Submission from Royal College of Obstetricians and Gynaecologists

As part of their inquiry into scientific developments relating to the Abortion Act 1967, the Science and Technology Committee invited comments on three areas. In response, the Royal College of Obstetricians and Gynaecologists is pleased to submit the following.

1. **THE SCIENTIFIC AND MEDICAL EVIDENCE RELATING TO THE 24-WEEK UPPER TIME LIMIT ON MOST LEGAL ABORTIONS, INCLUDING:**

1.1 **Developments, both in the UK and internationally since 1990, in medical interventions and examination techniques that may inform definitions of foetal viability**

1.1.1 The major development since the 1990 modification to the Abortion Act has been an improvement in the survival of babies born at 24 weeks. Table 41 provides data from 1995. This shows that 26% of babies born at 24 weeks survived to discharge. Additional data relating to 2006 will be available shortly when the results of the EPICure-2 study are published. However regional data from the Trent Survey (unpublished personal communication) suggests that survival in the last 10 years has risen to 40% of neonatal intensive care admissions at 24 weeks, although there has been little improvement in survival at gestations below this.

1.1.2 If the gestational age limit for termination of pregnancy under Clauses C and D were lowered this would be close to the gestational age at which detailed scans are undertaken to confirm or refute earlier findings. For example, fetal cardiac scans are frequently done at 22 to 23 weeks in women with a suspicious prior scan. This is because the images of the fetal heart anatomy are better at the later gestational age. Having a gestational age limit for termination shortly after the time of this detailed anomaly scan could have the effect of increasing the rate of termination if patients are not prepared to accept any risk. One of the advantages of late termination of pregnancy under Clause E is that patients with abnormalities of uncertain significance (e.g. mild ventriculomegaly) can continue their pregnancy until the prognosis becomes clearer, in the knowledge that late termination of pregnancy for a severe outcome will still be available.

1.1.3 The College has under frequent review its report on fetal awareness, and although this was published some time ago is aware of no new evidence relevant to alteration of current abortion practice as outlined in the RCOG Guideline *The Care of Women Requesting Induced Abortion*.

1.2 **Whether a scientific or medical definition of serious abnormality is required or desirable in respect of abortion allowed beyond 24 weeks**
1.2.1 There seems to be little reason to change the current law regarding the definition of serious abnormality. A strict definition is impractical for two reasons. Firstly, we do not have sufficiently advanced diagnostic techniques to always (i) precisely define the abnormality and (ii) predict the ‘seriousness’ of the outcome, albeit that the 1996 RCOG Report on Termination of Pregnancy for Fetal Abnormality provides helpful guidance on the scaling of severity. This states that both the size of the risk and the gravity of the abnormality are important.

1.2.2 Secondly, the outcome can have serious consequences not only for the fetus in terms of viability or residual disability (which can be physical, intellectual or social), but also for the child or for the family into which the child would be born. Thus a ‘serious abnormality’ should be based upon individual discussion agreed between the mother and the most senior clinician taking into account all clinical information available (obstetric and other relevant specialists e.g. paediatric) and the wishes of the mother (ideally parents). The difficulties in this area and the effects on the mother and the family require clinical care of the highest standard and experience.

2. **MEDICAL, SCIENTIFIC AND SOCIAL RESEARCH RELEVANT TO THE IMPACT OF SUGGESTED LAW REFORMS TO FIRST TRIMESTER ABORTIONS, SUCH AS:**

2.1 **The relative risks of early abortion versus pregnancy and delivery**

2.1.1 The evidence suggests that termination of pregnancy in the first trimester (done in an appropriate healthcare setting) is associated with a reduced mortality and morbidity risk compared to continuing the pregnancy. This means that women in the first trimester could be seen as automatically fulfilling the criteria of the Abortion Act. Although this was not the original intention of the Act, in practice it facilitates access to induced abortion within the current law.

2.2 **The role played by the requirement for two doctors’ signatures**

2.2.1 It is assumed that two signatures were put into the 1967 Abortion Act to show the seriousness of the decision to terminate rather than to maintain clinical standards. It may be appropriate to continue to involve two appropriately trained and experienced clinicians in more complex cases (e.g. late fetal abnormality, the very young and those with learning disabilities). However, the current use of the Abortion Act by the population and the profession (98% are done under clause C or D) suggests that, in the majority of cases, the need for two signatures is anachronistic. Overall, women support the right to abortion and the GMC guidance that alternative provision must be offered if the practitioner cannot support a request for abortion is evidence for the woman’s autonomy to seek help. The refusal to sign HSA1 does not prevent a woman from going to another provider for a signature.

2.2.2 The disadvantage of obtaining two signatures is that it has the potential to cause delay which can increase clinical risk. Women commonly have to find a
doctor who will refer and they may or may not provide a signature. Furthermore, some services send women back to their GPs for the second signature when the abortion has been granted. If the GP does not provide the second signature, this causes delay, which may cause additional stress to the woman who is already distressed. It does not make sense for the system to cause additional distress and delay unless there is a benefit in obtaining two signatures.

It has been argued that some delay is a good thing since it allows women more time to reflect on the decisions about abortion. There is good evidence that the vast majority of women who are referred for abortion are absolutely certain that the pregnancy is unwanted and have no doubts about wanting the procedure. This fact was clear even in the early 1980s when in an interview study of over 200 women undergoing abortion, only 6% said that they had been unsure of their decision and only 3% admitted to having wanted to conceive. Two more recent studies undertaken in Scotland using a validated measure of pregnancy intention and using either interviews or self-administered questionnaires have shown that 90% of pregnancies that end in therapeutic abortion were clearly unintended. The suggestion that the need to have two doctors sign the form would help those women who do have some doubt about abortion to make up their minds seems unpersuasive. If there are concerns that a few women who are unsure of the decision would ‘slip through the net’, the use of the simple intended-ness tool used in two of the studies would be a much more scientific and efficient way to identify women at risk of regretting the decision to proceed with abortion.

2.3 The practicalities and safety of allowing nurses or midwives to carry out abortions or of allowing the second stage of early medical abortions to be carried out at the patient’s home

2.3.1 Many hospital based abortion services already rely on nurses to run their medical abortion units. Allowing nurses to take consent for abortion (medical or surgical) would help to make these services run more efficiently. There is no reason why a properly trained nurse should not be competent to obtain consent to abortion, although this role should not be taken over by clinical ethics committees or bureaucratic review processes (as occurs in France, Israel and Western Australia). A recent Randomised Controlled Trial published in the Lancet has shown that first trimester abortion using manual evacuation can be provided safely by appropriately trained nurses. If medical abortion can be undertaken safely at home (see below), it can certainly be supervised by nurses.

2.3.2 Managing a woman in the abortion service requires a number of clinical skills which nurses have demonstrated in other healthcare settings. For example most services use routine ultrasound scanning to determine gestation and eligibility for medical or surgical abortion. Nurses are now trained to undertake these and other similar procedures (e.g. colposcopy and cervical surgery), which require similar skills and judgement.
2.3.3 Regarding abortion at home, there is an increasing body of evidence from both developed and developing countries that home use of mifepristone/misoprostol is safe, effective and acceptable to many women.\textsuperscript{8-12} More work is needed to assess safety and acceptability in the UK context, but this would require a change in the current law or a different interpretation of the abortion process within the current law.

3. **EVIDENCE OF LONG-TERM OR ACUTE ADVERSE HEALTH OUTCOMES FROM ABORTION OR FROM THE RESTRICTION OF ACCESS TO ABORTION**

3.1 There are a number of publications on the physical risks of abortion in the short and long term (e.g. infection, haemorrhage, injury, infertility, miscarriage, preterm delivery). There seems to be no increased risk of certain complications such as breast cancer. Many of the studies on outcomes have methodological problems, for example the patients studied are unrepresentative of the population, and it is often difficult to obtain an appropriate control group. These issues are discussed in the RCOG Abortion Guideline.

3.2 Adler gave evidence to the U.S. House of Representatives (March 16, 1989)\textsuperscript{13} in which she stated that studies demonstrate that the predominant feeling following abortion is one of relief and diminution of stress. The incidence of severe negative reactions is low, although some factors are known to increase risk (e.g. abortion when the pregnancy had been planned and late gestation abortion).\textsuperscript{14-15} Subsequent studies tend to support this view as indicated in the RCOG Abortion Guideline. Where problems do arise there is often a history of susceptibility which predates the abortion procedure. Again studies in this area suffer from a difficulty of adequate controls as clearly demonstrated in the recent New Zealand study.

4. **CONCLUSION**

The College does not feel the upper gestational limit of 24 weeks should be lowered on the basis of recent improvements on fetal viability. This would restrict the option of termination in some particularly difficult cases. The decision about the seriousness of the abnormality in a fetus is best left to discussion among parents and specialists. Practitioners no longer feel that the signatures of two doctors are necessary to proceed with an abortion. By and large long term follow up studies of physical and psychological sequelae, harmful effects or reproductive outcomes following abortion are reassuring. Furthermore there is no evidence that medical, as opposed to surgical methods, are different in this respect. The College is commissioning further work to update current guidelines which address a number of these issues, including fetal awareness and long term sequelae.

*September 2007*
<table>
<thead>
<tr>
<th>Outcome</th>
<th>22 Wk (N=138)</th>
<th>23 Wk (N=241)</th>
<th>24 Wk (N=382)</th>
<th>25 Wk (N=424)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>number (percent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Died in delivery room</td>
<td>116 (84)</td>
<td>110 (46)</td>
<td>84 (22)</td>
<td>67 (16)</td>
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<tr>
<td>Admitted to NICU</td>
<td>22 (16)</td>
<td>131 (54)</td>
<td>298 (78)</td>
<td>357 (84)</td>
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<td>Died in NICU</td>
<td>20 (14)</td>
<td>105 (44)</td>
<td>198 (52)</td>
<td>171 (40)</td>
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<tr>
<td>Survived to discharge</td>
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<td>26 (11)</td>
<td>100 (26)</td>
<td>186 (44)</td>
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<tr>
<td>Died after discharge</td>
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<td>1 (0.4)</td>
<td>2 (0.5)</td>
<td>3 (0.7)</td>
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<td>Lost to follow-up</td>
<td>0</td>
<td>3 (1)</td>
<td>25 (7)</td>
<td>39 (9)</td>
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<tr>
<td>At 6 yr of age</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Had severe disability</td>
<td>1 (0.7)</td>
<td>5 (2)</td>
<td>21 (5)</td>
<td>26 (6)</td>
</tr>
<tr>
<td>Had moderate disability</td>
<td>0</td>
<td>9 (4)</td>
<td>16 (4)</td>
<td>32 (8)</td>
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<tr>
<td>Had mild disability</td>
<td>1 (0.7)</td>
<td>5 (2)</td>
<td>26 (7)</td>
<td>51 (12)</td>
</tr>
<tr>
<td>Survived without impairment</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a percentage of live births</td>
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<td>3 (1)</td>
<td>10 (3)</td>
<td>35 (8)</td>
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<td>As a percentage of NICU admissions</td>
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<td>3 (2)</td>
<td>10 (3)</td>
<td>35 (10)</td>
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<td>Survived without severe or moderate disability</td>
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<td>As a percentage of live births</td>
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<td>8 (3)</td>
<td>36 (9)</td>
<td>86 (20)</td>
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<tr>
<td>As a percentage of NICU admissions</td>
<td>1 (5)</td>
<td>8 (6)</td>
<td>36 (12)</td>
<td>86 (24)</td>
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</table>

* NICU denotes neonatal intensive care unit.
REFERENCES