Response by the LIFE charity to the Department of Health Consultation on the Revised Standard Operating Procedures for abortion clinics

Question 1. Do the updated RSOPs include the necessary conditions to ensure women receive a safe, high quality, service from independent sector abortion providers which meets the requirements of the Abortion Act?

1. As things stand, we cannot agree that the draft updated RSOPs ensure that women will receive the necessary standard of care. These RSOPs do not take into account several key areas of concern about the health, wellbeing and fair treatment of women seeking TOP.

Our concerns fall into a number of main areas:

(a) A continuing lack of clarity about the research base concerning abortion and mental health, and the resulting doubt about the meaning of "good faith" in the context of induced abortion for mental health reasons under the 1967 Act. We are particularly concerned about the RSOPs' potential to undermine the Act by possibly removing the need for a doctor to see women requesting abortions at all, and to limit their involvement in the actual procedure.
(b) The absence of clear "informed consent" guidelines explaining exactly what it is that doctors should tell women seeking induced abortion about the possible health consequences of the procedure.
(c) The seemingly inadequate rules for responding to women who are seeking abortion in the context of an abusive relationship.
(d) A lack of responsiveness to recent revelations about abuse and circumventing of the abortion authorisation process.

2. These RSOPs do not do enough to clarify exactly what is expected of doctors in terms of making a decision about a woman's eligibility for an abortion under the 1967 Act "in good faith". This has for a long time been an area of uncertainty and ambiguity, both in theory and in practice, and recent developments and discoveries concerning the potential effects of abortion on women's mental and physical health have only heightened this confusion.

3. It now seems far from clear that a doctor can sign off on an abortion for an individual woman on the grounds that it is required for her mental health, while still acting within the bounds of evidence-based medicine. The suggested guidelines in this area do not reflect or incorporate the current level of knowledge about mental health and abortion. There is now a growing body of research suggesting that abortion can have a detrimental effect on women's health, and little evidence to support the view that abortion can improve maternal mental health. RSOPs need to explicitly emphasise to authorising doctors the current state of medical knowledge.

4. In 2013, a large-scale meta-analysis of existing research published in the Australia and New Zealand Journal of Psychiatry by Fergusson et al concluded that "there is no available evidence to suggest that abortion has therapeutic effects in reducing the

mental health risks of unwanted or unintended pregnancy” . That study also concluded that "abortion may be associated with small to moderate increases in risks of some mental health problems" . This is in accordance with a number of previous papers published by Dr Fergusson and his research team. Overall, the various papers issued by Fergusson et al strongly suggest a link between abortion and poor mental health outcomes. Their 2006 study found that “abortion in young women may be associated with increased risks of mental health problems” . In 2008, they reported that “the evidence is consistent with the view that abortion may be associated with a small increase in risk of mental disorders…other pregnancy outcomes were not related to increased risk of mental health problems” . A 2009 paper issued by the same research group found that women who had negative feelings immediately following abortions are more likely to have emotional wellbeing problems in the future .

5. For an abortion on grounds of risk to mental health to be legal, a doctor must form the opinion in good faith that the risk to mental health from the continuation of the pregnancy is greater than from termination. The evidence mentioned above suggests that it is now very difficult for a doctor to form such an opinion in good faith. The Royal College of Psychiatrists' 2011 report into abortion and mental health also notably failed to find evidence that abortion improves mental health outcomes for women in crisis pregnancy. That report was commissioned and published by the Academy of Medical Royal Colleges (AoMRC). It was funded by the Department of Health, and carried out by the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists .

6. Legal and clinical clarity on this question is urgently required. If the evidence does not support induced abortion as an appropriate intervention for women in crisis pregnancy from the mental health perspective, then this casts severe doubt on the vast majority of TOPs carried out in the United Kingdom each year. As well as the “good faith” angle, it is far from clear that women are being made aware of the state of this research and the possible repercussions of abortion on their health. This is a basic issue of informed consent.

7. We strongly believe that there is a need for this research to be explained to women honestly and openly and fully, and if necessary for a specific pathway to be created enabling women to give informed consent to abortion. We also wish to note that maintaining good mental health for women is not simply a question of avoiding specific defined mental health conditions. A lot of the clinical literature that purports to show women do not suffer serious ill-effects after abortion does not take into account that a woman may suffer severe consequences to her wellbeing, without necessarily recording a mental health “episode” defined as a visit to a doctor or a diagnosis of a specific condition.

8. We need clearer guidelines for staff on exactly what women must be told as part of the informed consent procedure. Like the “good faith” requirement, this must be more than a simple rubber-stamping exercise. The guidelines contained in the RSOPs as they stand are overly vague and non-prescriptive, and leave women’s access to the best information to the vagaries of individual clinics and staff. Section 5

of the RCOG document “The Care Of Women Requesting Induced Abortion” deals well and thoroughly with this subject .

9. Another aspect of the “good faith” requirement that is not considered in these RSOPs, but needs to be, is whether the practice of doctors signing off on abortions without even meeting the woman concerned is widespread. Recent reports indicate that it is widespread, and this is clearly against the spirit of the 1967 Act, and deeply irresponsible and unprofessional from the clinical perspective. If we are to have the 1967 Act, it must be enforced correctly and strictly, in accordance with the intentions of its authors and framers. It also seems clear to us that, given the state of the evidence concerning abortion’s effects on mental health, a reasonable amendment to the RSOPs would be that a woman seeking abortion on grounds of mental health must be seen by a mental health specialist and her abortion must be specifically authorised by that professional as part of the two doctors’ signatures procedure. It is no longer acceptable for doctors to authorise abortions without seeing the woman, or for a non-mental health specialist to authorise an abortion on mental health grounds in defiance of clinical evidence. Recent reports that such practices are widespread make it particularly important that these RSOPs are strengthened to deal with this issue. Authorising a serious procedure such as an abortion without seeing the woman concerned is a gross violation of basic expectations of good care as outlined in the Royal College of Obstetricians and Gynaecologists’ clinical guidelines, and borders of negligence. The highest professional medical standards must always be expected and enforced in this area.

10. Women must have access to the very best and most up-to-date information about all aspects of abortion, especially the potential consequences. The RSOPs do not mandate enough detailed provision of information. According to the most recent edition of BPAS’s Abortion In Practice: A Guide For GPs , “up to 10%” of women experience infection after abortion. Although many abortion providers now routinely provide antibiotics to minimise this risk, these infections have the potential to lead to fertility-threatening complications. Around 1% of surgical abortions and between 3-5% of chemical abortions are “incomplete” and require further medical intervention.

11. As far as future fertility is concerned, the most recent statement by the Royal College of Obstetricians and Gynaecologists notes that “the effect of induced termination of pregnancy on future reproductive outcomes remains a controversial area. Current evidence is limited, and further research is needed to assess reproductive outcomes following the use of more recent techniques…Induced abortion may be associated with a small increase in the risk of subsequent miscarriage and preterm delivery, but further research is needed” . To return to the advice offered BPAS, we see that there is “a small increase in your chances of having a miscarriage or pre-term delivery in the future”.

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?

12. There is still a lack of a really robust framework helping and encouraging doctors to recognise and report pregnancies resulting from an abusive or coercive relationship. Recent data indicates that a large number of women seeking abortion,

perhaps as many as 25%, have experienced intimate partner violence at some point. We cannot accept that merely providing TOP with minimal checks or further investigation is the best way to help such women. There must be clearer pathways to establish whether abuse is ongoing, whether the woman is being pressured into seeking TOP, and whether TOP will add to a woman's problems. The recent report into the failure to protect at-risk young women by Rochdale council specifically highlighted the issue of young and clearly vulnerable individuals accessing abortion and all the signs of their need for help being missed . Abortion must not be allowed to be a way of covering up abuse, and the written guidelines need to provide a way both of ensuring that this does not happen, and of reporting doctors' suspicions and concerns.

13. Over the past few years a number of specific problems to do with the way abortion is practised in the UK have emerged. One of the most serious of these is the revelation that the pre-signing of abortion authorisation forms was a widespread practice, having been discovered in at least fourteen separate health Trusts. Following investigation by the Care Quality Commission, we are assured that this is no longer a problem. However, we do not see any effective mechanism in the RSOPs for monitoring bad practice in abortion clinics in the long run. This needs to be remedied as a matter of some urgency.

14. A doctor certainly cannot be said to have formed an opinion in good faith if he has not met the woman, as these RSOPs allow (see paragraphs 2 and 3 above). Any provisions for doctors to authorise abortions without meeting the woman involved must be removed from the draft RSOPs.

15. The same can be said for the lax attitude shown here to sex-selective abortion. Although the evidence is still unclear, there are some indications that the UK may have a problem with sex-selective abortion. Guidelines for doctors need to contain a firm clarification of the exact legal situation concerning sex-selective abortion, at the very least, and perhaps also to point out that sex-selective abortion is very much against the spirit of the 1967 Act.

16. Connected to this issue is how the regulations treat pre-natal scanning. There seems to be little recognition in the updated RSOPs of the huge practical, ethical and legal dilemmas raised for doctors and the consequences for their decision-making by detailed scanning technology. Our recommendation to address the problems of the problem of sex-selection, for example, is that induced abortions on certain grounds should not be allowed to take place after scans revealing certain information have been carried out. Such a provision would not be difficult to work into the RSOPs, and would be a small but definite measure in making sure that the 1967 Abortion Act is taken seriously.

17. We appreciate some of the suggested audit targets in the proposed RSOP 15, especially the monitoring of how many women seen by abortion clinics do not eventually have an abortion. This is an important indicator of how sensitively and appropriately women are being treated by clinics, and of how seriously clinics are taking their responsibilities to assess women's eligibility under the Act. Not all women who approach clinics will be eligible for an abortion under the Act's provisions, and for many others an abortion will not be appropriate, for a variety of

reasons (see the discussion of proper informed consent in paragraphs 7 and 8 above). Access to abortion should not be a conveyor-belt process. However, we do note that the suggested audit targets here are merely suggestions, rather than stipulations. We would like to see the targets mentioned in RSOP 15 given more force.

Consultation Question 3. Do you have any other comments you would like to make in relation to this consultation?
Nothing further at this stage.