

2. Allow suitably trained nurses and other health care practitioners to carry out abortions⁷ (NC2, NC14) – Frank Dobson MP et al

Nurses across Britain are already involved in the care of women having abortions. In the case of both first and second trimester medical abortions, nurses carry out virtually all the tasks except prescribing the drugs, which is not permitted in the formulary. Nurses can take consent for abortion procedures but not sign the form authorising the abortion, because the 1967 Abortion Act restricts signing that form to a registered medical practitioner.⁸ That was clearly a consequence of the era in which the law was made, when nurses simply did not perform many of the roles they now carry out.

While nurses in Britain cannot currently carry out first trimester vacuum aspiration abortions, experience in both developed and developing countries has shown that they are well able to do so.⁹ Nurses currently carry out procedures such as inserting intrauterine devices and sub-dermal contraceptive implants, and colposcopies,⁵ all of which require comparable levels of skill to doing a vacuum aspiration abortion in the first trimester of pregnancy. At Early Medical Abortion pilot sites in 2008,¹⁰ research showed that nurses were seen as professionally sensitive to the issues and their presence reassuring for women, and women believed they could play a larger role in providing these abortions.⁵

Formalising the role of nurses, GPs and other appropriate non-physician health care practitioners involved in abortion care and allowing provision at primary care level would mean fewer professionals would be required to see the woman, allow for easier access of women to abortion services, reduce waiting times and minimise the delays many women still face when seeking an abortion. The earlier an abortion is performed the safer it is. The Royal College of Nursing supports moves to enable suitably trained nurses to carry out abortions; many of their members are already involved in caring for women having an abortion or carrying out medical abortions under Patient Group Directions.¹¹

Last year, the House of Commons Science and Technology Committee also supported this change, stating that “subject to usual training and professional standards nurses (and midwives) could be permitted to sign the HSA1 form, for which they currently obtain consent, and prescribe the necessary drugs [for medical abortion], which they currently administer;... that subject to usual training and professional standards nurses (and midwives) could be permitted to carry out early surgical abortions; and that such practice would not compromise patient safety or quality of care.”¹²

This change is also supported by the Faculty of Sexual and Reproductive Health Care and the Royal College of Obstetricians and Gynaecologists.¹³

⁷ Vacuum aspiration abortion is the currently used and recommended form of surgical abortion up to 13-14 weeks of pregnancy. Medical abortion involves a woman taking two types of pills, first mifepristone and then misoprostol within 24-48 hours. Medical abortion is effective from 4-24 weeks of pregnancy. The medications cause a miscarriage to occur. Both vacuum aspiration abortion and medical abortion are very safe, simple to carry out and manage, and have a very low rate of complications. Physician involvement is required in the rare event of serious complications, and procedures for referral for such care should be robust.

⁸ French K, Advisor on sexual health to Royal College of Nurses. The role of nurses in abortion care. Presentation to Bpas conference on the Future of Abortion. London, 26 June 2008.

⁹ Berer M. Provision of abortion by mid-level providers: international policy, practice and perspectives. Bulletin of WHO 2008 (in press).

¹⁰ Results of pilot study on early medical abortions in community medical settings published.

Department of Health press release, 7 May 2008. At:

<<http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=366752&NewsAreaID=2&NavigatedFromDepartment=False>>.

¹¹ Scientific Developments Relating to the Abortion Act 1967, op cit.

¹² Scientific Developments Relating to the Abortion Act 1967, op cit.

¹³ Scientific Developments Relating to the Abortion Act 1967, op cit.

3. Extend the locations where abortions can take place to primary care level (NC7, NC10) – Jacqui Lait MP et al

In 1967, medical abortion was not possible in early pregnancy and with justifiable concerns about 'backstreet' abortion and making surgical abortion safe, Parliament saw fit to specify that in the NHS, only hospitals could provide abortions. In 1990 it was already envisaged that this provision was out of date and a regulation-making power was inserted to allow more venues to be approved. This has – however – never been used.

In 2006, 39% of abortions were performed in NHS hospitals. The World Health Organization's *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2003, recommends that:

- abortion services be provided at the lowest appropriate level of the health system; and that
- aspiration abortions can be provided at primary care level up to 12 completed weeks of pregnancy and early medical abortion up to 9 completed weeks of pregnancy.¹⁴

The majority of abortions (90%) in England and Wales are carried out under 13 weeks of pregnancy, and 93% under 14 weeks in Scotland, using either vacuum aspiration or medical abortion, which are vastly simpler and safer procedures than the methods in use when the 1967 Abortion Act was drafted. This represents a profound change from the days when a hospital was the only place where abortions could safely be carried out using methods that required the skills of a trained gynaecologist. Now that the methods have changed and been simplified, complications from abortion are so rare, and so rarely serious, that the whole process of providing a safe abortion service can be "de-medicalised" appropriately.

This amendment is clearly in line with UK government policies aiming to provide care "closer to home", greater patient choice and more responsive services. This is also the basis upon which WHO's guidance recommended situating first trimester aspiration abortion and early medical abortion at primary care level. The Department of Health agrees that early medical abortion could be provided in non-hospital settings. In May 2008, the results of an evaluation of two pilot sites to provide early medical abortion in community clinics, commissioned by the Department of Health, were published.¹⁶

Commenting on the findings, the Department noted: "The study shows that large community contraceptive centres, cottage hospitals or polyclinic-type settings could offer a safe, high quality service for women. It shows that some women welcomed the informality and increased availability of staff support. This confirms the experience of other countries which already offer early medical abortion in non-hospital settings."¹⁷

Primary care settings would not be appropriate for second trimester abortions, or any procedure in which the woman opted for general anaesthesia. However, for first trimester aspiration abortions and early medical abortions, both GP surgeries and family planning clinics are suitable - on a daycare or outpatient basis by trained GPs and nurses, using local anaesthetic or other oral forms of pain control. Robust referral links to hospitals and 24-hour advice and back up would of course need to be established if not already in place.

There is no need for statutory barriers to NHS primary care providing abortion care. Quality inspections, codes of practice, compliance with contracts with commissioning primary care organisations, professional standards and regulation, and good medical and nursing practice all currently exist to maintain safe practice as in all other fields of medicine.

4. Allow women the choice to be at home to complete early medical abortion (NC9) Chris McCafferty MP et al

¹⁴ World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO, 2003.

¹⁶ Ingham R, Lee E. *Evaluation of Early Medical Abortion (EMA) Pilot Sites*. Final report. London: Department of Health, 2008.

¹⁷ Results of pilot study on early medical abortions in community medical settings published. Department of Health press release, op cit.

Early medical abortion is defined as abortion from 4–9 weeks (28–63 days) of pregnancy using a two-drugs that in combination causes an early miscarriage. Use of this method is growing quickly among women in the UK. Early medical abortion has increased national capacity for early abortion care and is allowing more women to have an abortion at an earlier stage.

However, the law as currently interpreted by the Department of Health in this area works against the best interests of women by requiring both drugs used (mifepristone followed by misoprostol 36–48 hours later) to be administered within a hospital or clinic approved by the Secretary of State. The Department's interpretation of the law confounds best practice, as defined in a number of other European countries and the United States.

A woman takes the first drug (which ends the pregnancy) at the hospital or private clinic. Instead of being allowed to go home with the second drug to take as advised 35–48 hours later, as occurs in other countries the woman has to return to the hospital to take it. Currently, the 13,000+ women opting for early medical abortion from BPAS each year incur the cost and inconvenience of returning to the clinic for a clinically unnecessary visit, just to be handed the misoprostol pills. This is burdensome for women, who have other responsibilities to manage; half of all women having abortions are already mothers¹⁹. Although the pills are taken in the clinic, women do not want to be confined to a clinic following misoprostol administration, and these very early abortions can be completed at women's home or the place where they are staying, with access to 24-hour telephone support. If she then chooses this option there is a risk that bleeding will begin while the woman is travelling home. This problem which would be eliminated if their taking the pills at home were permissible.

This requirement can also mean that women who are not within a reasonable travelling distance to abortion services may not be able to choose early medical abortion at all, because of the repeated journeys. This particularly affects women living in rural areas, and younger and poorer women. A study of self-medication for treatment of spontaneous abortion by the Early Pregnancy Unit, Royal Free and University College Medical School in London, showed that with spontaneous abortion (miscarriage) up to 12 weeks of pregnancy, self-administration of misoprostol at home was efficacious, safe and acceptable to women. 93.3% of women said they preferred administering the misoprostol at home.²⁰ Yet women seeking early medical abortion are legally barred from doing this, even though the drug is the same and the consequence of taking the drug is the same.

In the USA, almost 100% of over 366,000 women who have obtained a medical abortion from 289 Planned Parenthood clinics since September 2000 have taken the misoprostol at home following mifepristone. From 2000–2001, this was permitted up to 7 weeks gestation. It was then extended to 9 weeks. On the basis of as yet unpublished data, in February 2008, Planned Parenthood began to allow clinics to provide medical abortion with misoprostol taken at home up to 63 days gestation.²¹ The 2005 American College of Obstetricians and Gynecologists Practice Bulletin²² describes in its "Alternative regimens" section the fact that multiple studies have demonstrated that women can safely and effectively self-administer misoprostol at home.

In France, since the end of 2004, both gynaecologists and suitably trained GPs have been permitted to prescribe medical abortion pills in their private surgeries up to 7 completed weeks (49 days) of pregnancy as long as they are linked to a referral hospital as back-up in case of serious complications or failures. In 2007, 8.5% of all medical abortions were managed by these doctors in their private surgeries, and all of these involved home use of

¹⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_085508

²⁰ Shankar M, Economides DL, Sabin CA, et al. Outpatient medical management of missed miscarriage using misoprostol. *Journal of Obstetrics & Gynaecology* 2007;27(3):283–6.

²¹ Communication by e-mail, M Fjerstad, CAPS Director of Quality and Learning for Planned Parenthood Federation of America, United States. 16 June 2008.

²² ACOG Practice Bulletin. No. 67, October 2005.

misoprostol. In 2005, 44% of all abortions were medical abortions in France (latest official data available).²³

In Sweden, in order to update the law to take account of early medical abortion, in June 2004, a regulation was approved that said: "For a medical abortion, the initiating medical treatment should be administered in a hospital or in a clinic approved by the Board of Health and Welfare. The abortion treatment should be followed up to confirm complete abortion and the outcome noted in the patient's file."²⁴ In other words, the woman should receive the mifepristone pill from a clinician, and is then free to take the misoprostol pills and complete the abortion at home, with follow-up afterwards. This regulation was accepted on the grounds that the point in time at which the abortion takes place with medical abortion cannot be pinpointed but should be understood as occurring at the intake of the first drug, mifepristone, which is the "point of no return" and will lead to the expulsion of the products of conception.²⁵ This allows flexibility as regards home use of misoprostol and for changing norms as to safety and acceptability.

In Norway, the Parliament is about to pass a regulation permitting home use of misoprostol with medical abortion, with the support of the health authorities and a majority in the Health Committee of the Parliament. Formerly, the law in Norway required that abortion take place in a hospital gynaecology department, but the Regional Medical Officer can give permission for it to take place in other places. To make home use of misoprostol possible with medical abortion, a similar regulation to the one from Sweden above has been proposed.²⁶

The proposed amendment to the 1967 Abortion Act is intended to accomplish the same thing.

A pilot study has already been undertaken to assess the safety, effectiveness and acceptability of completing the second stage of a medical abortion at home in the UK.²⁷ Further study has not been possible because the Department of Health indicated that they considered that this was not lawful without legislative change.

The Science and Technology Committee were impressed by the evidence that there are no particular safety concerns about early medical abortions. They concluded that: "subject to providers putting in place the appropriate follow-up arrangements, there is no evidence relating to safety, effectiveness or patient acceptability that should serve to deter Parliament passing regulations which would enable women who chose to do so taking the second stage of early medical abortion at home, or that should deter Parliament from amending the act to exclude the second stage of early medical abortion from the definition of "carrying out a termination".²⁸

For the minority of women, e.g. adolescents, who may have good reasons why they do not wish to complete an early medical abortion at home, the option of completing the termination in a hospital or clinic would remain.

²³ Communication by e-mail from Dr Danielle Hassoun, Obstetrician-Gynaecologist and Director of Medical Abortion Training, REVHO (Réseau entre la Ville et l'Hôpital pour l'Orthogénie), Paris, France. 15 June 2008.

²⁴ Swedish Board of Health and Welfare. SOSFS 2004:4 (M). Communication by e-mail and translated from Swedish by Prof K Gemzell-Danielsson, Department of Woman and Child Health, Division of Obstetrics and Gynecology, Karolinska Institutet, Stockholm..

²⁵ Communication by e-mail, Dr C Fiala, Gynmed Clinic, Vienna, Austria. 16 June 2008.

²⁶ Communication by e-mail from Dr M Lokeland, Obstetrician/Gynaecologist, Haukeland University Hospital, Bergen, Norway. 19 June 2008.

²⁷ Hamoda H, Ashok P, Flett G, Templeton AA. Home self-administration of misoprostol for medical abortion up to 56 days' gestation. *Journal of Family Planning and Reproductive Health Care* 2005;31(3):189-92.

²⁸ Scientific Developments Relating to the Abortion Act 1967, op cit.

5. Ensure that anti-abortion organisations are transparent about their approach when advertising or offering women “counselling” (currently NC11) John Bercow et al

Most women faced with an unintended pregnancy decide whether they want to continue or terminate the pregnancy before they ever approach a health care provider. Those who are not sure what to do may seek counselling. If for any reason they feel unable to approach their GP, they may seek help from an independent agency. Talking things through with a supportive, neutral person who is able to offer accurate information on the options (described as ‘non-directive counselling’) can be helpful in allowing women to reach their own decision. At the same time, women should be protected from or at least be told the nature of counselling provisions who would seek to direct and mislead their decision-making on the basis of a religious or political view.

In recognition of this, the Department of Health registers organisations that offer non-directive counselling and referral for abortion as approved Pregnancy Advice Bureaux if they comply with the Department’s Required Standard Operating Principles.²⁹ This includes the power of unannounced inspection as part of regulation.

‘Crisis pregnancy counselling centres’ operate outside the Department’s guidelines, however, and are not subject to any regulation. They may advertise counselling that purports to be non-directive, when in fact the aim is to dissuade women from having an abortion. They may not always make this clear in their literature or on their websites, nor indicate clearly that they do not provide abortions and do not refer women to abortion providers.

These centres may give untrue or selective information about the safety of abortion, or make false claims about its risks, e.g. that abortion increases the risk of breast cancer, a claim that the evidence does not support. They may use deceptive advertising practices in order to get women to come to their centre, such as advertising under “abortion services” in the phone book or using a name for the centre that is similar to those of charities which do provide non-directive counselling. Perhaps most disturbingly for women seeking counselling, such centres may use distressing video material or manipulative tactics such as requiring the holding of fetus dolls during their counselling.

This amendment if passed will not prevent such centres from continuing their current practice but it would bring such services into line with existing consumer protection regulations and require all such centres to clearly state in their advertising and promotional material that they do not refer for, or advise on abortions. This will better enable women to approach a counselling centre knowing that it best suits their needs and will help to prevent women from losing valuable time needed for making an informed decision and seeking appropriate medical care, whether antenatal or abortion care.

This amendment will not restrict the freedom of speech of any religious or other organisation to counsel against abortion – as long as they make it clear in their advertising or promotional material that they do not refer for, or advise on abortion.

The amendment therefore is about preventing women being misled by the advertising of ‘crisis pregnancy’ counselling services.

²⁹ Department of Health. Procedures for the Registration of Pregnancy Advice Bureaux. 2001. <www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005566>.

6. Clarify that the statutory right for health care professionals to conscientiously object in abortion does not extend contraception (NC12) Dr Evan Harris MP et al

The duties of a doctor (and, by extension, other health care professionals) start with making the needs of the patient the primary concern. When considering the rights and duties of health care professionals, Parliament has never provided for in law a general right of health professionals, on the basis of their personal beliefs, to pick and choose which patients to treat, or whether or not to provide a treatment that is both lawful and in the best interests of the patient. It was however deemed necessary for the 1967 Abortion Act and the 1990 HFE Act to expressly provide for the right to conscientiously object. This right is narrowly drawn, in that it cannot be claimed in an emergency situation, and in any court case the burden of proof falls on the health professional to show a genuine conscientious objection. Some doubt remains as to whether the 1967 and 1990 Acts provide a statutory basis for professional regulators to allow health care professionals to opt out of providing other lawful, clinically appropriate interventions.

Some doctors and pharmacists have claimed a right to conscientiously object to the provision of contraception, for example, refusing to provide it to unmarried women, or refusing to provide, prescribe or dispense emergency contraception (the morning-after pill). There has been a spate of newspaper stories since 2005³¹ with reports that women seeking emergency contraception in several pharmacies (e.g. branches of Asda, Boots and Sainsbury's) were told by the pharmacist on duty that he or she objected to supplying the pills on religious, moral or ethical grounds, and in some cases also saying that their refusal was supported by the Royal Pharmaceutical Society of Great Britain's guidelines. While most were reported to have referred the woman concerned to another provider, such as another branch of the store or the woman's GP, time is of the essence with emergency contraception, as its name implies, and time lost in seeking another provider puts the women at greater risk of pregnancy. Indeed, one woman whose story was published in October 2008 was refused emergency contraceptive pills at a Tesco pharmacy became pregnant and gave birth, the supermarket apologising 'for any inconvenience caused'.³²

Parliament has never approved by statute this refusal by health care professionals in respect of contraception provision. Nor is it justified by the Human Rights Act, which although it protects a person's (including a doctor's or pharmacist's) right to religious belief, limits the right to manifest that belief when it infringes upon the rights and freedoms of others. Furthermore, anti-discrimination laws – where health care is included in the definition of goods and services – make it potentially unlawful for health care professionals to pick and choose who they treat or for what conditions. Neither contraception nor emergency contraception are abortion. Emergency contraception has been available over the counter from pharmacists since 2000. That this contraception is not abortion, was confirmed in a High Court judgement in April 2002 against Society for the Protection of Unborn Children and in favour of the Department of Health, who defended it as contraception.³³ This amendment has been proposed to put that case law on a statutory footing and to clarify that the provision of contraception is not covered within conscientious objection rights under the 1967 Abortion Act.

³¹ See, for example:

<www.manchestereveningnews.co.uk/news/health/s/174/174873_woman_denied_pill_on_moral_grounds.html>;
<<http://news.bbc.co.uk/1/hi/wales/4649425.stm>>;
<http://news.bbc.co.uk/1/hi/england/south_yorkshire/6049750.stm>; <www.examiner.co.uk/news/local-west-yorkshire-news/tm_headline=chemist-refused-woman-pill-on-religious-grounds&method=full&objectid=19862496&siteid=50060-name_page.html>

³² http://www.metro.co.uk/news/article.html?Woman_refused_morning_after_pill_gives_birth_-_store_apologises_for_inconvenience&in_article_id=338579&in_page_id=34

³³ Mayor S. Court rules that emergency contraception is lawful. *BMJ* 2002;324(27 April):995. See also: Lee E. SPUC legal challenge on emergency contraception. Pro+Choice Forum. 13 February 2002. At: <www.prochoiceforum.org.uk/comm81.asp>.