Termination of pregnancy

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 31/05/19 **email:** ToP@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Christian Medical Fellowship
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**None**

Please return to: ToP@nice.org.uk

Termination of pregnancy

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 31/05/19 **email:** ToP@nice.org.uk

Name of commentator person completing form:	Philippa Taylor
Type	[office use only]

Comment number	**Document** [guideline, evidence review A, B, C etc., methods or other (please specify which)]	**Page number** Or **'general'** for comments on whole document	**Line number** Or **'general'** for comments on whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	Guideline	16	45	We are concerned that this recommendation may imply that ……..
Example 2	Guideline	17	23	Question 1: This recommendation will be a challenging change in practice because ……
Example 3	Guideline	23	5	Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact…….
Example 4	Guideline	37	16	This rationale states that…
Example 5	Evidence review C	57	32	There is evidence that …
Example 6	Methods	34	10	The inclusion criteria …
Example 7	Algorithm	General	General	The algorithm seems to imply that …
1		General	General	Please note that we suggest alternative or additional wording to replace, amend or add to the NICE draft guidance, with reasoning evidence provided for each proposal. Our alternative guidance wording is clearly highlighted as **bold blue text.** The rationale of the draft guidance is that an abortion is a right rather than a procedure that is permitted under the law only in certain circumstances. See pages 45-55 which states that: "*Termination of pregnancy is an integral part of reproductive health care for women… This guideline will help ensure that termination procedures are carried out based on*

				the best available evidence, and that a choice of services is easily accessible to all women who request a termination of pregnancy." We are concerned that no details are provided about the duty of commissioners and providers to satisfy the requirements of the law. This should be the basis of the guidelines and reiterated throughout in order to ensure that the law is complied with. The Department of Health Required Standard Operating Procedure (RSOP) 1 states that: '*The law provides that, except in emergencies, two doctors must certify that in their opinion, which must be formed in good faith, at least one and the same grounds for abortion set out in the Act is met*.[1] Also, the Care Quality Commission (Registration) Regulations 2009, Human Medicines Regulations 2012 and regulations on the use of abortion pills at home all cover terminations. We are concerned that not all service providers, and certainly not service users, will be aware of the law and the legal framework surrounding abortion. **We recommend that references to the legal framework be more visible at all relevant points in the guidance.**
2		General	General	We are concerned that, from the settings listed in the scope, the time of 'Requesting termination of pregnancy' is not well delineated. The decision is usually a process over time, starting with an approach to a GP or abortion provider for a consultation, deciding to have the abortion and then actually proceeding with it or not. Clinical experience shows there may be a large degree of ambivalence at all points. A woman may have a consultation with a provider in order to explore the options and decide to proceed, but may continue with ambivalence and go back on that decision later on. We think this needs to be taken into account as the number of terminations carried out may increase substantially if this guidance assumes all requests are definitive or even autonomous at the point of first contact. It is clear from the draft wording of 1.1.1 and 1.1.2 (page 4, lines 4 and 9) that enabling the woman to reach the point at which she can 'request termination of pregnancy' is being *included* within the guidance. If that is NICE's approach then equally there must be more about information and counselling provision as a means to helping the woman make the request in a fully informed manner.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313443/final_updated_RSOPs_21_May_2014.pdf

3		General	General	There is no guidance provided for women who change their minds after an initial decision to have a termination.
4	Guideline	4	4	**1.1.1 Commissioners and providers should work together to:** • **make information about termination of pregnancy services (including how to access them) widely available** • **ensure that women are promptly referred onwards if a service cannot provide a termination of pregnancy after a specific gestational age or by the woman's preferred method.** We are concerned that making information widely available about abortion services is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy' - you do not need to tell people how to access a service that they have already accessed. Making information about termination of pregnancy services 'widely available' will reach women BEFORE the 'entrance point' and their decision making (as well as after) so this must be balanced with making information about alternative options widely available. In which case the guidance must correlate to both GMC and BMA guidance which encourages doctors to explain to patients the importance of knowing the options open to them while respecting a person's wish not to know. As noted in our general comment 2 above, even after the entrance point to the guidance, it cannot be assumed that the decision is final. NICE guidance must correlate with RSOP 14 which says: "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and* ***this offer should be repeated at every stage of the care pathway.***" Women should, as part of the information provision, and in order to ensure there is valid informed consent, be informed of possible adverse outcomes or complications of the procedure. **Montgomery ruled that doctors must spell out *any* (even tiny) material risks and any reasonable alternatives in dialogue with patients.**[2] For example, there is evidence of a small but real risk of physical complications from abortion, including subsequent preterm birth and for some women, a risk of mental health problems post abortion.[3]

[2] Montgomery v Lanarkshire Health Board UKSC 11. 2015.

[3] The review into the mental health outcomes of induced abortion by the Academy of Medical Royal Colleges found that women with mental health problems before an abortion were at greater risk of mental health problems post abortion. It also found that other factors may be associated with increased rates of post-abortion mental health problems, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion or experiencing other stressful life events.

				It is therefore in the interest of providers to ensure that all women with an unplanned pregnancy have sufficient information about the different options, and the risks involved, before consenting to proceed with the option chosen. Our experience at CMF, working with members who have had well over 30 years of practice, is that around a third of women continue their pregnancies after being offered reassurance and help, and none have regretted this whereas many regret TOPs even decades later. **We would be willing to present our experiences to the Committee**. **If 'information on termination' is to be made 'widely available', then information on *alternatives* to termination must also be made widely available, as both will reach women prior to the entrance point as well as after.** **At minimum we propose referring to the DoH guidance for abortion providers, which states that women: 'must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally and covering:'** ■ Alternatives to abortion (for instance adoption and continuing with the pregnancy) ■ Abortion methods appropriate to gestation ■ The range of emotional responses that may be experienced during and following an abortion ■ What to expect during and after the abortion (including potential side-effects, complications and any clinical implications). ■ Full discussion of contraception options and the supply of chosen method ■ Testing for sexually transmitted infections including HIV and strategies in place for infection prevention' Propose that the guidance additionally states: • **Make information about termination of pregnancy services, continuing with an unplanned pregnancy and adoption options (including how to access them) widely available** **Or** • **Make information about termination of pregnancy services and alternative pathways and options (including how to access them) widely available.** **And:**

				• **Women must be informed that they have a right to change their minds at any time, that the procedure can be postponed or cancelled and that they remain free to continue with the pregnancy, if they wish.**
5	Guidance	4	9	**1.1.2 Commissioners and providers should allow women to self-refer to termination of pregnancy services.** We are concerned that this guidance is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy'. If self-referral takes place before the woman has made a request and decision on termination then this guidance is out of scope and should be removed (making an appointment with an abortion provider comes before the request for the termination) If the self-referral is to an abortion clinic after a request has been approved and complies with the law, then the guidance must clarify this, and stipulate that woman can only proceed with self-referral with a signed HSA form. We have the additional following concerns: If women self-refer, how does this meet the law's requirements that two doctors have separately formed the opinion, in good faith, that to continue the pregnancy would constitute a risk to the physical or mental health of the woman, greater than if the pregnancy were terminated? If women self-refer, how will it be ensured that a medical professional has provided objective gestational age dating? If women self-refer, how will it be ensured that there has been screening for medical and psychological contraindications?[4] If women self-refer, how will it be ensured that there is no coercion or intimate partner violence (IPV) for vulnerable women? What is the evidence basis for this guidance? It is very poor and surveys find the opposite:

[4] https://www.aafp.org/afp/2006/0301/p925a.html

				92% of women thought they should always be seen in person by a doctor when requesting an abortion.[5] In an ICM survey 38% of respondents said two doctors should see a woman compared to 15% who said no legal approval should be required, and 12% who said it should be one doctor, midwife or nurse.[6] **We propose that this guidance is removed as it is out of scope** **If it is not removed, then add:** • **Commissioners and providers should allow women to self-refer to termination of pregnancy services, after it is confirmed that the abortion is legally permitted, the relevant HSA forms are signed and she is screened for any medical contraindications**
6	Guidance	4	11	**1.1.3 Healthcare professionals should not allow their personal beliefs to delay access to termination of pregnancy services.** If a request for termination does not fulfil the parameters of the law, the healthcare professional should not refer a woman for a termination. Professionals may have a valid reason not to participate or refer a woman and declining or delaying access does not imply stigma nor may it be a reflection of personal beliefs but that abortion is not clinically indicated. If a healthcare professional does hold personal beliefs that are opposed to termination, s/he has the right to exercise his/her freedom of conscience in this. As long as the woman has the information she needs (as per GMC guidance), the healthcare professional has fulfilled his/her responsibility within the law. S/he should not be required to go against her conscience. The UK Equality Act (2010) prohibits direct or indirect discrimination on the grounds of religion and belief, amongst other grounds. It is strongly arguable that the 'philosophical belief' in the sanctity of life from conception would be protected under its provisions. A clinician holding this belief, whether for religious reasons or otherwise, and who is required by her

[5] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf
[6] https://www.icmunlimited.com/wp-content/uploads/2017/10/OlOm-Abortion-Documentary-v2.pdf

				professional body to refer her patient for a procedure that is at odds with her convictions, would therefore have a case under the terms of the Equality Act. Following a recent European Court of Human Rights decision, ([2013] IRLR 231) the protection afforded under Article 9 of the European Convention of Human Rights (ECHR) has been expanded to protect 'a practice or manifestation motivated, influenced or inspired by religion or belief....regardless of whether it is a mandatory requirement of the religion or belief'. Further, the Court determined that the availability of alternative employment in the workplace, that would accommodate the employee's beliefs, is no longer to be a limiting factor. Thus healthcare professionals may well be able to claim that to be 'required' to participate in the process would make them complicit in any subsequent abortion and would discriminate against them under the terms of the ECHR. We are concerned therefore that this recommendation will place undue pressure on medical staff with conscientious objection to refer women to termination. We have concerns that some healthcare professionals may allow their personal beliefs to pressure women into accessing termination of pregnancy services more quickly than they are comfortable with, which is a particular concern if the woman is ambivalent at all. There is evidence already that this is happening. A report on MSI clinics by the CQC said that women who had decided not to have an abortion – and were less than five and a half weeks pregnant – 'were being called and offered a later appointment'. Inspectors found evidence that this was a policy across all 70 Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses. [7] The following proposed wording provides a necessary balance to the current draft: • **Healthcare professionals should not allow their personal beliefs (or an employer) to pressure a woman into having an abortion but must ensure she knows she is able to change her mind at any time** • **Healthcare professionals must ensure that a termination is clinically indicated and within the law**

[7] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

				• **Healthcare professionals who want to exercise their conscientious objection to providing or referring women to termination should follow professional guidance such as the GMC.**
7	Guidance	4	13	RSOP 14 states that '*Care pathways to antenatal services for those who choose to continue their pregnancy, and for women considering adoption, should be in place.*' If funding is provided for terminations for eligible women, it should be provided for antenatal care. All options must be supported. Unless funding for all options is offered upfront, for women who need it, there is a clear message that the preferred option is termination. **Commissioners should consider upfront funding for travel and accommodation for women who are eligible who have changed their mind about a termination and are considering continuing the pregnancy and either keeping the baby or placing it for adoption.**
8	Guidance	4	18	The evidence for this is limited and the recommendation here for minimal delay is not backed up by the evidence cited. More common reasons for later terminations are not delays in access but women's uncertainty in the decision or not realising they were pregnant. Decisions on termination for some women can be difficult and require time to think, not pressure to make quick decisions.
9	Guidance	4	21	**1.1.6 Ensure minimal delay in the termination of pregnancy process, and ideally:** • **provide the assessment within 1 week of the request** • **provide the termination of pregnancy within 1 week of the assessment.** Evidence shows that women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – in polls 79% agree compared to 9% who disagree with this.[8] (While this poll is not a pure subset of women having terminations, it will include many women who have had terminations and these guidelines should recognise that abortion research is unusual due to the emotional and highly personal nature of the procedure and its implications. As a result, many women will have views and experiences but not want to talk about them. Data from follow ups after abortion may be skewed as women with negative experiences may be keen to forget

[8] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf Q6.

				them and move on, whereas those who are keen or willing to engage in follow up are more likely to be those with a positive view of abortion in general. Hence the value in qualitative research as well as polling data and quantitative data) Peer reviewed evidence also warns that: *'Hasty early abortions as well as delayed abortions create problems and should be avoided.'* [9] And some women find the decision to terminate "*difficult and reported that it took them time to decide to proceed with it."* [10] See also Ingham et al.[11] Despite the regulation in RSOP 8 that consent must '*Be provided voluntarily and without undue pressure on the woman to accept or refuse treatment*', this draft guidance could put undue pressure on women to proceed quickly. There is evidence already that this is happening. A report on MSI clinics by the CQC said that women who had decided not to have an abortion – and were less than five and a half weeks pregnant – 'were being called and offered a later appointment'. Inspectors found evidence that this was a policy across all 70 Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses. [12] For balance, and based on evidence, the guidance needs not just to focus on speeding up the abortion process but must ensure women do not make too hasty a decision and that there is no undue pressure on women. Even if a woman has been offered a termination, and fits the legal criteria, as with any medical operation, some women will change their minds about it, and this must be made clear to all women. Add in following guidance:

[9] Holmgren et al, 'Ambivalence during Early Pregnancy among Expectant Mothers', Gynecol Obstet Invest 1993;36:15–20

[10] This is of women who had awareness of their pregnancy at an early stage. Marie Stopes International. Late Abortion: A Research Study of Women Undergoing Abortion between 19 and 24 Weeks Gestation. London, MSI, 2005

[11] '…for *all age groups and gestations, most reasons for delay are best considered "woman-related'' – i.e. delays in suspecting and confirming the pregnancy and in* ***deciding to have an abortion*** *–* ***rather than "service-related"****. This suggests, for England and Wales at least, limits on the extent to which policy changes directly related to early abortion services can be expected to reduce the proportion of second trimester abortions. This conclusion may come as a surprise;* ***it has been a long-held assumption in the British abortion debate that making early abortion more accessible is the best way to reduce demand for second trimester procedures."*** Ingham et al, 'Reasons for Second Trimester Abortions in England and Wales', *Reproductive Health Matters*, 2008, 16:sup31, 18-29.

[12] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

				• **Ensure women know that they can change their minds at any time, and have the procedure postponed or cancelled at any time if she wants to continue with the pregnancy.**
10	Guidance	5	1	**1.1.7 For women who would prefer to wait longer for a termination of pregnancy, explain the implications so they can make an informed decision.** NICE guidance must correlate with **DoH RSOP guidance 14** which states that if a woman is ambivalent (following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.*' There is also currently no mention of making women aware of alternative pathways, which was highlighted in **RSOP 14:** '*Care pathways to antenatal services for those who choose to continue their pregnancy, and for women considering adoption, should be in place*.' Women may decide to follow this route even after an initial decision for termination. Requests to wait longer for termination generally reflect ambivalence which makes women more vulnerable to long-term mental health issues. Women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – 79% agree compared to 9% who disagree with this.[13] NICE must ensure that MSI and other clinics do not pressure women into making decisions quickly or stopping them from changing their minds, as has been widely reported. To make an informed decision women must be told of **alternative pathways** and: • **Explain to women that they can change their minds at any time and the procedure postponed or cancelled.** • **Ensure that provision is put in place to prevent pressurising women who may be ambivalent to having a termination**
11	Guidance	5	4	**1.1.8 Do not require women to have compulsory counselling or compulsory time for reflection before the termination of pregnancy.**

[13] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

				We are concerned that this recommendation implies negativity towards counselling and may deter women from accessing it. There is evidence that many women have ambivalence in their decision-making and will change their minds.[14] [15] The process towards termination must include opportunity for women to change their minds and to be given the opportunity to reflect on the decision and to discuss the decision at any time (as with any medical operation) as a decision may not be a settled decision. As currently drafted, this implies counselling and reflection are unimportant, indeed unhelpful. Our experience at CMF, working with members who have had well over 30 years of general practice, is that around a third of women continue their pregnancies after being offered reassurance and help, and none have regretted this whereas many regret terminations even decades later. **We would be willing to present our experiences to the Committee**. For cases where there may be coercion, or IPV, an opportunity for counselling could be essential to safeguard women. **Counselling must** be **offered, although the woman should be free to decline it**. We propose a reword of this provision to correlate to RSOPs 8 and 14[16] and DoH guidance with NICE guidance. DoH RSOP regulations state that every woman who requests an abortion 'should be offered' the opportunity to discuss her options and choices with a 'trained pregnancy counsellor'.[17] 'A trained pregnancy counsellor is someone trained to Diploma level. Counselling must be non-directive and non-judgmental and should not create barriers or delays. Counsellors should undergo continuous professional development and training similar to other professionals.'

[14] Ingham et al, p. 25

[15] Husfeldt et al, 'Ambivalence among women applying for abortion', Acta Obstet Gynecol Scand. 1995 Nov;74(10):813-7.

[16] "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and this offer should be repeated at every stage of the care pathway*."

[17] Department of Health. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion). London: DH; 2014:24. bit.ly/1PJlqy1.

				RSOP 14 says *"All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and **this offer should be repeated at every stage of the care pathway.**"* There also needs to be informed consent, RSOP 8. Research shows that women can sometimes suffer harm – particularly psychological harm – post-abortion and this may be compounded if there is ambivalence or pre-existing mental health problems, or other factors. If such women are rushed into a decision without time to reflect, these will be compounded. RSOP guidance states that if a woman is ambivalent (albeit following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes*.' (RSOP 14) **At every stage of the pathway women must be offered the opportunity to discuss all her options and choices with a trained pregnancy counsellor, who is non-directive, and to be able to take time to reflect on the decision if she wishes.**
12	Guidance	5	7	**1.1.9 Consider providing termination of pregnancy consultations by phone or video call, for women who prefer this.** RSOP 14: *'Clinicians caring for women requesting abortion should be able to identify those who require more support than can be provided in the routine abortion service setting, for example young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion*.' How can this RSOP be complied with by a phone call? A telephone consultation is inadequate, particularly to ensure there is no coercion from another person. IPV is a consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[18] The problem of coercion and forced abortion is becoming more commonplace in the UK. Whilst coercion is chiefly carried out by intimate partners, it can also be initiated from a host of sources, including wider family, friends, health-workers or employers. Coercion can manifest in threats of violence, emotional blackmail and continuous pressure to undergo an abortion. Research by polling company D-Cyfor recently revealed that 7% of UK women have been forced to undergo an abortion.[19]

[18] https://www.ncbi.nlm.nih.gov/pubmed/22959631

[19] https://www.independent.co.uk/news/uk/home-news/pregnancy-coercion-reproduction-abortion-a8834306.html

				UK healthcare professionals need to be *more*, not less, vigilant in screening for coercion. CQC Inspectors found evidence that pressure to have an abortion was common across Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses.[20] This guidance ignores overwhelming opinion of women (92% according to a ComRes survey) that a woman requesting an abortion should always be seen in person by a qualified doctor.[21] Moreover the health of women considering an abortion will be put at risk otherwise and surveys concur: most women (73%) think the health of women will be put at risk unless the doctor who signs the abortion sees the patient in person.[22] This guidance also raises concerns about safeguarding of patient confidentiality and data protection (RSOP 6) - how is text messaging considered confidential? Or indeed video calls? **We propose removing this guidance or at least modifying it to ensure vigilance against coercion**
13	Guidance	5	9	**1.1.10 Consider providing termination of pregnancy services in a range of settings (including in the community and in hospitals), according to the needs of the local population.** What is the evidence base for this proposal considering that: *'Non-RCT evidence showed there was no clinically important difference between the time between referral and assessment in the 'community services' group and the 'hospital services' group'*[23] ? There is no explanation of what 'community' entails? Is it Schools? Colleges? Sexual health clinics? homes?

[20] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

[21] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf

[22] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

[23] Evidence Review A, p. 30

				If this guidance is not removed, then clarification is required that Government guidelines permit only *misoprostol* to be taken at home only up to 9 week + 6 days gestation at the time *mifepristone* is taken.[24] **Clarify what 'community' entails and what locations in the community comply with the legal requirement that terminations be carried out in an 'approved' place.** DoH RSOP 2 states*: 'Under Section 1(3) of the Abortion Act 1967 treatment for EMA can only take place in a NHS hospital or approved independent sector place. The courts have decided that this means that both drugs (mifepristone and misoprostol) for the medical abortion must be taken in the hospital or approved place.'* Add in the following guidance: • ***mifepristone* must be taken in a NHS hospital or approved independent sector place** • **Clarify this applies for pregnancies up to 9 week + 6 days gestation at the time *mifepristone* is taken.** When terminations take place outside medical centres, it removes medical information, supervision and support for what is a medical procedure. While this is of concern for all women it is particularly so with **teenage girls or other vulnerable women.** Women with learning difficulties or co-existing medical or mental health conditions, who may struggle to understand or interpret guideline recommendations for medicines, will also be vulnerable where the trend is towards home-based abortions. Minors being sexually abused will be more easily missed if the age of the father is not inquired about. Nearly all the major reports on sexual abuse (eg Rochdale, Oxford, etc) all implicate doctors and abortionists for not asking the questions they should. The problem is that outside of medical supervision, there is no control over *when*, *where* or even *who* is taking the pills. Taking such strong drugs is not to be taken lightly; in trials, *almost all women* using *mifepristone* for medical abortions experienced abdominal pain or uterine cramping; and a significant number experienced nausea, vomiting, and diarrhoea. For many, the outcomes are worse (see comments below). Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered. Surgical abortion is an option for those who cannot get home before bleeding begins, or those who cannot access medical services quickly after the abortion.

[24]Approval of home use for the second stage of early medical abortion, Dec 2018
https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

				Add in new guidance: • **Consider if this is appropriate or in the best interests of young and/or vulnerable women.** • **Where women have transport problems, medical abortion is contra indicated and surgical abortion should be provided instead.** A further concern with removing the medical supervision is that the precise time interval between taking *mifepristone* and taking *misoprostol* is critically important in the effectiveness of the regimen and directly affects how likely the woman is to experience a failed drug-induced abortion and require subsequent surgery. *Misoprostol* is recommended to be taken 24 to 48 hours after taking *mifepristone,* otherwise its effectiveness is significantly lowered,[25] with one study finding that nearly one out of every three to four women who took buccal *misoprostol* shortly after *mifepristone* **failed to abort**.[26] Yet there is nothing to stop a woman taking this outside the recommended hours if she is outside of medical supervision. Research has shown that women have a strong preference for a short time interval between the *mifepristone* and misoprostol, and consequently may well be inclined to take it quicker.[27] For women who are *over seven weeks* gestation (when medical abortions are most commonly used) the **failure rate was up to 31%**.[28] Removing medical supervision over the timing of *misoprostol* administration, allowing women take it at a time 'convenient for them', will increase failure rates, complications (including infection) and need for subsequent surgery.
14	Guidance	5	13	**1.1.11 Termination of pregnancy providers should maximise the role of nurses and midwives in providing care.** 92% of women thought they should always be seen in person by a doctor when requesting an abortion.[29] In an ICM survey 38% of respondents said two doctors should see a woman compared to 15% who said no legal approval should be required, and just 12% who said it should be one doctor, midwife or nurse.[30]

[25] https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf
[26] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[27] https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1
[28] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[29] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf
[30] https://www.icmunlimited.com/wp-content/uploads/2017/10/OlOm-Abortion-Documentary-v2.pdf

				Again, the guidance needs to clarify the legal context to ensure it is complied with, particularly the prescribing role of the two RMPs. RSOP 1 states: *The Abortion Act 1967 regulates the provision of abortion services in England, Wales and Scotland. If an abortion is performed which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and /or the Infant Life (Preservation) Act 1929.* *The law provides that, except in emergencies, two doctors must certify that in their opinion, which must be formed in good faith, at least one and the same grounds for abortion set out in the Act is met.* Nurses and midwives must be permitted to exercise their right to refuse involvement in any abortion procedures on the grounds of conscience. [31] Include: • **Termination of pregnancy providers should maximise the role of nurses and midwives in providing care, provided that two registered medical practitioners have certified that the abortion request meets the legal criteria.** • **Ensure the rights of nurses and midwives to exercise their freedom of conscience under the Equality Act are protected**
15	Guidance	5	15	**1.1.12 Trainee healthcare professionals who may care for women who request a termination of pregnancy (for example nurses, midwives, and GPs) should have the chance to gain experience in termination of pregnancy services during their training**. It is of paramount importance that there is no pressure for conscientiously objecting doctors or other medical staff to engage with the training. There is evidence that conscientiously objecting doctors are liable to perform them due to pressure within work.[32] In particular, there is evidence that Muslim doctors are pressured to go against their religious beliefs (anecdotal evidence from BIMA, and Strickland 2011 shows discrepancy for Muslims in particular). Please add in the following words to this guidance:

[31] The UK Equality Act (2010) prohibits direct or indirect discrimination on the grounds of religion and belief, amongst other grounds. It is strongly arguable that the 'philosophical belief' in the sanctity of life from conception would be protected under its provisions. A clinician holding this belief, whether for religious reasons or otherwise, and who is required by her professional body to refer her patient for a procedure that is at odds with her convictions, would therefore have a case under the terms of the Equality Act.

[32] Strickland, JME, 2011 shows significant discrepancy between those who have an objection to the procedure and those who would refuse to perform it.

				• **Trainee healthcare professionals who may care for women who request a termination of pregnancy (for example nurses, midwives, and GPs) should have the OPPORTUNITY to gain experience in termination of pregnancy services during their training IF THEY WISH** We recommend comprehensive teaching on the law and ethics of abortion developed jointly by pro-choice and pro-life clinicians to fairly represent the range of views within the medical profession. We also recommend the same for nursing students, and recommend that this includes information on clinical assessment for whether they meet the legal criteria, in line with the best evidence on physical and mental health. We recommend also accurate resources made available for doctors who want to practise in accordance with their faith. • **Training in termination of pregnancy services must include teaching on the law and ethics of abortion, including both pro-abortion and pro-life views**
16	Guidance	6	1	**1.1.14 If a trainee's placement service does not provide termination of pregnancy, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector).** • **Trainee healthcare professionals who may care for women who request a termination of pregnancy should have the opportunity to opt-into training if they wish**
17	Guidance	6	8	**1.1.16 Providers should develop pathways for women with complex needs or significant comorbidities to:** NICE guidance must correlate with **DoH RSOP guidance 14** which states that if a woman is ambivalent (following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.'* RSOP 14 also details the extra care required for women who need more support. Accordingly, we propose an additional requirement based on RSOP 14: • **refer them to specialist centres if needed** • **minimise delays in accessing care**

				• **avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations).** • **Ensure that women are aware of alternative pathways and have the opportunity to change their minds at any point before the termination and be informed that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.** • **Services should have referral pathways in place with access to trained counsellors with appropriate expertise**
18	Guidance	6	15	**1.1.17 When caring for women who are having a termination of pregnancy, be aware of:** • **the anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals** • **the impact that verbal and non-verbal communication may have on them.** Medical practitioners have to be able to justify in good faith that the legal requirements for an abortion request are complied with, and they have to do so through the whole process from request to termination It would therefore be appropriate to communicate the legal requirements to women when necessary. If a medical practitioner does not believe in good faith that one of the legal requirements is being fulfilled (for example if there are pre-existing mental health factors that would be exacerbated by an abortion, or if there is coercion, or if an abortion may not be taking place in an approved place) s/he has a duty under the law not to sign the forms or proceed with termination. This is about fulfilling the law, not perceived judgemental attitudes. Moreover anxiety for women is caused by a wide variety of factors, including coercion and ambivalence towards the termination. For example, IPV is a known consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[33] It is important to ask questions particularly for minors or vulnerable women. Minors being sexually abused will be missed if the age of the father is not inquired about. Nearly all the major reports on sexual predators in Rochdale, Oxford, etc implicate doctors and abortionists for not asking the questions they should. We are concerned that this guidance is not balanced, as there is more evidence (from the CQC) that women are likely to be under pressure from abortion providers to proceed with the termination, even if they are ambivalent.

[33] https://www.ncbi.nlm.nih.gov/pubmed/22959631

				There is evidence from CQC Inspections that pressure to have an abortion was common across Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses.[34] We recommend the following additions to the guidance: • **Any anxiety from pressure to proceed with the termination from providers or others, or any anxiety or ambivalence in her decision** • **Any evidence of possible coercion**
19	Guidance	6	21	**1.1.18 Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the termination of pregnancy will be shared with healthcare professionals not directly involved in their care.** RSOP 3 states: *'It is recommended that, wherever possible, the woman's GP should be informed about any treatment for abortion. Then, in the event of a woman requiring post-abortion emergency care or related care in the longer term, the GP would be aware of all treatments provided and be in a better position to determine the appropriate therapy. All women should be told of their right to confidentiality and their decision must be respected if they do not want their GP to be informed.'* Providers should also be aware of concerns with possible coercion or abuse when confidentiality is requested. IPV is a consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[35] Note our comments above (comment 12) about confidentiality and self-referral and phone calls The following guidance should be included, from RSOP 3:

[34] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

[35] https://www.ncbi.nlm.nih.gov/pubmed/22959631

				• **Wherever possible, the woman's GP should be informed about any treatment for abortion so that in the event of a woman requiring post-abortion emergency care or related care in the longer term, the GP would be aware of all treatments provided and be in a better position to determine the appropriate therapy.**
20	Guidance	7	2	**1.2.1 Reassure women that having a termination of pregnancy does not increase their risk of long-term health problems (such as infertility, cancer or mental health issues).** Providing information about the long-term effects of abortion services is part of informed decision-making. Women should be told this before they decide whether to proceed with their pregnancy or not otherwise their consent cannot be informed. Thus this guidance is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy'. If this information is provided before the termination, then women must be told of other options and pathways prior to the decision. This guidance will be challenging in practice because it is incorrect and does not comply with the law. **Following the Montgomery v Lanarkshire Health Board ruling, [36] [37] doctors must spell out any (even tiny) material risks and any reasonable alternatives in dialogue with patients.** The evidence for long-term mental health effects of abortion on women is controversial but what cannot be ignored or dismissed is the largest, most comprehensive and systematic review (by the Academy of Medical Royal Colleges, funded by the Department of Health in 2011) into the mental health outcomes of induced abortion.[38] This found that women with mental health problems before an abortion were at **greater risk** of mental health problems post abortion. It also concluded that other factors may be associated with **increased rates of post-abortion mental health problems**, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion or experiencing other stressful life events. These factors together will affect significant numbers of women.

[36] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf

[37] Montgomery v Lanarkshire Health Board UKSC 11. 2015.

[38] Induced Abortion and Mental Health: A systematic review of the evidence — full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC). December 2011

				'The most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to the abortion. A range of other factors produced more mixed results, although there is some suggestion that stressful life events, pressure from a partner to have an abortion, and negative attitudes towards abortions in general and towards a woman's personal experience of the abortion, may have a negative impact on mental health.[39] The AMRC evidence also concluded that the rates of mental health problems for women with an unwanted pregnancy were **the same**, whether they had an abortion or gave birth. Therefore, when a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth. Furthermore, it found that abortion was associated with a moderate **increase** in the risk of suicidal behaviour.[40] The results of the AMRC review were re-examined by Fergusson, who confirmed that there is no evidence that abortion reduces the mental health risks of unwanted pregnancy. He found that there were small to moderate increases in risks of some mental health problems post abortion.[41] Even the evidence in the NICE reviews (0 and A) cite some of the known risks of abortion as does the NHS website on abortion. **Also, there is strong evidence of a link between abortion and subsequent preterm birth.** The risk of a preterm birth in someone who has had a previous abortion is small but real. In 2013 a review of induced abortion and early preterm birth found *'...a significant increase in the risk of preterm delivery in women with a history of previous induced abortion*.' [42] Women who had one prior induced abortion were 45% more likely to have premature births by 32 weeks, 71% more likely to have premature births by 28 weeks, and more than twice as likely (117%) to have premature births by 26 weeks. Another research study in 2013 in Finland found a 28% higher risk of an extremely preterm birth.[43] A review published in the *American Journal of Obstetrics & Gynecology* in 2010, found that terminations in the first and second trimesters are

[39] National Collaborating Centre for Mental Health. Induced Abortion and Mental Health. London: Academy of Medical Royal Colleges; 2011.bit.ly/2aOxGgZ

[40] (AOR 1.69, 95% CI 1.12-2.54; p<0.01). Fergusson DM et al. Does Abortion reduce the mental health risks of unwanted or unintended pregnancy? A reappraisal of the evidence. *ANZJP* 4 April 2013. DOI: 10.1177/0004867413484579.

[41] Fergusson D, Horwood L & Boden J. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Aust N Z J Psychiatry* 2013;47:1204-1205 *bit.ly/W5FPm5*

[42] Hardy G, Benjamin A, Abenhaim H. Effect of induced abortions on early preterm births and adverse perinatal outcomes. *J Obstet Gynaecol Can* 2013;35(2):138-143 *bit.ly/1nsj5UU*

[43] Räisänen S, Gissler M, Saari J, Kramer M, Heinonen S. Contribution of risk factors to extremely, very and moderately preterm births — register-based analysis of 1,390,742 singleton births. *PLoS One*. 2013;8(4):e60660 *1.usa.gov/1ClLhmd*

				associated with a '*very small but apparently real increase in the risk of subsequent spontaneous preterm birth*'. [44] The link is supported by two European studies from 2005 [45] and 2004 [46] and a further two studies from 2009 by Swingle and Shah. Swingle et al. found a 64% increased risk of preterm birth at less than 32 weeks with just a single abortion.[47] Shah et al. found an increased risk of preterm birth of 35% in patients with only one abortion. The risk increased as the number of abortions increased. [48] There are now over 100 studies in the medical literature confirming this association. **In the context of the Montgomery ruling, these known risks must be stated clearly to all women.** • **Inform women of the risk of abortion to their mental health if they have a pre-existing mental health difficulty, ambivalence, stressful life events or any pressure from others to have an abortion** • **Inform women of the risk of a pre-term birth in future pregnancies** • **Inform women of the small risk to their future fertility** • **Reassure women that they can opt out at any point and continue with their pregnancy**
21	Guidance	7	5, 10-12	**1.2.2 Provide information about the benefits and risks of medical and surgical termination of pregnancy (see table 1). Do this without being directive, so that women can make their own choice.** Evidence shows that complications from medical abortions are **common**, not rare according to official CIOMS criteria.[49] NICE's own evidence states that the effectiveness and safety of the two methods is not similar: '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*.' (p36) In the UK we have poor data collection, so complications are often not linked to abortion, but in countries where data collection on abortions is better, we know that complications after medical abortion higher than after surgical abortion.

[44] Iams J, Berghella V. Care for women with prior preterm birth. *American Journal of Obstetrics & Gynecology* 2010;203(3):89-100 *1.usa.gov/Y7WEib*
[45] Moreau C et al. Previous induced abortions and the risk of very preterm delivery: Results of the EPIPAGE study. *Br J Obstet Gynaecol* 2005;112:430-437 *1.usa.gov/1A1nvlh*
[46] Ancel P et al. History of induced abortion as a risk factor for preterm birth in European countries: Results of the EUROPOP survey. *Hum Reprod* 2004;19:734-40 *1.usa.gov/1nskDhS*
[47] Swingle H, Colaizy T, Zimmerman M & Morris F. Abortion and the risk of subsequent preterm birth: An asystematic review with meta-analyses. *J Reproductive Med* 2009;54(2):95-108 *1.usa.gov/1qWMU0Q*
[48] Shah P, Zao J. Induced termination of pregnancy and low birth weight and preterm birth: A systematic review and meta-analysis. *BJOG* 2009;16(11):1425-1442 *1.usa.gov/1tWgfxm*
[49] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

				The largest and most accurate study of medical abortions, a Finnish study of 42,600 women, found that women had **four times as many serious complications** after first trimester **medical abortions than surgical** abortions: 20% compared to 5.6%.[50] Another Finnish study of 24,000 women who had a medical abortion found that 15.4% were later diagnosed with bleeding, 2% had an infection, 10.2% an incomplete abortion, and 13% had to proceed with a vacuum curettage.[51] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled − increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Moreover, of medical abortions: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[52] Several other studies published in the last ten years show similar differences, with the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9% and up to 33% for later abortions.[53] **Therefore, around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhaging or to remove fetal remains left inside the uterus.** Even for early medical abortions, up to 9 weeks gestation, the RCOG reports (p41) a Finnish study that found 6% of women needed subsequent surgical intervention compared with less than 1% of those having surgical abortions.[54] Part of the reason for this is that high doses of the abortion drugs can lead to unacceptably high levels of side effects, but with lower doses some failures will occur and then abortion by another method is needed. Research by pro-abortion authors has found that for women over seven weeks the failure rate can be up to 33%.[55]

[50] Niinimaki M et al. Immediate complications after medical compared with surgical termination of pregnancy. *Obstetrics and Gynecology* October 2009;114(4):795-804 https://bit.ly/2DJcrIc

[51] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB

[52] **Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study.** Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

[53] Mulligan E, Messenger H. Mifepristone in South Australia: The first 1343 tablets. *Australian Family Physician* May 2011; 40(5) https://bit.ly/2Pw6hpC ; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. *Obstetrics and Gynecology* December 2008;112(6):1303-10 https://bit.ly/2zXJW9W ; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 2013; 87:26-37 https://bit.ly/2S10BRF

[54] https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

[55] https://www.ncbi.nlm.nih.gov/pubmed/17707719

				For medical abortions after 13 weeks, subsequent surgical evacuation rates vary widely between studies, but in one **UK multicentre study** reported by the RCOG (p42), it reached up to **53%.** [56] Medication guides for these pills warn they may cause a number of very serious side effects and they are only available in the USA through a restricted medical program (REMS) and only in certain healthcare settings.[57] Since the deaths of at least 22 women in the USA from taking mifepristone, plus several cases of severe infection and at least 1445 cases with adverse effects since 2012 (289 per year),[58] the FDA has updated its guidance on mifepristone.[59] The medication guide warns that it can cause several serious side effects.[60] Mifepristone is only available in the USA through a restricted medical program (REMS) and only in certain healthcare settings.[61] There is limited data on the outcomes of self-administering abortion pills (to either conclusively prove it is safe or not) but one peer reviewed study found that **78%** of participants had excessive bleeding, 13% had severe anaemia and 5% shock. 63% had incomplete abortion and 23% had failed abortion. They also found that surgical evacuation had to be performed in 68% of the patients, 13% with a blood transfusion. The authors' conclusion? *'Unsupervised medical abortion can lead to increased maternal morbidity and mortality*.' [62] The RCOG reports that women are more likely to seek medical help for bleeding after medical abortion than after surgical, and to report heavier bleeding than they expected, and for longer. The incidence of haemorrhage is much higher in women undergoing medical abortion, (although there are discrepancies in reported rates due to ill-defined criteria in reporting). The Finnish record-linkage study of 42,600 women found rates of consultation for haemorrhage were 15.6% after medical compared to 2.1% after surgical abortion.[63]

[56] https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

[57]

[58] FDA. Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2017. https://bit.ly/2Pz0MH6

[59] **US Food and Drug Administration. *Questions and Answers on Mifeprex*. 28 March 2018 https://bit.ly/2yrBtMt**

[60] FDA. Highlights of prescribing information (mifepristone) revised March 2016. https://bit.ly/2Q33bZK

[61] Specifically, clinics, medical offices and hospitals, by or under the supervision of a certified prescriber. It is not available in retail pharmacies and it is not legally available over the Internet. US Food and Drug Administration. *Art cit* https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

[62] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347129/pdf/jcdr-9-QC01.pdf

[63] https://www.ncbi.nlm.nih.gov/pubmed/19888037

				Hospitalisation rates, while low overall - but data linkage with abortion is very poor - are worse for medical abortions. Government statistics for England and Wales show complications involving hospitalisation are more than twice as likely after medical abortions than after surgical ones: 206 compared to 88.[64] However the RCOG acknowledges that a lack of standardisation in reporting in the UK hampers collection of accurate data **so this number is likely to be higher.** Statistics are usually drawn from clinic or hospital records that will under-represent the true rate as some women experiencing complications follow up elsewhere. NICE currently states that *'The effectiveness and safety of both methods is similar'.* **This statement is incorrect and should be removed.** **Add in guidance to ensure women are informed of the elevated risk of complications from medical termination compared to surgical, specifically the risk of haemorrhaging, infection and incomplete or failed medical abortion.** We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic, and explaining to women that *mifepristone* must be taken at an approved hospital or clinic.[65]
22	Guidance	11	2	**1.2.3 As early as possible, provide women with detailed information to help them prepare for the termination of pregnancy.** As noted in our general comment above, even after the entrance point to the guidance, it cannot be assumed that the decision is final. NICE guidance must correlate with RSOP 14 which says: "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and* ***this offer should be repeated at every stage of the care pathway.***" • **Inform women that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.**

[64] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679028/Abortions_stats_England_Wales_2016.pdf
[65] Approval of home use for the second stage of early medical abortion, Dec 2018
https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

23	Guidance	11	6	**1.2.4 Provide information in a range of formats, for example video or written information. Include information based on the experiences of women who have had a termination of pregnancy.** • **Include a range of experiences such as those with prior and post mental health problems, those who have been hospitalised, who have experienced other complications with their termination, and those who have had a subsequent pre-term birth, in order to fairly reflect the true breadth of experiences** • **Include information in different languages**
24	Guidance	12	5	**1.2.6 Ask women if they want information on contraception, and if so provide information about the options available to them.** • **Ask women if they want information on contraception, and if so provide information about the options available to them, including effectiveness of different types.**
25	Guidance	12	7	**1.2.7 For women who are having a medical termination of pregnancy, explain:** • **that they may see the pregnancy as they pass it** • **what the pregnancy will look like** • **whether there may be any movement.** If a woman is not told that it is a small fetus or baby that she is 'passing' she will be more adversely affected than if she is warned that she will be passing recognisable human parts, particularly for later terminations. We are concerned about the use of language in this guidance. The word fetus should be used, not pregnancy, for consistency and medical accuracy. NICE Evidence clearly warns of the problems with lack of accuracy and information provision: *"women were not given enough information to prepare them for the abortion, which is a responsibility of the caregivers: "I was not prepared for the*

				"little human being" about 12 in."[66] [67] Another study described how "*The picture of the fetus was something they would never forget. "You could see fetus, where the ears were, the arms, I was really frightened."*[68] Amend the guidance: • **that they may see recognisable human parts as they pass it** • **what the human parts may look like**
26	Guidance	12	19	**1.2.11 If termination of pregnancy for fetal anomaly cannot be provided in the maternity setting, establish a clear referral pathway with ongoing communication between services so that women can:** • **easily transfer to the termination service** • **get more information about the anomaly** In one British study, when parents were offered perinatal hospice as an option, 40% chose to continue with their pregnancies.[69] The comparative figure in US studies was between 75% and 85%.[70] Amend the guidance: • **Provide more information about the anomaly from parents who have a child with the anomaly or from written resources provided by specialists** • **inform women that they can change their minds at any point and can access support services for continuing the pregnancy, palliative care, perinatal hospices and specialist disability groups** • **Be informed of the likelihood of the diagnosis being correct or incorrect**

[66] Evidence Review B, p. 42
[67] Evidence Review B, p. 69
[68] Evidence Review B, p. 69
[69] Arch Dis Child FetalNeonatal Ed. 2007 Jan;92(1):F56-8. Breeze AC et al. Palliative care for prenatally diagnosed lethal fetal abnormality.
[70] http://www.aaplog.org/wp-content/uploads/2015/07/AAPLOG-Practice-Bulletin-1.compressed.pdf

				• **Ensure women can change their minds at any point in the process** • **Access specialist counselling at any stage in the process**
27	Guidance	12	24	**1.2.12 Explain to women that the fetus may not look abnormal despite there being a fetal anomaly.** A British Parliamentary Inquiry into abortion on the grounds of disability concluded that: '*...the studies have all found that around 20% of women, between one and two years after an abortion for fetal abnormality, have a psychiatric condition, usually a complicated grief reaction, a depressive disorder or post-traumatic stress disorder*.'[3] **Warning of possible long-term mental health outcomes should be included in guidelines**
28	Guidance	15	5	**1.6.1 Offer a choice between medical or surgical termination of pregnancy before 24+0 weeks' gestation (see table 1). If any methods would not be clinically appropriate, explain why.** Complications from medical abortions are **common**, not rare according to official CIOMS criteria.[71] See comments at 21 above for comparative safety of medical and surgical abortions. The evidence review states that (Page 36 lines 27 to 29) '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*'. • **Inform women of the higher risk of complications from later medical abortions (serious complications for 1 in 5 women after the first trimester[72])** • **Inform women that medical abortions between 10 and 24 weeks will require subsequent surgery to completely empty the womb in 13% of cases[73]** • **Consider if medical abortion, unsupervised, is appropriate or in the best interests of young or vulnerable women.**

[71] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf
[72] Niinimaki M et al. Immediate complications after medical compared with surgical termination of pregnancy. *Obstetrics and Gynecology* October 2009;114(4):795-804 https://bit.ly/2DJcrIc
[73] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB

				Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered. Surgical abortion is an option for those who cannot get home before bleeding begins, including those who cannot access medical services quickly after the abortion. • **Where women have transport problems, medical abortion is contra-indicated and surgical abortion should be provided instead.**
29	Guidance Evidence Review F	15 11	10 14-52	**1.7.1 Consider termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.** We are concerned that this recommendation is based on speeding up the process towards termination, over-riding the prioritising of safety concerns from a possible ectopic pregnancy. There is no clear evidence provided that women would prefer to access abortion so quickly that they are prepared to risk their own health and future fertility. Evidence shows that women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – 79% agree compared to 9% who disagree with this.[74] **Women's safety and health must always override timeliness (CF RSOP 11)** **We recommend that this guidance be removed.**
30	Guidance	15	13	**1.7.2 For women who are having a termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):** **We recommend this guidance be removed (see comment 29 above).** If is it retained then strengthen the following guidance: • **explain that women must have follow-up appointments with subsequent ultrasound to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy**

[74] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

31	Guidance	16	5	**1.8.1 Offer the option of expulsion at home to women who are having a medical termination of pregnancy if they will be taking the mifepristone before 10+1 weeks' gestation.** Complications from medical abortions are **common**, not rare according to official CIOMS criteria.[75] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled – increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Of early medical abortions at home: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[76] There is limited data on the outcomes of self-administering abortion pills but one peer reviewed study found that 78% of participants had excessive bleeding, 13% had severe anaemia and 5% shock. **63% had an incomplete abortion and 23% had a failed abortion**. They also found that surgical evacuation had to be performed in 68% of the patients, 13% with a blood transfusion. The authors concluded that: *'Unsupervised medical abortion can lead to increased maternal morbidity and mortality*.'[77] The second visit to a medical clinic builds in an important safety feature by allowing for direct observation and monitoring of the administration of *misoprostol* at a precise time, method and place after *mifepristone* administration. The precise time interval between taking mifepristone and taking misoprostol is critically important in the effectiveness of the regimen and directly affects how likely the woman is to experience a failed drug-induced abortion and require surgery. Yet there is nothing to stop a woman taking this outside the recommended hours if she is outside of medical supervision. One study (by authors who campaign for abortion) found that using *misoprostol* sooner than 24 hours after *mifepristone* leads to a significantly increased failure rate: women under seven weeks gestation had a failure rate of 27% while women between seven and eight weeks gestation had a failure rate of 31%. The authors of this study recommend that buccal

[75] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

[76] Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study. Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

[77] Nivedita K et al. Is It Safe to Provide Abortion Pills over the Counter? A Study on Outcome Following Self-Medication with Abortion Pills. 2015. https://bit.ly/2B7soKu

				misoprostol not be taken immediately after mifepristone because of the high abortion failure rate.[78] A further study also concludes that a six-hour gap '*…is not as effective at achieving a complete abortion compared with the 36- to 48-hour protocol*.'[79] When part of the termination process takes place outside medical centres, it removes medical information, supervision and support for what is a medical procedure. While this is of concern for all women it is particularly so with **teenage girls or other vulnerable women.** Women with learning difficulties or co-existing medical or mental health conditions, who may struggle to understand or interpret guideline recommendations for medicines, will also be vulnerable where the trend is towards home-based abortions. It cannot be assumed that all women will follow, understand or even be able to read the directions before taking the powerful drug. There is no legal requirement for a woman to follow medical instructions and there is no monitoring, so there can be little (if any) control over following instructions. Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered. In view of the high rates of bleeding and haemorrhaging after medical abortion, there are clear dangers if a woman is unable to reach a hospital quickly in an emergency, or if the home has no working telephone (or other basic equipment) in a crisis. We note that the evidence review states that (Page 36 lines 27 to 29) '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*'. • **Inform women that the frequency of complications is higher for women having early medical abortions at home.[80]** • **Ensure that gestational age is correct before offering options[81]** • **Consider if taking *misoprostol* at home is appropriate or in the best interests of young or vulnerable women**

[78] Lohr PA et al. Oral mifepristone and buccal misoprostol administered simultaneously for abortion: a pilot study. *Contraception* September 2007;76(3):215-20 https://bit.ly/2qP7vxG

[79] Guest et al. Randomised controlled trial comparing the efficacy of same-day administration of mifepristone and misoprostol for termination of pregnancy with the standard 36 to 48 hour protocol. *BJOG* February 2007;114(2):207-15. https://bit.ly/2qLAdzo

[80] **Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI**

[81] One-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.

				• **Where women have transport problems, medical abortion is contra-indicated and surgical abortion should be provided instead**
32	Guidance	16	9	**1.9.1 Offer interval treatment (usually 24 to 48 hours) with mifepristone and misoprostol to women who are having a medical termination of pregnancy between 9+1 and 10+0 weeks' gestation** Research has shown that women have a strong preference for a short time interval between the mifepristone and misoprostol, and consequently may well be inclined to take it quicker.[82] But the use of misoprostol sooner than 24 hours after mifepristone leads to a significantly increased failure rate with one study finding that nearly one out of every three to four women who took buccal misoprostol shortly after mifepristone failed to abort. For women who are *over seven weeks* gestation (when medical abortions are most commonly used) the failure rate was up to 31%.[83] Removing medical supervision over the timing of misoprostol administration, allowing women take it at a time 'convenient for them', will increase failure rates, complications (including infection) and need for subsequent surgery. • **Ensure that gestational age is correct before offering options[84]** • **Ensure women are aware of the importance of the interval in treatment**
33	Guidance	16	12	**1.9.2 For women who are having a medical termination of pregnancy before 9+1 weeks' gestation, give them the choice of having mifepristone and misoprostol at the same time, but explain that:** **• the risk of ongoing pregnancy may be higher, and it may increase with gestation** **• it may take longer for the bleeding and pain to start** **• it is important for them to complete the same follow-up programme that is recommended for all medical terminations before 10+1 weeks before 9 weeks**

[82] https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1
[83] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[84] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

				Research has found that one-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.[85] Because of increasing uterine sensitivity to misoprostol with advancing gestational age, regimens for medical termination change in the late first trimester and second trimester to repeated, lower doses of misoprostol. The woman's experience will also be more painful later in gestation, with an exponentially increasing rate of haemorrhage and complications after just seven weeks gestation. BPAS state that taking both medicines at the same time causes more side effects and is less effective than when they are taken at least one day apart – the recommended protocol.[86] One study (by authors who are pro-abortion) found that for women under 49 days' gestation, the failure rate was 27% if they took the misoprostol immediately after mifepristone.[87] For women between 50-56 days' gestation, the failure rate was 31%. **The authors of this study strongly recommended that buccal misoprostol not be taken immediately after mifepristone because of the high abortion failure rate.** Another study also concluded that a six hour gap '*…is not as effective at achieving a complete abortion compared with the 36- to 48-hour protocol*.'[88] A meta-analysis of 20 studies in 2015 comments on the lack of research and understanding of the effect of taking misoprostol at varying times after mifepristone. It warns of the '*paucity of data on the actual time interval at which women actually administer misoprostol when instructed'.* It adds that: '*Our ability to fully understand if buccal misoprostol is more effective with a dosing interval closer to 48 hours is limited by the relatively small number of women in protocols.*'[89] We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic.[90]

[85] Ibid
[86] https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/
[87] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[88] https://www.ncbi.nlm.nih.gov/pubmed/17305893
[89] https://www.ncbi.nlm.nih.gov/pubmed/26241251
[90] Approval of home use for the second stage of early medical abortion, Dec 2018 https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

				• **Explain that *mifepristone* must be taken at an approved hospital or clinic so *misoprostol* will also need to be taken there** • **Recommend that buccal misoprostol not be taken immediately after mifepristone because of the high failure rate (for 1 in 4 women)** • **Ensure that the gestational age is correct before offering options**[91]
34	Guidance	17	2	**1.10.1 For women who are having a medical termination of pregnancy between 10+1 and 23+6 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36 to 48 hours after the mifepristone) of:** **• 800 micrograms misoprostol, given vaginally, or** **• 600 micrograms of misoprostol, given sublingually, for women who decline vaginal misoprostol.** **Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.** '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age.[92] One-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.[93] The later in gestation that medical abortions take place, the less effective and the more dangerous they are. Ten weeks is the maximum gestation recommended. Because of increasing uterine sensitivity to misoprostol with advancing gestational

[91] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

[92] https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

[93] Ibid

				age, regimens for medical termination change in the late first trimester and second trimester to repeated, lower doses of misoprostol. The woman's experience will also be more painful later in gestation, with an exponentially increasing rate of haemorrhage and complications after just seven weeks gestation. • **Ensure that the gestational age is correct before offering options**[94] • **Inform women that medical abortions between 10 and 24 weeks will require subsequent surgery to completely empty the womb in 13% of cases.**[95]
35	Guidance	17	10	**1.10.2 Use a shorter interval between mifepristone and misoprostol if the woman prefers this, but explain that it may take a longer time from taking the first misoprostol dose to complete the termination of pregnancy.** See comment 33 above We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic, and explaining to women that *mifepristone* must be taken at an approved hospital or clinic.[96] • **Ensure that the gestational age is correct before offering options**[97] • **Recommend that buccal misoprostol not be taken immediately after mifepristone because of the high failure rate (for 1 in 4 women)**

[94] '…*Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

[95] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB

[96] Approval of home use for the second stage of early medical abortion, Dec 2018 https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

[97] '…*Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

36	Guidance	18	1	**1.11.3 For women who are having a medical termination of pregnancy after 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.** Amend guidance: **For women who are having a medical termination of pregnancy after 28+0 weeks' gestation, for serious fetal abnormality or if the life of the mother is at risk, consider….**
37	Guidance	20	10	**1.14.1 For women who have had a medical termination of pregnancy before 10^{+1} weeks' gestation with expulsion at home, offer the choice of self- assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.** Information about abortion history becomes particularly and critically important when evaluating a woman for infection after abortion and this cannot be done effectively and safely and privately over text messaging. Follow up using mobile phone apps or text messaging is highly irresponsible, since complications from medical abortions are common, not rare, according to official CIOMS criteria.[98] We cite above examples of the high rates of haemorrhage after early medical abortion and the significant numbers of women requiring surgical follow up. Several studies published in the last ten years show the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9% and up to 33% for later abortions.[99] **Therefore, around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhaging or to remove fetal remains left inside the uterus.**

[98] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

[99] Mulligan E, Messenger H. Mifepristone in South Australia: The first 1343 tablets. *Australian Family Physician* May 2011; 40(5) https://bit.ly/2Pw6hpC ; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. *Obstetrics and Gynecology* December 2008;112(6):1303-10 https://bit.ly/2zXJW9W ; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 2013; 87:26-37 https://bit.ly/2S10BRF

				Abortion pill provider, Women on Web, also found from their own surveys that 12–21% of women subsequently needed a surgical intervention and almost half of women who were over twelve weeks gestation (45%), required a surgical intervention.[100] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled − increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Moreover, of medical abortions: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[101] • **Inform women that significant numbers of early medical abortions will require subsequent surgery to completely empty the womb** • **Strongly recommend that women follow up with a GP or the abortion provider** • **Remove the reference to text messaging**
38	Guidance	20	17	**1.14.3 Explain to women:** **• what aftercare and follow-up to expect** **• what to do if they have any problems after the termination of pregnancy, including how to get help out of hours** **• that it is common to feel a range of emotions after the termination.** **The guidance needs to provide information on the necessary follow up of patients**: what information should be given? How long will support be offered? What guidance is there to ensure a successful procedure? **And what guidance should be provided for patients who do not engage with follow up?**

[100] https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

[101] Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study. Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

				Add in the following guidance: • **Recommend routine GP or clinic follow up for all patients to ensure physical and emotional health**
39	Guidance	20	22	**1.14. 4 Advise women to seek emotional support if they need it, and how to access it (if relevant). This could include:** • **support from family and friends** • **peer support, or support groups for women who have had a termination of pregnancy** • **counselling or psychological interventions.** • **Information on independent counselling services not linked to the abortion provider**
40	Guidance	21	5	**1.14.4 Providers should offer emotional support after termination of pregnancy, and (if needed) provide or refer women to counselling services.** It is rare that women return to the place where they had the termination, instead preferring to have counselling from independent clinics not associated with the termination. We know from anecdotal data that the psychological fall out from medical abortions completed at home can be severe, partly because women usually see the fetus, which they then have to flush away themselves. It is not hidden from them in the way a surgical abortion keeps the fetus from view of the woman. Moreover, the reminder of the abortion is always in the home, not in an anonymous clinic that they can leave behind. **Commissioners must ensure that there is sufficient capacity and resourcing to provide counselling services for women following terminations** • **Providers should offer information on independent counselling services.** • **In cases of abortion for fetal anomaly, providers should offer or refer to bereavement midwife support**

Insert extra rows as needed

Termination of pregnancy

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 31/05/19

email: ToP@nice.org.uk

Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF).**
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
- **Mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms **do not include attachments** such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. Further information regarding our privacy information can be found at our privacy notice on our website.