



“All hands on deck”: a qualitative study of safeguarding and the transition to telemedical abortion care in England and Wales

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ABSTRACT

The COVID-19 pandemic raised significant challenges for in-person healthcare provision, leading healthcare providers to embrace digital health like never before. Whilst changes were made as part of a public health response, many have now become permanent fixtures of the healthcare landscape, significantly altering the way care is provided not only for patients, but also for the healthcare professionals that provide care. In abortion care in England and Wales, previously stringent regulations on in-person care provision were relaxed to permit the use of telemedicine and self-administration of medications at home. These changes have since been made permanent. However, there remains opposition to remote abortion care pathways on the basis of safeguarding. Opponents argue that it is not feasible to effectively safeguard patients accessing abortion care remotely. We conducted a qualitative study using semi-structured interviews with abortion care providers in England and Wales. Participants were asked about their views and experiences of the transition to remote care provision, with a particular focus on how they adapted their safeguarding practice. In this article, we present three themes that highlight the changing roles of healthcare professionals in abortion care: (1) a challenging backdrop and resulting apprehension, (2) adaptive practices, and (3) the continued importance of professional curiosity. Across all three themes, participants reflected significantly on how changes were made and what they experienced in the period of transition to telemedicine. In particular, they discussed the changing nature of their professional roles amidst digitalisation. Our findings provide a basis for reflection on the increasing introduction of digital approaches to healthcare provision, highlighting points for caution and emphasising the need to involve professionals in the transition process to ensure vital buy-in. Through this, we articulate two novel understandings of digitalisation: (1) the impact of speed-associated pressures on professional adaptation during digitalisation, and (2) off-proforma safeguarding through telemedicine as a form of invisible non-routine work.

1. Introduction

In 2020, as a lockdown was instated across the UK as a public health response to the COVID-19 pandemic, significant changes were made to abortion law and provision (Parsons and Romanis, 2021a). Before the end of March 2020, the law in England and Wales required that those seeking abortion care attend clinics in person to be prescribed abortion medications (mifepristone and misoprostol) and that mifepristone must be taken at a licensed clinic (Romanis et al., 2021a). In response to the difficulties these requirements posed in the pandemic context, public health and reproductive health specialists successfully campaigned for a relaxation of the law to permit digitalisation through remote

consultations (facilitated through a range of mediums including telephone call, video call, and webchat) and at-home self-administration of the medications. These changes to the law were initially intended as temporary but have since been made permanent in England and Wales in 2022 (Wilson, 2022).

During the initial temporary period of regulatory relaxation, a substantial body of evidence as to the safety, effectiveness, and acceptability of telemedical early medical abortion (TEMA) was built (Aiken et al., 2021). This built on an already strong evidence base (Endler et al., 2019). However, there remains opposition to TEMA on the grounds that it cannot adequately safeguard those accessing care (Christian Action Research and Education, 2020; Christian Concern, 2021). Remote

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provision of care is argued to interfere with the ability of healthcare professionals to carry out their safeguarding duties under the Care Act 2014 (in England) and Social Services and Well-being (Wales) Act 2014 (in Wales).

Safeguarding is defined as the broader duty of professionals in ‘protecting an adult’s right to live in safety, free from abuse and neglect’ (Department of Health, 2014: para 14.7), thereby going beyond a narrow focus on the medical complaint that caused a patient to access the healthcare system. Opposition to TEMA on safeguarding grounds suggests that in-person interaction is necessary to adequately identify abuse and neglect. Whilst there is academic literature that critiques these concerns around safeguarding in the context of TEMA (Nevill and Hills, 2021; Parsons and Romanis, 2021b, 2022; Romanis et al., 2021b; Lowe, 2023), there are limited empirical data. In this article, we seek to fill this gap and answer the research question “how do healthcare professionals experience digitalisation of abortion care provision and associated safeguarding?”. To that end, we present the findings of the first empirical study exploring the views and experiences of healthcare professionals working in abortion care in England and Wales about remote safeguarding. We conducted a qualitative study using semi-structured interviews with professionals (n = 20), before thematically analysing findings.

In this article, we report on three themes: (1) a challenging backdrop and resulting apprehension, (2) adaptive practices, and (3) the continued importance of professional curiosity. Across all three themes, participants reflected significantly on *how* changes were made and what they experienced in the period of transition to TEMA. In particular, they discussed the changing nature of their professional roles. Our findings provide a basis for reflection on the increasing introduction of digital approaches to healthcare provision, highlighting points for caution and emphasising the need to involve professionals in the transition process to ensure vital buy-in. Most notably, we articulate two novel understandings of digitalisation: (1) the impact of speed-associated pressures on professional adaptation during digitalisation, and (2) off-proforma safeguarding through telemedicine as form of invisible non-routine work.

2. Theoretical underpinnings

2.1. Theoretical background

Digitalisation can come with various benefits for employees, such as increasingly flexible working arrangements (Hinds and Kiesler, 2002: 1602). Even where complaints are recorded by employees, there may be overall enhanced job satisfaction (Bisht et al., 2023). These benefits are true of the uptake of telemedicine, albeit with some restrictions. Whilst remote consultations, for example, afford greater flexibility in allowing healthcare professionals to work from home either some or all of the time, there remains a need for the timing of such consultations to be within operating hours. The flexibility does not ordinarily, therefore, extend to personal choice over when to fulfil contractual hours in this context. For some, the option of working from home will be welcomed for reasons such as reduced travel time and expense. Though with regards to our subject matter, digitalisation and the switch to providing care remotely was not introduced as an *option* for professionals – the need was such that professionals did not have a choice, in much the same way many people were forced to work from home during the height of the pandemic.

Whilst employees may perceive certain “perks” to the digitalisation of the workplace, there may be some drawbacks. For example, increased digitalisation may come with greater datafication (Hansen, 2015; Leonardi and Treem, 2020). Telemedical service provision may be more easily monitored by management for the purposes of, for example, tracking the use of clinical time. Call logs will provide data on the length of consultations in a way that is not practicable with in-person provision, shifting this aspect of care to the more plainly visible – with the balance

of pros and cons that come with that (Star and Strauss, 1999: 10). Bain and Taylor, for example, discuss how digitalisation enables the monitoring of employee productivity ‘to an unprecedented degree’ (2000: 5). This could feasibly give rise to resentment from healthcare professionals who feel they are not being trusted to execute their roles responsibly – a possible shift from intrinsic to instrumental value. Broadly tracking the generational digital divide, this may be more likely amongst long-term staff who are more used to in-person ways of working. On the specific safeguarding matter, this datafication may prove problematic if it results in a drive to improve metrics with more direct financial implications (such as reducing time spent with each patient), potentially damaging the “care” aspect of healthcare. Safeguarding, as we will shortly discuss, can be an especially sensitive part of the patient-provider interaction and it being rushed can significantly impact on its effectiveness. Relatedly, too much datafication may in this way contribute to burnout amongst professionals (Gomez et al., 2021: S65).

Leonardi and Treem (2020) have raised another potential concern arising out of the “three Ds” of digitisation, digitalisation, and datafication – that of behavioural visibility. This relates more broadly to the increase in social media usage, and how the blurring of the private-public divide in the lives of individuals affords greater scope for employers to monitor the now public aspects of employees’ private lives. One’s digital footprint – or absence of one – provides information that an employer can monitor. For example, political comments made on X (previously Twitter). This may be of particular relevance to abortion care given how politicised this aspect of healthcare is. With many abortion care providers being involved in political campaigning, it follows that their staff may well be advocacy-active on social media, which the employer could monitor and respond to when deemed necessary. Nonetheless, given our focus in this paper is on care pathways themselves, behavioural visibility is unlikely to have any meaningful pertinent impact.

A rather more straightforward issue might be a lack of ‘digital competence’ amongst employees (Shahlaei et al., 2020). With abortion care always having been provided in person, some healthcare professionals may have had insufficient digital literacy to effectively carry out the new processes. This extends beyond the functioning of IT systems themselves and can also be thought of as incorporating a broader skillset in conducting consultations online. For example, ensuring empathy comes across in providing person-centred care via digital means, something that we know patients value (Mason, 2022). Whilst evidence suggests there is no reason that such aspects cannot be of equivalent quality when providing care through telemedicine (Cheshire et al., 2020), it is something to bear in mind as a potential (even if short lived) shortcoming. Inevitably, any overhaul of procedure in a workplace requires a process of adaptation, but it remains a possible source of resistance (Shulzhenko and Holmgren, 2020). This may be more so the case where digitalisation takes place without sufficient regard for the interests of employees (Braverman, 1974).

Digitalisation – and indeed digitisation – are nonetheless often regarded as necessary to remain competitive in certain industries (Leonardi and Treem, 2020: 1603). This may also be true in certain healthcare settings, such as countries with privatised healthcare and citizen choice over insurers. Though in England and Wales, with the NHS, such a driving force is reduced. Whilst private healthcare is available, the NHS does not perceive itself as in competition with such providers. With most abortion care being provided on NHS contract by the organisations our participants are drawn from (Office for Health Improvement & Disparities, 2023), one might perceive some level of competition. Particularly with the introduction of telemedicine and associated increase in geographical reach of each provider, some patients may find themselves with greater choice of provider. Nonetheless, the providers do not currently operate in that way. Indeed, they are highly cooperative with one another, at least in part owing to the political aspect of abortion care we will discuss shortly.

In many ways, the safeguarding aspect of care provision exemplifies

so-called abortion exceptionalism (Parsons and Romanis, 2022). Abortion exceptionalism is the reiteration of abortion as distinct from routine, essential healthcare. In legal terms, it means that abortion is inappropriately subject to ‘unique, and uniquely burdensome’ regulation (Borgmann, 2014: 1048) dictating where, when, why, and how abortion may be provided (Parsons and Romanis, 2021). Whilst all healthcare professionals have a safeguarding duty, in no other area of healthcare (with the exception of paediatrics) are requirements so extensive as to provide for a fixed, active approach. Enhanced safeguarding requirements relative to other areas of healthcare inherently imply a certain vulnerability and/or untrustworthiness in those seeking abortion care. At the beginning of the COVID-19 pandemic, the House of Lords Under Secretary for Health and Social Care stated:

‘it is an essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues. Do we really want to support an amendment that could remove the only opportunity many women have, often at a most vulnerable stage, to speak confidentially and one-to-one with a doctor about their concerns on abortion and about what the alternatives might be? The bottom line is that, if there is an abusive relationship and no legal requirement for a doctor’s involvement, it is far more likely that a vulnerable woman could be pressured into have an abortion by an abusive partner’ (HL Deb Wednesday 25 March 2020, vol 802, col 1762, per Lord Bethell).

Whilst appealing to norms around informed consent and the idea of reasonable alternatives clarified in the landmark case of *Montgomery v Lanarkshire Health Board* ([2015] UKSC 11) and making an emotional appeal to the basis of safeguarding in protection from abuse, this statement exemplifies an infantilising characterisation of those seeking abortion care and an expectation of vulnerability in abortion-seekers that is not corroborated with evidence. The safeguarding expectations on abortion care providers thus restrict the ability of healthcare professionals to treat their patients in an appropriately respectful manner, responding only where safeguarding concerns are identified in the course of care provision. One result is heightened potential for moral distress amongst professionals forced to go through extensive safeguarding procedures that they do not deem appropriate in a given situation.

2.2. Theoretical framework

As a lens to explore the perspectives of participants with regard to the process of digitalisation in TEMA and associated safeguarding, we look to Chen and Reay’s model of professional identity restructuring. This centres on four stages:

‘(1) resisting identity change and mourning the loss of previous work, (2) conserving professional identity and avoiding the new work, (3) parking professional identity and learning the new work, and (4) retrieving and modifying professional identity and affirming the new work’ (2021: 1541).

Treating these stages as a means of assessment, we will examine if and how the sudden implementation of TEMA and associated safeguarding allowed for such a process. Were professionals afforded the opportunity to adapt in this way to reconfigure their professional identity in light of increased digitalisation and, equally, did they want to? Whilst not explicitly intended as a theoretical approach, Chen and Reay’s model is appropriately applied as such for our purposes given certain unique aspects of the move to TEMA.

Existing theorisations of the process of digitalisation we have highlighted indicate certain expectations we may have of the reaction of employees. A certain amount of push and pull, a learning curve of variable steepness, but an eventual process of acceptance, even if reluctant. Though in the context with which we are concerned, there are reasons to anticipate marked variation. Such reasons run along two axes. First, the

COVID-19 pandemic creating an environment of heightened pressure. Second, abortion care provided through the dedicated providers our participants were drawn from is, for want of a more accurate term, more politicised than other healthcare in England and Wales.

The rather gentle process of adaptation outlined by Chen and Reay (2021), we suggest, was less realistic in spring 2020. Ordinarily, organisations have the time to move gradually towards digitalisation in a supportive way that allows for employee buy-in, thus entailing the four stages Chen and Reay detail to play out naturally. Pandemic-related digitalisation, however, was abrupt. Choroszewicz has highlighted how the pressures might result in insufficient support for staff in adapting to new processes (2023: 13). The planning stages of TEMA were rushed relative to the usual rate of healthcare service improvement, thereby introducing a greater chance of friction upon implementation. This was the case even though providers had been undertaking research about a potential move to TEMA in the future. Pressures on healthcare during the pandemic, however, did not allow for a transitional period that could in any way be considered gentle or gradual. From this one might hypothesise some manner of divergence from the model.

This must be balanced against the nature of abortion care as heavily politicised. The dedicated abortion providers our participants were recruited from exist due to historic challenges with abortion care provided directly through the NHS. They have, therefore, always had a certain political aspect to them, frequently voicing the reality of abortion exceptionalism. Most notably, the British Pregnancy Advisory Service (BPAS) is heavily involved in campaigns to improve access to reproductive healthcare and decriminalise abortion (British Pregnancy Advisory Service, n.d.). Inevitably, this affects the recruitment of these organisations. It seems reasonable to say that someone who has moral qualms with abortion is unlikely to take up a position at such an organisation. The result being a group of employees that feel some sense of “cause” to what they do, heightening commitment.

These two axes of exceptionalism, we posit, move in almost opposite directions. COVID-19 pressures may cause a rough path to digitalisation that heightens pushback, whilst the specific dedication of healthcare professionals working for abortion care providers may foster a sense of camaraderie that will shoulder more employee-related burdens. The strength of force in either direction is difficult to predict, but at least indicates that we ought to expect this particular case study of digitalisation to play out somewhat differently to what the wider literature would suggest.

3. Research design

3.1. Context

As a further point for context purposes, we will briefly outline the nature of the TEMA services established in England and Wales towards the beginning of the COVID-19 pandemic – and therefore those about which participants were asked. TEMA care pathways exist on a spectrum, entailing varying levels of digitalisation (Parsons and Romanis, 2021). Examples globally range from use of videoconferencing in the clinical setting to facilitate a consultation with a professional who is based in another clinic (Grossman et al., 2011, 2013) to a fully remote service that entails no testing, asynchronous consultation, and the posting of medications (Women on Web, n.d.; Parsons and Romanis, 2021).

The services introduced in England and Wales in response to the pandemic were closer to the latter. BPAS (2020), for example, introduced its ‘Pills by Post’ service to allow for remote consultations and postal delivery of abortion medications. The patient makes initial contact by telephone call or completing an online call back request form. During this call, a consultation is booked. The consultation may then take place by phone call or video call – or, in some less conventional cases (examples of which will be discussed shortly), through an online

messaging service. A 'scan as indicated' policy was adopted, removing the standard requirement for an ultrasound scan where gestation could be reliably ascertained based on last menstrual period. Compulsory safeguarding proformas, whilst taking place remotely, remained as thorough. There was, indicative of a cautious approach on the part of the provider, an increase in enhanced safeguarding risk assessments (British Pregnancy Advisory Service, 2020: 5) and additional safeguarding practices for under-18s were introduced (British Pregnancy Advisory Service, 2020: 4).

With some minor variation, the TEMA care pathways setup by the other providers are almost identical. As such, they are not unlike telemedical models introduced across healthcare early in the pandemic (Hincapié et al., 2020).

3.2. Design

We were seeking detailed, rich understandings of the views and experiences of stakeholders in relation to our research topic, to which qualitative methods naturally lend themselves (Bowling, 2009). As such, we employed a qualitative study design using semi-structured interviews. Semi-structured interviews were chosen to strike an important balance between the production of a detailed account of a participant's views and experiences and answering the underlying research question. The use of an evolving topic guide allowed participants to be led through relevant areas of discussion whilst affording them the freedom to detail their views and experiences in the way that feels natural to them.

3.3. Participants and recruitment

Given our focus on the experiences of abortion care providers, our inclusion criteria required that participants be:

- (a) a qualified healthcare professional involved in the provision of abortion care in England and Wales,

or

- (b) in a management role overseeing abortion care in England and Wales.

Whilst those in administrative roles at care providers would still have been party to the significant changes to care provision, they do not take on the same responsibility in relation to safeguarding.

In addition to fitting one of the above participant groups, all participants had to be able and willing to consent to participation and to communicate in English. Study resources did not allow for the use of an interpreter. However, the nature of our study population meant that it would not have been necessary – those in the two participant groups would be required to communicate in English as a necessary part of their employment.

Purposive sampling was used to focus on representing a range of professional perspectives within the study population – i.e., not prioritising doctors simply because they have a greater *legal* role in abortion care. We sought a range of perspectives including frontline healthcare staff and those with specific safeguarding oversight roles. This was important to enabling the identification of certain professional roles that were differently affected by the changes to care provision.

All participants were recruited through one of three abortion care organisations/providers: MSI Reproductive Choices (MSI), BPAS, and the British Society of Abortion Care Providers (BSACP; which includes some NHS providers). Recruitment was facilitated by a study collaborator at each site who identified eligible individuals based on the abovementioned inclusion criteria and made the first approach. The same person acted as study collaborator for MSI and BSACP.

As this study involved human participants, all necessary ethical approvals were in place before the research began. Ethical approval for this

study was granted by Durham Law School Ethics Committee (LAW-2022-03-03T15_00_18-fdgn34) and BPAS (2022/05/ROM).

Once all ethical approvals were obtained, participant information materials were shared with our study collaborators at each site for distribution amongst relevant staff/members. Distribution by study collaborators was at their discretion to suit the functioning of each site, but mostly consisted of all staff emails and direct approaching of eligible individuals. Potential participants then contacted the study team to express interest, at which point a more detailed participant information sheet was shared with them alongside an invitation to ask any questions they may have. Those who were then willing to participate had their eligibility confirmed before the interview was scheduled for an appropriate time.

Informed consent was obtained verbally at the beginning of each interview as part of the audio recording. After each interview, the audio recording was split into two files – one the verbal consent, the other the interview itself – which were stored separately. On completion of the interview, participants were provided with a £20 shopping voucher to thank them for their time.

3.4. Data collection

The abortion providers through which participants were recruited operate nationally rather than from a single geographical site. Indeed, with the move to telemedicine, many were working from home during the study period. As such, it was deemed most appropriate to conduct interviews remotely using Zoom videoconferencing – though only audio was recorded and used for analysis purposes. Remote qualitative interviewing has become more common since the beginning of the COVID-19 pandemic and is not considered to significantly impact on the quality or quantity of data (Krouwel et al., 2019).

All potential participants who expressed an initial interest chose to participate. Though that does not accurately reflect a dropout rate as we do not have data on how many were reached by recruitment efforts administered by study collaborators. Interviews took place between April and June 2022. Interviews with participants from BPAS began in May 2022, the slight delay being caused by the need for additional research ethics approvals in line with their institutional policies. The mean length of interviews was 53 min, with a range of 46–60 min. At the beginning of interviews, participants were informed that they could take a break or terminate the interview at any point without reason. Interviews were guided by a topic guide which was amended periodically throughout the data generation period in response to each interview. Examples of questions included on the first iteration of the topic guide include:

- Did you feel prepared for the change to TEMA?
- How have you found the transition to providing care remotely?
- Do you feel that safeguarding is easier or harder with TEMA?

We do not report on the occupational profiles of participants due to the high risk of deanonymisation. Participants span a range of specific roles within their organisations, with many being the sole holder of a position.

3.5. Data analysis

Our approach to data analysis was based on Braun and Clarke's (2006, 2019) account of reflexive thematic analysis. Following their outlined approach, this entailed data familiarisation, inductive coding, constructing themes, reviewing themes, and naming themes. The final stage of writing up the analysis is completed through this and other publications arising from the study.

The audio recordings of interviews were transcribed by an approved transcription service (UK Transcription, n.d.), being sent in small batches at regular intervals throughout the data generation period. All

returned transcripts were then checked for accuracy against the original recording and anonymised by a member of the study team.

An inductive, data-driven approach to coding was facilitated by Nvivo software (version 12). Nonetheless, whilst data driven, this was inevitably a subjective process (Braun and Clarke, 2021). Each transcript was initially coded by a member of the study team other than the one who conducted that interview, increasing the familiarity of all members of the study team with the data. Data familiarisation and initial coding took place throughout the data generation period with regular study team meetings to compare thoughts. This also enabled continued revision of the topic guide in response to discussion points raised by participants.

Following completion of the interviews and initial coding of manuscripts, the construction of themes began. This was a collaborative process taking place over an extended period, deepening our collective understanding of the data. Once we had developed candidate themes, we also hosted a thematic workshop. Researchers and practitioners with a range of expertise were invited to discuss the candidate themes, allowing us to refine them ahead of write up. We visualise the data analysis process in Fig. 1.

4. Findings

By the end of this analysis process, three main themes were generated in relation to safeguarding and the transition to TEMA: (1) a challenging backdrop and resulting apprehension, (2) adaptive practices, and (3) the continued importance of professional curiosity. Within each theme there is considerable depth and breadth of views and experiences of participants – we highlight where there is divergence in perspectives.

In our presentation of themes here we purposefully omit the views and experiences of participants as they relate directly to the question of safeguarding those under the age of 18. Our focus is instead on adult safeguarding. A discussion of our findings relating to safeguarding those under the age of 18 and whether it is rightly considered distinct from the approach to adult safeguarding in abortion care is published elsewhere (Romanis and Parsons, 2023).

4.1. A challenging backdrop and resulting apprehension

Many participants spent considerable time reflecting on the broader backdrop against which any safeguarding within TEMA care pathways was taking place in the time preceding their interview. This backdrop

was presented as substantially complicated given the COVID-19 pandemic, which was the catalyst for the policy changes and resulting digitalisation in this area of care (as detailed above). There was a sense that “[t]elemed was throw upon us” (SP07) such that providers had to “hit the ground running” (SP05) and that “[i]t was like really all hands on deck” (SP01) given how quickly the changes came about. Whilst these organisations may have had long-term ambitions to introduce TEMA, it was wholly down to the pandemic that this digitalisation took place when and how it did. Participants here reflect the sense of urgency and ‘forced transition to video visits’ felt in other areas of healthcare during the early stages of the pandemic (Mann et al., 2020: 1133).

This overnight change in the regulatory landscape to permit TEMA gave rise to mixed emotions. On the one hand, the chance to introduce remote care pathways in a somewhat fast-tracked way relative to what participants anticipated would have been the reality without COVID-19 was highly favoured:

[I]t was an amazing opportunity and one that you’d never seen before in healthcare. Because healthcare – particularly NHS healthcare as well – is so slow. This would have taken 20 years, easy. This just would. (SP01)

Participants expressing this view generally felt that this digitalisation of abortion services had long been necessary and justified, hence their appreciation of the regulatory changes to allow it, even if not in the most ideal of circumstances.

Nonetheless, whilst not opposed to the regulatory changes on this basis, many participants did highlight how the speed with which they were expected to introduce changes back in 2020 was hugely challenging. It was “hard work. Frustrating, at times” (SP07), with several participants voicing apprehension. Indeed, this was heightened by anticipation of the political backlash that ended up materialising, which was discussed in terms of an inevitability of abortion care.

Whilst challenging, the process of achieving such significant changes in such a short period of time led many participants to express pride in being part of that. One described being “really pleased to be working in the sector right now, when this is happening. It feels quite exciting. It feels nice to be able to be part of that process” (SP02).

For some, however, the way in which their role in providing care changed left them feeling somewhat disenfranchised. SP09, for example, commented:

I felt like- not that I was becoming de-skilled, but it wasn’t necessarily the role that I’d put myself into when I wanted to qualify as a midwife. I didn’t want to be over the phone. I didn’t want to be doing

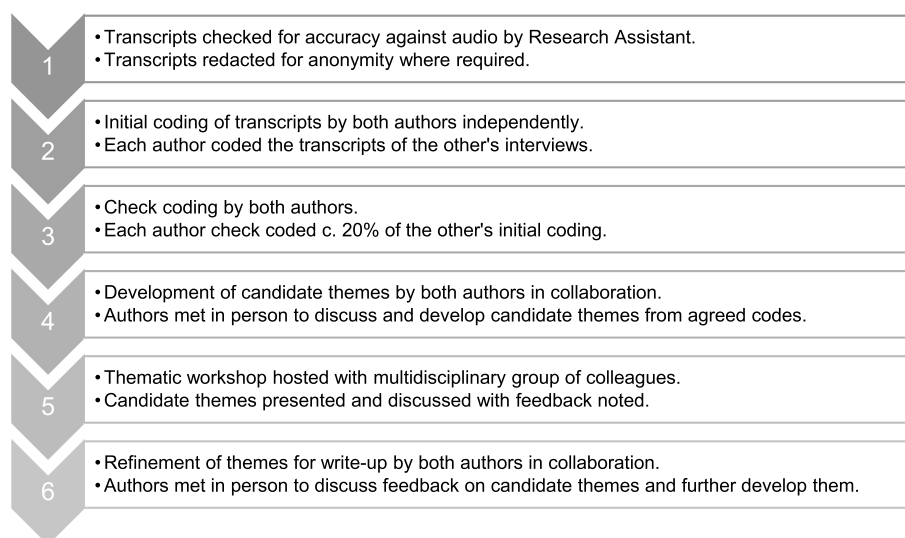


Fig. 1. Data analysis process.

stuff remotely. The reason I went into healthcare because I wanted to actually physically look after people and be with people, and I find that's part of my job that I love, that interaction, and things. (SP09)

There was acknowledgement, then, that such significant changes to care pathways can affect individual providers as much as their patients, and not always positively. Further, existing research indicates that members of staff not directly involved in the use of telemedicine amidst digitalisation may still have their work affected (Aas, 2001: 20) – such as those who may take on alternative work instead as part of a general restructuring. Whilst some enjoyed the flexibility of a more technology-led approach to care delivery and being able to work from home, which was not feasible for many participants under the previous regulatory landscape, others had a preference for working in a more traditional, in-person way. SP05 spoke of two colleagues that, in many ways, represent either end of this spectrum:

we had two counsellors and one absolutely hated going to not face-to-face and she left, whereas the other one, you know, it was like a duck to water and it suits her really well. (SP05)

Whilst some participants were, then, personally reluctant to see their professional role change so significantly, there was nonetheless a significant amount of enthusiasm from many. Such a mixture is not unexpected (Aas, 2001: 21). Regarding those on the reluctant end of the spectrum, some participants commented on “*colleagues who've struggled who don't like the video link. They much prefer telephone. They feel uncomfortable on it [the video link]*” (SP04). Another participant noted different reservations about video calling:

Our safety is as important as our patients'. For example, we only have our first names on our ID badges. We don't put our surnames on. We don't give out our full names. Definitely, video calling would be something that would worry me because of who might see me in the background. (SP12)

These comments indicate a level of specified resistance, whereby it is not the shift to remote care as a whole that some professionals struggle with but select aspects of digitalisation which are resisted. The implication being that it is the digital aspects that some participants disliked rather than providing abortion care and safeguarding remotely.

Amidst changes to care pathways for remote provision of abortion care itself, participants across providers spoke of how safeguarding took a prominent place in planning new care pathways from the beginning:

I think there was good importance and relevance placed on safeguarding, alongside the medical bits that we did. (SP10)

There was a sense that safeguarding was an important aspect of the new care pathways, with it being taken seriously to that point that there were “*some quite contentious discussions about how on Earth are we going to do this*” (SP01). That is, how safeguarding – which involves notably sensitive subject matters – might be effectively carried out via digital means without losing the human element. In other contexts, healthcare professionals have expressed concerns about the loss of personal connection during digitalisation, something they consider important to the professional-patient relationship (Gomez et al., 2021). However, the source of this importance was felt to be multifaceted. Participants highlighted the general importance of supporting vulnerable patients and a recognition that:

[w]hen it came to the implementation of telemedicine we had to review how we were safeguarding because obviously these weren't people that we were going to be seeing face-to-face. They were virtual consultations. And we needed to make sure that we were plugging any gaps in control that we might have had, you know, if we just were using the same process that we did for face-to-face clients. (SP06)

Nonetheless, at the same time, many commented on the need to centre safeguarding from the beginning for political reasons. SP03, for

example, commented on possible assumptions by those outside of care providers, which was largely felt by participants to be inaccurate:

[W]ithin the political sphere [...] there's maybe an assumption that we're not safeguarding people as effectively over the phone [or by videoconferencing]. But that's just a misunderstanding about what we're actually doing over the phone [or by videoconferencing]. The conversations we're having are much and the same. (SP03)

This came in part from a recognition of the anticipated different nature of remote safeguarding. SP06, for example, reflected on the potential limitations of existing safeguarding approaches to telephone consultations specifically:

I think the level of enquiry has been tweaked so that we get the right information. And that is because we are not seeing them face to face. [...] When you are seeing someone face to face you might see someone sitting there really scared. You will see facial expressions. There will be other cues. You are not getting that if you are on a telephone. You are just talking to someone. So that is why I think that the level of enquiry needs to be very, very comprehensive. (SP06)

This comment suggests that, for some providers, videoconferencing may be preferable to telephone consultation where remote care is being provided. Certainly, many participants expressed a preference for a visual element as more in line with what they were used to before digitalisation. That said, some also noted concerns regarding safety (like patients being able to see and record them, and potentially share that media) and so preferred the telephone for such reasons.

There was, then, an acknowledgement of the learning curve triggered by the introduction of telemedicine. It was “*more about training, at that time. Training and confidence. That's what that was*” (SP07). On the safeguarding aspect of changes in particular, one participant commented on how the whole country “*was just in this real state of flux*” (SP01) given sudden lifestyle changes such as working from home. This participant reflected on how such changes pervaded all areas of safeguarding – for example, children not physically attending school affecting established approaches to how teachers safeguard.

Participants, then, overwhelmingly felt that the sudden need for significant changes to the way care was provided and safeguarding carried out created a sense of mild frenzy and occasional apprehension. The challenging backdrop against which digitalisation took place applied not only to the medical aspects of the care pathway, but also, quite significantly, safeguarding.

4.2. Adaptive practices

Given the challenging backdrop against which telemedicine was introduced for abortion care, and the resulting changes in safeguarding approaches, many participants spoke of the importance of adaptive practice. This was framed in two ways: (1) initial adaptations to safeguarding proformas to allow for TEMA care pathways, and (2) continuous adaptation of such proformas as these care pathways were refined.

With the initial shift to TEMA, efforts to suitably incorporate safeguarding considerations were discussed at length. Such efforts consisted primarily of the development of “*telemed-specific safeguarding proformas that would guide your conversation a little bit more*” (SP09) and more specific training. This was out of recognition that conversations taking place via digital means rather than in a more traditional in-person consultation – or even just via telephone – would not allow for safeguarding in exactly the way existing proformas were designed. Despite a recognition of the need for continuous adaptation, which will be discussed shortly, there was a clear focus on ensuring the approach to safeguarding in TEMA care pathways was as good as possible from the beginning. SP01 described wide-ranging efforts made to understand what might be thought of as best practice at the time changes were being introduced:

[I]t was looking at the Royal College of GPs, where they'd already tested doing some telephone consultations and safeguarding. You know, just really going away and looking about how that looks in Australia and New Zealand, in GP land, what does that look like, and really just trying to draft something for safeguarding that felt as safe as possible (SP01)

Some acknowledged the underlying purpose of amendments to existing safeguarding proformas (i.e., for in-person care delivery) in meeting the needs of a new approach to care delivery. SP10, for example, spoke of how they were “*modified to suit our current needs*” in being able to “*ensure that they're [the abortion seeker] in a safe place, that they're happy to speak, and that there are no immediate concerns*”.

In seeking to meet this need of high-quality safeguarding carried out remotely, participants reflected on a range of creative approaches. Again, drawing on other contexts, SP11 described the possibility of safe words such as the ‘Ask for Angela’ system. ‘Ask for Angela’ is a codeword-based safety initiative in the UK whereby people in pubs, clubs, and bars ‘who feel unsafe, vulnerable or threatened can discreetly seek help by approaching venue staff and asking them for ‘Angela’” (Metropolitan Police, n.d.).

There might be something like that we can say that, you know, “if you're worried and want to talk to us privately, just use this phrase, and we will pick that up”. (SP11)

The implication being that a professional cannot be sure that the patient is alone when the consultation does not take place in person. On a video call, for example, it would be feasible that the patient's partner is watching them from behind the laptop – a possible drawback of digitalisation both in terms of safeguarding and confidentiality more generally.

An especially creative use of digital means to conduct abortion safeguarding was reported by some participants – a webchat system. We must note that the two instances highlighted did not concern adult patients, but we include them nonetheless as they speak to the broad – and more unexpected – benefits of digitalisation in abortion care. One described how a teenager was communicating on the webchat using emojis:

She was just showing us how upset she was about the pregnancy, using a tear face. Then, towards the end, as we were managing to get things sorted out for her, because she was saying she just couldn't leave the house, but she'd got this window when she was going to be in school. We were working with her and really supporting her. The feedback from her, using webchat, just like, “OMG, thank you so, so much”. Then praying hands and, “I can't believe you're helping me”. (SP01)

Another highlighted the benefits of the webchat to support a patient with whom contact is lost:

[The patient was] messaging saying that they weren't safe. They were being held in this house with other people. The person was trying to stay online to them to get more information, and they dropped off. So, we got the URL and reported it to the police. (SP02)

These two examples clearly demonstrate how digitalisation allowed for improved access to care and, by extension, improved safeguarding. Both patients were unlikely to have accessed care had it only been available through the traditional, in-person route. Further, it was the quick thinking and adaptive approach of the professionals in these scenarios that enabled the patients to be supported. The second in particular – had the healthcare team not thought to use the URL as a means of locating the patient, the patient may have continued in their abusive situation.

Many participants stressed the importance of one particular aspect of TEMA-specific proformas from the very beginning of the changes, that being providers reserving the right to ask a patient to come in if there are concerns:

If there are any concerns that we're not dating her [pregnancy] safely, any concerns about safeguarding, then they will be asked to come in for a scan and then a face-to-face discussion. (SP04)

Participants who spoke of the need for such discretion on the part of individual care providers did so in terms of both safeguarding the patient and affording the provider confidence that the care being provided is appropriate. For example, as discussed above, the risk that a coercive partner is behind the laptop during a video consultation, or, on appropriateness of care, a desire to confirm that a pre-existing condition is not a matter of concern in choice of abortion method.

These wide-ranging efforts in adapting to remote safeguarding were thought by many to have paid off in creating a suitably robust approach to TEMA safeguarding. SP18 here echoes a perspective shared by many participants:

[I]t worked very well because we were absolutely stringent in how it would be managed with our safeguarding clients, and just putting the extra tier of questioning and professional judgement. (SP18)

Indeed, many spoke of an overall sense of purpose amongst their colleagues that the standard of safeguarding within the new TEMA care pathways was high relative to other areas of healthcare.

I think there was a desire for us, and there still is a desire for us, to ensure that our safeguarding processes are right up there. They absolutely meet best practice. (SP06)

However, on the matter of new training as care pathways were changed, participants had slightly more mixed views. Some explained that they had received no specific training on safeguarding within TEMA care pathways:

[My employers] try and change the angle of their teaching every year, and I think something on telemed, virtual would be really helpful. So, no, we've had no specific training at all on safeguarding and telemed. (SP05)

In a similar vein, SP04 spoke of having to “*kind of make it up as I go along really*” (SP04). However, SP02 explained that “*we have training as well [as proformas], to try and pick up clues on the phone [...] that there might be coercion, or other factors going on*” (SP02). There were, then, different experiences of training during this process of digitalisation which may be attributable to myriad factors – not least differences between providers' approaches. Further, rapid implementation has been found to lead to minor shortcomings in training in other settings, such as where a London hospital introduced remote consultation for musculoskeletal physiotherapy during the COVID-19 pandemic and most staff felt there was a need for greater training (Shorthouse et al., 2021: 5) – as might very well be anticipated (Bishop et al., 2013).

Several participants spoke of colleagues who struggled with the transition, even with modified safeguarding proformas and additional training. For the most part, this was framed as “*purely a technology thing and fear of change*” (SP04). At least in the early stages of TEMA, some participants who hold more specific safeguarding roles acknowledged that “*it must have been a really, really hard time, actually, being frontline*” (SP01). Reflecting on their own experience in this regard, SP09 explained:

So, you would be doing something one week, and then in a couple of weeks' time, it would be like, “oh, actually, we've worked out that this is the better way to do it”. So, it was difficult to keep up with those changes, as someone who was working on the shop floor. [...] It did get a little overwhelming. (SP09)

Aside from initial efforts in adapting safeguarding approaches, participants spoke of the evolving nature of remote safeguarding following the introduction of TEMA. A dynamic approach was described, whereby things such as safeguarding proformas were continually revisited to ensure they were fit for purpose.

Proformas were changed constantly [...] Maybe every month, there was a new question added, or something taken away, to either cut down the time or to make sure that we homed in on anything that went wrong. (SP07)

A big part of this, for some, was the need “to make sure it was safe, or as safe as it can be” (SP18) given how novel the approach was to providers back in 2020.

Efforts were collaborative rather than a purely top-down revision process. For example, SP01 described the use of feedback workshops that allowed those directly providing care to feedback on their own experiences and what they had learned. The importance of this approach was partly badged to the reality that remote safeguarding – and, indeed, TEMA more generally – “was such a learning process when it started” (SP01).

Certainly, many participants voiced their support for some manner of case discussion for learning purposes. Several talked about patients they had supported and what they took from that process where it was not perfect. SP06 described how instances that resulted in a safeguarding referral were scrutinised for potential learning points, but also to identify good practice:

Every week, for example, we will share some high-profile safeguarding cases that we have picked up in the last week and we will celebrate the fact that we have actually managed it really, really well. And if we haven’t managed it really well then we will make some changes and strengthen, whether it is through improved education, training or in better monitoring for us. Or make some changes in our policy. (SP06)

Others spoke of how they examined not only the more challenging cases but also those that were more straightforward and perhaps entailed no safeguarding concerns.

I think there are always lessons that we can learn from every discussion we have, and thankfully, often, there are common themes there that we can draw lessons from and apply to the next case. (SP10)

As much as participants worked to ensure their approach to remote safeguarding was effective as soon as TEMA was introduced, there was a strong feeling that it being a moving picture was both inevitable and favourable. SP15 spoke of how “safeguarding will evolve continually as things happen” and that the result was that the service is “more robust now”. The ability to adapt to newly identified needs was suggested to be paramount even before TEMA when care was provided in person. Indeed, there was broader reflection from some participants about how safeguarding is never perfect. This was discussed in a comparative context, whereby it was suggested that even in-person safeguarding can overlook instances for various reasons:

[I]ncidents happen where safeguarding is missed or overlooked. Sometimes, because we have to rely on people telling us the truth, people don’t. That happens whether you’re face to face or whether you’re doing a telephone call or a video call, frankly. (SP14)

Given this, SP01 spoke in support of remote safeguarding in that “it’s good to have both, because then we’ve increased our chance of finding the situation that’s comfortable for that person”. This recognition that different people will engage with care in different ways was prevalent across participants as a perceived benefit of, and thus justification for, digitalisation in abortion care as an option.

4.3. The continued importance of professional curiosity

Throughout the various complexities of the shift to safeguarding during remote care provision, participants clearly expressed their view that a key part of high-quality safeguarding is professional curiosity. It was suggested that there are huge benefits to specific training and revised proformas, but that such instruments have their limits in what is

ultimately felt to be a human endeavour.

Safeguarding was framed as an ability to recognise where there may be a safeguarding concern and create an open environment in which the patient may feel able to disclose if they want – “you’ve got to empower her first” (SP08). This ability was felt to be something that comes with experience, such that training alone cannot equip a professional with all they need to effectively safeguard. Indeed, many framed this in terms such as a “gut instinct” (SP01), “a bit of a feeling” (SP03), and a “Spidey sense” (SP05) that comes with time. SP14 summarised a breadth of feeling amongst participants as to the nature of safeguarding in practice:

[I]t’s a subtle art, isn’t it? You know, it is an art to this, that I think it is overwhelming when you first start because you think, “oh, it’s just a bunch of questions”, but actually, it’s a huge topic and you’ve got to be really skilled at doing that. (SP14)

There was recognition that this view of safeguarding as something somehow innate may seem very particular and limited in scope. Commenting that “sometimes you just have a vibe where you’re just a bit more worried”, SP04 observed that such an approach is “not scientific”. But in refining this intuition-based practice, participants strongly emphasised the importance of experience. Reflecting on a complex case they had been involved in, SP19 discussed feeling the benefits of experience:

[W]ould I be able to have done that when I first qualified? Probably not. I think, as I’ve got a little bit older and I’ve learnt from things like serious case reviews. (SP19)

Indeed, many spoke of reviewing past cases as a learning process. Some also noted the importance of good mentors in developing their skill for safeguarding. SP14, in particular, spoke highly of a colleague from whom they learned a lot:

I think I was lucky, when I was training, I was mentored by some people who were absolute masters at this, you know, who would just have these lovely, happy, little chats and it would seem like a lovely, friendly conversation, but, actually, what they were doing within that was this really deep exploration of safeguarding issues or medical issues. Yes, I was very lucky in my training to have some people who were absolute masters at that. (SP14)

Training, then, was viewed more as an important starting point whatever medium care is being delivered by. Whilst there may be perceived limits to training and proformas, the benefits of them were highlighted, with many participants acknowledging that training contributes significantly to the development of effective safeguarding skills.

Obviously, you definitely need the training, but then sometimes it’s not until you have a patient in front of you and they’re telling you all these things. (SP12)

The question was more, then, about whether these instincts already developed by healthcare professionals were similarly effective in providing care remotely. For example, could they still get a sense that something was “off” during a video call as compared with an in-person consultation.

Those involved in safeguarding referrals and training directly expressed pride in their staff being “particularly highly trained” (SP06), such that they “train everybody to level three, which is higher than what’s expected” (SP20).

Some participants spoke of what training might be able to add to a provider’s approach to safeguarding. SP15, for example, favoured a more conversational approach to safeguarding questions, which they felt to be more appropriate than a quick, staccato questioning manner.

I listen to other practitioners doing their [telephone and video] calls, and there are some that are very, boom, boom, boom, boom, boom. Very straight, “well you’ve said that and you’ve said that”. And I don’t actually think they probably get as much of that information out of that woman as potentially maybe I could because I’ve done it a little bit softer. (SP15)

Others spoke of how training might address how, during remote consultation, to “*pick up clues on the phone [...] that there might be coercion, or other factors going on*” (SP02). Certainly, this view went alongside the suggestion that any safeguarding instinct was actioned by way of professional curiosity in asking follow-up questions that may not feature on a proforma.

I would say my questions are almost like just a starting point, a guide, and then we've got to use our professional judgement, our training, or our knowledge to ask further questions around that, and then maybe further assessments as to what we need to do then when this patient leaves the clinic. [...] It's not just a set of tick-box questions. (SP12)

To that end, then, training and proformas were thought of as jumping off points. From them – and through experience – a professional can develop more of an instinct for when “*all is not well*” (SP17) by “*reading in-between the lines*” (SP06) and then proceed to go off-piste with safeguarding questions where deemed appropriate. Importantly, this learned skill was felt to be equally true of safeguarding remotely. Whilst it may entail a further learning curve, participants were, for the most part, confident that they could be as effective carrying out this aspect of their role remotely as in person.

I'm not depending on the physical appearance of the abdomen anymore because I haven't got that anymore. Everything else, I suppose your senses are trying to highlight other things I guess. (SP08)

The overall feeling was thus that professional curiosity remains an important and effective means of safeguarding post-digitalisation, but that there is a need for adjustment of approach to fit with these new means of care delivery. This, participants felt, could be supplemented by appropriate training and guidance.

5. Discussion

5.1. Contributions

Our findings highlight a range of important learning points in the continued move to more digital approaches to healthcare provision. In particular, the necessity of involving the healthcare professionals who will be expected to deliver new telemedical care pathways in their development, ensuring a collaborative approach that fosters vital buy-in. Whilst our focus in this study is on safeguarding within healthcare – and, as such, many of the takeaways relate to this – there are several key findings that relate to healthcare more broadly and how we approach increased digitalisation of healthcare provision.

First, safeguarding considerations. Participants strongly highlighted that safeguarding was another layer of complexity where digitalisation takes place, beyond questions of the safety, effectiveness, and acceptability of the abortion-specific element of new remote care pathways. This came as no surprise given the wider public debate that took place about abortion care throughout the COVID-19 pandemic (Romanis et al., 2021b; Parsons and Romanis, 2022). Such challenges have been similarly highlighted in relation to primary care. Dixon and colleagues, for example, reported GPs feeling that non-verbal communication in safeguarding identification was threatened with the loss of the consulting room as a private and confidential space (2022: e202). Further, some GPs considered their role to have become more lonely and less rewarding (Dixon et al., 2022: e205). Concerns have also been expressed as to the reliability of the technology and the risk of technical problems (Donaghy et al., 2019), which might be especially concerning if arising during a particularly sensitive discussion about a safeguarding issue – for example, internet signal dropping when a patient is describing abuse they have experienced, resulting in them having to be asked to repeat it.

In overcoming these challenges, participants highlighted the importance of learning from experiences from elsewhere in healthcare

and, more to the point, ensuring appropriate training to give staff necessary confidence in changes. Primary care was the main example explored, as well as international healthcare providers. Whilst recognising that certain aspects are specific to each area of healthcare – so the approach of primary care cannot necessarily be directly copied – there is still the opportunity to learn from what did and did not work elsewhere, possibly enabling the avoidance of obvious pitfalls. This may give professionals a greater confidence in the new care pathway as there is a sense that it at least draws on tried-and-tested models. Whilst some may still be wary of change, there being some evidential basis can at least satisfy the majority. Participants also spoke of drawing on existing practices more broadly, such as one who mentioned the ‘Ask for Angela’ campaign to address sexual abuse in clubs and bars. It is not, then, necessary to limit this research process to other healthcare settings. Indeed, where changes are more novel – as can more often be the case in healthcare where digitalisation is concerned – it may be more beneficial to research broadly and consider what might be adapted from an entirely different context. This is all about affording professionals greater confidence in the safeguarding aspect of their role and, in particular, the exercise of their professional curiosity.

Building on what can be learned from previous examples is the need for associated training for professionals. Given the loss of non-verbal cues that professionals previously utilised in identifying safeguarding concerns when contact is remote (and potentially non-visual), it is necessary that alternative approaches are explored, taught, and reflected on. This is ultimately about ensuring professionals feel as comfortable as possible carrying out their role in a new way that may feel quite alien to them. It can take a significant emotional toll if a professional fears that they are failing to identify instances of abuse. Such tolls may also be heightened in certain high-pressure contexts, as was the case during the COVID-19 pandemic (Shaukat et al., 2020). Telemedicine-specific approaches to safeguarding can reduce this by giving professionals the confidence that they are still able to identify safeguarding concerns, albeit in different ways. Certainly, this was something valued by participants who spoke about it.

The importance of drawing on existing approaches and providing training may be considered especially important where digitalisation is taking place very quickly. Whilst this does make it harder to develop evidence-based safeguarding training, the heightened apprehension associated with sudden drastic changes necessitates such leadership for the benefit of healthcare professionals as they make transitions in working practices. Particularly in certain healthcare settings where fast-paced, responsive change is not common – for example, changes within the NHS often take a significant amount of time. Thus, where the ideal of preparedness is not feasible, a swift, reactive focus on adaptation and training can help minimise the toll of the unexpected on professionals. As noted by Goddard and Patel, this must incorporate a ‘focus on organisational culture and staff wellbeing as integral to professionalism and central to patient care’ (2021: 951). Certainly, the importance of taking staff with you in such significant change cut across the views and experiences of all participants in this study.

Though any statement of the importance of this training must be appropriately caveated. Harteis and colleagues note that the development of training to support digitalisation ‘is based on the assumption that learning needs are well-known as well as foreseeable’ (2020: 4). In the case of safeguarding amidst the digitalisation of abortion care, there were significant unknowns. As recalled by participants, there were “*some quite contentious discussions about how on Earth are we going to do this*” (SP01). Because of the circumstances, there was not a lengthy development process for TEMA, but an overnight change in care delivery. Whilst it was understood that professionals would need to be supported in adapting to remote safeguarding, precise learning needs could not be said to have been well known. Another example, then, of the high-pressure situation introducing further digitalisation challenges.

A final point on safeguarding to consider is the role of professional curiosity, which was heavily emphasised by participants. An element of

instinct was highlighted, with the limits of proformas in the reality of care provision. Of course, this is not unique to the conduct of safeguarding through telemedicine. Where consultations take place within the clinical setting, a professional will still go beyond the proforma where there is an identified concern. However, in the TEMA context there is seemingly a heightened importance. With there being a greater element of the unknown during a remote consultation – recall examples such as a partner being in the room without the professional being aware – this professional curiosity becomes far more central to effective safeguarding.

We can conceive of this as articulation work (Strauss, 1985). That is, we are concerned with these scenarios wherein the healthcare professional ‘modifies action to accommodate unexpected contingencies’ (Star, 1991: 275). Our particular example of safeguarding in the TEMA context maps onto Hampson and Junor’s (2005) matrix of articulation work. Consider their fourth cell in which ‘invisible’ work meets ‘non-routine’ work. Hampson and Junor provide the example of the emotional labour in managing customer demands (given their concern with the customer service context). Tweaked just slightly, this holds true of managing a patient’s unanticipated needs, such as where there is an indication of a safeguarding concern. Where professionals consider safeguarding proformas to be limited and thus substitute them for their “Spidey sense” (SP05), the extent of adaptation sometimes constitutes invisible articulation work.

Thus, whilst digitalisation may have increased access to care and, by extension, access to safeguarding, it simultaneously presented a challenge for professionals so used to carrying out safeguarding face-to-face. Consider this alongside the potential for increased datafication alongside digitalisation and there is a risk of such work being underestimated to the point that professionals are rushed (Bain and Taylor, 2000; Hansen, 2015; Leonardi and Treem, 2020). Safeguarding undoubtedly forms part of the ‘arc of work’ (Strauss, 1985) in this context, but its proportion of clinical time may be less recognised by standard metrics under datafication. Such an eventuality was not recalled by participants. This may mean that they did not share these concerns over the monitoring of their time and feel sufficiently valued by their employer. Similarly, it might be attributable to the timing of our interviews amidst the changes. When the new care pathways are more established and participants are able to reflect, their views on this may alter. Nonetheless, there is this risk of undervaluing staff following datafication – whether in abortion care or other settings where safeguarding takes place.

Whilst not unanimous, then, participants largely agreed with what we find in the literature about quality equivalence between in-person and telemedical care (Cheshire et al., 2020).

Setting aside the safeguarding-specific points, participants highlighted the wider importance of staff buy-in where there are changes to care pathways. This is exemplified by the fact that shortcomings associated with a lack of consideration for staff and resulting resistance to change (Braverman, 1974; Shulzhenko and Holmgren, 2020) did not materialise in a significant way in this context – there was some resistance, but far less than might be anticipated of such a sudden and drastic change to working practices. Even if moves towards more digital healthcare are somewhat inevitable, learning from the COVID-19 experience – and particularly the experience of abortion care providers – is important *ahead* of changes, not after. Thus, there is a need for continued engagement with staff throughout the process of care pathway redesign. The benefits of such an approach are twofold: practically, it allows staff to highlight where proposed changes may need to be reconsidered based on their professional experience, and as a principle, it speaks to the importance of collaboration. Indeed, this level of engagement may even result in staff feeling pride for the changes, as was highlighted by participants in this study.

That brings us to the broader question of changes to the nature of professionals’ work and their response and adaptation to digitalisation. The immediate responses of participants to the changes to their working

practice were varied in ways that both map onto and suggest limits to Chen and Reay’s (2021) model. Recall Chen and Reay’s four stages to a process of professional identity restructuring:

‘(1) resisting identity change and mourning the loss of previous work, (2) conserving professional identity and avoiding the new work, (3) parking professional identity and learning the new work, and (4) retrieving and modifying professional identity and affirming the new work’ (2021: 1541).

Some clearly demonstrated the instant resistance anticipated by this model (Chen and Reay, 2021: 1564). SP09, for example, stressed that they went into a healthcare career to “*physically look after people and be with people*”, which they felt was lost in the move to TEMA. This was at least partly attributable to ‘digital competence’ (Shahlaei et al., 2020) in some instances, with participants noting that some colleagues struggled to adapt. Our study was not longitudinal and thus cannot confirm that participants that felt this way have now embraced their new way of working, but they had at least demonstrated the first of four stages early in the pandemic when interviewed.

For others, however, moving to TEMA “*was like a duck to water*” (SP05). Many participants embraced the new way of working with a certain pride. Even where they recognised the challenges in revising care pathways, they did not vocalise any opposition or sense of lost professional identity. It may be that by the point of interview they had already reached stage four, and with such surety so as to forget the extent of their earlier resistance. However, we can equally speculate that this was contributed to by the more political nature of abortion care (inevitable because there are vocal anti-abortion groups in this jurisdiction), such that those working in this area of healthcare provision sometimes simultaneously perceive themselves as campaigners. Certainly, ideas of abortion exceptionalism (Borgmann, 2014; Parsons and Romanis, 2021) pervaded participants’ views and experiences. The political nature of abortion care was strongly felt, such that some participants suggested the strong focus on safeguarding in the shift to TEMA was attributable to the need to appease certain political groups.

This being the case, it may be that the desire to further the political cause of abortion access is sufficient to somewhat bypass the stages outlined by Chen and Reay. Though it is also worth acknowledging that the extent of changes in the context of our study was less significant than in that of Chen and Reay’s. Their participants underwent rather more drastic reconfigurations of their job roles, whereas our participants continued in essentially the same role carried out by a different medium.

Whatever the explanation, this variation in participants’ experiences at least highlights the importance of remaining conscious of professional identity in considering staff wellbeing in an era of increased digitalisation. Some will need the space and support to adapt, whilst others may seemingly bypass ‘liminality’ (Beech, 2011) altogether. Increasing embrace of telemedicine necessitates being attentive to both those who take to change immediately and those who need additional support and time to adapt.

In a practical sense, being attentive to both groups might be achieved in the co-productive ways discussed by participants. For example, enabling people to share their thoughts on good practice, what they have learned, or what they are apprehensive about. A top-down managerial approach to such a significant change of care pathway presents a greater risk of disenfranchisement, even if based on adequate research on related practice changes within other settings (such as general practice, in this case). For example, Chudner et al. (2020) noted primary care physicians in Israel finding that telemedicine affected power relations between them and management, feeling that the introduction of new technologies was purely to satisfy patients regardless of the views of physicians. Whilst such a view was not so articulated by our participants, those that commented on not wanting their job role to change did allude to a feeling of being a lesser consideration. Certainly, power dynamics can be affected by increased uptake of digital health technologies as something of an ‘unintended consequence’ (Ziebland et al., 2021).

Teething issues with increased digitalisation are likely to be specific to different areas of healthcare, and even different providers – hence abortion care providers still experiencing some issues despite having taken on board the prior experience of primary care. A collaborative approach that involves those delivering care on the frontline may be more successful. Certainly, participants spoke positively of case review meetings as part of an agile approach to implementing broader change. Moreover, many spoke about the sense of pride they got from being actively involved in making changes and supporting others through change. In the context of this study, it was clear that this pride was a significant part of why providers felt so strongly about the benefits of the change.

What should not be forgotten, however, is that even with these more co-productive approaches to change, drawing on existing evidence and developing appropriate training, some staff will remain resistant. In the move to more digital healthcare provision, some will continue to prefer the in-person interaction of their work, and this will be important to their wellbeing. To the extent that having no option but to continue in a role where interactions with patients are fully remote may cause some to leave the profession (Salisbury, 2021). Depending on the nature of changes in a given situation, accommodating this may not be feasible, but in some settings, there may be scope for some roles to remain wholly in person. Either way, the continued resistance of some staff also serves as a useful reminder that there will be similar resistance from some patients. Whilst telemedicine is great for some, there is a need to remain conscious of digital exclusion and the risk of leaving some patients behind. Within reason, remote care pathways ought to be supplementary and not total replacements for in-person provision (Parsons, 2021; Parsons and Romanis, 2021), rather than in-person care becoming ‘Option B’, as some have suggested (Duffy and Lee, 2018).

5.2. Considerations beyond the COVID-19 pandemic

Whilst this has been touched upon in our discussion thus far, it is worth briefly reflecting on the transferability of our findings beyond the pandemic context. This study was conducted both during and about the COVID-19 pandemic. As such, our findings naturally speak to how such a context affects a process of digitalisation and healthcare professionals’ experiences thereof. Nonetheless, they hold relevance more generally and, most usefully, provide an interesting means of comparison as digital working in healthcare continues to be studied.

Our above discussion speaks to a range of factors that might be important to consider ahead of any shift to greater digitalisation in healthcare. Things such as learning from experiences elsewhere, giving thought to the nature, extent, and timing of training for professionals, and seeking to understand the nature of professional identity restructuring as it might apply in a given setting. Cutting across all of these considerations is the central importance of a co-productive approach.

The time pressure of implementation during the pandemic precluded significant advance planning for abortion care providers, but they were able to incorporate co-production in the form of a process of continued development. That is, their staff were consulted on a continuous basis amidst the changes, enabling responsive adaptation as and when required. However, owing to the political aspect of abortion care we have discussed as it related to abortion exceptionalism, it seems that such a driving force was key to the expedited process of professional identity restructuring we have explored. In the absence of this somewhat unusual element of healthcare provision, a more pre-emptive approach is likely to be necessary to ensure staff buy-in. Employing co-production in any process of digitalisation in healthcare, then, seems to be a learning point that can be taken forward in almost any context.

Thus, whether there are similar time pressures and unanticipated complexities or not, the experience of abortion care providers in implementing telemedicine during the COVID-19 pandemic raises important points of reflection for future shifts to digitalisation in healthcare.

5.3. Limitations and reflexivity

This study offers novel insights into the experiences of healthcare professionals involved in a transition to telemedicine but there are several limitations to note. First, this study represents a snapshot of the views and experiences of professionals working (primarily) at two of the largest abortion care providers in England and Wales. As we did not recruit through the NHS, it is absent the perspectives of many of those providing abortion care in the hospital setting (though some were included), which we anticipate would have been rather different – not least because of the COVID-19 changes to the running of hospitals. That being said, the majority of abortion care in England and Wales is provided by independent organisations – 77% per the most recent statistics (Office for Health Improvement & Disparities, 2023).

Second, this study was not longitudinal, so we were not able to compare the views and experiences of professionals pre- and post-implementation of telemedical care pathways. It may be that the experience of the transition changed the views of some on both telemedicine generally and remote safeguarding specifically, but we were unable to explore this. Further, given the timing of our data generation was two years into the transition to TEMA, it may be that those who had particularly poor experiences of it had left their position by this point.

We acknowledge the possible bias present in this work based on the positions of its authors. Both authors have heavily critiqued the regulation of abortion care in previous research. Indeed, we are both supportive of the introduction of TEMA. We have also both worked closely with several healthcare professionals working within the organisations from which this study recruited participants. Whilst we see such interactions as having afforded us a greater insight into the context under investigation (Parsons et al., 2024), we recognise that it may have introduced a particular bias. Efforts to minimise this impact were made by both authors independently engaging with the data before discussing it together, which resulted in some slightly differing interpretations that were worked out through extensive discussion. Further, the thematic workshop mentioned earlier was another opportunity to have our interpretations queried by others working in this area.

5.4. Directions for future research

To build on the contribution of this study, we have identified three key areas for future research.

We noted a limitation of this study being that it is not longitudinal. However, even without an initial datapoint *before* TEMA was implemented, there will be benefits to a repeat study in several years. This will allow the longer-term perspectives of providers to be explored in relation to our key findings, conscious that this study was conducted amidst the COVID-19 pandemic and when the TEMA care pathways were still very new.

It would also be beneficial to examine these issues in other contexts to assess whether TEMA is in any way an outlier, with a particular focus on the political aspect. That is, whether areas of healthcare provision that are less political than abortion care can muster the same sense of camaraderie amongst staff when implementing drastic yet swift changes to working practices. We suspect that abortion care will prove somewhat unique on this front.

Finally, we suggest there is a need for research to consider the feasibility, effectiveness, and acceptability of coproduction approaches to digitalisation in healthcare when the transition is pressing. Whilst a situation quite as time-sensitive as the COVID-19 pandemic may not arise again for a generation, there are other reasons why changes may have to be incredibly quick. For example, a change to regulatory requirements. It will be important to understand how strong staff engagement with the development process might be achieved within tight time constraints and whether coproduction might be better utilised for continued refinement in such instances.

6. Conclusion

The introduction of TEMA was remarkably sudden in England and Wales given the pandemic context – other countries to permit such care pathways did so with more notice. This created additional challenges for care providers, being forced to adapt to significant changes far more quickly than would ordinarily be the case. This study explored the views and experience of those working in abortion care in relation to safeguarding within the new TEMA care pathways. As well as discussing the broader policy of TEMA and impact on patients, participants reflected extensively on the provider perspective – that is, the changing role of professionals and the impact of the transition process.

Several takeaways can be drawn from our findings and resulting discussion. Where there is increased departure from “traditional” in-person care provision, the involvement of professionals in the development and implementation stages is hugely important. This minimises the risk of disenfranchisement and strengthens good will, both of which can contribute to the success of change. Indeed, whilst participants in this study emphasised the value of training on new approaches, they were clear that this should not be unidirectional. As well as learning from those responsible for the design of new pathways, professionals can learn from each other, particularly in the early stages of a significant change as everyone is adapting and sharing their experiences. This can also create a sense of pride amongst professionals, such that they feel they are contributing and may, as a result, be less likely to experience innovation fatigue. Given the process of altering care pathways in this way lasts beyond initial implementation, the good will of those who will be required to put things into practice cannot be undervalued.

In addition to these more general learnings, we provide two novel understandings of digitalisation in the healthcare context. First, the impact of speed-associated pressures on professional adaptation during digitalisation. That is, the gradual process of professional identity restructuring outlined by [Chen and Reay \(2021\)](#) is interfered with by sheer limitations on time. Whilst somewhat unavoidable in the COVID-19 context, best practice in digitalisation moving forward ought to pace things in such a way as to allow this important, gradual process of acclimatisation and identity formation. Such a process feeds into that broader importance of employee buy in. Second, a recognition of off-proforma safeguarding through telemedicine as a form of invisible non-routine work. Professional curiosity is a vital part of safeguarding in practice, and increased digitalisation (as well as datafication) risks its value being undermined where it does not align with finance-driven metrics. The reach of this latter understanding may appear limited as safeguarding is not centred in other care settings as it is in abortion care. However, safeguarding remains a duty placed on all healthcare professionals, meaning its risk of being undervalued ought to be a point of caution where digitalisation takes place in any healthcare setting.

CRedit authorship contribution statement

Jordan A. Parsons: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Elizabeth Chloe Romanis:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Data availability

The authors do not have permission to share data.

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