Required Standard Operating Procedures for Independent Sector Places for Termination of Pregnancy

Comments on the proposed draft

from

The Christian Medical Fellowship

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Reason for confidentiality:	

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The Christian Medical Fellowship (CMF) is an interdenominational Christian organisation with more than 4,000 British doctors as members, practising in all branches of the profession. Through the International Christian Medical and Dental Association we are linked with like-minded colleagues in over 100 other countries. CMF regularly makes submissions on ethical and professional matters to Government committees and official bodies.

Under Section 1(3) of the Abortion Act 1967 the Secretary of State for Health has a power to approve independent sector places as places where abortion can take place.

The consultation paper states that:

'*Approval of independent sector places are based on a core set of principles, the aims of which are to:*

- *Ensure compliance with all legal requirements*
- *Provide the best quality of care for women*
- *Provide sound management, organisational and clinical governance arrangements*.'[1]

(emphasis added)

Clearly it is essential that the RSOPs fulfil these requirements and that independent sector places are clear about all the legal requirements and offer the best quality care for women. If not, and the necessary changes are not made, their approval should be withheld or rescinded.

As the RSOPs are currently drafted, the legal requirements are unclear, they do not guarantee women are provided with the best quality of care and it is not made clear what is the procedure for investigation and action if the law is broken or care falls short of prescribed guidelines .

Question 1

Do the updated RSOPs include the necessary requirements to ensure women receive a safe, high quality, service from independent sector abortion providers which meets the requirements of the Abortion Act?

Please note that we have suggested a number of wording changes to several RSOP's and have put our proposed wording in red within the text for ease of reading.

RSOP 1:

We are very concerned with the following statement in RSOP 1:

'*We consider it good practice that one of the two certifying doctors has seen the woman, although this is not a legal requirement*.'

We are aware that the explanatory note to the Abortion (Amendment) Regulations 1976[2] allows for a doctor to state whether he has or has not seen and examined the pregnant woman. Nevertheless, we question how it can be ensured that doctors can form, and subsequently defend, their opinion regarding the request for abortion, in 'good faith', if they have never met the woman.

[1] http://consultations.dh.gov.uk/abortion-clinics/approval-of-independent-sector-places-for-the-term/consult_view

[2] http://www.legislation.gov.uk/uksi/1976/15/pdfs/uksi_19760015_en.pdf

In order to properly form an opinion in 'good faith' that a woman meets one of the grounds for an abortion, that can be defended, requires that at least one RMP will have seen and talked to the patient and given a medical assessment (as required under the 1999 RSOP4). (We comment further on the application and understanding of 'good faith' at Q3 below).

There is no procedure set in place in the RSOPs to follow up evidence and ensure that that an opinion made in 'good faith', especially one made by doctors who have not seen a woman, correctly meets the criteria of the Act.

It is also very poor medical practice – particularly with regard to a women's physical and psychological health - for her not to see a doctor at any point in the process. Induced abortion is a procedure with known contraindications and complications. Only a registered doctor will have the required training to ensure that a woman seeking an abortion is fully informed of the risks of the procedure, is properly cared for and that her request meets the requirements of the law. We would also submit that this was the intention of the legislators when the Abortion Act was passed.

Indeed, we recommend that women requesting an abortion under mental health grounds should be assessed by a medical practitioner qualified in mental health. The assessment that continuing with a pregnancy constitutes a greater risk to a woman's mental health than having an abortion is not easily made by those without mental health training. In fact the findings of the major 2011 Review by the Academy of Medical Royal Colleges into the link between abortion and mental health suggest that continuing with a pregnancy constitutes no greater risk to mental health than abortion. Put another way, abortion offers no **benefit** to mental health. Moreover, the Review recommends that: '*if a woman has a negative attitude towards abortion, shows a negative emotional reaction to the abortion or is experiencing stressful life events, health and social care professionals should consider offering support, and where necessary treatment, because they are more likely than other women who have an abortion to develop mental health problems*.' [3]

This raises a further point of consideration, in that if evidence does indeed increasingly suggest that abortion can cause greater harm to (some) women compared to continuing with the pregnancy, then permitting an abortion under Ground C could constitute a failure by RMPs to act in the best interests of women, which cannot easily be defended if an RMP has not seen the woman or does not have qualifications in mental health.

We therefore recommend that, in order to: '*ensure compliance with all legal requirements'*

[3] Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC). December 2011. http://www.nccmh.org.uk/publications_SR_abortion_in_MH.html

and *'to provide the best quality of care for women*[4], as the draft RSOPs state that they aim to do, RSOP 1 must make clear that at least one RMP must see the woman before signing the HSA4 and HSA1 forms:

We propose amending and incorporating the following wording for RSOP1:

If there is evidence that the certifying doctors have not formed an opinion in good faith, then the doctor performing the termination is not protected by the Act and has potentially committed a criminal offence by terminating the pregnancy. It is good medical practice, and clearly the intention of the framers of the Act, that at least one of the two certifying doctors has seen the woman, in order to obtain information specific to the woman seeking a termination as part of reaching their decision and for the RMP to have turned their mind to the particular facts of that case when forming their opinion. The RMP should have expertise in assessing mental health if this is relevant to the circumstances of the woman's health.

While the Act does not specifically state that the two RMP's must both see the woman, that is its natural reading and the intention of the legislators. It requires that both RMPs must be able to evidence how their opinion was formed in 'good faith' if asked to justify it subsequently, to avoid committing a criminal office. If a medical practitioner does not see the woman before performing an abortion, this may be illegal because it is incompatible with the legal requirement to form an opinion in 'good faith'.

The requirement about pre-signing HSA1 forms requires further clarity if abortion providers are to comply with the law.[5] If pre-signing forms is agreed to be 'incompatible' with the legal requirement to form an opinion in good faith, as the draft RSOP states, then this cannot be an 'unacceptable' practice but must be an 'illegal' practice. We have therefore amended the wording accordingly to the draft RSOP1:

'The pre-signing of HSA1 forms or "counter-signing" decisions of other doctors is illegal because it is incompatible with the legal requirement to form an opinion in "good faith".'

Given the apparent widespread incidence of pre-signing of forms, it must therefore be made clearer that pre-signing of HSA1 forms puts at risk the approval of the Secretary of State. We note that the CMO has made clear that: '*The pre-signing of HSA1 forms or "counter-signing" decisions of other doctors is unacceptable in this process and incompatible with the requirement to form an opinion in "good faith"…the Abortion Act places the responsibility for*

[4] http://consultations.dh.gov.uk/abortion-clinics/approval-of-independent-sector-places-for-the-term/consult_view

[5] There is, for example, a difference between pre-signing a form, counter-signing a form and un-evidenced signing of forms.

reaching a decision in good faith on the two doctors alone.'[6]

We propose incorporating the following wording for RSOP1:

'The pre-signing or un-evidenced signing of HSA1 forms or "counter-signing" decisions of other doctors is illegal because it is incompatible with the legal requirement to form an opinion in "good faith". It is a criminal offence if the decision cannot be proven to have been made in 'good faith.'

RSOP 2

While *RCN v DHSS 1981* allows nurses to administer drugs for medical abortion, this judgement interprets the Act broadly. It permits a doctor to provide a nurse with the means to terminate the pregnancy, which does not then mean that the doctor has him/herself terminated the pregnancy (as is required under the Act). The treatment requires that nurses participate in procedures calculated to bring about a termination of pregnancy. However the 1967 Abortion Act itself does not specify that other persons than an RMP can undertake other actions.[7]

The RSOP must therefore make it clear that there is a **lack of clarity** in the legislation on the role of nurses and midwives as this may be open to future challenge.

The draft RSOP 2 states that the Abortion Act requires that: '*Certain actions may be undertaken by registered nurses or midwives (who are not RMPs) provided they are fully trained and the provider has agreed protocols in place*.'

However this requirement for registered nurses or midwives to be fully trained or for protocols to be in place is not actually part of the Abortion Act and we do not consider it to be *best* practice, nor provide the *best* care for women. This guidance must not misrepresent the legal requirements of the Act. Rather it must make it clear that training of nurses and provision of nursing protocols was not part of the Act. Nurses were originally envisaged only to play a very limited role in the abortion process with this being limited to pre and post treatment care.

We note that the 1981 Law Lords ruling makes provision for RNs, but not explicitly RMs and we have drafted our proposed wording below for RSOP2 accordingly .

There must be greater clarity within the RSOPs as to what is legally required under the Abortion Act and what is good, recommended, medical practice.

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[6] https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAttachment.aspx?Attachment_id=101755

[7] 'Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion **when a pregnancy is terminated by a registered medical practitioner** if two registered medical practitioners are of the opinion, formed in good faith…'
http://www.legislation.gov.uk/ukpga/1967/87/section/1

We propose the following rewording for RSOP2:

'The Abortion Act requires that only a registered medical practitioner (RMP) is permitted to carry out an abortion. The RMP must personally decide upon, initiate and take full responsibility throughout the process. The protection provided by a House of Lords ruling in 1981 does permit other persons to administer drugs for the termination under the authority of the RMP (specifically registered nurses) however the legality and extent of their role is not clear under the Act itself. It is not good medical practice to rely on other persons than RMPs and may be open to future legal challenge under the Act.

The Act requires that an abortion occurs in an approved place. However draft RSOP 2 undermines this statutory requirement by permitting women: *'to go home soon after taking the second tablet, to be in the privacy of their own home for the expulsion*.' The 'expulsion' is clearly a part of the abortion process so, legally, should take place in an approved place. This draft RSOP therefore weakens the application of the law and we do not consider it appropriate here.

RSOP 3:

RSOP 3 is welcome however it mixes a number of different needs together and therefore requires more clarity.

First, there is a need for provision of information before an abortion beyond just the common physical symptoms that can occur as a result of an abortion. Women must also be informed of the common mental health symptoms that can occur as a result of an abortion.

Second, there are two separate requirements for follow up, because the physical and psycho-social requirements for follow up are very different, thus requiring different approaches.

Women are likely to contact the place where they had their termination if they have concerns about physical symptoms following abortion. However women are less likely to return to the facility where they obtained the abortion for any emotional or psychological concerns. The requirements regarding both concerns are very different and we do not consider that an abortion clinic is an appropriate place to seek help for post abortion psychological concerns.

RSOP 3 must therefore inform women of alternative options and/or locations for post-abortion counselling, not just those offered at the location of the termination. Note that we have changed the word 'should' to 'must' in order to ensure good medical practice takes place.

We propose the following rewording for RSOP3:

All women must be informed of the most common physical and mental health symptoms

following an abortion.[8]

All women having an abortion must be able to choose to return for routine follow up for any physical symptoms following abortion, and a 24-hour telephone helpline should be available for use after the procedure.

All women having an abortion must be informed of all options available for post-abortion counselling from both the clinic and alternative counselling centres.

RSOP 7:

We welcome the guidance under RSOP7, which states that sexual intercourse with a girl under 13 is a criminal offence.

The guidance must similarly make clear that under the Sexual Offences Act 2003 the age of consent for sex is 16 years in England, Scotland, Northern Ireland and Wales.

Moreover, clear protocols, fully in accordance with the law, must be stated here, prescribing what staff must do if they suspect that the pregnancy may be a result of an act that constitutes an offence under the Sexual Offences Act 2003 (eg. child abuse, rape, incest, sex with a minor).

RSOP7 sets out some of the consent requirements for providers. However, as well as the requirements drafted, the RSOP must also make clear that fully informed consent must be given prior to abortion according the principles of the DH *Reference Guide to consent for examination and treatment* (2009). For example it is advisable to inform the person of any 'material' or 'significant' risks or unavoidable risks, ***even if small***, in the proposed treatment; any alternatives to it, and the risks incurred by doing nothing. The primary duty of RMPs is to their patient and they are responsible to their professional body under a strict code of practice. This will include professional judgement on whether any girl is 'Gillick-competent.

RSOP 10:

We welcome the provision of clinical pathways for women having an abortion for risk to physical health. However, the same requirement must **also** be put in place for women having an abortion under Ground C, for risk of injury to the woman's mental health.

It is important that all abortion providers ensure that there are clinical pathways in place for access to appropriate medical back up services for women having an abortion for risk of injury to her mental health, as well as with her physical health. This is especially important if a woman has a history of mental health problems prior to the abortion, if she is feeling pressure from a partner to have an abortion, if she is experiencing stressful life events, or if she has

[8] As outlined in the DH Reference Guide to consent for examination and treatment (2009). These principles should be summarised in the document.

negative attitudes towards abortions in general and towards a woman's personal experience of abortion. Stigma, the perceived need for secrecy, and lack of social support have also been reported to be important factors associated with poorer post-abortion outcomes.[9]

We propose the following additional wording for RSOP10:

'Where women are having an abortion under the grounds of risk of injury to physical health e.g. where a pre-existing medical condition may exist, then the provider must ensure that there are clinical pathways in place for access to appropriate medical back up services, if needed.'

'Where women are having an abortion under the grounds of risk of injury to their mental health eg. where a pre-existing mental health condition may exist, then the provider must ensure that there are clinical pathways in place for access to appropriate medical back up services, if needed.'

RSOP 11:

We welcome this requirement for women to be given impartial evidence based information (verbal and written). We propose several additions to it, in order to clarify exactly the information required:

The information provided about alternatives to abortion (for instance adoption and motherhood) must include referral and access to clear pathways for those who wish to make use of them.

The impartial evidence based information (verbal and written) that women must receive should also include information about fetal development relevant to the stage of pregnancy and also about the possible long-term consequences especially with respect to mental health, subsequent preterm birth and possibly breast cancer.

First, with respect to mental health, the Academy of Medical Royal Colleges Review in 2011[10] found that women who had mental health problems before abortion were at greater risk of mental health problems after abortion. It found that other factors are associated with increased rates of post-abortion mental health problems, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion, or experiencing stressful life events. The Review did not find that abortion improves mental health outcomes for women with unplanned pregnancies. This suggests that

[9] Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC). December 2011. http://www.nccmh.org.uk/publications_SR_abortion_in_MH.html

[10] Induced Abortion and Mental Health: A systematic review of the evidence - full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC). December 2011. http://www.nccmh.org.uk/publications_SR_abortion_in_MH.html

doctors who authorise abortions in order to protect a woman's mental health may be doing so illegally.

Moreover, a growing body of evidence suggests that women may be at an increased risk of mental disorders (notably major depression, substance misuse and suicidality) following abortion, even with no previous history of problems. Influential professionals not associated with vested interest groups opposed to abortion have recognised this growing scientific evidence. These include Dingle in Australia, Pedersen in Norway and Fergusson in New Zealand.[11]

Second, there are a number of methodologically robust studies which have investigated the association between abortion and subsequent preterm delivery and these add to the weight of evidence that there is in fact a strong correlation between abortion and subsequent preterm birth. Most recently, in 2013 a McGill University review of induced abortion and early preterm birth found '…*a significant increase in the risk of preterm delivery in women with a history of previous induced abortion*.'[12] A 2013 retrospective population–based case-control study using data derived from the Finnish Medical Birth Register found a 28% higher risk of an extremely preterm birth.[13] Space precludes extending this list even further but there are currently over 100 studies in the medical literature confirming this association.

Third, we note the admittedly disputed evidence that there might be a positive association between induced abortion and breast cancer. For example, a review of 68 worldwide studies since 1957 on the association of induced abortion and subsequent development of breast cancer found that 53 studies show an association, and 15 studies show no association.[14] A major Chinese meta-analysis published in February 2014 confirmed this link.[15] Women should at least be aware that this is a matter of ongoing debate.

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[11] Dingle, K., Alati, R., Clavarino, A., Najman, J. & Williams, G. Pregnancy loss and psychiatric disorders in young women: an Australian birth cohort study. *The British Journal of Psychiatry.* 2008.193, pp. 455-460. http://bjp.rcpsych.org/content/193/6/455.full.pdf Pedersen, W. Abortion and depression: A population-based longitudinal study of young women. *Scandinavian Journal of Public Health.* 2008. 36, 4, pp. 424-8. Fergusson, D., Horwood, L. & Boden, J. Abortion and mental health disorders: evidence from a 30-year longitudinal study*. The British Journal of Psychiatry*. 2008. 193, pp. 444-51. http://bjp.rcpsych.org/content/193/6/444.abstract

[12] Hardy, G., Benjamin, A., Abenhaim, H. Effect of Induced Abortions on Early Preterm Births and Adverse Perinatal Outcomes. *J Obstet Gynaecol Can.* 2013. 35(2):138–143. http://www.jogc.com/abstracts/full/201302_Obstetrics_5.pdf

[13] Räisänen, S., Gissler, M., Saari, J., Kramer, M., Heinonen, S. Contribution of risk factors to extremely, very and moderately preterm births - register-based analysis of 1,390,742 singleton births. *PLoS One.* 2013. 8(4):e60660. http://www.ncbi.nlm.nih.gov/pubmed/23577142

14 Epidemiologic Studies: Induced Abortion and Breast Cancer Risk. Updated August 2013. http://www.bcpinstitute.org/epidemiology_studies_bcpi.htm

15 Yubei Huang, Xiaoliang Zhang et al. A meta-analysis of the association between induced abortion and breast cancer risk among Chinese females. *Cancer Causes & Control* February 2014; 25 (2):227-236 http://link.springer.com/article/10.1007/s10552-013-0325-7

As we have already noted above under RSOP7, informed consent for abortion should follow the principles accepted for any other treatment in the NHS.[16] Thus it is advisable to inform the woman of any 'material' or 'significant' risks or unavoidable risks, even if small.

We propose the following additional wording for RSOP 11:

Women must be given impartial evidence based information (verbal and written) covering the following:

- *Alternatives to abortions (for instance adoption and motherhood)* with information on referral, access to pathways if required, and details of the emotional and financial support that is available.

- Women should receive information about fetal development relevant to the stage of her pregnancy and must be informed of possible risks with respect to her health, mental and physical, and subsequent preterm birth.

RSOP 13:

We welcome RSOP 13.

However it would be helpful for clarity to separate out the provision of counselling before and after an abortion, and to clarify the need for *independent* counselling.

We do not see the need to include an extract from the RCOG's 2011 clinical guidelines, as this is not their area of specialist expertise. It would be preferable to include an extract from the RCPsych or a counseling body with specialist experience and knowledge of this area, or the form of words we set out below.

Independent counselling should be provided separately from the providers of abortion and by specialist counsellors, trained appropriately and accredited for crisis pregnancy counselling. Counselling should provide the opportunity for women to explore fully all their options in order to help them make a decision that is fully informed in a reasonable time frame and without coercion.

We suggest including a form of words in this section to describe independent pregnancy counselling, such as:

'A non-directional confidential pregnancy counselling service that is devoid of any financial conflict of interests and which enables women to make informed and considered decisions in an environment where they feel supported. The person or entity providing the pregnancy

[16] as outlined in the DH Reference Guide to consent for examination and treatment (2009). These principles should be summarised in the document.

counselling service should not be employed by, or benefit financially from the provision of, any onward service, including: abortion, adoption or keeping the baby.'

The benefit of independent counselling is that even if a decision for abortion has already been reached it can help a woman to explore fully why she believes continuing with the pregnancy to be undesirable, and may help her to be more reassured in her decision afterwards. Such an approach also allows women the space and opportunity to consider other options before them.

We also recommend the following wording changes to ensure that this RSOP is adhered to, that counselling is non-directional and impartial, and that it is a part of the total care package for all women:

'All women requesting an abortion must be offered the opportunity to discuss their options and choices with a specialist accredited counsellor who is not directly employed by, or can benefit financially from the provision of, any onward service, including: abortion, adoption or continuing with the pregnancy. This offer must be repeated at every stage of the care pathway.

All women must also be informed of the options of post abortion counselling from both the clinic and other specialist counselling services. Post abortion counselling must be offered by specialist counsellors who are not directly employed by, or can benefit financially from the provision of, any onward service, including: abortion, adoption or continuing with the pregnancy.

RSOP 15

We recommend the following additional wording:

'on-site availability of a full-time specialist counsellor who is not directly employed by, or can benefit financially from the provision of abortion at the clinic'.

RSOP 25:

RSOP 25 is confusing. It would benefit from greater clarity as to what is required practice, what is recommended best practice, what is a statement of fact and what is simply received opinion. Moreover, guidelines for operating procedures are not the appropriate place to recommend further research (p28).

For example, RSOP25 fails to mention that the view, cited by the RCOG report and others, that fetuses up to 24 weeks are unable to experience pain is highly contentious and disputed.

This RSOP must be amended to reflect the full range of existing academic opinion and ensure that fetal analgesia is provided routinely for abortions in order that the fetus may be given the benefit of any doubt.[17]

Question 2

Are there any other RSOPs or requirements that you think should be included? If so, what are they, and why are they needed?

Yes.

1. The need for **informed consent** before an abortion decision is made must be clearly set out. Although we have made reference to this under RSOP7 and RSOP11 above we recommend that new RSOPs specifically state that:

- Informed consent for abortion should follow the principles accepted for any other treatment in the NHS as outlined in the DH Reference Guide to consent for examination and treatment (2009). These principles should be summarised in the document.[18]
- A woman should be provided with information sufficient to make a fully informed decision about which of the three options open to her she wishes to pursue (abortion, adoption or continuing with the pregnancy). All three options should be discussed with her, explained and substantiated with accurate information.

2. Routine record keeping of NHS number for each abortion should be put in place. There is a need for the proper identification of women on the HSA forms (their NHS numbers in particular) for future medical treatment and care, and for future long term research into the outcomes of abortion on these women. The use of the NHS Number is fundamental to improving patient safety across all care settings. However commissioned providers of abortion in England are not required to routinely record the patient's NHS number. It should be included in both HSA1 and HSA4 forms and in ***all*** patient records.

3. There is a need for proper evidence-based guidelines for authorising abortions on mental health grounds and concluding in any given case that continuing with a pregnancy constitutes a greater risk to a woman's mental health than having an abortion.

[17] Martin Ward Platt. 2011. Fetal awareness and fetal pain: the Emperor's new clothes. *Arch Dis Child Fetal Neonatal Ed* 2011;96:F236-F237 http://fn.bmj.com/content/96/4/F236.full

[18] Relevant principles relating to informed consent from the following documents should also be made explicit in the guidance: GMC : `0-18 Years: Guidance for all doctors' (2007) (Para 70-72, page 29) provides information for doctors dealing with young people and abortion and `Protecting Children and Young People' – The responsibility of all doctors (2012); BMA: 'Law and Ethics of Abortion'. Consent requirements for providers of regulated activities are also set out under regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and in a Supporting Note "Consent to Treatment and Care.

4. An RSOP should be included to address abortion on the basis of fetal sex, and make it clear that any clinics found to be performing abortions on the grounds of fetal sex are acting illegally and will have their approval suspended or revoked, pending investigation.

Question 3

Do you have any other comments you would like to make in relation to this consultation?

Yes.

The RSOP document fails to set out clearly the procedure for rigorous investigation, inquiries and suspension of or rescinding of approval, should clinics fail to fulfil the RSOP requirements or comply with the requirements of the Abortion Act 1967. The CMO's letter on 23 February 2012 clearly states that: '*Places approved by the Secretary of State must also continue to comply with Departmental guidance in the form of Required Standard Operating Principles (known as the Yellow Book).*

Failure to comply with or maintain the standards required by the Secretary of State will lead to a withdrawal of approval at any time during the approval period, and individual doctors may be referred to the GMC.'[19]

The DH guidance for filling in the HSA1 form clearly states that: '*Failure to meet the certification requirements or properly complete HSA1 may be a breach of the Abortion Regulations*.'

We recommend that this statement is therefore incorporated within the RSOP's, particularly RSOP 1 and 2.

We note again, as under RSOP1, that there must be greater clarity within the RSOP's as to what is legally required under the Abortion Act and what is good, recommended, medical practice.

Lastly, the definition of what constitutes a decision to authorise an abortion made 'in good faith' is contentious and may be difficult to enforce in law.

We therefore suggest it is timely to consult further on this requirement to ensure that it is a meaningful requirement.

[19] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215147/dh_132849.pdf

The CMO stated in 2013 that: '*In light of the statement from the CPS, DH will work with the GMC, British Medical Association (BMA) and the Royal College of Obstetricians and Gynaecologists (RCOG) to provide urgent guidance to doctors.*

In particular, the CPS statement highlighted the lack of guidance around how both doctors should go about assessing the risk to physical or mental health to the pregnant woman and the proper process for recording the assessment carried out. The Department agrees, and will address these issues in revised guidance, while also acknowledging the discretion allowed to doctors under the Act in reaching a decision in good faith and the role of clinical judgement.'[20]

We request that any further discussion on guidance on decisions made in 'good faith' must not be carried out internally. Rather it must involve wider consultation with all interested parties, as this is an issue of wide public concern and relevance. The meaning of the term 'in good faith' also lacks clarity in both statute and case law but is crucial in these discussions.

Finally, please note that nothing in this submission should be taken as evidence that we support the use of abortion as a solution to an unplanned or unwanted pregnancy. However the Abortion Act permits abortion in limited situations and was intended to provide some protection for the mother and unborn child. We therefore make this submission in order to ensure that the Abortion Act is properly upheld and that women who are considering abortion are offered adequate and appropriate information, support and protection.

[20] https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAttachment.aspx?Attachment_id=101755