CMF Submission to the Royal College of Obstetricians and Gynaecologists consultation on The Care of Women requesting Induced Abortion

On 14 February 2011 CMF became aware of the presence on the RCOG website of draft revised guideline on this controversial topic. They had been posted on 21 January and the deadline for the consultation was initially 18 February. The official CMF **blog** gives an idea of the subsequent political action which resulted in the deadline being extended to 25 February.

CMF made the following submission on 24 February. It is in the form of the RCOG's table, with detailed comments set against line numbers in their draft **guideline.** It will be helpful to have that document open alongside the CMF response.

PEER REVIEW COMMENTS

Name of peer reviewer: Dr Andrew Fergusson, on behalf of the Christian Medical Fellowship

Chapter	Line number	Comment
Title page	Title of guideline and cp 307-309	The very title 'The Care of Women requesting Induced Abortion' begs many questions, as from its very beginning the guideline fails to consider the ambivalent early feelings of many women with an unintended pregnancy. We appreciate (lines 307-309) that the RCOG defines its starting point (not touching on the prevention of abortion) but respectfully suggest that this choice of language betrays a mindset which closes the door to other options for many women. The woman may request an abortion, but does she really want it?
Development of the guideline	209-211	We question the impartiality of the consultation process. The Declaration of Interest form is so constructed that it appears that those who derive income from the performance of abortion need not declare it. Surely such a powerful financial interest should be declared?
	215-232	We question the impartiality of the group members. Of the 18 we understand that 11 are identifiable as 'pro-choice' – most notably the representatives from Marie Stopes International and BPAS; 2 are members of the Department of Health, 4 are difficult to categorise, and one is a media doctor. No one has qualifications in mental health, and there is no one from any group working to restrict abortion.
	242-247	Who were the peer reviewers and how were they selected? The 'consultation' has not been carried out in accordance with the government Code on Consultations 2008. It is said that this is by a professional body and not 'government' but in a (literally) vital matter, and as the draft guidance is 'supported by the Department of Health' (line 203), we argue that government standards should apply.

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		The 7 key criteria for consultations are: **'1. When to consult** Formal consultation should take place at a stage when there is scope to influence the policy outcome. ***2.*** **Duration of consultation exercises** Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible. *3.* **Clarity of scope and impact** Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals. *4.* **Accessibility of consultation exercises** Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach. **5. The burden of consultation** Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained. *6.* **Responsiveness of consultation exercises** Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation. *7.* **Capacity to consult** Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience. These criteria should be reproduced in consultation documents.' Given that the topic of induced abortion has such broad psychological, social, public health, and ethical aspects, we believe this guideline should have been consulted on in accordance with these agreed principles, particularly the first four.

Chapter	Line number	Comment
1. Introduction and methodology	274-276	Given the growing evidence of long term sequelae, particularly psychiatric ones (on which we comment extensively later) we believe that abortion data should be linked confidentially to the woman's NHS number, to allow long term record-linkage studies.
	291-293	This statement is a campaigning one and not appropriate in professional guidance said to be 'evidence based'. We note that BPAS, one of the groups represented in the drafting group, is already quoting the guideline in the national press in a way that implies it has been finalised.
	307-309	Given the loss of human life when '200,000 procedures are performed each year in Great Britain' (line 262) and the damage to women so underestimated throughout this draft guidance, surely this statement should also acknowledge the ambivalent feelings of many women who initially consider abortion? It should therefore mention counselling to enable any woman to make a fully informed choice.
	354-404	We are concerned at the evidence which has been ignored later in this document, and question selection bias arising from a prior ideological commitment.
	445-449	See comments above on 242-247. We trust that even if the consultation is not extended properly and carried out according to the government code, substantial changes will indeed be 'made to the document' hereafter.
2. Summary of recommendations	455-933	We respond to the detail of subsequent individual recommendations.
3. Legal and ethical aspects	1005-1007 and 1028-1029	Ground C. '…the vast majority (97%) of abortions are carried out under ground C'. The guideline however omits to add that in 2009 less than half of one per cent of ground C only terminations were reported as being performed because of a risk to the woman's physical health, implying that about 96% of all abortions are carried out on mental health grounds (1). And yet there is no evidence of adequate quality that not having an abortion leads to adverse mental health outcomes. The reverse is true. The vast majority of abortions in Britain are therefore illegal, according to both the letter and the spirit of the law. The Royal College of Psychiatrists' 2008 'Position Statement on Women's Mental Health in Relation to Induced Abortion' (2) states that 'additional systematic reviews led by the Royal College of Psychiatrists' are needed to 'consider whether there is evidence for psychiatric indications for abortion'. The jury is still out on this matter, and this should be made clear in the guideline. 1. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116336.pdf 2. http://www.rcpsych.ac.uk/rollofhonour/currentissues/mentalhealthandabortion.aspx
	1102-1104	'The data published is anonymised.' It is time to link abortion data with the individual woman's NHS number so

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		that long term record-linkage studies can be performed. At the 21 February 2011 RSPH/FPH consultation event on the Public Health White Paper, Dr Margaret Eames (Head of Public Health Intelligence at the Acorns Public Health Research Unit, previously Croydon PHI and Beds and Herts PHI Unit) asked the following question for which the answer is still awaited: 'The sequelae from Terminations of Pregnancy cannot be tracked in England at the moment, since ToP are only released as cross-sectional data – without use of the NHS Number. Nearly all other procedures commissioned by the NHS require the NHS number to be used for private procedures. There is evidence that ToPs are leading to higher risk of subsequent pre-term births (OR = 1.43) from other European meta-analysis. Differences in outcome between providers cannot be measured. Can we enable linkage to the female health record to be able to do this research on English women, as this is a rising PH issue? (With 200,000 ToP per year and rising pre-term births.)'
	1125-1127 (and 1518-1520)	This claim is untrue and must be withdrawn. (It is repeated at 1518-1520 and must be withdrawn there too.) It is unsupported by General Medical Council guidance in *Good Medical Practice* (3) and *Personal beliefs in medical practice* (4), and by clarification we have received from the GMC (5) 3. General Medical Council. *Good Medical Practice*. See paras 1, 7, 8, 21, 33 4. General Medical Council. *Personal beliefs in medical practice*. See paras 21, 22, and 26: **Care of patients pre- and post-termination of pregnancy** 26. Where a patient who is awaiting[10] or has undergone a termination of pregnancy needs medical care, you have no legal[11] or ethical right to refuse to provide it on grounds of a conscientious objection to the procedure. The same principle applies to the care of patients before or following any other procedure from which you have withdrawn because of your beliefs. Footnote 10 reads 'This does not include care which is necessary preparation for performing a termination'. Footnote 11 reads 'The case of Janaway v Salford Health Authority All England Law Rep 1988 Dec 1;[1988] 3:1079-84 set a precedent and defined participation as 'actually taking part in treatment designed to terminate a pregnancy'. 5. When GMC guidance (4) first appeared in 2008, CMF obtained clarification regarding conscientious objection in the question of abortion from the Chair of the GMC Ethics and Standards Committee, who replied as follows:

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		'You ask three specific questions about whether our guidance obliges doctors to provide particular services: 1. Will doctors be obliged to sign abortion authorisation forms? 2. Will doctors be obliged to clerk patients for abortion (i.e. carry out pre op examination and assessment)? 3. Will doctors be obliged to refer patients seeking abortion to other doctors who will authorize it? The answer to all three questions is 'no' – see *Good Medical Practice* and paragraph 21. Reading paragraph 26 in the context of *Good Medical Practice* and the preceding paragraphs of the supplementary guidance (particularly paragraph 21), should ensure that readers understand our intention in this guidance. This is to distinguish between doctors refusing to participate directly in, or facilitate the execution of, procedures to which they have a conscientious objection on the one hand, and on the other, refusing to provide any other care on the grounds that the patients concerned were about to undergo, or had undergone such a procedure. It is the procedure to which the doctor objects, not the patient.' (PDF of original GMC letter at *http://admin.cmf.org.uk/pdf/publicpolicy/2008-03-26-GMC_letter_to_PSaunders.pdf*)
4. Commissioning and organising services	1415-1417	This statistic about the role of the independent sector in abortion provision underscores our comment (lines 209-211) about members of the GDG not declaring substantial personal income from providing abortions (6). Any such financial conflicts of interest must be declared. _____ 6. Statistical Bulletin. Abortion statistics, England and Wales: 2009. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116336.pdf Table 1, page 10 lists the proportion of abortions in the independent sector, funded by the NHS, and those funded privately.
	1438	We agree that 'people faced with an unintended pregnancy need information on their options, including abortion'. Women presenting to many abortion services get on a conveyor belt with only one outcome. Much more attention must be paid to real crisis pregnancy counselling with genuine options (see comment on lines 307-309).
	1518-1520	See comment and references on 1125-1127. This misrepresents the GMC guidance and must be withdrawn.
	1545-1547 1555-1556	We agree that 'written, objective, evidence-guided information' should be provided. Regrettably, parts of this draft RCOG guidance are no basis for such.
	1565-1566	The paternalistic and abrupt wording here does not suggest anything approaching unbiased counselling, which

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		uses open questions and facilitates a genuine exploration of feelings.
	1568-1569	Regrettably, parts of this draft RCOG guidance are no basis for such.
	1646-1647	Ethically, the intentional ending of a human life, the possible major sequelae for the woman, and the legal requirement for 'two doctors [to] decide in good faith' are so significant that there can be no substitute for face to face consultation. This recommendation trivialises very major matters.
	1726-1728	We are concerned that any inappropriate emphasis on 'significant cost savings for the NHS' where abortions are performed before 10 weeks may result in pressure being placed on vulnerable women in the earlier stages of pregnancy.
	1782-1783 1795-1796	Again, these statements seek to change the law, and their inclusion is inappropriate in a document purporting to be professional guidance.
5. Side effects, complications and sequelae etc	1824-1825	This statement is disingenuous. While it might be true in relation to maternal mortality, it ignores morbidity and is far too simplistic a summary comment.
	1830	It is not enough to discuss 'the overall safety of the procedure'. Subsequent possibilities must be raised.
	1851	'…psychiatric morbidity…in the first six weeks'. The study quoted fails to consider the longer term which is where significant evidence emerges. Its selection here indicates an attempt to conceal longer term sequelae (7). 7. Coleman P K. Misinformation and Naivety on Abortion and Mental Health. National Review Online 15 November 2010. http://www.nationalreview.com/corner/253296/misinformation-and-naivety-abortion-and-mental-health-priscilla-k-coleman#
	1860-1867	We agree that perception of risk is important and that numbers are needed as well as words to communicate risk. Later in the draft guideline the RCOG fails to communicate the reality of some risks.
	1897-1898	'…the range of emotional responses' considers the short term only and trivialises the severe psychiatric sequelae some women experience.
	2062-2063 ff Breast cancer	The headline recommendation must be amended. It is wrong to inform women unequivocally that 'induced abortion is not associated with an increase in breast cancer'. Breast cancer rates have been rising in Europe and North America for several decades and are projected to rise further (8). There is evidence suggesting that having an abortion may increase a woman's risk of breast cancer in later life. A 1997 review that pooled 23 studies found that the risk increased by 30% (9). There are clearly powerful vested interests on both sides of this debate and space and the duration of this consultation preclude an in-depth review. However, it is undisputed that a full term pregnancy protects against subsequent breast cancer, and that significantly pre-term deliveries make it more

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		likely. The link is therefore biologically plausible. Were the RCOG to perform a genuine consultation, then global experts in this complex field would have proper opportunity to make a contribution, citing evidence which has otherwise been omitted. It is prudent to acknowledge that 'the jury is out', to seek further research (which would require record-linkage studies – see comment on 1102-1104) to conclude the debate, and in the interests of informed consent to offer every woman considering abortion as much information about the possible risks as she wishes. _____ 8. Carroll P. *Abortion and other pregnancy related risk factors in female breast cancer.* London: Pensions and Population Research Institute. 2001 9. Brind J *et al*. Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis. *J. Epidemiology and Community Health*. 1997; 50:465-467
	2136-2137 ff Subsequent preterm birth	We are glad the RCOG states that induced abortion is associated with 'increase in risk of subsequent preterm birth, which increases with the number of abortions' (10). However, we dispute the implications of the prior word 'small'. There have been many reputable studies investigating the association between abortion and subsequent pre-term delivery. Thorp *et al*'s detailed 2003 review analysed results for 24 published studies (11) and reported that 12 found a positive association with increased risk ratios which were consistently between 1.3 and 2.0. Seven published studies found a dose-response effect: the risk estimate increased with increasing numbers of induced abortions. Rooney and Calhoun's 2003 review (12) showed at least 49 studies had demonstrated a statistically significant increased risk of premature birth or low birth weight following an induced abortion. Again most studies showed a dose response relationship. Only eight failed to show an increased risk of preterm delivery, and none demonstrated any protective effect of previous abortion. This association is further supported by two more recent European studies – EPIPAGE (13) and EUROPOP (14). There are now at least 119 articles in the world literature attesting to this association, a 2010 US study adding further data (15), and it is significant for health outcomes in subsequent pregnancies and for their economic costs. Extremely preterm delivery is associated with high risk of neonatal death and of permanent brain damage causing

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		long term disability. Approximately 50% of all abortions in England and Wales are undertaken in women under 25, whereas 75% of all live births occur to mothers aged over 25 (16). Thus most women considering abortion will subsequently deliver one or more live children, who will face these risks. Women should be adequately counselled about abortion and risk to subsequent pregnancies. 10. Shah PS, Zao J. Knowledge Synthesis Group of Determinants of preterm/LBW births. Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analyses. *BJOG* 2009; 116(11): 1425–1442 11. Thorp JM *et al*. Long-term physical and psychological health consequences of induced abortion: review of the evidence. *Obstetrics Gynecology Survey*. 2003; 58: 67-69 12. Rooney B, Calhoun BC. Induced abortion and risk of later premature births. *Journal of American Physicians & Surgeons*. 2003; 8: 46-49 13. Moreau C *et al*. Previous induced abortion and the risk of very preterm delivery: results of the EPIPAGE study. *BJOG*. 2005; 112: 430-437 14. Ancel PY *et al*. History of induced abortion as a risk factor for preterm birth in European countries: results of the EUROPOP survey. *Human Reproduction*. 2004; 19: 734 – 740 15. Iams J D, Berghells V. Care for women with prior preterm birth. *American Journal of Obstetrics & Gynecology.* 2010; 203(3): 89-100 16. Birth Statistics 2005, Office for National Statistics, London
	2165-2166 ff Psychological sequelae	How is a woman being counselled to understand the word 'most'? This casual reassurance is inconsistent with the earlier recommendation to use words and numbers to communicate risk (see lines 1860-1867). Until recently, any association between abortion and mental health problems was effectively dismissed not as causal, but as incidental due to other confounders. But since 2000, there has been much evidence from robust and methodologically sound controlled studies that abortion does cause the following: Increased psychiatric hospitalisation – admission rates were higher post-abortion than post-partum when those with a prior psychiatric history were excluded (17); increased psychiatric outpatient attendance **–** outpatient funding claims were higher in the post-abortion group when prior psychological problems were controlled (18); increased substance abuse during subsequent pregnancies carried to term **–** women who had aborted were significantly more likely to abuse cannabis, other illicit drugs and alcohol during a subsequent pregnancy (19); increased death rates from injury, suicide, and homicide **–** a controlled study in Finland 1987-2000 (20); and

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		perhaps most relevant for UK comparison, a landmark 2006 New Zealand controlled population study (21) showed higher rates not due to prior vulnerability of major depression, suicidal ideation, illicit drug dependence, and overall mental health problems. Further findings were published in 2009 (22). There is also qualitative evidence from women's accounts, but quantitative evidence that abortion causes significant rates of serious mental health problems is now overwhelming. The Royal College of Psychiatrists is publishing significantly revised guidance (23) this spring. Surely, on such a vital matter, the RCOG should await the RCPsych guidance and amend this draft guidance in the light of that. _____ 17. Reardon DC *et al*. *Canadian Medical Association Journal*. 2003; 168 (10): 1253-6 18. Coleman PK *et al*. *American Journal Orthopsychiatry*. 2002; 72,1: 141-152 19. Coleman PK *et al*. *American Journal of Obstetrics and Gynaecology*. 2002; 187,6: 1673-1678 20. Gissler M *et al*. *European Journal of Public Health*. 2005; 15, 5: 459-463 21. Fergusson D *et al*. *Journal of Child Psychology and Psychiatry*. 2006; 47(1): 16-24 22. Fergusson D *et al*. *British Journal of Psychiatry*. 2009; 195: 420-426 23. http://www.rcpsych.ac.uk/rollofhonour/currentissues/mentalhealthandabortion.aspx
6. Pre-abortion management	2201-2202	We agree that healthcare staff should particularly identify women who require more support, but emphasise that all women should be given proper counselling to ensure fully informed consent.
	2206-2207	The choice of the emotive words 'subjected' and 'compulsory' suggests an underlying ideological bias. All women should be given proper counselling to ensure fully informed consent.
	2223	There seems no recognition that many women who may have started with 'a clearly unintended pregnancy' change their minds as the pregnancy progresses and they bond with their baby. All women deserve genuine space to consider all their options.
	2233-2234	Psychiatric sequelae are trivialised here (see comments on 2165-2166 ff).
	2632-2635 Fetal awareness	This casual dismissal of a very real concern for many pregnant women, to say nothing of what should be a major ethical concern for all, relies solely on a 2010 RCOG report which has just been severely criticised in an editorial by a leading neonatologist (24). The author supports the current abortion law and is not addressing the political debate, but takes the RCOG to task over the science. He summarises the scientific argument in the RCOG document as: •The fetus is rendered unconscious during intrauterine life by endogenous substances. •And under 24 weeks does not have the neuroanatomical apparatus that would allow pain perception at a cortical level.

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		•Therefore the fetus is neither aware, nor can feel pain, under 24 weeks. After reviewing the evidence he concludes: 'So, what is the evidence that the human fetus lacks 'awareness'? In a word, there is none… I have looked at the references in the report, and the references in the references, and when I finally got back to the primary literature I found no evidence for the contention that humans lack awareness, or exist in some different conscious state, beyond the unwarranted extrapolation from sheep. In contradiction to the notion of the 'unaware' fetus, the everyday experience of pregnancy – the felt behaviours and responses of the unborn baby, especially to sound – as well as much primary research literature on the human fetus, contains strong evidence for an opposite view.' We are concerned that the RCOG has been selective with the evidence. It has inappropriately relied on specialists in disciplines such as psychology, and persistently ignored one of the world's leading scientific authorities, Professor KJS Anand who has written extensively on the neurodevelopmental changes of fetal pain (25) and has also ignored Professor Stuart Campbell, the UK's leading authority on 4-D fetal ultrasound. _____ 24. Ward Platt M. *Arch Dis Child. Fetal Neonatal Ed.* Published Online First: 3 February 2011 doi:10.1136/adc.2010.195966 25.See for example Lowery CL, Hardman MP, Manning N, Whit Hall R, and Anand KJS. Neurodevelopmental Changes of Fetal Pain. Seminars in Perinatology. Elsevier 2007; 31: 275-282 http://anes-som.ucsd.edu/VP%20Articles/Topic%20C.%20Anand.pdf
8. Care after the abortion	3541-3551	Psychiatric sequelae are again trivialised here (see comments on 2165-2166 ff).