Government Response to the Report from the House of Commons Science and Technology Committee on the Scientific Developments Relating to the Abortion Act 1967

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
November 2007

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Foreword

This Command Paper sets out the Government's response to the report of the House of Commons Science and Technology Committee on the *Scientific Developments Relating to the Abortion Act 1967*. We thank the Committee for its well-considered and timely report.

The Committee makes a number of recommendations, many of which invite Members of Parliament to consider its findings. We have therefore focused particularly on those recommendations that ask for Government action.

We note that none of the Committee's findings on the scientific evidence that supports the Act, as it stands, contradicts the current consensus of scientific opinion, including the evidence on fetal viability and fetal pain.

Rt Hon Dawn Primarolo
Minister of State for Public Health

Response to the Committee's conclusions and recommendations

The aim of the Inquiry

1. **In this Report, we set out the key issues that have emerged and the key questions MPs must ask themselves as they consider options for changes in the law. Where we have felt it appropriate and justified, we have drawn conclusions about what the science and medical evidence currently before us tells us. We urge all MPs to study the evidence we have taken and the conclusions we have reached. (Paragraph 12)**

2. **Because we recognise that what the science and medical evidence can tell us is only one of many factors that are taken into account when legislating on this issue, we have not made any recommendations as to how MPs should vote on abortion law. (Paragraph 13)**

As highlighted in the foreword, we are grateful to the Committee for producing a comprehensive and timely report. Responses to individual recommendations are set out below.

Defining viability

3. **Caution needs to be applied to unpublished data but the least the Committee is able to conclude is that we have not heard any evidence from EPICure that survival rates below 24 weeks gestation have significantly improved and we draw this to the attention of the House. (Paragraph 35)**

4. **We understand that the EPICure 2 results will not be published for some time. It is unfortunate that the published data may not be available in time fully to inform debate in the House. We hope that the emerging findings are published as soon as possible. (Paragraph 36)**

Individual neonatal intensive care units and results from abroad

5. **We reach the conclusion that the national and regional surveys of outcomes for very premature neonates are the best basis for establishing the limit of foetal viability. We draw this to the attention of the House and invite members to consider our conclusions when they consider the best basis for determining foetal viability. (Paragraph 45)**

6. Having considered the evidence set out above, we reach the conclusion, shared by the RCOG and the BMA, that while survival rates at 24 weeks and over have improved they have not done so below that gestational point. Put another way, we have seen no good evidence to suggest that foetal viability has improved significantly since the abortion time limit was last set, and seen some good evidence to suggest that it has not. We draw this to the attention of the House and invite Members and the Government to consider our conclusion when deciding when a foetus becomes viable. (Paragraph 46)

7. We make no conclusion on the legal upper limit for abortion but instead invite Members of Parliament to consider the role played by foetal viability, among other factors, in that decision and to consider our analysis. (Paragraph 48)

We note the Committee's findings and we concur with its view that survival rates below 24 weeks gestation have not significantly improved since the Act was last amended.

We acknowledge that there have been improvements in the care of babies born at low gestational ages in specialist neonatal units. However, we have been advised that it is not possible continually to push back the time at which a fetus becomes viable, as there is a limit beyond which the lungs will simply be insufficiently developed to sustain life.

Relevance to the upper gestational limit

8. We conclude that, while the evidence suggests that foetuses have physiological reactions to noxious stimuli, it does not indicate that pain is consciously felt, especially not below the current upper gestational limit of abortion. We further conclude that these factors may be relevant to clinical practice but do not appear to be relevant to the question of abortion law. (Paragraph 59)

9. We invite Members of Parliament, when considering the role, if any, of questions relating to pain, to clinical practice or abortion law, to consider our conclusions. (Paragraph 60)

We note the Committee's findings and are in agreement with the consensus of scientific evidence with regard to fetal pain at gestations below 26 weeks. This is a matter relevant to clinical practice.

Officials from the Department of Health have met with representatives of the Royal College of Obstetricians and Gynaecologists (RCOG) and we will be commissioning the College to review its 1997 working party report into fetal pain to re-examine the latest evidence, much of which has been considered by the Committee, and any new research currently under way. We will work with the College to ensure that the review committee is made up of a diverse and comprehensive range of specialists and that all the scientific evidence submitted to the Committee is included in the review.

4D images and foetal consciousness

10. We conclude that while new imaging techniques are useful tool in diagnosis of foetal abnormality, there is no evidence they provide any scientific insights on the question of foetal sentience. We invite MPs to consider our analysis when approaching this issue. (Paragraph 63)

We note the Committee's findings and agree that, while 4D imaging is a useful tool for observing fetal development and identifying fetal abnormality, it does not add anything to the science of fetal sentience.

Late presentation

11. We believe that consideration of late presentation and the production of guidance would be better enhanced by better collection of data relating to the reasons why women present for late abortions and how many women travel overseas for late abortions, and appropriate analysis of such data, with due regard to the need to protect the confidentiality of patients. (Paragraph 69)

12. We invite Members of Parliament to consider what research has to say about the impact that an alteration on the upper time limit would have on those women who present late for abortions. (Paragraph 70)

We note the Committee's recommendations. The collection of such data would be complex. It would be very difficult to collect information on the reasons for women travelling abroad for late abortions.

As highlighted in the Committee's report, this issue was recently considered by the Centre for Sexual Health Research at the University of Southampton. The study was published on 17 April 2007 and found that women present late for abortion because of:

- failure to recognise the pregnancy earlier (this can disproportionately affect teenagers or women approaching their menopause)
- delay in seeking abortion due to personal circumstances, including difficulty in deciding whether to have an abortion
- difficulty in accessing abortion services (not knowing where to go or not being referred promptly).

We are working hard to ensure that women have access to abortion services as soon as possible, as evidence shows that the risk of complications increases the later the gestation. The latest data, for 2006, show that very good progress is being made to increase early access: 89% of abortions were carried out at under 13 weeks gestation; 68% were at under 10 weeks.

Data on gestation are published by primary care trust (PCT). Individual trusts should be using this information to monitor the gestations at which women are presenting for an abortion. If there is a high number, or increasing number, of late abortions, they should take action locally to address this.

We discussed this issue with members of the RCOG and they were in agreement that there is little value in collecting these data, but suggested that the Department of Health seek a review of the Southampton study in the next five years.

Foetal abnormality

13. We invite Members of Parliament, when considering whether a clarification or a definition of 'seriously handicapped' is desirable and/or feasible, to consider our conclusions. (Paragraph 80)

14. The Department of Health should commission work to produce guidance that would be clinically useful to doctors and patients, and look at who is best placed to do so. (Paragraph 81)

We note the Committee's recommendation and agree that an exhaustive list of abnormalities is neither feasible nor desirable on the face of the Act, but we accept that a review of the existing guidance for professionals who are seeking to determine 'serious handicap' may be timely and of use to the medical profession.

We will therefore be commissioning the RCOG to review its 1996 guidance on the *Termination of pregnancy for fetal abnormality*. Again, we will work with the College to ensure that the review committee is made up of a diverse and comprehensive range of specialists and that all the scientific evidence submitted to the Committee is included in the review.

15. We believe that consideration of abortion for reason of foetal abnormality and the production of guidance would be enhanced by better collection of data relating to the reasons for abortion beyond 24 weeks for foetal abnormality, and appropriate analysis of such data, with due regard to the need to protect the confidentiality of patients. (Paragraph 82)

We note the Committee's recommendation and believe that the current data collected on abortions for fetal abnormality over 24 weeks are comprehensive enough to meet current research needs.

The current HSA4 form already requires that information is provided as to the main medical condition or abnormality that provides the grounds for the abortion.

All forms are scrutinised and particular attention is given to those cases where abortions are carried out beyond 24 weeks gestation. If insufficient information is provided or clarification is required, the form is returned to the practitioner. The information given in the published abortion statistics regarding fetal abnormalities does not reflect the level of detail provided on individual forms, nor do we think that it is appropriate that it should.

The current Abortion Regulations allow for individual information on the HSA4 forms to be used for "bone fide scientific research". Any research project to undertake more detailed analysis of abortions for fetal abnormality beyond 24 weeks gestation would be considered by the Chief Medical Officer on a case-by-case basis and be subject to obtaining the necessary ethical approval and be subject to strict conditions.

We therefore believe that comprehensive data are already collected on fetal abnormalities and that these can be supplied for research and more detailed analysis with the agreement of the Chief Medical Officer.

Two doctors' signatures

16. We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors' signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe there is a strong case for removing the requirement for two doctors' signatures. We would like see the requirement for two doctors' signatures removed. (Paragraph 99)

17. Members of Parliament, when considering whether the requirement for two signatures safeguards the interests of women and doctors or any other purpose, are invited to consider our conclusions. (Paragraph 100)

We note the Committee's recommendations. The requirement for two doctors' signatures was believed necessary when the Abortion Act 1967 was passed, to ensure that the provisions in the 1967 Act were being observed and to safeguard women. The decision to require two doctors' signatures was based on professional opinion at the time.

We note that both the British Medical Association and the RCOG believe that there is no need for two doctors' signatures in the first trimester, and this will be a consideration for Members of Parliament if this issue should come before Parliament.

Current evidence does not indicate that the requirement for two doctors' signatures is causing delay: the latest data, for 2006, show that progress is being made to increase early access, with 68% of abortions taking place at less than 10 weeks, and 89% at less than 13 weeks.

Other causes of delay

18. We urge the General Medical Council, while preserving the right of doctors to conscientiously object and not to refer directly to another doctor for an abortion unless it is an emergency, to make clear that conscientious objectors should alert patients to the fact that they do not consult on abortions and that if the issue arises during a consultation that they have a duty immediately to refer the patient to another doctor for the consultation. (Paragraph 102)

This is a matter for the General Medical Council (GMC).

Doctors who are ethically opposed to abortion should follow relevant professional guidance for those with a conscientious objection. The current GMC booklet *Good Medical Practice* states that doctors' views about a patient's lifestyle or beliefs must not prejudice the treatment they provide or arrange. If they feel their beliefs might affect the treatment, this must be explained to the patient who should be told of their right to see another doctor. Breach of this guidance may expose a doctor to a charge of serious professional misconduct and disciplinary action by the GMC.

Any amendment of these guidelines is a matter for the GMC. We understand that the GMC is currently preparing further guidance for doctors on personal belief and medical practice.

Increasing nurses' responsibilities

19. We are satisfied that there is adequate evidence, particularly in terms of the roles that nurses already play in service provision and in terms of the international experience, to conclude the following:

- **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, which they currently administer;**
- **that permitting nurses and midwives to sign the HSA1 form and prescribe the necessary drugs would not alter the rates of failed and incomplete abortions, abdominal pain or uterine cramping, nausea, vomiting, diarrhoea, vaginal bleeding or spotting, or pelvic inflammatory disease that can be associated with EMA;**
- **that since most women go home after taking the second pill, there is no direct involvement with either nurses or doctors at this point. What is crucial is the ready availability of appropriate care should a complication arise, and clear instructions to women about what to do in the event of complications, something that nurses routinely give;**
- **that subject to usual training and professional standards nurses (and mid-wives) could be permitted to carry out early surgical abortions; and**
- **that such practice would not compromise patient safety or quality of care. (Paragraph 108)**

20. We recommend that when Members of Parliament consider whether the statutory ban on anyone else than doctors carrying out abortion should remain, they consider the evidence and conclusions in this report. (Paragraph 109)

We note the Committee's recommendations.

It is a matter for the House to decide whether it feels there is a need for change and whether, based on the current evidence, the expansion of the nurse's role would be safe, effective, acceptable to patients and would significantly improve access to abortion services.

Places where abortions can be carried out

21. We conclude 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". This would enable a trial to take place. (Paragraph 123)

22. We invite Members of Parliament to consider our conclusions when considering the question of whether the 1967 Act should be amended or regulations passed to enable the second stage of early medical abortion to be self-administered in a woman's home. (Paragraph 124)

We note the Committee's recommendations.

Under the Abortion Act 1967, an abortion (surgical and medical) can only be performed in a hospital vested in an NHS trust, PCT or foundation trust or in an approved independent sector place. Section 1(3A) of the Abortion Act 1967 also gives the Secretary of State the power to approve a class of place to perform medical abortion which could enable this method to be available in a wider range of healthcare settings. This provision has not yet been used in England as we are awaiting the outcome of work to determine what any particular "class of place" should be.

Two hospitals are currently being funded by the Department of Health to run early medical abortion services in non-traditional settings, to evaluate the effectiveness and safety of provision in these settings.

A formal evaluation is under way to assess the safety, effectiveness and patient acceptability of providing early medical abortion services in non-traditional settings. The evaluation will be complete in the New Year and we will consider the results carefully.

Impact of abortions

Mental health risks

23. In view of the controversy on the risk to mental health of induced abortion we recommend that the Royal College of Psychiatrists update their 1994 report on this issue. (Paragraph 139)

We have consulted representatives of the Royal College of Psychiatrists who have told us that they are undertaking a literature review in this difficult, complex field. They intend to use the results of this review to develop a current position statement.

We are also discussing with representatives of the College whether we should commission them to undertake a full systematic review around abortion, mental health, mental disorder and stress.

24. We conclude that there is no strong evidence which contradicts the wording of the current RCOG guidelines on the risk to mental health of induced abortion.

We agree with the Committee's conclusions on this point.

Future reproductive outcomes

25. We found no strong evidence of links between abortion and negative future reproductive outcomes with the exception of a possible link with future pre-term deliveries and miscarriages. We conclude that there is no strong evidence which contradicts the wording of the current RCOG guideline on the risk to future reproductive health of induced abortion. (Paragraph 150)

We agree with the Committee's conclusions on this point.

Breast cancer

26. We found no evidence which contradicts the wording of the RCOG guidelines on the risk of breast cancer. (Paragraph 154)

We agree with the Committee's conclusions on this point.

Post-abortion infection

27. We did not receive any evidence which undermined the RCOG guidelines on post abortion infection. (Paragraph 156)

We agree with the Committee's conclusions on this point.

Informed consent

28. We therefore recommend to the Government and the National Institute for Health and Clinical Excellence (NICE) that the clinical guidelines on abortion provision, including health risks associated with abortion, should ultimately be taken over by NICE. (Paragraph 160)

29. We further recommend that the Government fund the RCOG or NICE to review the RCOG guidelines. (Paragraph 161)

It is the remit of the National Institute for Health and Clinical Excellence (NICE) to advise the NHS on issues of clinical practice and cost-effectiveness. If a clear case is made for referral to NICE on specific issues relating to abortion in the future, we will consider them alongside other departmental/NHS priorities through the established process for deciding which topics should be referred to NICE.

Officials from the Department of Health have met with representatives of the RCOG and will be commissioning the College to review its guidance. In addition, the Department of Health will be issuing best practice guidance on reproductive healthcare, which will include guidance on the commissioning of integrated abortion services, in the New Year.

30. While we recognise that obtaining informed consent is a process that is not always best carried out through leaflets and checklists alone, we recommend that abortion providers are required to ensure this information is given to patients as part of the process of informed consent. (Paragraph 163)

Providing high-quality information and advice, including written information, is already an intrinsic part of the treatment package, not just part of obtaining consent. The healthcare professional should ensure that a woman is fully informed about the procedure, risks and benefits when she first seeks an abortion and should offer her counselling.

Before proceeding with an abortion, both in the NHS and the independent sector, women sign a consent form to acknowledge that they are fully informed about the procedure, including risks, and that they have received appropriate literature and counselling.

In the independent sector, it is already a requirement under the National Minimum Standards of the Care Standards Act 2000, monitored by the Healthcare Commission, that written information is provided to women seeking or considering an abortion. In the NHS, currently it is good practice.

As part of the Health and Social Care Bill currently before Parliament, it is proposed to create a new regulator, the Care Quality Commission. Subject to Parliamentary approval, one of the functions of the Care Quality Commission will be to register care providers for the first time, including NHS providers as well as social care and independent sector healthcare providers.

The Government accepts the recommendation subject to Parliamentary approval for new regulation by the Care Quality Commission to monitor this provision where it is not already required.

31. To ensure that no patients are misled, we further recommend that the Government consider ways of ensuring that all those claiming to offer pregnancy counselling services make the guidelines available or indicate clearly in their advertising that they do not support referral for abortion. (Paragraph 164)

We note the Committee's recommendations.

Existing advertising guidelines state that no marketing communication should mislead, or be likely to mislead, by inaccuracy, ambiguity, exaggeration, omission or otherwise. Individual cases where this is being breached may be reported to the Advertising Standards Agency. We will work with the Committee of Advertising Practice to consider whether an advertising code applicable to pregnancy counselling would be appropriate.

32. We recommend that Members of Parliament, when considering the issue of health risks in the context of clinical guidance and informed consent, consider also our report and conclusions. (Paragraph 165)

See above.

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