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## The changing body work of abortion: a qualitative study of the experiences of health professionals

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**Abstract** ‘Body work’ has emerged at the nexus of sociologies of work and bodies as a means of conceptualising work focusing on the bodies of others. This article utilises this analytical tool in the context of contemporary abortion work. Abortion provision in Britain has seen significant change in the last 25 years, paralleling developments in medical methods, and the option for women under nine weeks’ gestation to complete the abortion at home. These shifts raise questions around how abortion work is experienced by those who do it. We apply the conceptual lens of body work to data drawn from in-depth interviews with 37 health professionals involved in abortion provision, to draw out the character, constraints and challenges of contemporary abortion work. We explore three key themes: the instrumental role of emotional labour in facilitating body work; the temporality of abortion work; and bodily proximity, co-presence and changes in provision. By drawing on the conceptual frame of body work, we illuminate the dynamics of contemporary abortion work in Britain and, by introducing the idea of ‘body work-by-proxy’, highlight ways in which this context can be used to expand the conceptual boundaries of body work.

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**Keywords:** early medical abortion (EMA), EMA completed at home, body work, abortion work, health professionals, ‘body work-by-proxy’

### Introduction

The concept of ‘body work’ has emerged at the nexus of the sociologies of work and the body, as an analytical tool for examining work which takes as its focus the bodies of other people. In this article we utilise body work as a means of understanding the experiences of health professionals working in abortion provision and the factors which predominate in shaping these experiences. Significant shifts have taken place in abortion provision in Britain in recent years,<sup>1</sup> primarily due to the growing dominance of medical (rather than surgical) methods of abortion, first licensed in the Britain in 1991.<sup>2</sup> Developments in abortion medication have facilitated earlier treatment, and the replacement of in-patient abortion care with the option of women returning home to pass the pregnancy. The aim of this article is to make visible the contemporary body work of abortion and the challenges which accompany it in the

context of these shifts, and to use this context to explore the conceptual boundaries of body work.

We begin with a brief outline of pertinent issues in the literature on body work and abortion work. This highlights knowledge gaps and positions abortion as a context in which to explore some of these theoretical lacunas. We then outline the study health of professionals involved in abortion provision from which our data are drawn, before presenting our findings around the themes of: instrumental emotional labour in body work; temporality; and bodily proximity, co-presence and changes in provision. By applying a body work framing, we illuminate the dynamics of contemporary medical abortion work in Britain and suggest ways in which the conceptual boundaries of body work might be expanded.

## Body work

Body work has been proposed as a productive conceptual lens for interpreting paid work on the bodies of other people (Wolkowitz 2006), and thus for understanding the work of health and social care (Twigg *et al.* 2011). Body work is ‘work that focuses directly on the bodies of others: assessing, diagnosing, handling, treating, manipulating and monitoring bodies, that thus become the object of the worker’s labour’ (Twigg *et al.* 2011: 171). In Twigg *et al.*’s (2011) conceptualisation, body work is thus an integral component of a range of healthcare occupations, attention to which can further understanding of precisely what work is performed, where and by whom, and how it is experienced by those who do it.

Addressing the ways in which spatial and temporal factors interrelate to shape different forms of body work highlights specific challenges in the often opposing demands of ‘body time’ and ‘clock time’; challenges which emerge due to the need for bodily co-presence for body work to be enacted (Cohen 2011). This requirement constrains when and where body work can take place, while ‘body time’ dictates that body work be carried out when bodily – medical, care – needs demand it (Twigg *et al.* 2011).

A body work lens also foregrounds questions around the characteristics associated with those performing the work: for example, regarding the ‘dematerialising tendency’ in healthcare in which professional status is ‘marked by distance from the bodily’ (Twigg 2000: 391). Body work conducted by those of higher status may be mediated through technology or symbolic spaces (such as the operating theatre); or alternatively, and more often, done by those lower in the healthcare hierarchy (Twigg *et al.* 2011). Occupational status arguably also relates to the character of the body work undertaken, where health professionals atop the hierarchy work ‘with a bounded body [...] leaving lower status ones to deal with what is rejected, left over, spills out and pollutes’ (Wolkowitz 2002: 501). It has been suggested that nursing and bodily caring work tend to be organised in ways which obscure the clinical and physical reality of their messier and more stigmatising aspects (Lawler 1991, Twigg 2000). In this sense body work shares conceptual territory with ‘dirty work’ (Hughes 1958), and can be understood as ‘ambivalent work that may violate the norms of management of the body’, around what workers see and touch (Twigg *et al.* 2011).

### *Body work and abortion*

The potential relevance to abortion work of many of the issues discussed in the body work literature – including not only co-presence and dematerialisation, but also temporality, spatiality and stigma – suggests that body work may offer a useful conceptual framework with which to draw out the dynamics of contemporary abortion work in Britain. The 1967 Abortion Act, which provides the medico-legal framework for abortion provision in Britain, medicalises

abortion by stipulating that the need for treatment must be agreed upon by two doctors, and that abortion medication must be administered on Department of Health approved premises (typically an NHS hospital or independent sector clinic). Hence, in this context of provision, the person providing and woman seeking medication must be co-present. Despite the restrictions of this framework, the times and spaces of contemporary abortion work are nonetheless changing. As we explore below, this poses interesting questions in relation to dimensions of body work, in particular regard to co-presence and dematerialisation.

In the last 25 years, medical methods have increasingly replaced surgical methods of abortion worldwide (Swica *et al.* 2011). In Scotland, where our study was conducted, 80 per cent of abortions in 2014 were carried out using medication (Information Services Division Scotland 2015). Medical methods have also contributed to a higher proportion of abortions taking place before nine weeks gestation, including 72 per cent of those conducted in Scotland in 2014 (ISD 2015), via a treatment regime known as 'early medical abortion' (EMA). The currently recommended EMA protocol comprises two phases (World Health Organization 2012). An oral tablet, mifepristone, accelerates treatment by blocking the effect of progesterone, the hormone necessary for the pregnancy to continue. This is followed 24–48 hours later with four vaginal tablets (misoprostol). Combined, these cause the breakdown and expulsion of the 'pregnancy tissue', that is (depending on gestation) the uterine lining and yolk sac or embryo.

The increasing proportion of medical abortion, and of EMA in particular, raises questions about how contemporary abortion work is experienced by health professionals. A suggested advantage of medical methods is that 'the provider *does not have to do the abortions*. For providers, it is a matter of giving information, dispensing pills, monitoring progress and giving support. . . .' (Berer 2005: 31, our emphasis). The shift from surgical to medical methods has resulted in the transfer of much of the hands-on bodily work of abortion down the medical hierarchy in ways which appear to support arguments in the existing literature regarding dematerialisation in body work. While doctors continue to be involved in assessment (in order to complete the legally required paperwork), and in the care of patients with complex medical needs, their role has changed significantly. In the medical abortion process, doctors typically conduct no hands-on clinical work *per se* although, following Twigg *et al.*'s (2011) definition, their role can still be understood as involving some body work in the shape of; assessment and adjudication of the woman's suitability for abortion; taking a medical history; obtaining informed consent; and prescribing medication. For nurses, the shift to medical abortion has marked an increase in their direct involvement in abortion provision in both outpatient clinic and ward work (Lipp and Fothergill 2009). This may have been mirrored in the role of clinical support workers (CSWs, also known as healthcare assistants/ nursing aides), although their experiences have not previously been explored.

Abortion work also further illustrates a dematerialising tendency in body work, in light of a recent shift toward EMA completed at home where, rather than remaining as a day patient, women may now leave the clinic once the second abortion medication (misoprostol) has been administered. This shift marks a two-fold change in abortion work. First, this has included further shifts in the role of nurses and CSWs, including a reduced component of hands-on bodily care. Second, it has involved a transfer of aspects of abortion work from health professionals to women seeking treatment. Specifically, these relate to the administration of analgesics, monitoring of bleeding, monitoring and disposal of passed pregnancy tissue, and managing the side-effects of the medication (nausea, vomiting and diarrhoea).

By focusing on relations involving co-presence and physical contact, Twigg and colleagues (2011) deliberately exclude from their conceptualisation of body work the 'work-transfer' in which patients perform for themselves tasks formerly conducted by paid body workers. However, we argue through this article that addressing issues around such 'work transfer' is crucial

to understanding contemporary abortion work, and to conceptualising work which has until recently taken place entirely in a hospital context, under medical/nursing supervision. Moreover we consider whether what now takes place is indeed a 'transfer' of work in relation to responsibility for and control over the process. This is particularly interesting to explore where the work in question can be understood to occupy an ambiguous position in the healthcare hierarchy due to an association with stigma and taboo (Bolton 2005, Lipp 2011a); and at a time when advocates of women-centred care are increasingly calling for women to be allowed to self-administer medication for early abortion at home (Gold and Chong 2015, Lohr *et al.* 2010).

Abortion is also an interesting case through which to explore body work because it raises questions about the relationship between body and emotional labour (Hochschild 1983), again in no small part due to the sociocultural location of abortion. Health professionals have been found to discursively and physically distance themselves from their abortion work as a means of coping with its demands (Gallagher *et al.* 2010); and to experience that work as stigmatised and as impacting their emotional wellbeing (Harris *et al.* 2011, Lipp and Fothergill 2009). The emotional labour performed by health professionals when 'concealing or conceding' their attitudes and emotional responses to women seeking abortion has also been identified (Lipp 2011b). Health professionals have been found to engage with women undergoing abortion on a spectrum ranging from emotional 'investment' to 'detachment', with the latter facilitating treatment of more challenging patients (Wolkomir and Powers 2007). Existing body work literature argues that workers often have to manage both the emotions of others and their own emotional responses to the fleshy corporeality of their work, while simultaneously conducting body work tasks (Kang 2013). This convergence of bodily and emotional factors may be of particular relevance to abortion work, given the social significance – specifically the physical, social and moral 'taint' (Bolton 2005) – attributed to the process and bodily products dealt with in this work. Indeed, the handling and disposing of pregnancy tissue in particular has been identified as a particularly challenging feature of abortion work (Gallagher *et al.* 2010, Nicholson *et al.* 2010). While the body work literature might point to a reduction in these demands as a result of the dematerialisation noted above, the impact of these developments are as yet unexplored.

Moreover, existing research on abortion does not address in-depth the interaction of organisational factors and bodily and emotional care (James 1992). Specifically, it does not consider the potentially instrumental (as opposed to affective) role of emotion management in the bodily management of women seeking abortion, nor the contexts in which healthcare workers might choose to emphasise emotional components alongside, or over, relatively more corporeal aspects of their work (Twigg 2006). Existing scholarship has to some degree explored the relationship between emotional labour and body work, including the role of emotional rapport in care (Twigg *et al.* 2011); in facilitating hands-on body work (Brown *et al.* 2011); as a technique of control of less cooperative bodies (Jespersen *et al.* 2013); and the ways in which the interaction varies by organisational context (Kerr 2013). We therefore suggest that it is useful to consider this relationship further, in specific relation to the management of emotion in the body work of abortion, and the ways in which this emotional labour is constrained by the organisational context of the hospital/clinic.

Following an outline of our qualitative study of medical, nursing and support staff involved in NHS medical abortion provision, we discuss our findings. We argue that medical abortion is: (i) a useful context in which to interrogate the utility of body work as an analytic lens; and (ii) a means of making visible, and furthering understanding of, what contemporary abortion work comprises. This includes ways in which physical, emotional, temporal and spatial factors in its organisation impact on health professionals' experiences.

## Methodology

A qualitative design comprised semi-structured interviews with 37 health professionals involved in abortion provision: 17 nurses, eight doctors, seven clinical support workers (CSWs) and five sonographers. These were recruited via an opt-in procedure from two hospital and one sexual and reproductive health centres (SRHC) in the same NHS area of urban Scotland, between October 2013 and April 2014. This mix enabled us to: address the range of occupational groups doing abortion work; track the tasks carried out by each group; capture experiences of in-patient and out-patient abortion work; and to draw out similarities and differences where relevant. Women who had undergone EMA were also interviewed in order to address the primary aim of the study, which was to explore and compare women and health professionals' experiences of EMA provision in hospital and SRHC settings (see Purcell *et al.* 2016). The study was granted ethical approval by the University of Edinburgh Centre for Population Health Sciences Research Ethics Committee.

Interviews were conducted primarily in participants' workplaces and ranged from 29 minutes to over two hours. A flexible topic guide addressed the research aim of exploring health professionals' experiences across sites, while also allowing unanticipated issues to arise (Kvale 2009). Interviews addressed participants' views on their current and past roles; perceptions of abortion work (their own and those of others); service developments and changes over time. Participants were encouraged to talk at length and to raise issues they felt were important to their working experience. All interviews were digitally recorded, transcribed verbatim and fully anonymised. NVivo 10 software (QSR International, Melbourne) was used to facilitate data management. Taking a thematic analytic approach informed by the Framework method (Spencer *et al.* 2014), transcripts were read independently by CP and JH then discussed in order to compare interpretations and identify key themes across participants' accounts. A coding framework was developed and applied to transcripts, based on the initial themes identified. From this descriptive stage the data were interpreted further in order to: establish links between themes; develop potential explanations around such links; and unpack the situated nature of the themes. This stage also considered similarities and differences in participant accounts between occupational groups and across clinical settings. The initial themes which emerged – namely the management of women's bodies, practicalities of abortion work, space and time – suggested that the conceptual tool of 'body work' would prove a useful means of further interpreting the data.

## Findings

We present here in detail three key themes which emerged in our analysis, namely: the instrumental emotional labour which facilitates the body work of abortion; the temporal dimensions of abortion work; issues raised by bodily proximity, co-presence and changes in provision. This analysis follows a brief outline of the medical abortion work under consideration. We focus primarily on medical – and particularly EMA – provision as this now makes up the majority of our participants' work.

### *Medical abortion work: an outline*

Medical abortion work in Britain currently includes a range of hands-on bodily manipulation and management, and a significant component of information provision, carried out over at least two clinic visits. At the initial 'assessment' stage, the clinical pathway for early and later medical and surgical abortion is the same, and women are seen by the same health

professionals. With some variation between our three sites, the process for women attending the hospital or SRHC for medical abortion was as follows.

On the first visit, a CSW takes the woman from the waiting room to a clinic room for an ultrasound scan. A sonographer conducts an abdominal or vaginal scan to confirm an ongoing intrauterine pregnancy and to establish gestational age. The CSW then explains to the woman how to do a routine vaginal self-swab for sexually transmitted infections, and collects the completed test. In a second room the CSW then takes blood samples and measures her height and weight, after which a nurse or doctor sees the woman in a third room. Here the doctor/nurse confirms the woman's eligibility for abortion; completes the required paperwork; discusses treatment options; and advises on future contraception. Divergence in the clinical pathways for medical and surgical methods occurs at the end of this visit where, once the doctor has signed the legal documentation, women having surgical treatment would be given the relevant appointment and sent home. For those proceeding with medical abortion, the doctors would prescribe the relevant medication and, if appropriate, a nurse would administer the first (oral) abortion medication, in order to begin treatment. This first appointment typically takes around two hours.

If under nine weeks' gestation, the woman returns 24–48 hours later for a second visit lasting 15–30 minutes. Usually only a nurse would see her in order to provide further advice and information, analgesics, antibiotics and, if agreed to, contraception (Purcell *et al.* 2016). The nurse then provides the second medication in the form of four vaginal tablets. These are either inserted by the nurse, or the woman is given latex gloves and lubricant gel to self-administer. The majority of women at these sites would then return home to pass the pregnancy, providing safety criteria are met and she has an adult to accompany her for 24 hours. On returning home, the woman would usually experience uterine cramping and vaginal bleeding accompanied by nausea, vomiting, fever and diarrhoea (side-effects of the medication). Pain and bleeding typically peak within four to six hours when the pregnancy tissue is expelled, and then subside, with lighter bleeding expected to continue for several days or weeks (Swica *et al.* 2011).

The minority of women who have in-patient treatment go through the same process in a four-bed day ward or side room, and are typically accompanied by a nurse and/or CSW when passing the pregnancy. Though not included in the present study, women at 14 to 20 weeks' gestation were also treated using medication, using a similar regimen, but involving repeated doses of the second medication provided on an in-patient basis for six to eight hours or possibly overnight.

*Instrumental emotional labour: managing emotions to manage bodies*

Abortion work as a whole comprises a significant amount of body work and an inextricable component of emotional labour. Carried out in a context of time and other resource constraints, we suggest the emotional labour conducted by health professionals has an instrumental role in enabling the body work of the abortion process to be achieved. Participants described a range of challenges and successes in their abortion work, which commonly focused around the nexus of bodily and emotional factors. Sonographers' accounts of scanning, for example, highlighted the convergence of body work and emotional labour in their work. They described having to put women at ease in order to scan effectively:

The women have to decide they're going to trust you enough to move their trousers down past the pubic bone and lie there relaxed, 'cause if someone's tense you can't scan anyway. (Frances, sonographer)

CSWs and nurses also described doing emotional labour, and their ability to 'read' women's emotional state in a way that enabled them to most effectively engage with women in order to carry out the practical tasks required. Experiences of navigating this aspect of abortion work were expressed with greater confidence by those with more extensive experience as Denise, a CSW of 15 years, explained:

I've been here long enough to judge how they're feeling ... it vibrates off you ... Yeah, I can read people very well [...] I can usually always win them round, even if they're not on my side at first. It's usually the chat [laughs]. (Denise, CSW)

All CSWs made reference to having to 'calm' women to facilitate the completion of body work tasks such as blood-taking which, for many, involved an instrumental use of touch. When asked to elaborate on how she might do this, Kay explained she would 'give them a wee reassuring pat, and if they want a cuddle they can have a cuddle'.

Some found the emotional components of abortion work challenging, such as Pat, who sometimes felt at a loss for words with women:

I don't know what it is, but it's sometimes like, well, what can you say, you know? [...] [Colleague] talks to them and strokes their arm and mollycoddles them a wee bit, which ... I find hard to do. Not because I'm not soft or anything, just ... [...] I'm better saying nothing than saying the wrong thing to upset somebody. (Pat, CSW)

The difficulty Pat expresses here highlights an acute awareness of the empathy with which health professionals are expected to treat women, which Pat wanted but felt under-equipped to do. It also highlights the additional pressure that the perceived 'sensitivity' of the abortion context can place on health professionals as they carry out body work tasks.

There was a sense that a key part of the CSW role was to 'be there' for women, and the skills required of CSWs in embodying this companion role were explicitly recognised by some senior staff:

The CSW, she can make a huge, huge impact. Again, partly with a friendly bit of, you know [...] your 'milk of human kindness'. You don't need any degree or qualification to be civil to somebody, to be nice to somebody and to just be there for them. (Brenda, nurse)

While intended as praise, phrases such as 'milk of human kindness', 'being human', and descriptions of CSWs as 'down to earth practical people' and 'friendly faces', also naturalise the skills involved in this work. This is emblematic of the devaluing of both emotional labour and body work by rendering them intrinsic characteristics of workers rather than acquired skills and of the (in)visibility of the expertise involved in presenting a caring face while successfully managing bodily tasks. Significantly, while much of the hands-on work of abortion has previously been carried out by doctors, and increasingly nurses, a significant portion of the bodily tasks which now feature in abortion provision are carried out by CSWs, that is, those lowest in the occupational hierarchy of health professionals who currently do abortion work. This speaks to the related issues of dematerialisation, occupational status and bodily proximity, which are discussed further below.

Nurses positioned emotion management as a core part of their role in abortion work and key to their enjoyment of it, as Stella (nurse) explained: 'I do enjoy [abortion work] because people come in feeling very anxious and then hopefully they're going away not quite so

anxious, so it's quite satisfying'. However, this view of abortion work's emotional component sat alongside (and perhaps related to) the negotiation of their own feelings about its physical component, and health professionals' emotional labour in this respect was evident in several accounts, particularly from nurses. Many were keen to emphasise their commitment to the service, while also distancing themselves from women's decisions, which Helena summed up:

[It] doesn't upset me because at the end of the day it's not my decision and I'm not here to put my preconceived judgements on anybody else [...] they've made the decision to have it done. But that's their decision, it's not mine. (Helena, nurse)

Some voiced ambivalence regarding some of the physical components of abortion work, saying they preferred not to 'dwell' on its results. Despite reporting satisfaction with their role overall, Iona (nurse) noted: 'I don't particularly like the outcome, that is that you're terminating all these fetuses'. Others spoke very positively of their involvement, framing the abortion service as 'important' and 'necessary' and a source of professional 'pride' and 'purpose'. Significantly, nurses tended to emphasise that a 'non-judgemental' face should be presented to women seeking abortion, and that their own feelings should ideally not be evident in the emotional or physical components of the care they provide.

While doctors also described being 'empathetic' or 'non-judgemental', this tended to be in a general way, and they reported often handing over to nurses to address women's social and emotional needs. By contrast, doctors tended to frame the 'counselling' (that is, the information exchange) which constitutes their role in medical abortion, as relatively routinised and undemanding, compared with the application of 'medical' knowledge required elsewhere in their work. The relative distance from the hands-on work related to their emotional involvement: 'it's a bit more kind of formulaic and tick boxing and you don't get too emotionally into it' (Carla, doctor).

### *Temporality of abortion work*

The second theme to emerge in the course of our analysis relates to the temporal dimensions of abortion work, which clustered around two main factors: conflicts between the 'body time' of women seeking abortion and the 'clock time' of the clinic; and the ways in which the gestational age of the pregnancy adds a further temporal constraint to health professionals' work. This can be understood as a dimension of the instrumental aspects of emotional labour outlined above, but also as a constraint which those doing abortion work must work within.

The impact of standardised clinic 'clock time' on the shape of the abortion body work carried out by our participants was evident in a number of ways. For example, several used the trope of a 'conveyor belt' to describe the emphasis on time management which shaped the way in which women are progressed through the abortion process:

[It's] just such a turnover, it does feel like that sometimes, you know, just like a – what's the word – 'conveyor belt', one in, one out and, you know, you've got one in the room and one waiting and then it's in-out-in-out-in-out. (Jess, Nurse)

Suggesting a highly regulated temporal (and spatial) organisation of the clinic, this metaphor is somewhat discordant with ideals of individualised care, and suggests that a drive to do body work in a time-efficient manner may limit the opportunities for health professionals to engage more fully with women and their emotional care needs.

A key challenge for health professionals, therefore, was to reconcile clinic time constraints with bodily and emotional facets of abortion work, and some felt the realities of this were not recognised by those who allocate time and other resources to the service:

Somebody up there [management] thinks they walk in, take a tablet and go home. If they do walk in, they're either already starting to bleed, throwing up everywhere, in a lot of pain, an emotional disaster, just having a fight with their partner, feeling really sick and you've got to try to continue with a termination. (Alison, nurse)

Tensions around time and other resource constraints are not exclusive to abortion work, and reflect large-scale health service organisation more broadly. However, there was some feeling among participants that abortion provision was more constrained than other services, particularly obstetrics, as Alison (nurse) went on to explain: 'There's a great pressure to get our patients out before the antenatal patients come in [...] They're all expanding and they're trying to reduce us, so we kind of get squashed out'.

As noted earlier, doctors described handing over some work to nurses to keep the body work of the clinic running smoothly. This related closely to the temporal constraints of the clinic:

Sometimes, if it gets very complicated, I'll maybe get one of my nurse colleagues to take them and have a further chat, 'cause I've got to be careful I don't – I know it sounds a bit heartless, but I don't want to hold up the process of the clinic too much. (Una, doctor)

In this way, the challenges women's emotional and physical needs present to the pressured clock time of the clinic are addressed by delegating body/emotion work to other health professionals. Nurses and CSWs, on the other hand, gave accounts of adding in time to accommodate the needs of some women on a case-by-case basis. For example, Kay (CSW) said that she would offer a visibly upset woman 'a wee five minutes to get [herself] drawn together' before proceeding with the necessary body work. Gloria (nurse) noted nurses' attempts to make treatment times more flexible, explaining: 'if there's sort of capacity within the clinic, we'll say to them 'if you come Tuesday morning at quarter to nine, I will do your treatment before the clinic starts''. Cathy (nurse), on the other hand, explained how easily the timing of the process could be upset: 'All you need is one patient to be very sick or to be delayed in some way and before you know it the whole clinic then goes on forever'.

Sonographers also spoke to the tension between body and clock time, in that pregnant women's relatively unpredictable and variable corporeality created additional demands on the very brief time (five to seven minutes) they spend with women in the assessment clinic:

If they're very easy to scan it may only be a couple of minutes. If you have to do internal trans-vaginal scans [...] – [if] they're at a very early gestation – and it's a bit more technically challenging, then you do tend to spend longer with them. (Kelly, sonographer)

This also points to a further dimension of body time – and a further constraint within which they operate – that arose in the health care professional's accounts, namely the gestational age of the pregnancy. For sonographers, the sensitivity of modern home pregnancy tests means that some women actually present at services too early for the pregnancy to be detectable by ultrasound. Because clinic protocols demand that gestation is established by ultrasound prior to treatment, this results in women being asked to re-attend at a later date:

Because people are finding out that much earlier now, they're coming in so much earlier. And we're having to scan them [and we] can't see anything [and have to] bring them back. [...] Normally they'd have to be five or six weeks post-LMP [last menstrual period] before they even got into the clinic. But now some of them are like two and three weeks, supposedly, and it's really quite difficult with the ultrasound because you can't see anything. (Andrea, sonographer)

In tandem with treatment protocols and legislation, gestation thus creates a specific window within which abortion treatment can take place, the beginning of which is marked by the visibility of the pregnancy via ultrasound.

Since EMA is currently only offered to the ninth week of pregnancy, gestation also determines what type of treatment women can undergo, and thus what emotional and physical care providers may be required to engage in. Comparing the priorities of women with the constraints of the availability of treatment appointments, Danielle highlighted the additional emotional stress this can introduce:

She wants to get on with it, she doesn't want to wait too long [...] That's another reason why it's really important we get started [with abortion medication] with them, because spaces for surgical terminations can take up to ten days, and so you've got a lady who's been seen in clinic at 9½ weeks [...] or ten weeks, and suddenly she's having a termination at 12 weeks? That's significantly different, mentally. And she's got 10, 12, 14 days of angst and waiting, that's a lot to ask of somebody. So, if we can offer medical terminations at that gestation, rather than having to make them wait, I think that would be a far better service that we could provide for the patients. (Danielle, doctor)

Regarding the hands-on body work providers are required to engage in, later medical abortion (13–24 weeks) was commonly presented as a particular point of contrast, against which EMA-related body work was seen as relatively easier, both physically and emotionally. The way in which this was presented suggests that the body time specific to pregnancy impacts health professionals' willingness to engage in aspects of abortion work:

I don't do the lates, I would refu- I don't- I wouldn't like to see a late pregnancy delivered. I find even the early pregnancies, seeing them delivered . . . if it's a fetus, it's not . . . I don't like seeing it. Even although that wouldn't stop me going to help a patient, I just don't like seeing it. (Ellen, nurse)

Ellen's framing of this as about 'seeing fetuses' foregrounds the centrality of staff interactions with the expelled pregnancy tissue as a key challenge of in-patient medical abortion provision, and one which is felt to increase with gestational age.

#### *Bodily proximity, co-presence and changes in provision*

A range of hands-on body work tasks were carried out, primarily by CSWs, which required varying degrees of bodily interaction and management of bodily fluids, including blood-taking, height and weight measurements, and asking women to conduct a vaginal self-swab. While the swab did not involve hands-on contact, it did require direction from CSWs on how to do it, as Niamh explained:

I'll say 'right, you insert this into the vagina and you swab'. And I usually stand and go [demonstrates action] like this [laughs] [...] Sometimes you get urine back, you get the

stick not in the bottle, you get it back in the paper. Some girls think you're going to do it, so they're about dropping their underwear and you're like 'no, no, wait! Let me out the room!' (Niamh, CSW)

Niamh's surprised reaction to women who mistakenly thought she would do the test enacted a discursive distancing from something more potentially intimate. While self-tests distance abortion care providers from the intimate bodily contact required for a more direct method of sample collection, CSWs nonetheless had to take receipt of bodily fluid samples, sometimes (as Niamh illustrates) in unexpected and unwanted ways.

In a similar vein, the shift toward medical methods had the potential to reduce the amount of hands-on body work done by providers, and to re-frame the question of who is 'doing' the abortion. This was evident in nurses' accounts of administering abortion medication. There was some variation around whether nurses inserted the vaginal tablets, and Ellen explained her preference in this respect:

I don't enjoy putting the pessaries in myself. [...] The majority of patients do it themselves but sometimes you do have to. [CP: What is it about that that you don't like?] I think it's probably because I'm terminating a pregnancy. Giving the [oral] tablets, fine, you know? But it's just putting the pessaries in, I feel as if I'm more involved in the termination itself. (Ellen, nurse)

While only a minority of participants expressed feelings of responsibility for the abortion in direct relation to providing the medication, it is apparent that as well as marking a reduction in hands-on body work, women's self-administering of the tablets has at least the potential to create both bodily and symbolic distance between providers and the 'doing' of abortion.

To enable EMA completion at home, a significant amount of co-present, hands-on body work has been replaced by verbal explanations of what women should expect and do as the medication takes effect. However, despite the reservations that some raised regarding in-patient work, participants did not explicitly frame this move away from hands-on body work as a positive change in their work role. Instead they reported a degree of unease relating to key aspects of EMA at home. For one CSW this unease related to concerns with how women would dispose of the pregnancy tissue. She described how she was initially uncomfortable with the idea of the expelled yolk sac/embryo being flushed down the toilet, contrasting her experience with tissue disposal on the ward:

I think it was more sensitive when they were in the hospital. I just feel it's quite insensitive, going home and flushing it down the toilet [...] I'm starting to get to grips with it now but when they started it at first I just couldn't get this at all, folk going home to abort a baby down the toilet? [...] When the girls came in you were checking every bedpan that they used, looking for products. And it always went in a wee box and I liked to make it a wee bed. [...] But you've got to go with the changes, eh? (Kay, CSW)

For most, any unease related less to the bodily products passed in the course of abortion work, and more to concerns with how women might experience EMA at home without the direct supervision of health professional, and how services can address this. In particular, many discussed concerns about the descriptions provided of what to expect at home, given the relative unpredictability of women's subjective experiences of pain and medication side effects. Julia explained it thus:

Normally you'll get the pessaries and then normally nothing starts happening 'til about an hour after that, so that's enough time for you to get home. At home, the average duration is roughly about six hours for the products to be passed. Normally you'll start bleeding, the bleeding can build up and be quite heavy. At that point you'll normally experience – some people feel like it's quite a strong period-type cramp, other people don't notice it too much, and other people find it very severe. You'll then pass what will probably be more like blood clots [...] We'll give you a chart of when to worry and when to contact us [for example] if you soak through a certain amount of pads in a certain amount of time. Normally after about six hours of bleeding it should start to settle down. We'd expect you to bleed for about 10 days, and that would normally be like a normal period. (Julia, doctor)

As Julia's account clearly demonstrates, health professionals set the parameters for what the woman should regard as 'normal' and what is potentially dangerous, to enable women to make such judgements in the absence of direct health professional supervision. While they acknowledged that 'every woman is different', with their own expectations about the treatment, perceptions of pain and so on, Julia's and others' accounts of this explaining work highlighted that women were generally being provided with the same, standardised set of instructions.

While providers did not voice any specific issue with their role in defining what woman should regard as 'normal', they did express anxieties about women doing by themselves what has been done until recently under immediate supervision in a healthcare space. While many health professionals were matter of fact about describing the process and happy to 'lay it on thick' (Olive, nurse), some expressed anxiety around 'overstepping the mark' (Elaine, nurse). In general, the aim seemed to be to strike a balance between preparing women for the worst and providing concrete, realistic expectations without terrifying them (and, as such, can be read as a further example of emotional labour which facilitates the body work of abortion).

Participants also noted the limits to any control they now have over women's experiences at home. For example, health professionals conventionally encouraged women undergoing in-patient treatment not to look at the expelled pregnancy tissue, lest this cause further distress. The shift to completion at home marked a change here: 'If they're at home we don't know what they look at, we don't know what they do. It's not up to us to say that they can or they can't' (Alison, nurse). Uncertainty about how women would cope at home was compounded by the lack of closure that some described. Since a home pregnancy test is now the established method of follow-up after the abortion, some felt (as Helena noted) that 'there's no closure from our point of view'. The relative open-endedness of EMA completed at home left some participants – particularly those who had previously provided hands-on care – pondering how women might experience the process:

I sometimes wonder what effect that has on them when they're at home, because at least if they were in the ward you were able to monitor it [...] put fluids up, because they were having a lot of bleeding. [...] You just think 'hmm ...' (Helena, nurse)

## Discussion

Through the analysis presented above it becomes evident that abortion is a fruitful context in which to think through the concept of body work. In this section we consider the implications of the ways in which the relationship between body work and emotional labour plays out in

the context of abortion; and propose developing the concept of body work to include an alternative view on work-transfer, which we term 'body work-by-proxy'.

First, the context of abortion work highlights the potential instrumentality of the emotional labour performed in healthcare. Paralleling the strategic deployment of body work practices in other contexts such as gynae-oncology and randomised controlled trials (Brown *et al.* 2011, Jespersen *et al.* 2013), health professionals' emotional labour constitutes not just care for care's sake, but also a means of facilitating the completion in a timely manner of the practical body work tasks of abortion. Within the often morally and emotionally charged field of abortion, this may in part reflect the importance for healthcare providers of offering a non-judgemental service.

It may also be the case that drawing attention to the emotion work they do is useful to health professionals' own interpretations of their work insofar as it assists them in effacing some of the stigma associated with its corporeal components (Twigg 2006). This is arguably acute in abortion provision, since aspects of the body work here relate to a process (and bodily product) which is highly stigmatised (Bolton 2005). This echoes the obscuring of bodily caring work noted by Lawler (1991) and others, and speaks to the higher status associated with work on relatively bounded bodies (Wolkowitz 2002). It may also be that they value the emotional labour as highly as the body work required in abortion provision or (as some participants noted) that they do not like to 'dwell on' the 'outcome' of abortion, and prefer to frame their achievements as making women feel 'less anxious' and 'more calm'.

While we have identified many different components of the body work of abortion, health professionals' accounts at times focused on the bodily products of the process to a greater degree than the body of the woman, in a way which may be peculiar to abortion. The aim of abortion work is to bring about a change in the woman's overall bodily state, as is the case with many other forms of therapeutic body work such as massage or acupuncture. However, it also comprises the removal from her body of tissue which has a powerful symbolic significance. We could question whether dental nurses, for example, would conceptualise removed teeth, or cosmetic surgeons speak of removed fat in a similar way. While we do not equate abortion work solely with interactions with the pregnancy tissue/embryo/fetus, health professionals' accounts suggest this is a core issue in abortion work, which has significant implications for how they conceptualise their work, and for the emotional labour they are required to perform.

Our analysis suggests that the instrumentality of emotional labour may also relate to temporal tensions experienced in abortion work. The clinic's temporal organisation was reported as being fragile, often at odds with the bodily experiences of the women treated. Health professionals presented themselves as fighting a demanding uphill battle to reconcile the time required to address the variable bodily (including emotional) needs of women seeking abortion with the standardised 'clock time' of the clinic. That health professionals must work not just with body time, but pregnant body time, adds an additional organisational pressure here. Pregnant body time is framed within a legislative context of abortion provision in Britain which reflects a normative view that it is more problematic to terminate a more advanced pregnancy (Beynon-Jones 2012). In addition, policy and clinic protocols converge to create an imperative to provide abortion before nine weeks' gestation (NHS Quality Improvement Scotland 2008) while also currently preventing provision before five weeks. Hence, health professionals' experiences are framed not only by clinic-clock time, but also by the temporal constraints of legislation and policy regarding pregnant body time.

Second, with the introduction of EMA completed at home, abortion work now comprises lesser components of co-presence, bodily proximity and hands-on body work, and more information-giving including detailed, visceral explanation of the process. Body work has been

conceptualised as requiring co-presence (shared time and space), and does not include work that has been 'transferred' to others (Twigg *et al.* 2011). We suggest that the work done by health professionals to facilitate EMA completed at home might usefully be understood as 'body work-by-proxy'. In this category we place the explaining and demonstrating work which enables women to do an STI self-swab or insert the vaginal tablets; detailed explanations given to women in lieu of hands-on abortion care, which enables them to manage passing the pregnancy at home; and concerns expressed about how women will cope outside of a medical setting.

We conceptualise this as body work-by-proxy, rather than 'work transfer' in order to acknowledge that while the abortion is completed outside of a healthcare space, the overall framing and power over the situation remains very much in the hands of health professionals. The flow of information and thus women's expectations of what will happen at home are set by the nurses and doctors they see, as are the limitations around what is 'normal', and what is acceptable for women to manage for themselves without seeking assistance. While EMA at home can be understood to de-medicalise abortion, at least with regard to the space in which it is completed, the body work-by-proxy in which they engage sees health professionals retain a degree of medical authority. This somewhat ambivalent position is reflected in the concerns and continued sense of responsibility that health professionals expressed regarding women completing EMA at home. As such, this speaks to the ambivalence described in Simonds *et al.*'s (2001) early work on medical abortion, in which health professionals experienced some disempowerment in the shift from surgical to medical methods, while simultaneously retaining power over their interactions with women seeking abortion. Examination of the perspectives of women who have undergone EMA at home is essential to fully understand the power balance in this context and our analysis of this will be reported elsewhere.

This finding is specific to a setting where abortion has until recently taken place exclusively in a hospital setting, and health professionals' experiences may be markedly different in, for example, online or pharmacy-based abortion provision. What it highlights, however, is that conceptualising this sort of work as body work-by-proxy underlines why it should/can be productively included as part of the concept of body work. In the present context of provision, body work-by-proxy constitutes a dual dematerialisation of abortion work; the component of hands-on body work is vastly reduced (compared with surgical treatment and in-patient medical abortion), and that which continues to involve direct contact is being passed down the healthcare hierarchy from doctors to nurses to CSWs. Furthermore, the symbolically 'dirtiest' and literally messiest part of abortion – the passing and disposal of pregnancy tissue – is increasingly being dealt with not just 'behind the screens' (Lawler 1991) but by women in their own homes. It has been argued that the organisation of abortion work in some hospital and clinic settings perpetuates secrecy and stigma around abortion work (Chiapetta-Swanson 2005, Harris *et al.* 2013) which in turn creates a 'legitimacy paradox' for health professionals. In this light, our findings beg the question of the longer-term impact on abortion work, as many of its hands-on components are not so much obscured as negated. From a provider perspective, EMA completed at home arguably sees the pregnancy tissue component – highlighted in our data and elsewhere (Gallagher *et al.* 2010, Nicholson *et al.* 2010) as a potentially problematic feature of the process – dematerialised completely.

However, while we might assume that moving the abortion process into women's homes makes abortion work less problematic for health professionals, participants in our study made relatively little comment on this. This may reflect, for some, the fact that they were not all currently involved in ward work and so could not draw comparisons between this and EMA at home and, for all, that EMA at home was a relatively new and ongoing development in

provision. It may therefore be useful to revisit the experiences of providers as completion at home becomes more established practice, as it is the US, where recent research suggests that providers would support the shifting of more of the process (ie. the administering of both medications) out of the clinic and into women's homes (Gold and Chong 2015).

## Conclusions

The contribution of this article has been two-fold. Examining body work in the case of abortion has enabled us to make visible the work of contemporary abortion provision in Britain, and to explore the analytic opportunities and limitations of a body work lens. Advocacy for equitable access to abortion requires understanding not only of the needs of women requiring treatment but also the challenges faced by health professionals in providing it, that they might be best supported to do so. The analysis presented in this article furthers understanding of the experiences of those doing abortion work; the day-to-day challenges they face in balancing the needs of women seeking abortion with the constraints of health service organisation; and the changes to the character of abortion work created by the increasing proportion of medical methods and EMA completed at home. This study was limited to focusing on a relatively small number of health professionals within one geographical area, since this is where the service in question had initially been rolled out. Potential areas for further research would include the longer-term impact of EMA (including completion at home) on the experiences of providers, on the organisation of abortion work, and on the perceptions of health professionals not involved in abortion provision.

The context of abortion has enabled examination of the relationship between body and emotion and work, and has further highlighted an instrumental dimension to emotion management at points of convergence with body work. Close examination of the body work of abortion has further evidenced a dematerialising tendency, which sees work involving (potentially stigmatising) close bodily interaction passed down the healthcare hierarchy. It has also highlighted that the work which facilitates the transfer of body work from health professionals onto women can be usefully conceptualised as 'body work-by-proxy'. EMA at home remains a peculiar case in the context of work-transfer, in the sense that patients are not technically 'sick', and that treatment represents an acute rather than chronic event. It would be interesting for future research to explore the insights which this extension of the conceptual tool of body work to include 'body work-by-proxy' might offer in other healthcare contexts where similar shifts may be taking place.

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## Notes

- 1 We use 'Britain' rather than 'United Kingdom' here to indicate Scotland, Wales and England, since the 1967 Abortion Act does not extend to Northern Ireland, where access to abortion remains more restricted.
- 2 We use the terms 'medical' and 'surgical' to categorise the different types of abortion since these were the terms used locally by our participants. The term 'medication' abortion may also be used to refer to the former procedure.

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