

Legal interpretation of the Abortion Act 1967: the role of nurses in surgical induced abortion

Gill Wakley

Background

The review by Argent and Pavey¹ in this issue of the *Journal* analyses the Abortion Act 1967 and subsequent case law and concludes that health professionals, not just registered medical practitioners, can legally perform surgical abortion under certain conditions. The health professionals should be suitably trained and be under the direction of a registered medical practitioner, who may not need to be physically present throughout the procedure. Like many other procedures, legal abortion care is currently provided by a team that includes both nurses and doctors.

Of course, we still need the best possible access to and provision of contraception, and especially an increase in the use of long-acting methods, to try and prevent the need for abortion. Increased openness about discussing sexual feelings and activity with early, gradual and repeated information requires a social, not just a medical, change. But the need for abortion will not disappear in the near future. No-one is perfect, nor are contraceptives infallible.

The proposal here is not about the rights and wrongs of abortion. It is not about changing the present Abortion Act. It is about the legal interpretation of the Abortion Act, which clarified the situations in which pregnancies might be ended. The Abortion Act 1967 also provides protection from prosecution for those who terminate pregnancies under its regulation. The Act restricts the availability of abortion to premises licensed for the purpose, controls access by imposing the agreement of two doctors to the procedure, and requires procedures to be carried out under the supervision of a registered medical practitioner. The Act was extremely successful in making the procedure much safer.

Historical perspective

We should not forget that abortion was a common occurrence before the 1967 Abortion Act. The first references to abortion in English law appeared in the 13th century. It followed Christian teaching that abortion was acceptable until 'quickening' occurred, at which time it was believed that the soul entered the body. In 1803, the law became restrictive and abortion became a criminal offence from the time of conception, with penalties of up to life imprisonment for both the pregnant woman and the abortionist. In 1861, Section 58 of the Offences Against the Person Act 1861 made abortion a criminal offence punishable by imprisonment from 3 years to life, even when performed for medical reasons. No further legal changes occurred in England until 1929. The Infant Life (Preservation) Act 1929 amended the law so that abortion would no longer be regarded as a felony if it was carried out in good faith for the sole purpose of preserving the life of the mother. Abortion was hidden

unless things went wrong. A parliamentary commission, set up to investigate abortion in 1959, estimated that one in five gynaecological admissions were for the complications of an illegal abortion. One study of 44 women in Holloway Prison in London, UK for criminal abortion in the early 1960s revealed that most were ordinary women between 50 and 70 years of age, who gave their employment as housewives or retired, motivated by a desire to help other women. While poorer women resorted to their neighbours, women who had money could pay for a psychiatric opinion and a private abortion by a doctor.²

Current situation and future considerations

Women still face problems obtaining an abortion. The main problems now are those of organisation and funding, rather than because of the law itself. Access to National Health Service (NHS) facilities has improved but is not available to everyone in all parts of the UK and is often under threat. In 2005, 40% of abortions were performed in NHS hospitals and 44% in approved independent sector places under NHS contract (NHS Agency). The remaining 16% were privately funded.³

Staffing NHS units is always a problem, increased by the vociferous opposition of a minority, unreliable media reporting and polarised debate. Choice of method and access may be limited by lack of trained staff. A survey of younger doctors working in obstetrics and gynaecology in 1999⁴ found that many declare a conscientious objection to abortion more because of lack of training than from religious or moral beliefs.

Nurses, after training, perform many gynaecological procedures such as hysteroscopy, colposcopy and insertion of intrauterine contraceptive devices. Nurses, as part of a team, perform the majority of medical abortions and can easily acquire the technical skills required for surgical termination of pregnancy in the first trimester. Argent and Pavey¹ provide references to regions where nurses and physicians' assistants safely carry out surgical abortions. Although the proportion of medical abortions is increasing (24% of the total in England and Wales in 2005 compared with 19% in 2004),³ there is still a need for surgical techniques. An expansion of the role of nurses could offer improvements in the quality and access of provision.

The way forward might be:

- Seek a Directive from the Department of Health.
- Confirm the legality of the procedure with the General Medical Council and Nursing Midwifery Council, who may wish to seek an opinion from Counsel.

If all are agreed with the analysis outlined in the Argent and Pavey review:¹

- Amend the Faculty of Family Planning and Reproductive Health Care Abortion Syllabus⁵ to include nurse training for first-trimester surgical termination procedures.
- Include first-trimester surgical termination procedures in the guidelines on practice⁶ produced by Royal College of Nursing: Nurses Working in Termination of Pregnancy Group.
- Set up a NHS pilot site where health care practitioners can be trained by an accredited abortion trainer.

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A BETTER WAY OF WORKING**Development of UPCASH (Update in Contraception and Sexual Health) Flexible Continuing Medical Education**

Fran Reader

Why was change needed?

Continuing Medical Education (CME) is an essential part of clinical governance. As lead clinicians we were involved in updating staff, working in reproductive and sexual health, in our own services and primary care. We wanted a flexible CME tool that could be used for the variety of settings in which we offer updates and refreshers and which could also be used for self-directed learning.

How did you go about implementing change?

The flexible CME package was initially developed in Suffolk, UK in 1997. It was a flexible package of five modules that offered a refresher and updating of knowledge in the fields of both reproductive and sexual health.¹

Since the initial work the multiple-choice questions (MCQs) have been used in a variety of ways as a CME tool. A typical approach was for an MCQ to be sent in advance to CME participants followed 1 week later by a CME discussion group, facilitated by an experienced practitioner. At the group meeting the short answers were given and a discussion followed. At the end of the meeting the longhand answers were circulated.

In 2005/2006 the UPCASH Development Team updated the reproductive health part of the package and

developed the UPCASH website (www.upcash.co.uk).

The current flexible package contains four reproductive health modules as follows:

- 1 Hormonal contraception
- 2 Non-hormonal contraception
- 3 Uterine contraception
- 4 Emergency contraception.

This package will be updated in January each year or as appropriate if essential information changes. In 2007 it is hoped to expand the package to include modules in termination of pregnancy and the menopause.

Sections can be downloaded from the website and used by trainers to pick and mix from the modules. The modules can also be used to support self-directed learning at home.

The website contains the complete CME package; the MCQs for each of the four modules, together with the short and long answers where the true and false answers are expanded and points for discussion explained. Relevant references are also provided.

What advice would you give to others considering a similar course of action?

The UPCASH site is not copyright protected and so the modules can be downloaded and adapted for local training programmes. We would, however, expect both the website and the original authors to be acknowledged.

How did you show that change had occurred?

This was demonstrated by positive evaluation of training events.

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Reference

- 1 Reader F, Hunt K, Passmore H, Royce S, Adapa U. Professional development in reproductive and sexual health – a pilot study from Suffolk, UK. *Br J Fam Plann* 1999; **24**: 135–140.

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