



# The illusion of treatment choice in abortion care: A qualitative study of comparative care experiences in England and Wales

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## ARTICLE INFO

Handling editor: Medical Sociology Office

**Keywords:**  
Abortion  
Choice  
Equity  
England  
Wales

## ABSTRACT

Treatment choice is a key component of quality, person-centred care, but policies promoting choice often ignore how capacity to choose is unequally distributed and influenced by social structures. In abortion care, the choice of either medication or a procedure is limited in many countries, but the structuring of treatment choice from the perspective of people accessing abortion care is poorly understood.

This qualitative study explored comparative experiences of abortion treatment choice in England and Wales, using in-depth interviews with 32 people who recently accessed abortion care and had one or more prior abortions. A codebook approach was used to analyse the data, informed by a multidisciplinary framework for understanding the relationship between choice and equity.

Abortion treatment choice was structured by multiple intersecting mechanisms: limitations on the supply of abortion care, incomplete or unbalanced information from providers, and participants' socio-economic environments. Long waiting times or travel distances could reduce choice of both treatment options. In interactions with providers, participants described not being offered procedural abortions or receiving information that favoured medication abortion. Participants' socio-economic environments impacted the way they navigated decision-making and their ability to manage the experience of either treatment option. Individual preferences for care were shaped in part by the interplay between these structural barriers, creating an illusion of choice, as the health system bias towards medication abortion reinforced some participants' negative perceptions of procedural abortion.

The erosion of choice, to the point it is rendered illusory, has unequal impacts on quality of care. People's needs for their abortion care are complex and diverse, and access to varied service models is required to meet these needs. Treatment choice could be expanded by integrating public and private non-profit sector provision, aligning time limits and workforce requirements for abortion care with international standards, addressing financial pressures on service delivery, and revising the language used to depict each treatment option.

## 1. Introduction

Person-centredness is a key characteristic of quality healthcare, meaning care is responsive to patients' preferences, needs and values, and enables their active engagement in decision-making (WHO, 2019). National guidelines in England and Wales recommend shared decision-making between provider and patient to ensure patients are informed and empowered to make decisions about their care (NICE, 2021a). Participation in choices about treatment options is important to patients and has benefits for psychological wellbeing, while being uninformed about treatment options is a common cause of patient dissatisfaction (Coulter, 2010; Shay and Lafata, 2015). Yet the extent of shared decision-making varies in practice: patients are not always sufficiently

informed to make choices nor offered a range of options in healthcare interactions (Pilnick, 2008; Toerien et al., 2018; Irvine et al., 2021).

Choice of treatment and provider has been a health policy focus in recent decades in England and other European countries, though less so in Wales (Sheppard, 2016; Gabe et al., 2015; Peckham et al., 2012). The pursuit of choice alongside competition-based policies has been closely linked to the role of neoliberalism in shaping health system reform (Gabe et al., 2015). Choice policy discourses have been influenced by neoclassical economic theory (Fotaki et al., 2005) which tends to commodify health care and position patients as rational consumers who make choices to maximise their interests (Gabe et al., 2015; Nordgren, 2010). These ideas have been critiqued for ignoring social context, informational asymmetries, the unpredictability of health care needs,

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<https://doi.org/10.1016/j.socscimed.2024.116873>

Received 22 November 2023; Received in revised form 12 March 2024; Accepted 4 April 2024

Available online 7 April 2024

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and the role of trust between patient and provider (Gabe et al., 2015; Collyer et al., 2015). However, alternative theorisations of patient choice have been limited, as have investigations into broader factors that structure healthcare choices (Collyer et al., 2015).

To contest neoliberal assumptions about patient choice, researchers have applied Bourdieusian concepts of capital, habitus and field to consider how social context influences and structures healthcare choice (Collyer et al., 2015; Fotaki, 2010; Broda et al., 2018). Taking this further, Fotaki has developed a theoretical framework that combines Bourdieusian sociology with economic concepts of supply and demand and feminist insights on structure and agency to understand the relationship between patient choice and equity (Fotaki, 2010). This framework illustrates the mechanisms by which patient choice policies can deepen inequities, as demonstrated by studies that highlight how increased choice is afforded to those with more financial resources, stronger social networks, and greater knowledge, capabilities, status and assertiveness (Irvine et al., 2021; Perrotta and Hamper, 2022; Jomeen, 2007; McPherson and Beresford, 2019; Lewis et al., 2021). Theories from psychology have also been applied to patient choice, demonstrating how choice can be influenced by the way we process information and the way decisions are framed (Fotaki et al., 2005). However, Fotaki's framework is unique in considering from a multidisciplinary perspective how patient choice is influenced by a comprehensive range of structural and individual level factors, including health system structure, health providers' perceptions, socio-economic environments and the beliefs, values and perceptions of health care users (Fotaki, 2010). Explicitly focussing on the relationships between choice and equity is important because these concepts are sometimes thought to be in conflict, raising questions about the value and feasibility of patient choice policies (Fotaki, 2010; Appleby et al., 2003). Although patient choice policies have the potential to reduce inequity by making services more responsive to individual needs (Dixon and Le Grand, 2006), choice reforms can disproportionately benefit more socially advantaged health care users (Costa-Font and Zigante, 2016) and unconstrained choice might result in one patient's choice denying another from treatment in the context of a fixed health care budget (Appleby et al., 2003).

This study applies Fotaki's theoretical framework for patient choice and equity to the topic of abortion care as there have been significant changes to abortion treatment choice in recent years. Although studies have compared individual preferences for (Kanstrup et al., 2018) and experiences of abortion methods (Kapp and Lohr, 2020), little research has critically addressed the issue of abortion treatment choice, its relationship with equity, and the structural factors that may limit choice. For abortion care, service acceptability is highest when people can choose and receive their preferred option (medication or procedural abortion), as the two treatment experiences are very different (Kapp and Lohr, 2020). For a medication abortion (also known as medical abortion or abortion with pills), two medications are taken which cause the pregnancy to pass vaginally, usually at home. A procedural abortion (also known as surgical abortion) involves a health provider conducting a gynaecological procedure to remove the pregnancy in a facility setting. Completion rates and complication rates are similarly low for both options (NICE, 2023). Although satisfaction is higher for procedural abortion, both methods have very high acceptability (Kapp and Lohr, 2020). However, socio-economic variations in abortion method preference, use and satisfaction have been identified in several studies. For example, studies from the USA and Canada suggest medication abortion preference and acceptability is lower among younger age groups (Wiebe, 1997; Teal et al., 2007) and some evidence from the USA and the UK suggests that Black or Asian care-seekers may prefer procedural abortion or may prefer in-person and clinic-based care (Wingo et al., 2021; Lohr et al., 2010; Porter et al., 2021; Heath et al., 2019). Having higher levels of education was associated with choosing a medication abortion in studies from the UK, Brazil, and Denmark (Cameron et al., 1996; Rørbye et al., 2005a; Slade et al., 1998; Veiga-Junior et al., 2023). These findings suggest treatment choice may be important for equitable

access to quality care but the mechanisms that explain these socio-economic variations are not well understood.

Although research on abortion treatment choice has assessed individual preferences and experiences, few studies have examined the issue from a structural perspective, considering factors at the provider, institutional or health system level that may be influencing changes in abortion method use. Substantial variation in rates (Miani, 2021) and trends (Popinchalk and Sedgh, 2019) of medication abortion use between countries suggests that a range of factors may influence changing use of treatment options, and that some of these factors may be systemic. In England and Wales, medication abortions have increased from 43% of abortions in 2010 to 87% in 2021 (Footman, 2023a) and these very high levels of medication abortion use raise questions about choice (Miani, 2021). Research in this context has identified systemic constraints on access to procedural abortions, which include legal restrictions on who can provide procedural abortion, higher costs of procedure provision, competitive commissioning practices which incentivise provision of lower cost treatments, and resulting organisational policies to offer medication abortion as 'default' (Footman, 2023a). These structural constraints are thought to have produced inequities in person-centred care (Footman, 2023a, 2023b). However, this research only assessed abortion treatment choice from the perspective of health system gatekeepers, rather than the perspectives of people having abortions (Footman, 2023a).

In this paper, I therefore explore comparative experiences of treatment choice in England and Wales from the perspective of people having abortions, informed by Fotaki's multidisciplinary framework for understanding choice and equity (Fotaki, 2010). Specifically, I explore how people experience abortion treatment decisions and how this varies between episodes of care, how treatment decisions are structured by provider and health system factors, and the relationships between choice and inequities.

This study makes an empirical, theoretical, and practical contribution. Studies in England and Wales and elsewhere have often focussed on abortion treatment preferences and experiences without critically assessing the structural factors that impact treatment decisions from the perspective of people having abortions. Additionally, studies have identified socio-economic variations in abortion treatment preferences and use but the mechanisms that explain these variations are not well understood. Conceptual frameworks have been developed for understanding the decision to have an abortion (Mavuso et al., 2020) or trajectories to obtaining care (Coast et al., 2018), but studies of abortion treatment choice lack theoretical frameworks (Kanstrup et al., 2018). By applying a theoretical framework for patient choice and equity, this study strengthens understanding of abortion treatment choice and its relationship with equity, which can inform abortion guidelines and improve person-centred care.

## 2. Materials and methods

### 2.1. Study setting: England and Wales

Abortion has been legalised in England and Wales since 1967 if two medical practitioners believe the abortion is justified on certain grounds (including risk to physical or mental health) (UK Parliament, 1967). Since 1967, three private, non-profit sector providers have delivered most abortion services: 77% are now provided by this sector, but almost all (99%) are under contract with the public National Health Service (NHS) and free at the point of use (DHSC, 2022). People can self-refer to abortion services.

Clinical guidelines (NICE, 2020) recommend that providers offer a choice of medication or procedural abortion up to 24 weeks, and this choice is one of six quality standards for abortion (NICE, 2021b). The language of 'medication' and 'procedural' abortion is used in this paper in light of recent recommendations (Upadhyay et al., 2023), but these treatments are commonly referred to as 'medical' and 'surgical' abortion

in England and Wales.

Most abortions under 10 weeks are medication abortions, particularly in the non-profit sector (Footman, 2023a). In 2020 new legislation allowed both abortion medications (mifepristone and misoprostol) to be home-administered which removed the need for a clinic visit. Private, non-profit providers started to provide ‘pills by post’, with consultations conducted remotely and pills mailed directly (Aiken et al., 2021). An ultrasound is only required in specific circumstances, for example due to uncertainty about last menstrual period dates or irregular cycles.

Medication abortions beyond 10 weeks must be completed in-facility. In the NHS, most abortions after 10 weeks are medication abortions due to a lack of skills and willingness to provide procedural abortions (Footman, 2023a). In contrast, almost all private, non-profit facilities only offer procedural abortion after 10 weeks, as they lack inpatient capacity (Pillai, 2017). Procedural abortion can be provided with local or general anaesthesia or conscious sedation.

## 2.2. Data collection

Between July 2022 and February 2023, I conducted 32 in-depth interviews with people who had recently accessed abortion care, recruited from one non-profit provider and two NHS hospitals. People were eligible if they accessed an abortion from participating sites between one and four months prior to recruitment, if they consented to be contacted for research purposes or have their contact information shared with me for this study, were aged 18 or over, spoke English, had one or more abortions prior to their most recent abortion, and gave informed consent to participate. Additionally, I only contacted individuals from the non-profit provider if they had not previously been invited to take part in other studies. I interviewed individuals who had an abortion experience prior to their most recent abortion to explore their comparative perspectives of different episodes of care, to enable inclusion of a greater range of abortion experiences, and to better understand how prior lived experiences of abortion impact preferences and decision-making for abortion care.

The research methods are described in detail elsewhere (Footman, 2022). In brief, the non-profit providers’ clients are routinely asked whether they consent to being contacted in future for research. For NHS recruitment, health professionals asked eligible patients whether they consented to be contacted about this study specifically at the end of consultations, either by email or verbally. I contacted consenting individuals with a research summary and link to a sign-up form. If participants completed the form, I shared the full study information via email, WhatsApp or verbally through a phone call, depending on their preferences. Participants completed an online informed consent form. Participants received £20 compensation.

I conducted interviews by phone or videocall, which varied in length from 30 to 70 min. Interviews were semi-structured and conducted using a topic guide (Footman, 2022), which was piloted in two interviews and then adapted to improve the flow of the interview. During the interviews, I started by asking participants why they had taken part in the study and asked them to tell me about themselves and their life. I then asked participants about their most recent abortion experience, their options for the care they received, how they wanted the abortion to take place, their experience of the treatment option, and how their most recent experience compared to previous abortions. I audio-recorded the interviews and transcribed them verbatim after each interview.

## 2.3. Participant characteristics

The 32 participants reported 71 total experiences of abortion care. The number reported per participant ranged from one to four, as one participant did not report a prior abortion during the interview, though their clinical record indicated they had. Table 1 contains participant characteristics. Almost all (n = 31) participants were recruited from the non-profit provider, and most prior abortions were accessed at the same

**Table 1**  
Characteristics of participants (n = 32).

<b>Gender</b>	
Female	29
Missing	3
<b>Age</b>	
18–19	1
20–24	12
25–29	4
30–34	9
35–39	3
40–44	3
<b>Ethnicity</b>	
Black/African/Caribbean/Black British	4
Mixed/multiple ethnic groups	2
Other	1
White	21
Prefer not to say	1
Missing	3
<b>Highest level of education</b>	
Upper secondary education	13
Graduate and above	14
Level of diploma/qualification not stated	2
Missing	3
<b>Current relationship status</b>	
Single	10
Married or in a relationship	22
<b>Children</b>	
No children	13
1 or more children	19
<b>Urban/rural status</b>	
City	14
Town	12
Village	5
Missing	1
<b>Region of residence</b>	
Midlands	11
London	5
North of England	4
Wales	4
South of England	4
East of England	3
Other country	1

Notes: Three participants did not complete the socio-demographic information form, which was not a requirement for study participation.

provider. However, participants also had prior experiences of contacting or receiving services from other non-profit and NHS providers. Of the prior abortions (n = 39) reported by participants, 16 occurred more than five years ago, 12 occurred one to five years ago and 10 occurred within the past year.

Participants’ abortion treatment trajectories are described in Fig. 1. For their most recent abortion, most participants (n = 21) had a medication abortion, eight of whom received pills in the post while thirteen collected their pills. Eleven participants’ most recent abortion was a procedural abortion. Sixteen participants had only ever experienced a medication abortion, three had only experienced a procedural abortion, and 13 had experienced both treatments.

## 2.4. Data analysis

For analysis, I selected a codebook approach to combine the qualitative values of reflexive thematic analysis with a structured and comprehensive approach to coding, earlier theme development, and conceptualisation of themes as topic summaries (Ritchie and Spencer, 2002; Braun and Clarke, 2021). This allowed me to ground the analysis

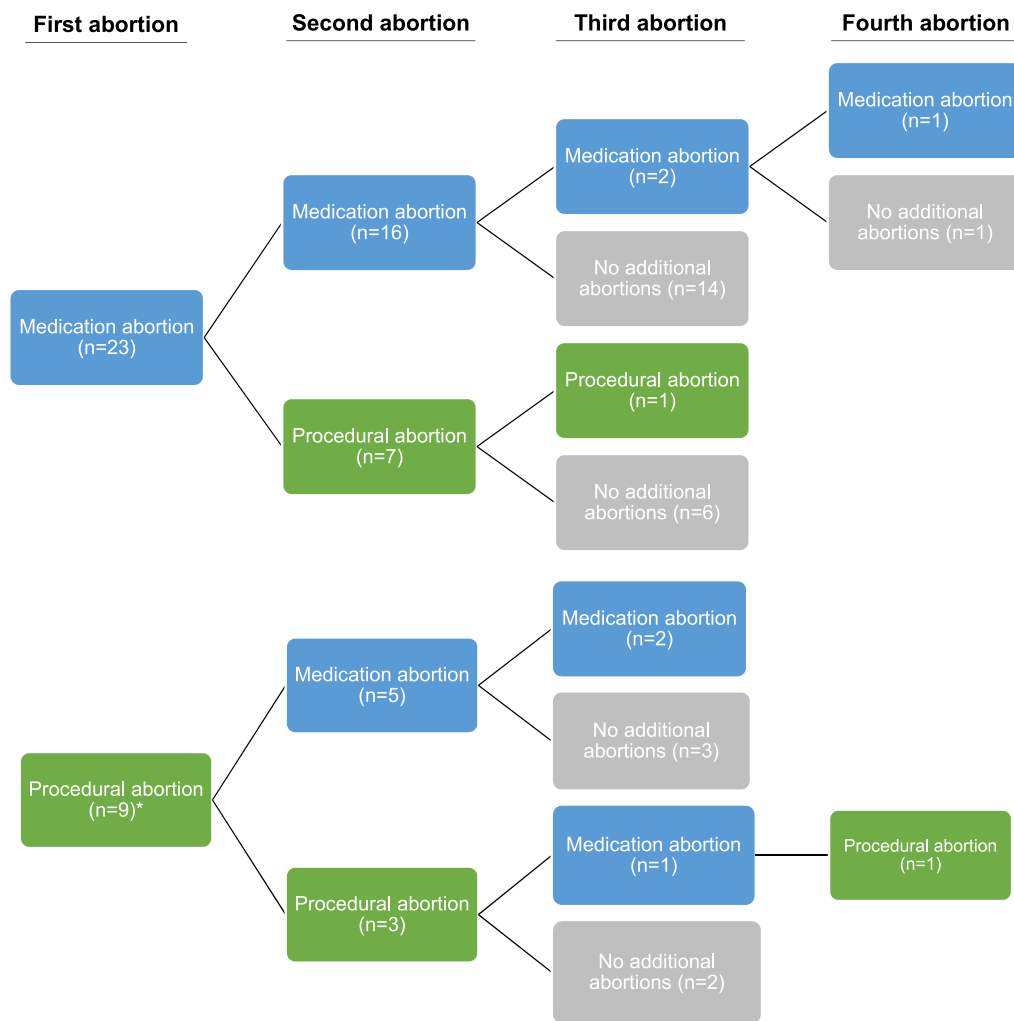


Fig. 1. Abortion treatment trajectories of participants \*Note: one participant did not report any additional abortion experiences.

in the participants’ subjective experiences while ensuring analysis was informed by relevant theory and the initial research questions, and that findings were salient for policy-focussed research (Ritchie and Spencer, 2002).

First, I re-familiarised myself with the entire dataset by re-listening to all recordings and taking detailed notes. I then developed a coding framework, which I used to code transcripts in Dedoose (2022), and then to chart the analysis as I developed summaries for each topic based on the coded excerpts. The coding framework was informed by topics that I identified through re-reading transcripts, and which I structured using Fotaki’s analytical framework for understanding patient choice and equity (Fotaki, 2010).

I used this framework to organise material as it is comprehensive, multidisciplinary, and it makes explicit the structural inequities in health care which are often absent from discourses about patient choice. This framework was selected after data were collected and did not inform the topic guide or interview process. The framework highlights four overarching factors that influence the process of choice and its relationship with equity: supply of health services, as determined by health system structure; the influence of providers and the power dynamic between provider and user; user demand of services, which is influenced by beliefs, perceptions, and expectations; and health care users’ socio-economic environments, which includes the impact of gender, ethnicity, income, education, and age on decision-making. These categories were understood broadly, to ensure evidence that did not neatly ‘fit’ the framework was not excluded. For example, in Fotaki’s

framework the influence of providers is focussed on providers’ perceptions of patient needs, which I was not able to assess in this study, but instead I considered how participants’ reported interactions with providers influenced their choice.

2.5. Ethics

The research was approved by the British Pregnancy Advisory Service (BPAS) (ref: 2021/07/FOO; 21/10/21) and NHS (ref:22/WA/0079, 31/03/22) research ethics committees, and was therefore exempted from full review by the London School of Economics and Political Science research ethics committee (ref:23692, 13/04/21).

3. Results

In the following sections, I analyse participants’ experiences of treatment decisions across the four individual and structural factors identified by Fotaki’s framework (Fotaki, 2010): supply of health services, influence of health providers, socio-economic environment and demand from users.

3.1. Supply of health services

Participants described their ability to choose both procedural and medication abortions being limited by supply constraints. Most commonly, limited availability of procedural abortion appointments

and the resulting waiting times and travel requirements meant some participants decided to have medication abortions after originally wanting a procedure (commonly referred to as surgical abortion).

*“Actually, at first, I wanted the surgical because I just wanted it done. I didn’t want to go home and bleed for- I just wanted it all done. And then she said that they hadn’t got appointments and I’d have to be back like in a week or so ... So I just went ahead with, went for the pills”*

(30–34, England, medication abortion, 1 prior abortion of each type)

*“The travel would’ve been difficult ... so the likelihood is I would have probably had to stay locally in the area, stay there overnight, come home the day after. So it just financially, the travel, the childcare, it just wouldn’t’ve worked”*

(20–24, Wales, medication abortion, 1 prior medication abortion)

Travel requirements impacted the treatment decisions of those living in rural areas with limited clinic availability, but participants living in large cities also described significant journeys to neighbouring towns to access procedural abortions due to limited appointment availability. Even relatively short journeys created significant barriers if participants were reliant on someone else to drive or lacked resources to pay for travel.

By contrast, participants usually described rapidly accessing medication abortion appointments, and a couple of participants noted how access had improved since their prior abortion(s). However, some participants described significant service delays and travel times for medication abortion when an ultrasound was required or when underlying health conditions meant that general practitioners had to be consulted. One participant described waiting 10 days and taking two trains for an ultrasound appointment because the clinic she had previously used had closed. Service delays created distress and anxiety for participants who were concerned about reaching a pregnancy duration where they would no longer have the choice of medication. These factors also resulted in some participants having to have a procedure when they would have preferred medication:

*“It’s when I went for my scan ... they told me how far gone I was. And that’s when I kind of, in my head, I kind of thought ‘ahh it’s past the pill date’ ... I missed my one appointment because I couldn’t get to it because ... they kept booking far ones.”*

(20–24, England, vacuum aspiration, 1 prior medication abortion)

### 3.2. Influence of health providers and patient-provider dynamics

Participants’ treatment decisions were impacted by the options and information offered by their health care providers. Many participants described medication abortion being the first and often only treatment option mentioned, both in recent abortions and in participants’ prior abortions over the past decade with other NHS and non-profit providers. Providers’ information provision was often described as leaning towards medication abortion, using words such as “recommended”, “easier”, “preferred” and “best”. There was also a perception that procedural abortions were only an option after 10 weeks.

*“I only got the option of having the tablets. Um. I think you only have the surgical one, like the actual um surgery if you’re too far on ... But you didn’t get like given an option. I think they choose like the best option for you, if that makes sense.”*

(20–24, England, medication abortion, 1 prior medication abortion)

Some were however aware that there was another option through their own research.

*“It wasn’t like discussed with me that there were other options. It was almost like taken for a given that you would just have the pill. I think*

*maybe you’d have to say ‘I specifically want this’, having read the information on the website.”*

(30–34, England, medication abortion, 2 prior medication abortions)

In some cases, participants felt they hadn’t received information about alternatives because they were already certain they wanted medication and (might have) expressed this to their provider, particularly when they had a prior abortion experience or if they had done research online.

There were also participants who said they received comprehensive information about their options or who felt they had been offered both treatments. However, some participants who perceived they had been offered a choice also described receiving inadequate information, not being offered both options, being advised towards medication abortion, or just being asked to confirm they were happy to go ahead with the pills. For example, one participant described how “they did say that they advise that if I am going to do it, then yes do the pills because it’s obviously a bit easier than doing surgical”, but went on to say, “they did make me aware that it’s obviously my choice”. Most participants described unbalanced information without labelling it themselves as such, but one characterised her experience by saying:

*“I felt like I was definitely given the choice, but I don’t think I was given enough information ... it definitely affected the option that I went for, put it that way, in the way in which they described it.”*

(20–24, England, medication abortion, 1 prior medication abortion)

A couple of participants explicitly described medication abortion being “pushed” as a treatment option in their most recent abortion or in previous abortions with other non-profit providers. However, both participants stated they did not feel pressured to choose medication over a procedure, and that the decision was their own.

*“They very much would rather I think just send the pack out, with the tablets in. Um, and again, you know, that’s not something that I wanted ... I was a bit put off by the pushing of the pill option, to be honest, so um, yeah, I didn’t really get too into it with [another private non-profit provider]”*

(30–35, England, vacuum aspiration, no prior abortion reported)

*“I definitely felt like she wanted to push the pills on me. I didn’t feel pressured. But I felt like that was the first option and that was kind of like, I don’t think she would have gone into detail about it surgically if I hadn’t have actually brought it up to her”.*

(35–39, England, medication abortion, 1 prior procedural abortion)

Participants also reported mixed experiences of being prepared for medication abortion, which may influence treatment choice if the experience is not fully explained. While some knew what to expect and felt that the severity and range of symptoms they might experience was well-explained, others felt they were not prepared.

*“They basically said it was kind of like a period, times by like 10 maybe ... So yeah, then, I- I knew what to expect, pain wise”*

(20–24, England, medication abortion, 1 prior medication abortion)

*“In my experience, they just didn’t tell me like just how bad it would be ... In like the leaflets it’s just described as like strong period cramps ... I just don’t think it’s really emphasised as much how, how much it is”*

(20–24, Wales, medication abortion, 1 prior medication abortion)

However, several participants also noted that it is difficult to prepare people without sounding too off-putting, given how much the experience varies.

### 3.3. Socio-economic environment

Multiple intersecting aspects of participants' socio-economic environments impacted their treatment decisions and choices in diverse ways, including age, home environments, access to financial resources, childcare responsibilities, social support, underlying health conditions, location, working conditions, and agency. These factors could influence a preference or need for either treatment, impact the way participants navigated decision-making during the health care interaction, or influence their ability to access and manage the experience of either treatment.

Participants who recalled prior adolescent abortion experiences highlighted the impact their age had had on their decision-making and options. For example, one participant explained that her lack of awareness and recognition of pregnancy symptoms as an adolescent meant she was offered no choice other than a procedure by the time she found out she was pregnant. Some felt they had been less able to inform themselves or ask questions:

*"My decision was a lot more informed [this time] than when I was 16 ... at 16, I think you're just like, I want to get this over and done with. And you've got that kind of like, anxious feeling .... I made a really, really good, informed decision this time ... I wasn't afraid to ask questions, whilst when I was younger. I was really um, you know, you don't want to ask."*

(30–34, England, vacuum aspiration, 1 prior medication abortion)

Those who had prior adolescent experiences of abortion also recalled challenges with travelling independently, which made it harder to keep clinic-based abortions a secret. One participant emphasised how pills by post would have made her medication abortion much easier to manage as she had struggled to save up enough lunch money to pay for a train fare. However, another, who had an inpatient medication abortion as a teenager 20 years ago, felt pills by post would not have suited her as she needed to be "looked after".

Home environments impacted participants' experiences, particularly for abortions that occurred at younger ages or for participants who kept their abortion a secret from people they lived with. A couple of participants said it was easy to explain away their symptoms as a bad period, but one participant described her adolescent experience of medication abortion as "traumatising" due to her difficulty hiding the pain. Another participant described her pain being exacerbated by trying to hide it from parents, which she managed for her second abortion by booking a hotel room with her boyfriend. Others, who were able to send their children to stay with family or who had a supportive home environment, said they also would have booked a hotel room if their living situation were different. One participant who lived in shared accommodation said she was able to manage by staying in her (ensuite) bedroom and having her partner help her get food and water, but that she could not have had the abortion at home if she had a shared bathroom.

Access to financial resources enabled some participants to better manage their experience or to access timely care despite supply constraints. Aside from booking hotel rooms, others needed to cover the costs of travelling for a procedure or for ultrasound appointments. One participant emphasised she would have had to borrow money for travel if she had not waited for a nearer procedure appointment, while another wasn't able to choose her preferred option (procedure) owing to the costs and logistics of travelling. Others were able to speed up access by paying for private ultrasounds, which enabled greater choice of treatments.

Having dependent children influenced participants' treatment decisions, as juggling childcare with service access was often challenging. In several cases, participants described making decisions based on the needs of their family rather than their own preference. Having support with childcare therefore enabled some participants to travel for an ultrasound or for a procedural abortion. Access to social and practical

support could also make the medication abortion experience easier to manage physically and emotionally when being looked after by friends, partners, or family. Although some participants expressed a strong preference to be alone for the experience, others would have opted for a procedure if they hadn't had support or felt in hindsight they should have opted for a procedure because they lacked adequate support.

Participants' decisions were also limited by factors such as health status, as underlying health conditions or body mass index could influence which treatment options were offered due to limitations on provider capacity; location, as travel time had more impact on treatment decisions of participants living further from urban locations; and working conditions, as some chose their treatment based on whether they could manage the side effects or travel alongside work to avoid losing pay.

Finally, participants emphasised the need to be self-informed, "research things yourself" and to "push for surgical" as the procedure option was not always explicitly offered. A couple of participants highlighted that persistence and repeated phone calls to check for cancellations allowed them to access timely care.

### 3.4. Demand of services: beliefs, perceptions, and expectations

Demand for treatment options was influenced by participants' perceptions of each treatment, their prior experiences, information from family and friends, their practical concerns, and emotional responses. Demand was also shaped by the structural barriers created by supply constraints, health provider interactions and socio-economic environmental factors.

Importantly, although participants' experiences suggest limited access to or information about procedural abortion was provided, many participants did not want a procedure and did not mind that they were only offered medication abortion:

*"I didn't want it [a procedure]. No one offered it. So I just went with ... what they were offering and what I preferred anyway"*.

(30–34, England, medication abortion, 2 prior medication abortion)

Several participants expressed strong negative reactions to the idea of a procedural abortion, were fearful of having to have a procedure and were relieved that medication was an option. A couple of participants stated they would not have had an abortion or had considered not going ahead with their abortion if medication hadn't been an option. Those who thought they might have to have, or did have to have, a procedure due to the provider not offering medication abortion beyond 10 weeks described "panic" and being "freaked" initially.

For several participants, discomfort with procedural abortion specifically related to what would happen during the process, such as being in a clinic, having a procedure done by a doctor, having an injection for local anaesthesia, being awake and aware during the process, having a tube entering the uterus and use of suction.

*"I knew that that was like sort of going in with a vacuum really, and it involved like local anaesthetic, um, and the idea of like, of that local anaesthetic just er threw ... I'm really awful with needles."*

(20–24, Wales, medication abortion, 1 prior medication abortion)

Among these participants, there was often a desire to avoid medical environments or procedures: "doctors and hospitals and ... the whole clinical surrounding is just scary sometimes ... really cold and uninviting". However, participants who disliked some aspects of clinical environments did not necessarily desire an entirely demedicalised experience. For example, some wanted to avoid feeling like a patient or being around doctors and hospitals and people in gowns, but also said they would have preferred to take the pills in a clinic, have the pills inserted vaginally by a provider in a clinic, have the entire medication abortion as an inpatient under supervision, or have an ultrasound for reassurance prior to the abortion. Some participants also desired a routine follow up

ultrasound appointment or phone call for reassurance.

Perceptions of each treatment also related to the language and labels used by providers: “*you know you hear surgical, and it’s kind of like, ‘ooh ok no’ [laughing] - you hear pill, and it sounds a bit nicer in a way*”. After learning that a procedure was her only option, one participant described then being reassured when “*they explained like it wasn’t really properly surgery and stuff like that, so that calmed me down*”, while another was reassured by her colleague that “*it’s not as bad as the name makes it sound*”. Some participants stated they wanted to avoid “*vacuuming*” or the “*hoover*” due to the language surrounding the main procedure, ‘vacuum aspiration’.

*“The vacuuming bit, it just sounds really ... it just sounds a bit barbaric?”*

(25–29, England, vacuum aspiration, 1 prior medication abortion)

In contrast, a few participants described medication abortion sounding “*easier*” and “*simple*”, as it involved “*just taking a pill*”. However, this perception was also felt to be misleading:

*“I would’ve thought the tablets would be the easier option ... I was a lot more naive, I just thought taking tablets and it’d all be over. But it’s not quite works like that.”*

(30–34, England, vacuum aspiration, 1 prior abortion of each type)

Some of participants’ concerns about procedural abortion related to (inaccurate) understandings of the health risks of each option, with procedural abortion being seen by some as less medically safe, having higher risks of complications and higher risks for future fertility. It was unclear in some cases whether concerns about procedural abortion reflected participant’s own perceptions and experiences, or information received from their provider:

*“They did say that you could have [a procedure], but their preferred method ... because obviously it’s a lot of trauma to have a surgical procedure for a person. So they recommended that before ten weeks that it would be an easier process for you to, you know, take the tablets yourself and, instead of having to go under all the stress of the procedure.”*

(20–24, England, vacuum aspiration, 1 prior procedural abortion)

Negative perceptions of procedural abortion also stemmed from wider societal influences, as one participant described her mum reassuring her that “*it’s not how you see it on, on the movies and stuff*”.

Participants’ perceptions of the two options impacted treatment decisions, but experiential knowledge also influenced decision-making. Several participants chose to opt for medication because it had worked well for them in the past or because they “*knew what to expect*” and would be better placed to manage the symptoms and experience this time. Others made decisions based on a negative previous experience. For example, one participant had experienced a six-week delay accessing a procedural abortion, which led her to choose medication the second time. A couple of participants described negative experiences of procedural abortions as adolescents due to the intimidating medical environment, unkind treatment by staff, and feelings of loneliness and being out of control. Whilst one wanted a medication abortion in the comfort of her own home as a result, the other still initially wanted to have a procedure because it would be easier to balance with childcare and her need for secrecy, illustrating how participants balanced multiple concerns in their decision-making. Similarly, several participants wanted a procedural abortion due to negative previous experiences of medication abortion, including difficulty managing pain or other symptoms, discomfort seeing the pregnancy pass, difficulty hiding the abortion, or having a complication. The experiences of friends, family or acquaintances also informed participant’s treatment decisions. Although one participant described negative accounts of procedural abortion from friends, several participants wanted a procedure due to positive experiences of friends or due to hearing negative accounts of medication abortion.

Individual preferences influenced participants’ decisions, but their decisions were also impacted by practical concerns, including how easily they could keep each treatment a secret, juggling work and childcare, timing, speed, and travel. Participants also described making decisions to manage their emotional reactions and well-being. For example, desire to be unconscious was a common reason to decide on procedural abortion under general anaesthesia, while others wanted to avoid procedural abortion if it was done under local anaesthesia and involved being awake. A couple of participants opted for procedural abortion or would opt for it in future because prolonged physical symptoms after a medication abortion felt emotionally difficult: “*I had bleeding for months ... kept reminding me about what happened*”. Treatment decisions were also related to stigma management in some cases, for example some participants wanted to avoid returning to a clinic out of “*embarrassment*” that it was their second abortion, or due to stigmatising treatment by health care professionals in prior abortion experiences. Some expressed a desire to avoid being around other people having abortions, and this was commonly recalled as a difficult part of the process for participants with previous in-clinic experiences.

#### 4. Discussion

Patient choice is considered a key component of quality care for abortion and for healthcare more broadly, and abortion treatment choice is recommended by clinical guidelines in England and Wales (NICE, 2020; NICE, 2021b). However, this study illustrates how abortion treatment choice is socially structured and produced, meaning there are inequities in people’s ability to make an informed decision about their treatment type. This study makes a significant contribution to understandings of abortion treatment choice by drawing on the comparative experiences of people who have had multiple abortions, and by using a multidisciplinary framework to explore these experiences and their relationships with equity from a structural perspective (Fotaki, 2010). Applying Fotaki’s framework has highlighted how choice in this context is constrained through multiple mechanisms: through the limited supply of abortion care, through asymmetries of knowledge and power between patient and provider, through wider socio-economic environmental factors, and through the resulting impact of these influences on individual perceptions, expectations and needs. Using the example of abortion care, these findings also contribute to broader understandings of patient choice and equity in health care, by demonstrating the vast range of factors that can influence treatment decisions and the interplay between them. For example, socio-economic characteristics (such as age or agency) altered the patient-provider dynamic for some participants, who were better positioned to recognise or push back against the limited choices or information they were offered.

Constraints on treatment decision-making have significant implications for equity in person-centredness of abortion care. This research found participants were better able to access their preferred choice if they could afford to travel, lived closer to (urban) clinics, had social support, could self-inform about their options, and felt comfortable to ask questions of providers and to advocate for their own needs. However, while Fotaki’s framework demonstrates the tensions between choice policies and equity (Fotaki, 2010), in this context it is the illusion of choice rather than the policy of choice which creates inequities in person-centred care. Abortion treatment choice is available in principle in England and Wales, but in practice this choice is constrained by financial pressures on providers, insufficient workforce, and legal restrictions on services (Footman, 2023a). Although choice policies can conflict with equity goals (Fotaki, 2010; Appleby et al., 2003), this research suggests that removing the recommendation to offer abortion treatment choice would not reduce inequities because the experience of each treatment is also heavily influenced by socio-economic factors, a finding that is supported by previous research (Lohr et al., 2010; Rørbye et al., 2005b; Mosley et al., 2022). The experience of medication abortion, for example, may be more difficult for those who are younger, lack

a private or supportive home environment, have inflexible working conditions, lack financial resources, or lack social and emotional support through the process. Therefore, protecting treatment choice in policy and in practice is necessary to reduce inequities in the experience of abortion care. Some participants reported that they considered keeping their pregnancies when unable to get the type of abortion they wanted, illustrating how abortion access and reproductive justice may be harmed when services cannot provide choice. Participants' emphasis on how they would feel during and after the abortion also highlights the potential emotional impact when denied a preferred treatment, as observed in previous work (Kerns et al., 2012).

Given the importance people attach to choosing their preferred abortion treatment (Robson et al., 2009), choice needs to be strengthened by countering the impact of structural constraints and inequities. Health system constraints on the supply of more resource-intensive abortion treatment options partially relate to under-resourcing of abortion services and the impact of competitive commissioning (Footman, 2023a), underlining how the commodification of healthcare can conflict with choice policies by weakening the position of patients (Coulter, 2010; Nordgren, 2010). The resulting lack of procedural abortion availability restricts decision-making and impacts experiences of care, particularly for those living further from urban clinics. However, these pressures on abortion services, poor integration with the public health system, and the shift to increasingly remote models of care may also be impacting choice and experiences of medication abortion. Some participants described significant service delays or travel distances for medication abortion if they had additional health needs which necessitated communication with their general practitioner, or if they required an ultrasound due to clinic closures and the limited supply of ultrasound appointments. This caused anxiety and denied participants the choice of a medication abortion in some cases due to the non-profit sector's limited capacity to provide medication abortion beyond 10 weeks. Greater integration between private non-profit and NHS providers is needed to ensure equitable and timely access to ultrasound scans for those who require one, or to enable medication abortion access at later gestations for those who prefer this option. Additionally, in Scotland, abortions can be provided at home up to 12 weeks of pregnancy, as recommended by WHO guidelines, and extending this limit from 10 to 12 weeks in England and Wales could improve choice (Reynolds-Wright et al., 2021; WHO, 2022). Health system constraints on abortion treatment choice could also be reduced by strengthening training and workforce planning to expand procedural abortion skills, amending commissioning practices to ensure fair reimbursement for service delivery, and expanding the role of nurses and midwives in line with WHO abortion guidelines (Footman, 2023a; WHO, 2022).

As seen in other settings and other areas of healthcare (Toerien et al., 2018; Irvine et al., 2021; Karnieli-Miller and Eisikovits, 2009; Donnelly et al., 2019), this research highlights how the nature of information offered by health care providers can prevent informed choice. Interestingly, although a few participants explicitly identified that medication abortion was pushed or information was skewed, several participants still perceived they had made a choice despite their options being limited or information being restricted. The way options are described, who raises them and when they are raised within healthcare interactions can create a false impression of choice due to asymmetries of knowledge and power between patient and provider (Toerien et al., 2018). The illusion of choice in abortion care may partly persist because the health system bias towards medication abortion is aligned with the preference of many care-seekers, given the strong aversion to procedural abortion among some participants. However, in some cases, negative perceptions of procedural abortions were shaped by information offered by providers and the language used to describe each method, highlighting a need for more accurate, person-centred language (Broussard, 2020; ACOG; Upadhyay et al., 2023). For example 'in-clinic procedure', 'abortion procedure' and 'gentle suction' could replace 'surgical abortion' or 'vacuum aspiration' (Broussard, 2020; ACOG). Negative

perceptions of procedural abortions may also relate to their stigmatised and over-medicalised depictions on television or film (Herold and Sisson, 2019) as misinformation and stigma have been found to influence medication abortion preference (Wingo et al., 2021; Turner et al., 2024). While perceptions are an important component of experience, even when at odds with 'factual' understandings of what a service involves (Simonds et al., 1998), people require enough information to make a well-informed decision. This is particularly important for people with longer pregnancy durations or underlying health issues, as stigmatised perceptions of procedural abortion may create anxiety and distress for those who have limited access to medication abortion. Research has highlighted the need for improved guidance from providers to assuage potential concerns surrounding procedural abortion (Nguyen et al., 2023). In the UK, while most abortion providers would prefer to offer both treatment types, over half only provide medication abortion, reflecting the impact of broader health system constraints on their practice (Footman, 2024). Supply issues with procedural abortion therefore mean providers may have to rely on and possibly even reinforce care-seekers' negative perceptions of procedural abortion, rather than address their potential concerns.

Shifts in abortion care over the past decade have sought to increase accessibility and person-centredness by reducing clinical involvement and control. These new, demedicalised pathways tend to become the default (Purcell et al., 2017; Blaylock et al., 2021): most services in England and Wales now do not provide the option to take medications in a clinic, or to have an in-person appointment. However, this study has highlighted that people do not have simple preferences around the medicalisation of care: participants rejected some elements of clinical establishments (hospitals, doctors, equipment) while desiring other aspects of medical care (reassurance from an ultrasound scan, emotional support from a nurse, closure from a follow up appointment or call). Treatment decisions were determined based on varied and complex needs, balancing personal preferences, emotional and practical considerations, prior experiences, and information from providers, family, and friends. Beyond treatment choice, this study highlights that abortion services need to encompass varied models that meet the diverse needs of people having abortions where possible. Excessive emphasis on a demedicalised model of care may exacerbate inequities in settings where abortion can be legally provided through the health system. These results are important for abortion care decision-makers in England and Wales, but have broader international implications given that these shifts to more remote, medication abortion-focussed models of care are occurring globally (Singh et al., 2018).

This study has several limitations. I recruited almost all participants from only one non-profit provider, albeit the largest in England and Wales. In NHS recruitment, far fewer people were approached due to lower service volumes and the more time-consuming recruitment method, and there was low interest in participating. Participants discussed their prior abortions with other non-profit or NHS providers in the interviews, but experiences of the public sector and of other non-profit providers are not fully represented in this study. The study only included perspectives of care-seekers, but broader perspectives of providers and other stakeholders have been addressed in previous research (Footman, 2023a). Additionally, I only included individuals who had a prior abortion, who may vary in characteristics from those accessing their first abortion: having a previous abortion experience is associated with increased age and parity, being of Black ethnicity, fewer years of education, and living in rented accommodation (Stone and Ingham, 2011). However, this variation does not reduce the value of understanding these experiences as almost half of abortions in England and Wales in 2021 were among people who had a previous abortion experience (DHSC, 2022). The exclusion of individuals who do not speak English means I could not assess the impact that language may have on health care interactions and migrants may have been disproportionately excluded. Finally, I was limited to participants' recalled accounts of their consultations and I could not use conversational analysis of



recordings of interactions, for example, which would have helped to better distinguish between participant perceptions of treatment options and the information provided by their health care professional (Pilnick, 2008). However, this study makes a significant contribution to our understanding of abortion by applying a multidisciplinary theoretical framework to the under-theorised topic of abortion treatment choice, by interviewing people who have had multiple abortions to understand their comparative experiences, and by using a structural perspective to explain some of the mechanisms that might produce socio-economic variations in abortion method preferences and use.

## 5. Conclusion

Abortion treatment choice is considered a key component of quality care in England and Wales, but this research identifies structural factors that limit choice, from the comparative perspective of individuals with multiple experiences of abortion care. Supply factors, health provider influences, and socio-economic environmental factors interplay with one other and with demand factors to inequitably constrain decision-making. Socio-economic factors also affect the experience of each option, meaning the removal of choice has inequitable impacts on quality of care. Treatment choice must be strengthened so that choice is both offered and experienced, available in practice as well as in principle. Health system constraints on both medication and procedural abortion need to be addressed by better integrating private non-profit and public provision, aligning requirements for the timing and provider of each treatment with WHO guidelines, tackling financial pressures on services to redress their influence on provider policies and practice, and revising the language used to depict each abortion treatment option. Finally, a one size fits all approach to de-medicalising abortion provision ignores the complex and varied needs of people seeking abortion. Beyond treatment choice, the research highlights the imperative for broader choice within abortion care to ensure that service models meet these diverse needs in England and Wales and elsewhere.

## Ethics

The research was approved by the British Pregnancy Advisory Service (BPAS) (ref: 2021/07/FOO; 21/10/21) and NHS (ref:22/WA/0079, 31/03/22) research ethics committees, and was therefore exempted from full review by the London School of Economics and Political Science (ref:23692, 13/04/21).

## CRedit authorship contribution statement

**Katy Footman:** Writing – review & editing, Writing – original draft, Validation, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

## Declaration of competing interest

The author declares no competing interests.

## Data availability

Data will be made available on reasonable request.

## Acknowledgements

The UK Economic and Social Research Council funded this research through a doctoral grant [F79676A]. The funder had no involvement in the research design, writing or interpretation. The project also received financial support from the Parkes Foundation. I would like to thank Professor Ernestina Coast and Dr Tiziana Leone for their guidance with this work. I am grateful to the British Pregnancy Advisory Service,

Homerton University Hospital and Peterborough City Hospital for their support with recruitment of participants. Finally, I would like to thank all the participants who gave up their time and shared their personal experiences for this study.

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