Reforming abortion services in the UK: less hypocrisy, more acknowledgment of complexity

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BACKGROUND

A moment when the world's most powerful country has just elected one of its most anti-abortion presidents might seem an odd time for UK abortion care providers to be seeking the liberalisation of Britain's abortion law. But 50 years on from the passing of the 1967 Abortion Act, abortion care in the UK is heading towards a crisis, and practitioners are undeterred by the political climate. This is reflected in the founding of a new support organisation for service providers, the British Society for Abortion Care Providers (BSACP),[1] a new campaign for legal reform by the UK's largest service provider, the British Pregnancy Advisory Service (BPAS),[2] active consultation processes on abortion care quality and legal reform within the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual & Reproductive Healthcare (FSRH), and a constant stream of material submitted to this journal.[3–13]

CHALLENGES

Among many challenges women seeking abortion face, inequitable access, inadequate numbers of appropriately trained staff, stigmatisation, and a culture of exceptionalism, or ghettoisation, have often been highlighted.[14 15] Much abortion care in the UK is provided outside the National Health Service in specialist organisations, excluding students and trainees, among them the potential service providers of the future. As well as reinforcing stigma, this deprives trainees of valuable learning opportunities. It is noteworthy that while the RCOG has offered an Advanced Training Skills Module in abortion care since 2007, fewer than 1% of trainees completing such modules have taken it (RCOG, personal communication, November 2016).

OPPORTUNITIES

For practitioners not excluded by conscientious objection – a right which within limits must be upheld and respected[16] – abortion care offers an important learning environment. Here, we encounter the same women whose babies we may also deliver at other times, but at a different stage in their reproductive life-course. We gain confidence and skill in early pregnancy examination and safe uterine intervention, and see medical and surgical care in a complex ethical, legal and biopsychosocial context. This teaches high-level, transferrable consulting skills. All practitioners need to be able to facilitate ethically complex, patient-centred decision making with interest, confidence and self-reflection.

ABORTION LAW

Problems of access and stigma, familiar worldwide, are compounded in the UK by an abortion law that is now widely seen as not fit for purpose. Framed as a medically sanctioned defence against a piece of criminal law passed in 1861,[17] UK law is out of step with technical advances in safe medical abortion, the trend away from paternalism towards patient-centred and nurse-led services, and current UK social values.[18] Hence, while many women now attend our services in early pregnancy believing they have a right to make their own choice, as they would in most of Europe[19] – British law still requires the identification of serious physical or mental health risk by two doctors not necessarily qualified in psychological disciplines, who may not know the woman personally. There is broad consensus among practitioners that this is hypocritical and anachronistic.

REFLECTION

But if the law is to be reformed as BPAS, the Royal College of Nursing, the Royal

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College of Midwives, and other women's health organisations propose, space must first be made for reflective debate. That debate needs to place women's wellbeing centre stage, but also acknowledge ethical complexity. Agreeing how far a woman's autonomy can be extended, and what processes can best safeguard this core value while also acknowledging its ethical context, will require a degree of mutual respect which has been lacking. We need to move beyond the kind of violent communication that sees a minority of so-called 'pro-life' campaigners bullying women seeking abortion, and a minority of so-called 'pro-choice' campaigners refusing to acknowledge moral complexity. Achieving social consensus will be no less demanding a process than that faced by each individual woman forced to weigh serious and conflicting concerns in considering whether to end her pregnancy.

ACKNOWLEDGING COMPLEXITY

In joining this debate, we must not as practitioners fall into the trap of focusing narrowly on clinical concerns and conceding the moral debate to extremists – an argument made cogently in a new book reviewed in this issue.[9 11] For many women seeking abortion, acknowledging it as a sad and serious event seems an essential part of reaching a decision that they can live with and learn from. For others, the decision is more straightforward, and individual difference needs to be respected. But where ambivalence, guilt, regret or other 'difficult' feelings do exist, we should not, in our eagerness to avoid 'abortion-negativity', suppress these. Abortion care must not be an obstacle course, but neither should it be a conveyor belt.

WHAT IS IN THIS JOURNAL ISSUE?

One casualty of exceptionalism and factionalism is good evidence to inform care quality. While two articles in this journal issue highlight specific areas in which UK abortion care could improve – cervical preparation before,[10] and contraceptive provision after,[8] abortion – a systematic review highlights a much broader problem with agreement over care quality indicators.[3] A linked commentary calls for valid quality criteria to be set in the UK.[4] Looking at an Australian experience of abortion law reform, a mixed methods study of practitioners' views cautions that despite empowering women and increasing clarity and safety for practitioners, it failed to address stigma, access and workforce sustainability.[5]

Other contributions remind us that apparently neutral language can reinforce stigma,[7] and of the 'inverse care law', which compounds disadvantage for poor women, wherever services are poorly accessible.[12]

So your contributions on abortion keep flooding in, because abortion care remains a high-volume, under-researched and under-integrated area of women's healthcare. And 2017 is an excellent time for practitioners to be challenging hypocrisy and exceptionalism in UK abortion care, and leading respectful debate centred on women's needs, with complexity acknowledged.

Competing interests None declared.

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Erratum: 'Reforming abortion services in the UK: less hypocrisy, more acknowledgment of complexity'

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An editorial in our January issue contained the erroneous statement that the Royal College of Nursing (RCN) supported the British Pregnancy Advisory Service's We Trust Women campaign - a campaign seeking abortion law reform in the UK. It was pointed out to us that RCN has no such policy. The Journal wishes to apologise unreservedly to the RCN for this error in a sensitive area of debate.

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JOURNAL OF FAMILY PLANNING AND REPRODUCTIVE HEALTH CARE

Abortion care in the UK is "heading towards a crisis", warns expert

The law is now widely seen as not fit for purpose

Abortion care in the UK is "heading towards a crisis" and reform of the law is just one of the many obstacles that needs to be overcome, argues an expert in the **Journal of Family Planning and Reproductive Health Care**.

Among the challenges women seeking abortion face include inequitable access, a lack of trained staff, stigmatisation, and a culture of exceptionalism, explains Dr Sandy Goldbeck-Wood, editor in chief of the journal, and clinical lead for abortion services at Cambridge University Hospitals.

She argues that "problems of access and stigma, familiar worldwide, are compounded in the UK by an abortion law that is now widely seen as not fit for purpose" which is considered to be "out of step with technical advances in safe medical abortion and current UK social values."

Most women believe they have a right to make their own decision about abortion, but British law still requires the identification of serious physical or mental health risk by two doctors not necessarily qualified, and who may not know the woman personally.

The law is, therefore, widely seen by clinicians as "hypocritical andanachronistic," explains Dr Goldbeck-Wood.

Another problem is that abortion care has become artificially separated from the rest of reproductive health care, she adds. In the UK, a high proportion of abortion care is provided in specialist organisations outside the NHS.

Trainees in obstetrics and gynaecology - among them the potential service providers of the future - have too little opportunity to benefit from the learning environment that abortion care offers.

"As well as reinforcing stigma, this deprives trainees of valuable learning opportunities," she says

Organisations calling for the law to be reformed include the British Pregnancy Advisory Service, the Royal College of Nursing, the Royal College of Midwives and other women's health organisations.

And if the law is to be reformed, says Dr Goldbeck-Wood, there will be a strong need for debate which is respectful and acknowledges the ethical complexity in this sensitive area of health care.

"Abortion care remains a high-volume, under-researched and under-integrated area of women's healthcare," she writes. "2017 is an excellent time for practitioners to be challenging hypocrisy and exceptionalism in UK abortion care, and leading respectful debate centred on women's needs, with complexity acknowledged."

A study led by Dr Louise Keogh, from the University of Melbourne, assessed the decriminalisation of abortion in the Victoria state of Australia in 2008.

It found that a change in the law has empowered women, and increased clarity and safety for clinicians, but has failed to address stigma, access to services and workforce sustainability.

Commenting on the study, Sally Sheldon, professor of law at Kent University, says that the abortion law reform in Victoria has vital lessons for the UK.

She says that removal of specific criminal prohibitions against abortion “should not be seen as a panacea”, even though it is important to remove criminal law prohibitions and to establish abortion care as a health issue.

Much more work is needed to remove stigma, encourage doctors to provide terminations, and improve “equitable access to excellent, modern abortion services,” she concludes.