our purposes is their commentary on what they describe, borrowing from Joffe's work, as 'doctors of conscience'.

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

Our purposive sampling of participants was intended to select doctors who can be thought of as members of this 'stratified group'. Their outlook is not claimed to be typical of 'the medical profession' in general or even of the specialisms in it to which they belong. Rather, they are a group of doctors worthy of research attention, precisely because they are leaders in the delivery of abortion services and are best placed to describe aspects of change to abortion provision. Our data thus offers a sound basis for re-exploring the tensions and problems with the legal arrangements established in 1967 and explored by Macintyre almost five decades ago.

3. Study design

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

Ethical approval for the study was obtained from the Research Ethics Committee of the authors' University and from the independent service provider for which some interviewees worked. All participants were offered anonymity, with this reflected in the removal of