The Object of Your Abortion: An Autoethnographic Approach to Exploring the Importance of Reflective Practice in Abortion Care

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Introduction

Abortion care has long been a tabooed subject at all levels of society and across many countries and cultures. To explore this area of medicine further, I have used an autoethnographic approach by using my own experiences within abortion care as a medical student. By using this approach, this piece sets out to reflect on, examine and interpret my feelings and experiences of abortion care as a health care professional and therefore create an opportunity to learn from my subjective experiences. Specifically, by offering a first-person, subjective account of involvement in abortion care provision, I hope this piece will help other medical professionals who have little experience of abortion care, to take an interest as it is vital and yet often ignored area of Women's health. The importance of autoethnographic accounts of involvement in healthcare provision for medical education is increasingly recognised.[1] As such, offering personal reflections on involvement in abortion care may be instructive, providing an opportunity to explore the potential emotional and mental health impact of involvement in abortion care provision for medical students and healthcare providers.

[1] Laura Farrell, and others, 'Autoethnography: Introducing 'I' into Medical Research, *Medical Education*, 49 (2015), 974– 982 (p. 974)

Background

As part of my final year rotation at medical school, I chose the student selected component (SSC) 'Complex Abortion Care and Contraception'. I was based on the Women's Health ward, observing in contraception clinics, TOP (Termination of Pregnancy) clinics and interacting with various health care professionals from doctors, to surgeons, to specialist nurses and bereavement midwives. On this rotation, I often went home thinking about the cases I had seen and wondered how the women were feeling. A significant contributing factor to this, I think, was because many of the young women who were seeking these procedures were around my age, some of them also studying at university. Therefore, seeing the spectrum of emotions from devastation and confusion to acceptance and relief, it was not hard for me to empathise with those women. Although I did not perform the procedures such as MVAs (Manual Vacuum Aspirations) and surgical TOPs myself, the feelings generated from just observing them, still needed unpacking. Sandy Goldbeck-Wood, former editor in chief at *BMJ Sexual and Reproductive Health*, has said that 'we need structures and processes which support shared conscientious reflection. So that when the tissue is distressingly hard to remove, the practitioners involved know due process has been served'.[2] In the same article, Goldbeck-Wood also suggests that discussion before a procedure with the woman, is not only necessary to confirm compliance with abortion law and to encourage 'deeper reflection' so the woman can 'move on' but that the discussion 'protects [her], the surgeon'.[3] I interpret this as Goldbeck-Wood suggesting that in order to carry on performing the procedures, reflection is key to establishing shared value to the work i.e., the woman feels that

[2] Sandy Goldbeck-Wood, 'Reflection Is Protection in Abortion Care—An Essay by Sandy Goldbeck-Wood', *BMJ*, (2017), j5275.
[3] Goldbeck-Wood, j5275.

due process has been done and has benefited from the procedure and that the practitioner believes they have done their patient overall good.

Abortion Care

To fully appreciate this reflective work, some context, including the current laws relating to abortion care in England, is essential. UK Abortion law, enshrined in the 1967 Abortion Act as well as the Human Fertilisation and Embryology Act 1990 (which altered the gestational period of 'viability' from 28 weeks to 24 weeks) set out certain criteria, which if met, would mean the abortion would not be criminalised. These criteria, which are familiar to those working in the field are: the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated; the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; the pregnancy has NOT exceeded its 24th week and 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; the pregnancy has NOT exceeded its 24th week and 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 any existing child(ren) of the family of the pregnant woman; or there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled. In 2019 it was announced that if meeting the aforementioned criteria, the abortion pills could be prescribed by a doctor and a woman could take the second pill in her own home and would not need

to return to a clinic.[4] Furthermore, in March 2020, due to the COVID-19 pandemic, the Government and Public Health England announced that women seeking an abortion would be able to access early medical abortion care after an e-consultation or telephone consultation with an appropriate medical professional.[5] This step was an important and necessary development in women's health, to ensure that safe abortion care could continue despite the restrictions on travel and face to face interactions imposed during the lockdown.

An Autoethnographic Approach

Autoethnography is described as a 'research method that uses personal experience ("auto") to describe and interpret ("graphy") cultural texts, experiences, beliefs, and practices ("ethno")'.[6] In a chapter of *Transforming Research Methods in Social Sciences: Case Studies from Africa*, Jeannette Schmid expresses that autoethnography creates a platform in which to share narratives and experiences which enrich the gathering of information by using an individual's 'unique insights and realities'.[7] By using my own personal experience as a medical student (at the time of the reflections) I am adding my own voice and experience to a long-tabooed area of medicine and thereby adding to the collective information gathering of experiences related to and of abortion care in the UK. This personal slant on the research methodology used, I feel is appropriate for the subject matter as abortion

[4] Abortion Law. In *Doctors for Choice* [online]. 2020 [cited 28 September 2020]. Available from: <https://www.doctorsforchoiceuk.com/abortion-law>
[5] Alex Hern, 'UK Abortion Law Briefly Changes During Covid-19 Outbreak', *The Guardian*, 24 March 2020 <https://www.theguardian.com/world/2020/mar/24/uk-abortion-law-pills-home-covid-19-outbreak> [Accessed 28 September 2020]
[6] Tony E. Adams, Carolyn Ellis and Stacy Holman Jones, 'Autoethnography', in *The International Encyclopaedia of Communication Research Methods*, ed. by Jörg Matthes, Christine S. Davis and Robert F. Potter (Hoboken: John Wiley and Sons, 2017), p. 1.
[7] Jeanette Schmid, 'Autoethnography: Locating the Self as Standpoint in Post-Apartheid South Africa', in *Transforming Research Methods in the Social Sciences: Case Studies from South Africa,* ed. by Sumaya Laher, Angelo Fynn and Sherianne Kramer (Johannesburg: Wits University Press, 2019), pp. 265-279 (p.265).

care has numerous implications for emotional, moral and ethical reactions and therefore the use of personal experiences to try and digest the information gathered, can only help to understand the subject matter better.

During this rotation I was both surprised at and curious to explore the visceral and emotional reactions I had during the first surgical termination procedures that I witnessed. Not just the mechanics of the foetal remains being removed from the uterus, but how the simplicity and almost elegance of the tools and objects saffected me. In *The Cultural Politics of Emotion*, Ahmed highlights that Descartes argues that 'we do not love and hate because objects are good or bad, but rather because they seem "beneficial" or "harmful"'.[8] Where one stands on abortion care, the laws and how women can access it, will certainly impact whether the objects and tools used and described in this piece, will be considered "beneficial" or "harmful" or indeed, both. We tend to attach feelings and connotations to objects but how much of those feelings are reflexively influenced by the objects themselves (arguably a cold metal scalpel invites feelings of apprehension and coldness just by how it looks) and how much is influenced by our culture and individual beliefs?

I found myself focussing on how these objects, for example, the cervical dilators, the suction cannula, and the dilation forceps, subscribed to a strange dichotomy of health. The objects and tools described had both the potential of healing a woman's physical and mental health, as well as the potential for trauma and violence; violence of the foetal body as the procedure takes place and the potential (although very rare) trauma of the women's body. Lisa Harris, Assistant Professor, Departments of Obstetrics and Gynaecology and Women's Studies, University of Michigan, speaks about how violence is 'inherent in abortion, especially

[8] Sara Ahmed, *The Cultural Politics of Emotion* (Edinburgh: Edinburgh University Press, 2004), p. 5.

apparent in the second trimester'[9] and how speaking about this violence and being both truthful and reflective of abortion practices, is the best way forward for good abortion care as well as for the wellbeing of the practitioner. This links back to Goldbeck-Wood's argument that reflection of the events and violence surrounding abortion care are intrinsic in protecting the practitioner's ability to continually move forward and continue their work with confidence and meaning.[10]

Goldbeck-Wood also speaks about the violence of the procedures as she is still 'haunted' by an abortion she performed due to the tissue holding 'tightly to the uterine wall' and how she had to use several passes with the suction curette to remove the tissue and that the 'violence of the situation' stayed with her.[11] Clearly, the trauma of abortion comes in several forms, from the trauma of the foetal tissue, to the potential trauma of the woman's body to the possible emotional and mental trauma of the woman as well as the practitioner. In using my personal experiences of witnessing abortions, I employ an autoethnographic approach to my writing. I use the objects and tools used in abortion care as a framework for the reader to access and consider the emotions and thoughts I share, more readily. I hope to add another voice to an area of medicine that has scope for a more open and reflective approach towards practice. Although I use objects to frame this essay, I continually reflect on the emotions generated by the procedures and I hope this engenders a reaction from the reader. Whether this is a reaction to the procedures I am describing, the objects used or the feelings I am sharing, I hope that the reader can reflect on those reactions in order to broaden their understanding of experiences and current practices of abortion care in England and the UK overall.

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[9] Lisa H. Harris, 'Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse', *Reproductive Health Matters*, 16 (2008), 74-81 (p. 75).
[10] Goldbeck-Wood, j5275.
[11] Goldbeck-Wood, j5275.

The Objects

The Needle

On my first day on the Women's Health ward, I was sitting nervously in the corner of the procedure room. I had spent the morning watching patients going through the consent forms for their procedures and I admit that I was already feeling mentally drained. The sheer volume of women who had come to the ward, their stories, their social situations had all stayed with me. The Consultant had told me that the afternoon would be a list of MVAs and one Feticide. Emeka Oloto describes Feticide as 'causing the demise of the foetus before a legal induced abortion'.[12] Different medications are used to achieve this and the reasons for a Feticide before an induced abortion are wide ranging. I had never seen a Feticide procedure before, and I was a little apprehensive about how I would feel as it happened. In the morning I had met the patient who was going to undergo the procedure and I already felt slightly invested in her case as I knew it was going to be especially difficult. She was approximately 20 weeks pregnant. She had spoken about how although she was sure in her mind about the procedure, feeling the foetal movements was making her increasingly sad and anxious and that she just wanted to get it all over with. During the procedure, the Consultant asked me to come closer and look at the ultrasound screen. I could clearly see the woman's womb and the sac containing the pregnancy. I had noticed earlier how the sound was turned off from the machine and was told how this was kinder to the patient, not having to hear the foetal heartbeats. I was so thankful for this policy at this moment. Not just for the patient, who was lying on the

[12] Emeka Oloto, 'Feticide', in *Abortion Care*, ed. by Sam Rowlands (Cambridge: Cambridge University Press 2014), pp. 142-52 (p. 142)

bed, arm covering her eyes; the tears still visible, but for myself, as I felt the enormity of the procedure come over me.

Then, the needle came into view. Long and thin, I could not help but have the image creep into my mind, of a large balloon being popped by a pin, creating a loud bang, destroying the balloon. The sad irony of that image compared to what was happening right now, was not lost on me. I kept my eyes on the ultrasound screen from that point onwards. Watching the needle go into the sac, via the ultrasound, it felt almost like it was not happening in the same room I was in. I could pretend that with the blurry lines and black and greyness of the ultrasound that this was a recording and felt less real. I could see a thin white line (the needle) enter the pregnancy sac and some further blurring of the image, indicating that contents of the needle and syringe was being emptied into the pregnancy sac. And then it was over. Well, nearly over. The needle was withdrawn, and the patient was warned that she may feel foetal movements for a few more hours but that from this point onwards, the pregnancy had officially ended. I glanced over to the trolley that held all the equipment from the procedure and saw that the long thin needle had been hastily covered with a green sheet, so that the patient would not have to look at it again. Hearing the empty vials of Digoxin (the drug used to end the pregnancy) clanging against each other, I do not think I was fully prepared for how I would feel during that procedure. As soon as I saw the needle, so thin it looked almost innocuous, feelings of shock and sadness came rushing to the surface. I realised in that moment, as I saw the needle slide silently, surreptitiously, into the woman's belly, that just because I had a Pro Choice stance, did not mean I would not have a reaction towards the procedure that might make me feel sad and shocked.

I think these feelings had something to do with how being confronted for the first time with the actual procedure, with an actual person having to make this choice, my own beliefs and the reasons why I feel the way I do about abortion and women's rights were confronted for the very first time with something tangible. Something beyond argument and rhetoric. It took several weeks of seeing these procedures, listening to how the doctors performing the procedures felt about it, to even begin to unpack these feelings of sadness and shock. I am still unpacking and reflecting on this case today. But each time since, seeing a needle during this type of procedure, the same feelings, less intense and more thought-out, are still there. These feelings keep reminding me that to care for those who perform these procedures, a greater dialogue and transparency of abortion care and how practitioners feel about them, should be implemented. Goldbeck-Wood touches on this theory again when she states that she depends on her 'own capacity for conscientious reflection' in order to work with confidence in her judgements and with integrity'.[13]

The Surgical Trolley

As the doctor pushed the large blue syringe into the blue hospital tray, relieving the pressure, the contents of the syringe slowly, sluggishly, dripped out. There are no delicate ways to describe the foetal tissue at around 8 weeks; a red, lumpy slime, speckled with dark clots and pale stringy tissue. Of course, the neat sac that was in one moment intact and nestled in the womb was at the next moment, suctioned (albeit gently and with great care) into a small thin tube, jumbling its contents beyond recognition. At first, I thought that visually, without any context, the foetal tissue did not look much more significant than a heavy period. However, this kneejerk,

[13] Goldbeck-Wood, j5275.

superficial thought was quickly wiped from my mind as the moans of discomfort and pain drift over from the patient, to my ears. The tray of red slime somehow loses its innocuity.

Looking down on a bird's eye view of the surgical trolley, a very neat and now very familiar set up was presented to me: a sterile sheet to hold the contents of the trolley; a blue tray with a clear container filled with antiseptic fluid; gauze strips; a couple of vials of local anaesthetic; a bunch of cold metal forceps and cervical dilators; a long thin clear tube still in its packaging; and a large syringe for suction. Viscerally, this trolley and the objects laid out on it, almost looked pleasing to me; a couple of weeks into the placement and I knew what each object was for; what its own individual purpose was in this the task that was to follow: I was learning. It seemed strange to me that this collection of tools and objects, a couple of weeks before, unfamiliar, and even daunting, was now providing a sense of academic pride to me. I was seeing things that so many other medical students would never see, and let's face it, many would probably never want to.

At the end of each procedure, the once neat, familiar trolley was jumbled, bloody forceps here, spilt antiseptic fluid there, the HCA rushing to pour the foetal remains into a clear pot for the morgue, before the patient gets dressed and comes out from behind the curtain. The calmness, the safeness of the procedure masking the disorder of the aftermath was subtle, but still there. No matter how sure the patient was or how straightforward the procedure, the patient would enviably carry the procedure and its impact with her for the rest of her life, in one way or another. Similarly, no matter how neat and ordered the surgical trolley was before the procedure, the trolley would still be messy, bloodied and disordered in the aftermath.

The Box

The theatre list had finished for the morning and the surgical staff were clearing down the theatre. In the corner of the room, on top of a shelf, next to boxes of surgical gloves and theatre lists, there was a small cardboard box, smaller than a child's shoebox. It was closed, but almost bursting with its contents. It was a foetal remains box that the team give to the woman if they wish to take the remains home with them. The remains of course are held in a plastic bag and tied up and then placed into the box. On top of the box there is a space to write the name of the woman and the date of death of the foetus. I could not help but think that although this was not a term baby, that this was a sad little version of a coffin. Clearly, the woman had felt some connection to the foetus, to want to take the remains away with them. It just seemed poignant to me, the image of her walking home, clutching this small cardboard box containing something that a few hours ago, had been living inside of her.

These images then take me back to the clinic the previous day, with the Consultant, when the Feticide took place and the woman expressed her wishes to take the remains home next the day when the surgical termination would take place but was not sure about how to do that. The Consultant sensitively and carefully explained they could provide her with the remains inside a bag that would be placed into a box for her to take. It was then very delicately explained to the patient that whilst she could take the remains home, that the foetus would not be intact, due to the nature of the procedure. It felt to me that although the woman echoed back to the doctor the words 'not intact' and to my mind the Consultant had very sensitively but explicitly told her that she would not be taking a foetus home that resembled a miniature baby, there was still a part of me that felt she did not quite understand.

Something about her eagerness to take the foetus home, perhaps. Of course, it occurred to me that it must be extremely difficult to marry the image of a growing baby inside of your womb with the broken and mushed contents that I had seen suctioned out of the women in theatre, when you were not familiar with the procedure. However, there was still a part of me that wanted to talk to her to make sure she understood.

These doubts about her understanding were reverberated back to me a week later, when I was sat in with the bereavement midwife, who mentioned how she could not get hold of a woman who had requested the remains but did not take the box home with her. It was the same woman. Whilst I do not know her reasoning, and nor do I have a right to, there is still a small part of me that feels a little sad that this tiny little cardboard coffin is waiting in the morgue to be picked up and may never be. And whilst I know that the remains in that box are not physically any different to any of the other remains I had seen in any other procedure, there is just something about it being wanted to take home and then left in that small cardboard box, that just stays with me.

Take Home Messages

Using an autoethnographic approach to my writing has allowed me to reflect on the experiences from my time spent observing procedures and my interactions with the women seeking abortions. Rather than just regurgitating and describing what I saw, I have tried to interpret and reflect on what I felt. This continual self-reflection has also meant that I have been able to spend more time observing and working in abortion care services since qualifying as a doctor. I might not feel as able to spend time working in these services as the emotional impact of the procedures might eventually

weigh on me, without the opportunity to examine, interpret and reflect on those experiences. I also believe that by spending time with women as they had these experiences, highlighted the power and authority women should (but sadly do not always) have over their own bodies. In 2018, Lee, Sheldon and Macvarish conducted a review of interviews with doctors who provided abortion care in the UK.

This study showed that the doctors who were deeply involved in abortion care felt that the work held 'moral value' and that the doctors 'uphold the authority of women (not doctors) in abortion decision-making'.[14] Thereby indicating that abortion is a woman's right and women should be at the forefront of decisions regarding their own bodies. Moving forward, I hope that if I continue to have a role in abortion care provision, that I will always value the authority of women in making decisions about their own health. I also hope that in some small way, that just by adding one more voice to the debates and narratives surrounding abortion care, it makes others feel more able to listen, open up and share their knowledge.

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Patient consent not required (patient anonymised, deceased or hypothetical).

[14] Ellie Lee, Sally Sheldon and Jan Macvarish, 'The 1967 Abortion Act Fifty Years On: Abortion, Medical Authority and the Law Revisited', *Soc Sci Med*, 212 (2018), 26-32 (p. 26).

Abbreviations

MVAs: Manual Vacuum Aspirations

TOP: Termination of Pregnancy

HCA: Health care Assistant

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