BSACP
BRITISH SOCIETY OF ABORTION CARE PROVIDERS

Submission to the Royal College of Obstetricians and Gynaecologists consultation on the Advanced Training Review

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Introduction and background to the organisation

The British Society of Abortion Care Providers (BSACP) is the principal, authoritative Society for health professionals working in abortion care in the UK, its Crown Dependencies and its Overseas Territories. It aims to provide a supportive community to promote best practice in abortion care. It was formed in October 2015 and is a specialist Society of the Royal College of Obstetricians and Gynaecologists (RCOG). It is separate from the RCOG but works closely with it and with its Faculty of Sexual and Reproductive Healthcare (FSRH). Representatives of all devolved nations sit on its Council. Its membership comprises mainly doctors, nurses and midwives who deliver abortion care for the National Health Service (NHS) – whether in NHS settings or the independent sector. The three main independent sector providers (ISPs) are: the British Pregnancy Advisory Service (BPAS), MSI Reproductive Choices (MSUK) and the National Unplanned Pregnancy Advisory Service (NUPAS).

One of the aims of BSACP is to support holistic education on abortion for all health professionals and facilitate training for abortion care providers. The BSACP Education and Training Committee has a strategy and annual objectives to meet this aim which is does through course and event development and delivery, curating educational resources for members, advocating and advising on abortion education with key stakeholders.

Responses

Are the changes made to the current advanced training curricula and creation of new and reorganisation of the existing ATSMs into Special Interest Training Modules (SITMS) an improvement overall?

Agree

The Advanced labour ward practice ATSM and emergency aspects from the Acute Gynaecology & Early Pregnancy ATSM have been incorporated into the core curriculum.

Agree

Do you foresee any problems with this?

BSACP agrees that incorporating advanced labour ward practice and emergency aspects of the acute gynaecology and early pregnancy ATSM into core training is a positive development. However, BSACP is disappointed that the same approach has not been taken with abortion care. Rather than the RCOG choosing to integrate modules into core training based on popularity (as noted in the consultation document as a justification for these changes), BSACP feels integration should have been based on clinical need and current inadequacies in training and fragility within the workforce.

As many pregnancies end in abortion as in miscarriage and more women will have more than one abortion than more than one miscarriage. Abortion care is an essential

component of early pregnancy management that is of core importance to women and women's health services. Knowledge and competency in abortion care is equally important and relevant as management of miscarriage and both should be delivered at the same point of the curriculum.

The commonality of abortion means that every generalist obstetrician and gynaecologist should be knowledgeable about and able to provide competent abortion care. BSACP acknowledges that the law on abortion permits conscientious objection and respects that right of doctors to refuse to provide some aspects of abortion care. However, BSACP also notes that the curriculum as written seems designed with the presumption that most trainees will object. This perpetuates the idea that abortion care is not part of mainstream obstetrics and gynaecology. Furthermore, conscientious objection only extends to performing the procedure itself – all doctors should have knowledge and competency of abortion care so that they are able to advise patients and manage any complications.

BSACP is of the view that abortion care competencies must be obtainable in core training and that the SITM on abortion should be focused on service development and leadership, management of complications, and complex abortion care. The SITM can be a way to hone second trimester surgical abortion skills if this procedure is not offered in the trainee's NHS Trust. However, exposure to abortion care in the core years should include first and second trimester abortion by surgical and medical method, which may require out of programme rotation into the independent sector where 75% of abortions in England are undertaken.

BSACP is aware that abortion is listed in the core curriculum CiP 11. However, we understand from trainee and educational supervisor representatives on BSACP Council that trainees often have these competencies signed off based on exposure to miscarriage care. In fact, the core curriculum states that procedures to manage a miscarriage can be used as a proxy. There are no WBAs specific to abortion care meaning trainees get no exposure to the differences between abortion care and miscarriage management, nor will they gain the opportunity to learn how to counsel women about their options and to provide non-judgemental abortion care. The CiP also lacks specificity as to which aspects of abortion are to be covered and to what gestational ages. In addition, by being sited completely within CiP 11 (non-emergency gynaecology and early pregnancy), the curriculum fails to recognise that abortion is sometimes needed on an emergency basis/to save the life of the pregnant person nor its relevance to obstetrics. Finally, the CiP refers to section 10 (conscientious objection) which requires updating given the change in law in Northern Ireland.

BSACP is of the view that the knowledge and skills to provide abortion care are not entirely transferrable from miscarriage management. However, many of the skills needed to provide compassionate competent abortion care would enhance miscarriage and obstetrical care. For example, the management of second trimester pregnancy loss through dilation and evacuation (including when medical induction fails), methods of cervical preparation and dilation, and providing uterine evacuation under local anaesthesia or moderate sedation. It is notable that some abortion services in the NHS continue to provide misinformation about the safety of second trimester uterine evacuation techniques or do not offer this option at

all even when providing terminations for fetal anomaly due to lack of knowledge and skills. Many of these skills would also be of benefit to the obstetrician who needs to evacuate the pre-viable pregnant uterus rapidly such as in the case of infection and pre-term premature rupture of membrane or eclampsia and related complications such as HELLPs or DIC. Lastly, women who have complications of abortion often spontaneously present to or are referred to NHS hospitals for management. In some cases, this will be in the setting of incomplete procedures. The lack of basic skills or willingness to manage a uterine evacuation after approximately 12 weeks of pregnancy, to remove osmotic cervical dilators, perform feticidal procedures or continue a medical induction often leaves women and hospital staff vulnerable and unable to receive quality or timely care.

BSACP also notes that previously, the safe abortion care ASM could be taken alongside the Acute Gynaecology & Early Pregnancy ATSM and we are concerned that this will no longer be an option. The attachment of the abortion care ASM to the early pregnancy ATSM was intended to raise the profile of the abortion ASM and increase the number of trainees enrolling. We note that more trainees have taken up the safe abortion ASM that when it was an ATSM and are concerned that this will again reduce.

Obtaining skills in abortion during post-doctoral training (especially second trimester skills) is associated with future provision. BSACP is therefore concerned that any negative impact on skills acquisition during post-graduate training will have a negative impact on the already fragile abortion workforce.

Therefore, although we feel that incorporating advanced labour ward and acute gynaecology ATSMs into core training will be an improvement we strongly disagree that the changes will equip O&G doctors to better meet the needs of the clinical service (see question 6 and 8 responses).

Will the changes to the advanced training curricula equip O&G doctors overall to better meet the needs of the clinical service?

Strongly Disagree

It is proposed that doctors will be able to start SITMs in ST5.

Agree

Do you foresee any problems with this?

BSACP feels that the ability to start SITMs earlier may be an improvement for the abortion SITM. An earlier start may increase the likelihood of trainees being able to complete the module fully (particularly given the low numbers of NHS Trusts that provide abortion after 12 weeks of gestation, for any clause and without resort to general anaesthesia), practice skills over a longer period of time (particularly relevant for second trimester surgical abortion), and make it possible to obtain out of programme exposure if abortion provision is not available or limited in the trainee's local Trust.

However, BSACP is concerned that competition for places may be high if trainee complements over all three years are vying for the same training sites. BSACP is concerned that this will have a particularly negative impact on the SITM in abortion where training

locations are few and placements are not centrally organised. It may also lead to training sites continuing to overly rely on the SITM to provide all of abortion care training rather than finding ways for trainees to develop those skills during the core years and using the SITM to hone specialist skills.

BSACP also notes that this may impact the timing of sitting MRCOG because it has to be done by ST5 to embark on STIM competencies. This may impact the benefit of the extension to 3 years.

Will the changes to the current advanced training component improve the health of women and people receiving O&G care?

Strongly Disagree

Are there any capabilities in practice or key skills missing from any of the SITMs or subspecialty curricula?

Yes

If yes, please provide further specific detail and state which curriculum you are commenting on

As noted above, BSACP is of the view that the uterine evacuation skills taught in abortion care are important for the generalist obstetrician and gynaecologist, relevant for advanced labour ward practice, and emergency gynaecology. BSACP strongly advocates for improved abortion education and training in the core years revising the SITM to focus more appropriately on advanced (special interest) competencies.

The breadth of the abortion SITM as it is currently designed impacts the ability for it to be completed. This will remain a problem even with the extension to 3 years because it covers both basic and advanced skills. Its current design may be a barrier to training sites developing the ability to provide basic abortion education in core years as there is no incentive to do so if programmes can rely on this to be done by sites facilitating the SITM.

BSACP recommends that abortion education during the core years is enhanced and that the SITM on abortion care is focused on service development and leadership, complex abortion care, management of complications, and honing second trimester abortion skills. If these changes can be made, BSACP recommends that the title of the SITM also be changed from “Safe Practice in Abortion Care” (which should be a core competency) to “Advanced Abortion Care” or “Abortion Care Advanced Leadership” or similar. No other SITM or topic area emphasises “safe” in the title, which makes this SITM seem exceptional rather than mainstream.

BSACP notes that the current abortion SITM does not include procedures to induce fetal demise. However, feticide is recommended before medical abortion at 22 weeks or greater and often used before dilatation and evacuation at similar gestational ages to avoid signs of life should an extramural delivery occur between cervical preparation and uterine evacuation. This need is particularly acute given recent Coronial guidance recommending inquests whenever fetal signs of life are observed including in cases of induced abortion under any clause of the Abortion Act. There are not enough fetal medicine specialists

willing to provide feticide for abortions that are not due to anomalies. In addition, most second trimester surgical abortions take place outside of the NHS and cannot avail themselves of fetal medicine specialists to provide this service on their behalf. This skill should therefore be included in the SITM.

Other specific comments on the SITM that require review:

SPAC CiP 1

- Key skill - Plans management for high risk and protected groups appropriately. It is not clear what is meant by the use of the term “protected groups” in this context.
- Legal context needs updating with regard to Northern Ireland.
- No mention of telemedicine.
- As a potential lead for an abortion service, you need to know about dealing with conscientious objection, yet this is not clearly outlined in any CiP but may be best placed in CiP 1.

SPAC CiP2

- Specify “able to date the pregnancy across all trimesters”.
- Specify ultrasound guidance to identify instrumentation of cervical canal and uterine cavity.

SPAC CiP3

Consider language - why “fetal tissue” not “pregnancy remains”?

SPAC CiP4

- The key skills and descriptors are all muddled (e.g. managing “emotional difficulties” comes under key skill “Manages post-abortion haemorrhage and collapse”)
- Descriptors for cervical and uterine trauma don’t make it clear that they need to know how to manage –i.e. be level 5 independent.
- Rewording needed for descriptor under Key skill “Manages complex cases requiring medical or surgical abortion” “Recognises when a transcervical approach is not feasible and appropriately refers for hysterectomy or hysterotomy, for example, women with medical comorbidities, uterine or placental anomalies”. It makes it sound like you should do hysterotomy for most co-morbidities which is not the case.
- Here it really does need something like “seeks advice from other specialists/uses MDT to plan care”
- Not clear what is meant by “Acute complications” AND “Late complications” in section 2 procedures.

SPAC Procedures

- Gap in surgical methods from 14-18+6 weeks.
- Feticide not included.
- Medical methods not included.

BSACP is of the view that Maternal and Fetal Medicine speciality training would benefit from skills in second trimester surgical uterine evacuation. This would permit specialists to provide (not just counsel about) a choice of methods for termination methods in case of fetal anomaly. It would also provide the specialist the skills to rapidly evacuate the uterine in cases of severe deterioration of a maternal medical condition in the second trimester.

Are there any SITMs which you feel will be difficult to achieve within the training programme?

Yes

If yes, please state which SITM would be difficult to deliver

The feedback we have received from trainee and educational supervisor representatives on BSACP council is that most trainees will not achieve any bona fide competencies in abortion care during core training. Those that are documented as having been achieved are typically based on basic surgical uterine evacuation skills to 12 weeks of gestation under general anaesthesia for miscarriage management. Therefore, the current ASM - future SITM - is too broad to be achievable for most trainees. This will be partially improved by extending the time to obtain competencies from 2 to 3 years.

In addition to the content being too broad, there are too few training sites that provide the current safe abortion care ASM especially for later surgical abortion skills or later medical abortion for indications other than fetal anomaly. The RCOG hosts an abortion education hub on its website which states that there are 6 training sites nationally that can provide skills in abortion to 23 weeks and 6 days of gestation, however BSACP is aware that one of the sites does not provide abortion for Clause C or D (the most used clauses) beyond 21 weeks. All these sites are in England and 3 of the 6 are in London. This makes them difficult to access for many trainees and given the time required to learn second trimester abortion skills would require a significant period of out programme which many sites are not willing to facilitate or fund.

When the abortion ATSM was revised to an ASM, the intention was to establish a national application process, but this was never implemented. As a result, trainees are left to their own devices to contact training sites and arrange placements as well as negotiating funding and travel with their deanery. Since volume of services is limited in the NHS, this also often includes negotiation for placement in the independent sector and related costs. BSACP is of the view that the SITM for abortion should follow the model of advanced minimal access surgery model so everyone across the country can have the same opportunity to take it and can choose the location for training from a wider variety of sites. The RCOG, deaneries, and HEE work collaboratively to ensure that trainees have a smooth transition out of programme if this is required, including to the independent sector.

BSACP notes that the need for the SITM and out of programme training in abortion will only grow now that Northern Ireland has decriminalised abortion and services need basic and advanced training to meet the needs of the population there.

To be successful, placements sites need to be developed regionally that cross the NHS and independent sector. The vast majority of second trimester surgical abortions are provided in independent sector clinics working under contract to the NHS. Competency in dilatation and evacuation requires repetition of this technique which can only be achieved through such collaborations. This is likely to require trainees to have a period out of programme which must be funded and facilitated.

The Advanced Professional Module has been renamed Special Interest Professional Module (SIPM) and a SIPM in Medical Education and Leadership and Management have been created. The SIPMs can be undertaken at any point during the training programme and are not required for CCT. Do you agree with the additional SIPMs?

Neither Agree or Disagree

Do you have any further comments?

No

It is proposed that subspecialty training will consist of the relevant Special Interest Training Module(s) and the relevant subspecialty specific Capabilities in Practice (CiPs). The subspecialty specific CiPs can only be completed as part of an accredited subspecialty training programme. Any parts or all of the subspecialty relevant Special Interest Training Module(s) completed prior to commencing subspecialty training does not need to be repeated. Do you foresee any problems with this?

Neither Agree or Disagree

Do the proposed new Special Interest Modules and subspecialty curricula present any challenges to trainees who may be excluded and identify with one or more of the protected characteristics?

Yes

If yes, Please provide any further details and specify which curriculum you are commenting on

By not being in core and relegated to a SITM need to travel to obtain training in abortion may be a barrier to some groups such as those who are currently pregnant or having a disability, and those from Northern Ireland.

Do the proposed new Special Interest Modules and subspecialty curricula present any challenges to patients who may be excluded and identify with one or more of the protected characteristics?

Yes

If yes, Please provide any further details and specify which curriculum you are commenting on

Many NHS hospitals do not offer later abortion care except in cases of termination for fetal anomaly (medical abortion only), so patients travel out of area or go to independent sector clinics to obtain this care. For those from Scotland and Northern Ireland this requires travel across national borders.

Heads of School, TPDs, ATSM Directors only. Can all SITMs be delivered in your School/Deanery?

Not applicable

If No which ones and why?

N/A

Heads of School, TPDs, ATSM Directors only. The implementation timeline for the advanced training review is planned from 1 December 2023. All Schools and training programmes will be expected to implement by August 2024. Is this achievable in your region?

Not applicable

If No why not and when would it be achievable by?

N/A

Do you have any further comments on the proposed updated and new Special Interest Modules and subspecialty curricula?

In general, the terminology used should be “abortion” and not “termination of pregnancy” throughout.

BSACP feels it is positive that conscientious objection is to be addressed annually but proposes that a “partial participation” model is used to delineate which aspects of abortion care a trainee must learn because they are not protected under the conscientious objection clause (e.g., options counselling, knowledge of services and the law, management of emergencies or post-abortion care), what they will be asked to observe, and their willingness to engage in any or all aspects of abortion provision each year.

BSACP also notes that the conscientious objection section needs to be revised to reflect the current legal position of abortion in Northern Ireland and suggests that many of the specifics within it are moved to CiP 11 rather than relegated to a separate section.