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Abortion legislation: exploring perspectives of general practitioners and obstetrics and gynaecology clinicians

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Abstract Abortion legislation remains a contentious topic in the UK, which receives much attention from politicians, clinicians and professional bodies alike. In this study, the perspectives of general practitioners and obstetrics and gynaecology clinicians on the Abortion Act 1967 was explored. To this end, a short electronic questionnaire was distributed to all 211 GP and obstetrics and gynaecology clinicians affiliated with the University of Cambridge School of Clinical Medicine. Of the 100 anonymous responses collected, a significant majority felt that abortion law in Northern Ireland should be changed in line with the rest of the UK. The respondents’ votes, however, were either opposed to or divided over any other changes to the Abortion Act, including altering the 24 week time limit, clarifying the legal definition of fetal abnormalities, introducing abortion purely on the woman’s request, and modifying the requirement for two clinicians to approve any request for abortion. These perspectives were not entirely aligned with the recommendations of the Royal College of Obstetricians and Gynaecologists and the House of Commons Science and Technology Committee, or with current medical evidence and demographic data.

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Introduction

Nearly 50 years after the passage of the Abortion Act 1967, abortion remains a controversial and evolving area within UK law. Indeed, in the lead up to the Human Fertilisation and Embryology (HFE) Bill 2008, the Royal College of Obstetricians and Gynaecologists (RCOG) and the House of Commons Science and Technology Committee (STC) all expressed the view that certain aspects of the law on abortion should be changed (House of Commons, 2007). In turn, several amendments to the law on abortion were tabled during the consideration of the HFE Bill 2008, including clauses to extend the Abortion Act 1967 to Northern Ireland, to remove the requirement for two doctors’ signatures on abortion request forms, and to allow trained nurses to perform abortions (House of Commons, 2008). However, owing to insufficient time to debate and vote on these amendments, the law on abortion was not changed. Abortion law has also remained topical elsewhere in the European Union (EU), with Portugal, Spain and Luxembourg modifying their abortion legislation in 2007, 2010 and 2012 respectively (IPPF (International Planned Parenthood Federation), 2012; Center for Reproductive Rights, 2012).

Given the contentious and emotive nature of abortion legislation, this study aims to explore the perspectives of clinicians on whether or not UK abortion law should be changed. These perspectives are contrasted with the recommendations of the RCOG and STC, to explore whether a discrepancy exists between clinical, professional and political perspectives on abortion law. Similar work using questionnaires has been carried out with obstetrics and gynaecology clinicians in Great Britain (Savage and Francome, 2011) and in Northern Ireland (Black et al., 2001; Francome and Savage, 2011), as well as with British GPs (Francome and Freeman, 2000). This study builds on such work, by directly comparing the views of GPs with those of obstetrics and gynaecology clinicians, as well as with the recommendations of the RCOG and STC.

Materials and methods

A review of the literature was conducted using the NIH PubMed database to identify relevant past studies. Political and professional perspectives were also explored, using the RCOG website and the BBC News website, as well as the Hansard database of UK Parliamentary debates leading up to the Abortion Act 1967, the HFE Act 1990 and the HFE Act 2008. For comparison, abortion legislation in other European Union (EU) nations was reviewed (IPPF (International Planned Parenthood Federation), 2012). With the use of these resources, the most contentious areas of the Abortion Act were identified, and a survey was prepared to assess clinicians’ perspectives on these areas (Figure 1). Nine categorical questions (yes/no answers, or a single-choice answer from a selection of two or three options) were included, as well as optional free-text boxes for each question.

This study was completed as part of a final year medical student research project at the University of Cambridge School of Clinical Medicine. The Clinical School distributed the survey via email to all 211 GP and Obstetric and Gynaecology clinicians affiliated with the University, including both trainees and consultants. The contact details of these clinicians were

In England, Wales and Scotland, abortion is allowed until 24 weeks gestation if there is risk of injury to the physical or mental health of the woman or her existing children that exceeds the risk of abortion (Section 1.1.a).

Q1. Should the 24 week limit be reduced?

Abortion is allowed if there is substantial risk of abnormalities, such that the child, if born, would be seriously handicapped (Section 1.1.d). The nature of such abnormalities is not legally defined, and there is no gestational time limit for such abortions.

Q2. Should a gestational limit be set for Section 1.1.d?

Q3. Should ‘abnormalities’ be defined legally?

Legal abortion must satisfy the grounds of the Abortion Act, and is not allowed purely on the woman’s request at any stage of gestation.

Q4. Should abortion on the woman’s request be allowed?

Legal abortion requires two doctors to sign the HSA1 form in good faith.

Q5. Should only one doctor be required to sign?

Q6. Should a nurse or midwife be allowed to sign?

In Northern Ireland (NI), abortion is only legal if there is risk of grave permanent injury to the physical or mental health of the woman, or risk to the woman’s life.

Q7. Should the NI law be as for the rest of the UK?

Demographic data collection:

Q8. What is your specialty (Obstetrics & Gynaecology or General Practice)?

Q9. Do you routinely decline signing the HSA1 form for reasons of conscientious objection?

Figure 1  Survey questions, based on relevant sections of the Abortion Act (legislation.gov.uk).
not made known to the authors, and the survey responses were collected anonymously using SurveyMonkey, a free internet-based programme. Of the 211 clinicians contacted, 100 responded by completing the online survey. Chi-squared test for categorical data was used for statistical analyses ($P < 0.05$) taken to indicate statistical significance. The free-text responses were not subjected to detailed qualitative analysis, but extracts are included in the results of this mixed methods study to complement the quantitative findings.

Results

Up to 98% of UK abortions take place under Section 1.1.a of the Abortion Act 1967 (Department of Health, 2012), which allows for abortion until 24 weeks gestation (legislation.gov.uk). Only a small minority (3/100) of respondents approved of an increase in this time limit, although there was no consensus as to whether this limit should be decreased (41/100) or left unchanged (56/100) (Figure 2). Those who favoured a reduction mostly suggested time limits of 18–23 weeks, citing concerns about fetal viability and pain sensation at later gestation. In contrast, one respondent felt that later terminations often involve ‘the vulnerable women of our society, for whom an unplanned pregnancy is a disaster’, whereas another supported a limit ‘as late as possible before viability’.

Abortions is permissible under Section 1.1.d in cases of ‘substantial risk’ of ‘such physical or mental abnormalities as to be seriously handicapped’ (Legislation.gov.uk. Abortion Act, 1967). The terms ‘substantial risk’ and ‘abnormalities’ are not legally defined, and no upper limit of gestation is specified. Most (69/100) agreed that an upper time limit for this clause should not be set, as some abnormalities are only diagnosed late in pregnancy. Others, however, have suggested that most abnormalities are detected by 20 weeks, and so a limit should be imposed at the threshold of fetal viability. The respondents were split over whether the definition of ‘abnormalities’ should be clarified legally. Many warned that a legal definition would be ‘impractical and cause more problems’, urging that the decision should be left to the ‘discretion of clinician and patient’ to allow ‘flexibility’ for personal and cultural perspectives and ongoing ‘medical science advances’. Conversely, one clinician suggested that termination ‘should be limited to life threatening abnormalities only’, with three respondents isolating cleft lip as a condition that should not warrant legal abortion.

Abortion purely on the woman’s request is not strictly legal in the UK. However, as the risks associated with pregnancy generally outweigh the risks associated with early abortion, termination is effectively available in nearly all cases under Section 1.1.a (BMA (British Medical Association), 2007). Only a minority of clinicians (33/100) felt that the law should be changed to allow for abortion purely on the woman’s request. Of the 33 free-text responses returned, 18 took the opinion that UK legislation ‘effectively’ offers abortion on request, and so the law does not need to be amended, with some stressing that the law is in fact already too permissive. The majority of those who supported abortion on request, however, suggested that it be available only until 12–13 weeks gestation.

At present, a legal abortion requires the approval of two registered doctors. Only 30/100 respondents felt that the law should be changed so that only one doctor is required to sign the form, as the current law facilitates ‘safety-netting’ and helps ‘prevent unscrupulous practices’. Those opposing the need for two signatures, however, argued that the current law is ‘archaic’ and purely ‘administrative’, as the second clinician is often not greatly involved in the patient’s care. In contrast, there was no consensus over whether nurses and midwives should be allowed to provide one of the two signatures (45/100 ‘yes’ versus 55/100 ‘no’). Some felt that changing the law would further ‘trivialize’ termination and ‘make it too easy’ to obtain an abortion, whereas others stressed that only clinicians ‘competent to perform the procedure’ should be allowed to sign. A minority of respondents contended that nurses and midwives should take on this responsibility subject to suitable training, and that this would be in keeping with the culture of ‘multidisciplinary working’.

The Abortion Act 1967 does not apply in Northern Ireland, and terminations are only permissible if there is risk of grave permanent injury to the physical or mental health of the woman, or risk to the woman’s life (IPPF (International Planned Parenthood Federation), 2012). A significant majority of all respondents (84/100) felt that the law in Northern Ireland should be changed so that it is consistent with the rest of the UK. Some asserted that termination should be a ‘secular decision’, and that the current law is ‘archaic and smacks of religious input’. Five respondents, however, took the view that it should be up to Northern Ireland to decide their own laws,
whereas another felt that ‘education and cultural shift’ are required before changing the law. Indeed, another four respondents argued that the law in Northern Ireland is ‘better’ than the law in the rest of the UK.

Roughly equal numbers of GPs ($n = 58$) and obstetrics and gynaecology clinicians ($n = 42$) responded to the questionnaire, and the responses from both groups were broadly similar (Figure 3). Obstetrics and gynecology clinicians, however, were significantly more likely than GPs to respond that abortion on request should be allowed ($19/42$ versus $14/58$; $P < 0.05$), and that only one doctor should have to sign the HSA1 form ($18/42$ versus $12/58$; $P < 0.02$), whereas obstetricians and gynaecologist clinicians were less likely than GPs to vote for defining an upper time limit for Section 1.1.d ($6/42$ versus $25/58$; $P < 0.01$).

Respondents were also asked whether they personally routinely decline completing HSA1 forms for reasons of conscientious objection. A minority answered yes ($22/100$; $P < 0.05$), and their answers differed significantly compared with non-conscientious objectors for almost every question (Figure 4). Indeed, conscientious objectors were more likely to support a decrease in the 24 week time limit ($16/22$ versus $25/78$; $P < 0.001$), a clear definition of ‘abnormalities’ ($15/22$ versus $31/78$; $P < 0.02$), and an upper time limit for abortions involving such abnormalities ($12/22$ versus $19/78$; $P < 0.01$). They were also more likely to oppose abortion on request ($20/22$ versus $2/78$; $P < 0.001$).
Comparison of questionnaire responses with recommendations of the Royal College of Obstetricians and Gynaecologists

Discussion

Of the proposed changes to the Abortion Act 1967 described above, only the application of the Act in Northern Ireland received majority approval from respondents, with the remaining changes receiving either a split vote or majority disapproval (Figure 5). In contrast, the RCOG and the STC have recommended that only one clinician should have to sign the HSA1 forms, and that nurses and midwives should be allowed to provide the second signature, as well as supporting the application of the Abortion Act in Northern Ireland (House of Commons, 2007). These two bodies have not commented on abortion on request, although the British Medical Association has recommended that abortion on request should be available in the first trimester (BMA (British Medical Association), 2007).

The respondents who favoured a decrease in the 24-week limit cited concerns about fetal viability and pain sensation at 24 weeks, as well as hopes to decrease the overall abortion rate. The RCOG and the STC, however, have reported that the threshold of fetal viability and pain sensation has not improved significantly since the 24-week limit was defined by the Human Fertilisation and Embryology Act 1990, citing the highly regarded EPIcure study (Marlow et al., 2005). Further, only 0.1% of all abortions take place beyond 24 weeks, with over 91% being performed before 13 weeks gestation, so it is unlikely that reducing the 24 week limit would significantly reduce the national abortion rate (Department of Health, 2012). It is similarly unclear whether the introduction of abortion on request would greatly affect the UK abortion rate. Indeed, 21 out of the 27 European Union member states now allow abortion on request until 12 weeks (18 weeks in Sweden), and most of these nations have abortion rates lower than in the UK (Center for Reproductive Rights, 2012; Gissler et al., 2012). The RCOG and the STC also stressed that there is no good evidence that the requirement for two doctors’ signatures serves to safeguard women or doctors, and that the status quo may in fact cause avoidable delays leading to later abortions (House of Commons, 2007).

As such, it appears that the views of the respondents do not align exactly with those of the RCOG and the STC, or with the scientific evidence and demographic data on UK abortion. Indeed, it is striking that, in many of the free-text responses collected, the clinicians justified their views in terms of personal morality, rather than best practice guidelines and evidence. UK clinicians are entitled to object to procedures (not limited to abortion), even where such procedures are supported by guidelines, evidence and legislation. They are, however, duty-bound to explain their objection to their patients, and ensure that they are seen by an alternative doctor (GMC (General Medical Council), 2013). As such, it is interesting to consider to what extent organisations such as the RCOG and the Royal College of General Practitioners should reflect the views of its members, where these views may sometimes conflict with the available evidence and guidelines.

It is worth noting that the discrepancy between the respondents’ views and those of the RCOG and the STC may be partly due to inherent study limitations, including small sample size and response rate (100/211 clinicians contacted). As data were collected anonymously, we are unable to comment on the nature of non-responders, or on the gender, age, or grade of training of those who did respond. Furthermore, the respondents were all based at teaching hospitals and GP practices throughout East Anglia affiliated to the University of Cambridge. As such, it is possible that their perspectives on abortion legislation were influenced by local factors (e.g. age, socioeconomic status and abortion rate among their patient population), which may differ from the rest of the UK. Indeed,

<table>
<thead>
<tr>
<th>Question</th>
<th>Survey</th>
<th>RCOG / STC</th>
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<tbody>
<tr>
<td>Should the 24 week limit be reduced?</td>
<td>Split</td>
<td>No</td>
</tr>
<tr>
<td>Should the 24 week limit remain unchanged?</td>
<td>Split</td>
<td>Yes</td>
</tr>
<tr>
<td>Should the 24 week limit be increased?</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Should a time limit be set for 1.1.d?</td>
<td>No</td>
<td>No</td>
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<tr>
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<td>Yes</td>
</tr>
<tr>
<td>Should the NI law be as for the rest of UK?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
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Figure 5 Comparison of questionnaire responses with recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) and the House of Commons Science and Technology Committee (STC); *The RCOG and the STC did not comment on whether abortion on request should be allowed.
the abortion rate in Cambridgeshire (10.7 per 1000 women aged 15–44) is significantly lower than in England overall (17.6 per 1000), although other areas in East Anglia have higher (e.g. 21.7 per 1000 in Peterborough) or similar (e.g. 16.9 per 1000 in Bedfordshire) rates compared with the rest of England (Department of Health, 2012).

Conclusions

Abortion legislation remains a matter of professional and political debate. The British Medical Association’s ethical-legal guidance on abortion suggests that the moral considerations essentially relate to three stakeholders: the woman, the fetus, and society (BMA (British Medical Association), 2007). They explain that advocates of permissive legislation argue in favour of the woman’s autonomy over her body, whereas those favouring restrictive legislation argue that abortion ‘diminishes the respect society feels’ for its more vulnerable members. Thus, it is important that legislation keeps abreast of both new evidence and evolving public, professional and political perspectives, to ensure that the Abortion Act best considers the interests of pregnant women and society as a whole.

This study reveals a lack of consensus between individual clinicians over many areas of the Abortion Act, as well as between clinicians and bodies such as the RCOG. Further work is needed to explore the reasons for this lack of consensus, and to investigate to what extent (if any) clinicians’ perspectives impact the application and evolution of abortion legislation in the UK.

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