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Mismatch in notifications reveal a worrying problem in our abortion statistics

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In May, the Department of Health circulated a series of abortion-related publications including an awkwardly titled report highlighting historic medical practices, regulation and the role of the state as external scrutineer of abortions.

This report revealed a problem in the way that abortions are notified in the UK and a discrepancy between two national databases, where some reported abortions in one database could not be matched in the other.

Notification of abortion

After the Abortion Act 1967 came into force, it was recognised that a “great social responsibility” was placed by the law “on the shoulders of the medical profession”.

In effect, the Act created a medical monopoly over the abortion process in most of the UK. Save in emergencies, two doctors need to form (and record) an opinion in “good faith” that one of the statutory grounds for the abortion exists. One of these grounds is that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The registered medical practitioner who terminates the pregnancy is then legally responsible for notifying the Department of Health (DH) that the procedure has taken place. These notifications are used by the DH to compile its annual abortion statistics, to scrutinise data and to trigger further enquiries where necessary. A wilful failure to submit a notification is a summary criminal offence.

A second national database

A separate national database – the National Down's Syndrome Cytogenetic Register (NDSCR) – is kept of all notifications of prenatal and postnatal diagnoses of Down's, Edwards and Patau syndromes and what happened to the related pregnancy.

The DH carried out a matching exercise on the information contained in both databases for 2012 – later published in the May 2014 report – which showed that 498 abortions in the NDSCR dataset were not matched in the DH records and 11 of these were for abortions of 24 weeks and over. The report concentrated on the data for Down's syndrome.

Of the matched records, 81 did not contribute to the DH statistics for terminations on the grounds of abnormality where there was mention of Down's syndrome (five were late notifications to DH, 47 were recorded under other statutory grounds and 29 were recorded on the grounds of abnormality but without mention of Down's syndrome). And 93 of the DH-notified abortion procedures where Down's syndrome was confirmed or suspected had no matching record in the NDSCR database.

There was also some evidence of regional variation, but the report found that the evidence was inconclusive.

Potential failures in reporting

The Royal College of Obstetricians and Gynaecologists (RCOG) was also commissioned by the DH to undertake a review and "fact-finding" exercise that resulted in them visiting a sample of abortion providers and which fed into the 2014 report.

Their role was to ascertain local practice, to identify best practice and the likely reasons for the data discrepancy. The RCOG part of the report is couched in ambiguous terms, but it does give possible explanations for the discrepancies in reporting. These include:

• Some doctors who do not appreciate their statutory obligation.

• Doctors who are aware of their duty but have no robust and consistent system for submission.

• Confusion over responsibility for submission where medical administration takes place at more than one hospital.

RCOG found no “evidence or impression that there was wilful failure to comply with the law, but rather a lack of understanding of the statutory requirements, which in turn produced a lack of organisation and accountability”.

Discussion

Even if not wilful, the suggestion that some clinicians do not appreciate their statutory obligation is still a startling one. The statutory provisions are hardly new and the General Medical Council, which regulates doctors in the UK, requires doctors to be familiar and up-to-date with the guidelines and law relevant to their work.

Further still, RCOG is not independent and represents and supports the profession under investigation. Should it really be undertaking investigation and assessment of this problem? It makes sense to use a body with relevant knowledge, technical expertise and an interest in setting standards. Perhaps this could have been an appropriate role for the Care Quality Commission, the independent health and social care regulator.

The mismatch in these records may not present a problem in isolation but as we only have the NDSCR database, we cannot know for certain the extent of any under or misreporting of abortion procedures.

The notification provisions also represent one of the few mechanisms by which the state and society can scrutinise these procedures. Parliament built this process in to the Abortion Act to provide a check and balance to medical discretion. But the findings in the DH report could undermine public trust and confidence in the reporting system if the medical profession isn’t held to the highest possible standards.