*The General Practitioner and the Abortion Act**

FROM THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

The Royal College of General Practitioners welcomes the opportunity to review the working of the Abortion Act. Several problems arising from it have caused concern to the College and some of its members.

We understand from the terms of reference that sub-section 1 and sub-section 2 of the Abortion Act are to remain unaltered. Thus we do not present evidence for or against these two sub-sections nor do we comment on the approval of private nursing homes or on the ability of staff to contract out on grounds of conscience.

We regret that in the limited time available to submit evidence we were not able to mount a research project big enough to elicit statistically valid facts for the Lane Committee.

Instead, we invited the 25 Faculty Boards of the College to comment within the guidelines of the letter we received. Our evidence is a consolidation of these comments and we enclose as appendices four faculty reports giving regional views and a summary by Dr Ashworth of the statistical results of the survey of after-care.

The role of the general practitioner

Theoretical considerations

It is sometimes argued that abortion is exclusively the concern of the hospital service and its specialists. In fact, a historical survey shows the opposite to be true. The operation often no longer requires a long stay in hospital and is becoming a day-care procedure.

Furthermore, the need for hospital care in the future may be entirely eliminated if new medical methods of abortion such as prostaglandins and drugs of this type become available. If this were to happen we anticipate that such drugs would not be available directly to the public and would therefore be obtained through a general practitioner's prescription.

Personal doctors are, and will always remain, involved in such personal problems which we see as only one aspect of the total care needed by the patient.

Practical considerations

The general practitioner becomes involved in the working of the Abortion Act in several ways:

(1) in establishing the early diagnosis of pregnancy,
(2) in considering the desirability or otherwise of abortion,
(3) in referring and co-ordinating advice from other professional workers,
(4) in referring the patient for gynaecological advice,
(5) in providing or arranging after-care, including contraceptive advice.

The diagnosis of pregnancy

Early diagnosis of pregnancy is important in the interest of the patient and is always of significance to the family doctor.

The College believes that full facilities to assist diagnosis must be available to general practitioners so that confirmation can be obtained without delay. Delays of several days as sometimes occur are unacceptable, and such delays may lead patients away from general practitioners and outside the National Health Service. Laboratory tests are now being offered on a 'while you wait' basis.

Technically it is now possible for tests of pregnancy to be carried out in general practitioners' premises, but the required reagent is not allowable through the various National Health Service prescribing or reimbursement procedures.

The directors of some National Health Service laboratories are complaining that tests to

*Based on the evidence of the College submitted to the Lane Committee on the Working of the Abortion Act, February 1972.

determine pregnancy are outside their remit, when diagnosis is required for 'social' reasons. We believe, that on the contrary, diagnosis of pregnancy is always of medical importance to the general practitioner and that he should therefore have laboratory access to tests when he wishes.

In some areas considerable delays are occurring in communicating the results when the National Health Service laboratories are used. We believe that communications are of importance to the patient and this kind of information deserves, for example, first class postage.

In summary, the College believes that the general practitioner is the most appropriate person from whom advice should be sought. The College therefore deplores developments which may lead the patient away from general practitioners towards others offering alternative services.

Holistic care

The general practitioner's approach is different from that of any other doctor because:

(1) he is the only doctor likely to have personal knowledge, often during many years, of the woman's medical history;

(2) he is the only clinician likely to have knowledge of the whole family. As the effect on the existing children forms one of the legal indications for abortion the family doctor's opinion of this aspect is of special importance.

(3) General practitioners practise whole-person medicine and alone among doctors concern themselves with physical, psychological and social aspects of care.

Supporting services

The College is concerned at the inequality of services in different areas.

The College believes that the advice social workers may be able to give to general practitioners is considerable. If it could be given quickly and in association with the general practitioner rather than after referral to hospital it might be of even greater value to the patient. In order to achieve this there may be need to improve social service support in some areas.

It is important that social arrangements can be provided quickly and that social workers working with general practitioners should be professionally qualified as in some areas there is a considerable shortage, particularly of psychiatric social workers.

The availability of psychiatric opinion varies in different parts of the country. In some areas, referral to a consultant psychiatrist can mean a delay of three weeks which, if abortion is being considered, is unacceptably long. In effect such delays deny the patient and the general practitioner the opportunity of appropriate consultation.

The National Health Service and the private sector

The College would prefer to see a greater proportion of the abortions that are being done performed within the National Health Service rather than in the private sector.

The present situation is producing undesirable ethical difficulties and is giving patients who can afford a private abortion considerable advantages. We believe that many of the patients who have the strongest need of abortion may be unable to afford a private operation.

The College holds no views on the desirability of the private sector as such, but feels strongly that facilities should be made available within the National Health Service to meet the needs of most potential patients.

Furthermore, facilities provided within the National Health Service for this purpose should not involve reduction in the gynaecological service provided for other National Health Service patients.

Special clinics

We have no policy as to whether abortion should be performed in special clinics in the National Health Service.

However, we believe that all possible ways of achieving a smooth service without disrupting other gynaecological procedures should be investigated, including special outpatient clinics, special clinics with day beds, special departments and special operating teams.

Communications

There is ample evidence that communications between hospital and general practice are very poor at present. We deplore the delays which are occurring when hospitals inform general practitioners of clinical details of their patients, including discharge after abortion. This is particularly unsatisfactory for the patient after early discharge. If the postal service is to be used, we believe the patient is entitled to have this information sent by first-class post.

The College believes that a duty should be placed on the gynaecologist to ensure that when a patient is discharged the general practitioner is immediately informed of essential clinical details by swift and efficient means.

Communications in the private sector are even more inadequate. The College recognises the right of the patient to insist that information should be withheld from her general practitioner, but this right should not be used as an excuse for bad communication. If this right is to be exercised then the patient should formally sign a certificate to this effect comparable to the method used when patients now discharge themselves against advice.

Certification

The Royal College of Obstetricians and Gynaecologists has suggested that the right of certification under the Act should be restricted to those holding consultant appointments or the equivalent in the National Health Service.

We disagree. If indeed any restriction on certifying doctors should be necessary, there are other appropriate possibilities, such as requiring one of the signatories to have previous knowledge of the patient. There is a precedent for this in the Mental Health Act, 1959.

After-care

The general practitioner is the doctor who deals with many of the after-effects of abortion. We believe that women who have had an abortion are a potentially high-risk group and that their after-care is a matter of considerable importance, and their future physical and mental health may present special problems. In particular, there is a need to advise these patients of all the methods available to avoid further unwanted pregnancies.

Most of this work can be carried out in general practice, but in order to ensure that it is properly done it is necessary that general practitioners receive appropriate support in a community health team. This can be done by the attachment of health visitors, nurses and social workers to practices.

Training

Many gynaecologists and nurses are experiencing considerable difficulties in the working of the Abortion Act.

The College notes that most of them have not had the advantage of extensive experience during their training of practical clinical work in the community. Therefore, they have had little experience of the emotional and psychological factors which may affect patients in the community. They may have little experience or understanding of the reasons which lead general practitioners to recommend abortion.

The Royal College of General Practitioners has already supported the concept of the Royal Commission on Medical Education (1968) that doctors should experience broad professional training before specialising. In particular, we believe that all future consultant gynaecologists should have had, as part of their general professional training, a period of work in general practice.

Similarly, all nurses who are to work with patients having abortions in hospital should have general experience of clinical work in the community.

Prevention

We realise that the prevention of the necessity for abortion may not lie strictly within the remit of the Lane Committee.

Nevertheless, the College believes that this is a matter of great importance. Recent suggestions that contraceptives should be made available without prescription, education or advice, as in supermarkets are not, in our view, a satisfactory solution to the problem.

We believe that patients should receive proper medical advice on contraception and that there is no reason why this should not be provided by National Health Service general practitioners. There are precedents in the National Health Service for payments for preventive work by item of service such as 'payments in pursuance of public policy', cytology, and immunization.

The Royal College of General Practitioners is currently stressing the need for general practitioners to be trained in the field of contraception. Membership of the College is now by examination only and this subject is an item on the syllabus of the M.R.C.G.P. examination. The College also encourages its clinical tutors to organise refresher courses in this subject.

Recommendations

(1) All patients in the National Health Service should have reasonably equal facilities for the termination of pregnancy when indicated.

(2) Resources should be made available to the National Health Service to provide a smooth implementation of the Abortion Act without detriment to gynaecological or other health services.

(3) Better communications are urgently needed between gynaecologists and general practitioners both in the National Health Service and in the private sector.

(4) It is important to prevent the need for as many abortions as possible. This will require extensive health education and easily available contraceptive advice, particularly through the general practitioner.

(5) The training of gynaecologists and nurses should be altered so that it becomes more appropriate. In particular, those who will deal with abortion in hospital should have had adequate experience of clinical work in the community.

REFERENCE

The Royal Commission on Medical Education (1968). London: H.M.S.O.

APPENDICES

The College also submitted several appendices to the Lane Committee which formed the opinions of some Faculties, and which showed regional variations. It was made clear that material in the appendices was not meant to detract in any way from the main document.

THE PATIENT'S POINT OF VIEW

In a superb academic centre a patient may be a brilliantly managed case, though impersonally treated as an individual, whereas in smaller community hospitals the converse may be true. Can the patient perceive the difference? If his problem is irreversible will he recognise excellent care regardless of outcome? Although medicine is increasingly a science and seemingly less a compassionate and healing art, Paré's statement "I dressed his wounds; God healed him" should not be forgotten.

These are times that demand frank and honest communication between people. Despite the escalating demands upon them, cannot nurses, doctors and students somehow find more time to talk meaningfully with patients? If knowledge is strength, the informed patient may be better able to help his own recovery. The patient treated as a person is likely to perceive his hospital care as good. Is it not the responsibility of health professionals to ensure that perception is satisfactory, as well as to maximise the quality of care provided?

New England Journal of Medicine (1972). **286,** 1110.