Memorandum 22

Submission from Dr Vincent Argent

Summary of Main Points and Recommendations

Two Doctors' Signatures – HSA1 form – Certificate of Opinion

1.1 The need for two signatures is often mismanaged and doctors' are uncertain about the law of conscientious objection. For abortions under 12 weeks, the requirement should be abolished or replaced by two registered nurse signatures.

Nurses carrying out surgical abortions

1.2 Evidence from America and elsewhere shows that trained nurses can provide a safe and effective early surgical abortion service.

The law is unclear and there needs to be clarification of the current advice.

My opinion

1.3 In addition, I am of the opinion that the following changes should also be made:

The 24 week upper time limit for Grounds C and D (Section 1(1)a) (the ' social grounds ') should be reduced to 16 weeks. Abortions over 16 weeks, up to term, may still be permitted under Grounds A, B and E (Section 1(1)b, c, d.

Serious abnormality should be clarified either with a scientific definition or a statement that this can be left to a decision reached between the patient and her medical advisers.

Providers and Training

1.4 This Inquiry does not deal directly with issues of access, training and providers. This issue is important as there are problems with access and medical practitioners unwillingness to participate or be trained in abortion practice. Law reform may aid improvements.

General Comment on the Abortion Act 1967

1.5 The Abortion Act 1967, as amended by the HFEA Act 1990, needs to be reviewed in the light of modern practice and needs to reflect the views of modern society. Unclear areas, such as conscientious objection, need to be clarified. The debate is often monopolised by pro-choice or anti-abortion lobbyists but reform should reflect the pragmatic views of the public and professions.

My Role

1.6 I am a Consultant Obstetrician and Gynaecologist. I have worked as the lead in Sexual and Reproductive Health at East Sussex Hospital and Addenbrooke's Cambridge University Teaching Hospital. I have been Medical Director of bpas and still do sessions for the provider.

I am an acknowledged and published authority on abortion practice and abortion law. I am a Faculty of Family Panning and Reproductive Health Care accredited trainer in abortion care.

I have an interest in academic medical law and have been a medical law lecturer at the Universities of Warwick, Brighton and Cambridge.

Recent activities (2006 – 2007) include:

Adviser to Department of Health Working Party on Late Abortion
Adviser to National Patient Safety Agency project on abortion complications.
Author of draft Consent to Surgical and Medical Abortion Advice from the Royal College of Obstetrician and Gynaecologists.
Peer Reviewer RCOG Guidelines: Care of Women Requesting Induced Abortion
Commissioned Reviews and Articles in the Journal of the Faculty of Family Planning and Reproductive Health Care:

Can nurses legally perform surgical induced abortion – Argent V, Pavey L. *J Fam Plann Reprod Health Care* 2007; **33**(2): 79-82

Abortion law: Campaign groups and the quest for change – *Argent V.* J Fam Plann Reprod Health Care *2006; 32: 215-217*

How can abortion be made simpler for women? – Argent V. *J Fam Plann Reprod Health care* 2006; **32**: 67-69

Accepted for review on the Journal (due for publication in January 2008) – will be subject to editorial review:

Conscientious Objection and Abortion (Copy attached (not printed))

EVIDENCE

Requirement for two doctors' signatures

2.1 The current requirement for two doctors' signatures on the HSA 1 Certificate of Opinion is often misinterpreted and abused.

2.2 The advice on conscientious objection is conflicting. Many GPs and hospital doctors refuse to sign the HSA1 form on grounds of conscientious objection. The BMA suggests that doctors' are under a legal duty to take part in the provision of the form and cannot claim exemption under the Janaway case. The BMA does, however, state that doctors with objection should be allowed to claim exemption from this duty. Legal authorities also suggest that exemption may not be claimed for signing the form. Doctors may claim exemption because the Abortion Act section 4 may have been amended by the Human Fertilisation and Embryology Act section 38 which allows conscientious objection to ' any activity '.[124]

2.3 Doctors may also refuse to sign the HSA1 form if they are of the opinion that the patient does not fulfil the requirements under section 1 even if they have no conscientious objection.

2.4 There are widespread variations in the actual provision of signatures. The author has observed the following practices - some of these may be illegal and they need clarification.

Signing batches of forms before patients are even seen for consultation.
Signing the forms with no knowledge of the particular patient and without reading the notes.
Signing forms without seeing or examining the patients.
Signing forms after the abortion has been performed.
Faxing the forms to other locations for signature.
Use of signature stamps without any consultation with the doctor.

The HSA1 form is often considered to be just an administrative process where doctors make no attempt to form an opinion, in good faith, that the patient fulfils the grounds of section 1.

2.5 These practices show that the HSA1 is often considered as a mere formality and abolishing this requirement should be considered.

2.6 In practice, many nurses carry out the whole of early medical abortions including consultation, treatment and after-care and the doctor merely signs

the form and never sees or has any involvement with the patient. Such practice is covered by the RCN v DHSS case, but it might seem reasonable to allow nurses to sign the HSA1 form.

2.7 These arguments are quite separate from those who consider that the requirement should be abolished, as the abortion decision should lie with the woman rather than her medical advisers, especially before 12 weeks.

Nurses carrying out surgical abortions

3.1 It has been suggested that the current law would allow nurses (and others) to directly carry out surgical abortions under the overall supervision of a registered medical practitioner even if the practitioner is not present throughout the entirety of the procedure.[125] The Department of Health, the Royal College of Nursing and others have suggested that the law does not, in fact, allow this.

3.2 There is evidence in the literature that nurses and mid-level providers can provide a safe and effective service surgical service using Manual Vacuum Aspiration (MVA) or suction equipment. Such practitioners have been trained to partake in this work.[126] Planned Parenthood of Northern New England is a major provider of abortion care in New England and has extensive experience of nurse surgical practice.[127] The IPAS abortion training system is well established.[128]

3.3 In other areas of medical practice, nurses are extending their roles and performing surgical procedures. In gynaecology alone, nurses now perform invasive surgical procedures such as colposcopy, hysteroscopy and transvaginal egg collection under conscious sedation. Most midwives now suture episiotomies and extended role midwifery practitioners now undertake low cavity Ventouse and forceps deliveries.[129] Many subspecialty groups such as the British Society for Colposcopy and Cervical Pathology (BSCCP) and the British Fertility Society (BFS) have specific sections for nurse practitioners e.g the BSCCP Training programme open to nurse and doctors[130] and the BFS Assisted Conception – Specialist Certification Course – this is a Royal College of Nursing Approved Professional Course.[131] These courses teach nurses how to perform invasive surgical procedures such as colposcopic biopsy and ovarian puncture for egg collection.

3.4 Training in surgical abortion practice could be achieved by allowing nurse practitioners to undertake Certificates 4 and 5 on Abortion Care of the Faculty of Family Planning and Reproductive Health Care (Manual Vacuum Aspiration and

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[125] Argent V, Pavey L. Can nurses legally perform surgical induced abortion? *J Fam Plann* Reprod *Health Care* 2007; **33**(2) : 70-82.

[126] Warner I, Merik O, Hoffman M, Morroni C, Harries J, My Huong N, et al. Rates of complications in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial. *Lancet* 2006; **368**: 1965-1972.

[127] www.ppnne.org

[128] www.ipas.org/Topics/Training.aspx

[129] Contact Royal College of Nursing – Nurses in Gynaecology Forum – Currently consulting on draft document for Nurses Working in Termination of Pregnancy (revision of 1997 guidelines)

[130] Becoming a trainee. British Society for Colposcopy and Cervical Pathology. www.bsccp.org/index.asp?PageID=49

[131] Assisted Conception – Specialist Certification Course of the British Fertility Society– Royal College of Nursing Approved Professional Course. www.britshfertilitysociety.org

Surgical Evacuation under 12 weeks) which are currently only open to doctors.[132]

3.5 Nurse surgeons usually work under guidelines and protocols with responsibility to, and overall supervision by, a medical practitioner. There may be concerns about the capability of nurse surgeons to provide a competent response to complications such as bleeding or perforation of the uterus. This can be addressed by ensuring adequate training, ongoing experience together with well-defined support and back-up from the medical team.

3.6 Nurses already run medical abortion services with very little input from doctors (apart from the HSA1 signatures and overall supervision). Current nurse led services are safe and effective and popular with women.

24 weeks upper limit – Grounds C and D – section 1(1)a

4.1 Grounds C and D under section 1(1)a are often referred to as the ' social 'clauses although this has no basis in the law. The majority of abortions are performed under ground C where there would be a risk to the physical or mental health of the woman.

4.2 In practice, many NHS abortion services have arbitrary upper limits of 12 – 16 weeks. This is because colleagues are unwilling to participate ion later abortions because of partial conscientious objection or, more often, because they just do not wish to get involved or have no interest in such practice. Few NHS surgeons possess the skills or experience to undertake dilatation and evacuation procedures after 16 weeks.

4.3 Recent public opinion polls suggest that the public would like to see improved and easier access for early abortion but that the upper limit should be reduced or that later abortions should be subject to greater counselling and stricter approval criteria. The BMA, the RCOG the Nuffield Council on Bioethics have addressed the problems surrounding later abortion.

4.4 The debate on the upper limit is often polarised between pro-choice campaigners who would keep the limit as it is and the anti-abortion activists who would like a drastic reduction in the upper limit.[133] A pragmatic middle of the road view, as demonstrated by public opinion polls, does not have a very strong voice.

4.5 In practice, it would seem reasonable to reduce the 24 week upper limit for section 1(1)a C and D abortions to 16 weeks. Abortions could still be approved over 16 weeks under section 1(1)a Ground B where the termination is necessary top prevent grave permanent injury to the physical or mental health of the women. Agreement to such abortions would follow improved in-depth counselling and a concerted effort to confirm that there is a risk of grave injury. (No limits would be placed on abortions sanctioned under Grounds A and E).

Definition of serious abnormality

5.1 Ground E abortions are performed when there is a substantial risk that the baby would suffer from such abnormalities as to be seriously handicapped.

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[132] Faculty of Family Planning and Reproductive Health Care. *Syllabus and Logbook for the Certificate in Abortion Care of the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists.* http://ffprhc.org.uk/pdfs/AbortionCareLogbook.pdf

[133] Argent V. Abortion law: campaign groups and the quest for change. *J Fam Plann Reprod Health Care* 2006; **32:** 215-217.

5.2 The Jepson case and others have suggested that such abortions are carried out for minor abnormalities which would not cause serious handicap and may be amenable to good results from treatment e.g cleft palate and lip.
5.3 There is no legal definition as to what constitutes serious handicap. There is no strictly parallel medical or scientific definition of serious handicap.
5.4 The legislators should decide whether there needs to be comprehensive guidance or a legal definition of serious handicap or whether the decision is best left to the patient and her medical advisers under guidance form the Royal Colleges.
5.5 In any case, such abortions may be approved, before 24 weeks, under Grounds B,C and D rather than E.

Providers and training

6.1 Concern has been expressed about the increasing unwillingness of obstetricians and gynaecologist and general practitioners to get involved in abortion practice.[134]
6.2 Subspecialty training in obstetrics and gynaecology has led junior doctor in training to choose more popular areas of practice such as infertility, cancer and fetal medicine. Increasing numbers of doctors cite conscientious objection for their stance. The provision of abortion services is no longer seen as an essential part of mainstream gynaecological practice.
6.3 For these reasons and also because of PCT contracts, NHS funded abortions are increasingly performed by the two charitable providers bpas and Marie Stopes. These organisations do not train junior doctors. In many areas, there are no opportunities or structure training programmes for abortion training.
6.4 Changes in the law, with regard to certification and involvement in surgical procedures, would permit nurses to run these services and improve access for women.
6.5 Each area should have a Consultant in Sexual and Reproductive Health as the lead for the abortion service and as trainer of staff.
6.6 The charitable providers should play a major role in the training of doctors and other health care professionals.

General Comment on the Abortion Act 1967

7.1 The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990, does not reflect the reality of modern abortion practice. The majority view in the UK supports the need for easier access to earlier abortion but stricter access to later abortion towards the gestational age of fetal viability.
7.2 The abortion debate tends to be polarised between pro-choice and pro-life groups and a pragmatic approach would be more useful.
7.3 Some areas of the law are unclear such as the protection given by the section 4 conscientious objection and whether this has been amended by the HFEA Act.
7.4 It would be reasonable to accept that current or amended law would allow nurses to undertake some surgical procedures.
7.5 There are widespread variations in the practice of obtaining signatures for the HSA1 Certificate of Opinion and some of these may not be lawful. Current practice suggests this is usually seen as an unnecessary exercise.

[134] Argent V. How can abortion be made simpler for women? *J Fam Plann Reprod Health Care* 2006; **32**: 67-6

7.6 There is a lack of clear legal guidance on some matters e.g the definition of seriously handicapped.

7.7 Recent statements from professional organisations such as the BMA, the GMC, the RCN and the NMC have attempted to clarify the law on abortion but also to recommend changes in the law.

7.8 The RCOG and Faculty of Family Planning have produced current updated guidelines and training programmes for abortion practice

7.9 The government has expressed the view that it does not wish to change the Abortion Act.

7.10 I am of the opinion that these changes and challenges merit a thorough review and modernisation of the abortion legislation.

September 2007