SITM: Safe Practice in Abortion Care (SPAC)

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

SPAC CiP 1: The doctor communicates and manages effectively to provide safe abortion care.	
Key skills	**Descriptors**

Provides accurate information, without judgement, on the appropriate methods for termination of pregnancy for the gestational age	• Can counsel a person on all options and the associated health issues should they choose to terminate their pregnancy, including explaining:
	  ○ what support there is for continuing their pregnancy
	  ○ adoption
	  ○ the medical and surgical methods for terminating a pregnancy
	• Demonstrates understanding of the benefits, risks and alternatives for surgical and medical methods, including Manual Vacuum Aspiration (MVA), outside of a theatre setting.
	• Clearly explains treatment regimes, potential side effects of drugs and complications of procedures.

Communicates and puts together an appropriate management plan, taking into account the person's preferences and how urgent it is	• Identifies the reason for a consultation and allows the person to fully explain why they are there. • Deals sensitively with embarrassing and/or disturbing topics. • Structures interviews with people in a logical sequence, and phrases questions simply and clearly. • Involves other specialists, as appropriate; respects and observes confidentiality; and displays tact, empathy, respect and concern for the patient. • Discusses the potential consequences of not completing a treatment regime.
Plans management for high risk and vulnerable groups appropriately	• Ascertains whether a person under 16 has support from other people and encourages them to involve their parents or carers. • Respects religious and cultural diversity and beliefs. • Is aware of women experiencing coercive control from a partner or family member and the need for privacy in interviews. • Appreciates the range of sexuality, culture and lifestyle choices that patients might have, and the way these things can affect them and have an impact on how their abortion is managed. • Checks patient and carer is aware of the procedure, analgesia requirements, what support is available and the expected course of recovery.

	• Makes sure everyone knows what signs and symptoms after abortion are not normal, including who to contact in an emergency. • Works effectively as part of a multidisciplinary team (MDT) in high-risk situations.
Makes sure people receive screening for sexually transmitted infections (STI), post abortion contraception and appropriate follow-up care.	• Discusses and documents a plan for STI screening, post-abortion contraception, and indications for and availability of post-abortion follow-up care. • Prescribes contraception and gives sexual health advice appropriate to the person's circumstances.

Evidence to inform decision

• Mini-CEX • CbD • Reflective practice • NOTSS	• Local and deanery teaching • RCOG Learning • TO2 (including SO)

Knowledge criteria

- The UK legal and regulatory aspects of abortion care: the Abortion Act 1967 and The Abortion (Amendment) (England) Regulations 2002 (legislation.gov.uk)
- Abortion (Northern Ireland) (No. 2) Regulations 2020
- The role of the doctor in completing necessary forms for authorising an abortion and notifying the Chief Medical Officer
- Understand the benefits, risks and alternatives for surgical and medical methods, including MVA, outside of a theatre setting, depending on the gestational age, and the person's medical and social history
- Understand how these options change after 12 weeks and after approximately 19 weeks, depending on local policies
- Familiarity with local and national guidelines
- Local care pathways for high risk and protected groups, including any safeguarding issues
- Department of Health. *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health;* 2004.

SPAC CiP 2: The doctor has the ultrasound skills that are needed to provide safe abortion care.	
Key skills	**Descriptors**
Able to safely perform transabdominal and transvaginal scanning of the female genital tract.	• Is able to identify all key pelvic structures, recognises normality and deviations from normal. • Is able to optimise image quality. • Can store images securely and construct a clinically useful ultrasound examination report.

	• Recognises and adheres to infection control and chaperoning policies. • Is able to date the pregnancy across all trimesters. • Recognises normal and abnormal uterine anatomy. • Recognises the possibility of non-viable. intrauterine/ectopic/heterotopic/scar pregnancy and refers appropriately.
Uses ultrasound to guide and confirm that evacuation of the uterus.	• Identifies the endocervical canal and its instrumentation when the cervix is dilated. • Directs others to provide effective ultrasound guidance when the uterus is being evacuated. • Recognises successful completion of the procedure.

Evidence to inform decision	
• OSATS ○ Ultrasound examination of early pregnancy complications • Mini-CEX • Reflective practice	• NOTSS • TO2 (including SO) • Local and deanery teaching • RCOG e-Learning

Knowledge criteria
• Cervical, uterine and placental anatomy • The use of ultrasound to date crown rump length (CRL) or from 14 weeks head circumference (HC), abdominal circumference (AC) and femur length (FL) • The ultrasound features of normal and abnormal uterine anatomy and implantation (e.g. cervical or scar pregnancy) • The ultrasound appearances during termination and after the procedure has been successfully completed

SPAC CiP 3: The doctor has the procedural skills that are needed to provide safe abortion care.	
Key skills	**Descriptors**

Manages safe abortion using their technical skills	• Prescribes appropriately for a medical abortion, including abortifacients and analgesia.
	• Prescribes appropriately for cervical priming before surgical abortion.
	• Prescribes appropriately to reduce the risk of complications (eg. Infection, haemorrhage and alloimmunisation).
	• Identifies indications for, performs cervical preparation andsafely inserts and removes osmotic cervical dilators.
	• Safely performs mechanical dilatation of the cervix.
	• Completes the procedure and investigations by:
	  ○ confirming complete evacuation of products on inspection of these
	  ○ safely and sensitively disposing of the pregnancy remains

	○ arranging investigations, as indicated in the case of a fetal or placental anomaly or forensic examination ○ correctly placing intrauterine contraceptive, if chosen ○ producing a suitable report of the procedure

Evidence to inform decision

• OSATS: ○ performing termination with MVA ○ performing termination with electric vacuum aspiration (EVA) ○ performing termination with dilation and evacuation (D&E) (only required if the person is 13+6 or more weeks pregnant)	• Mini-CEX • CbD • Reflective practice • NOTSS • Local and deanery teaching • RCOG Learning

Knowledge criteria

- The pain management options for MVA:
  - local cervical anaesthesia
  - oral analgesia
  - mild-moderate (conscious) sedation
- The environment staffing, supplies and set-up required to safely and effectively provide:
  - office-based uterine evacuation
  - theatre-based uterine EVA
  - theatre-based D&E, including theatre set-up, positioning the patient and required equipment
- The indications and contra-indications to, and cautions for the, use of mifepristone and/or misoprostol or other prostaglandin analogue (e.g. gemeprost)
- The evidence-based recommendations for prescribing antibiotics, uterotonics and anti-D immunoglobulin
- The indications and contra-indications to, and cautions for, using osmotic cervical dilators [not required for surgical skills at 13+6 weeks]
- Familiarity with the Human Tissue Authority Guidance (2015) on disposing pregnancy remains following pregnancy loss or termination
- The indications for post-mortem examination and karyotyping when terminating for a fetal anomaly. Understand documentation and follow up for gestational trophoblastic disease (GTD).
- Best practice including:
  - *Renner R, Jensen JTJ, Nichols MDN, Edelman A.* Pain control in first trimester surgical abortion*. Cochrane Database of Systematic Reviews* 2009;(2): CD006712.
  - Okusanya BO, Oduwole O, Effa EE. Immediate postabortal insertion of intrauterine devices. *Cochrane Database of Systematic Reviews* 2010;(6): CD001777.
  - Department of Health. *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health;* 2004.

SPAC CiP 4: The doctor can safely manage complications associated with abortion care.	
Key skills	**Descriptors**
Manages cervical trauma	• Recognises when to call for assistance for cervical trauma. • Communicates and works effectively with the MDT when they are managing cervical trauma.
Manages uterine trauma	• Recognises when to call for assistance for uterine trauma. • Communicates and works effectively with the MDT when they are managing uterine trauma.
Manages post-abortion haemorrhage and collapse	• Recognises and manages immediate complications of surgical abortion (eg. Cervical laceration, uterine perforation, acute haemorrhage and vasovagal episode) and medical abortion (e.g. retained placenta, acute haemorrhage and uterine rupture). • Recognises and manages delayed complications of medical and surgical abortion (eg. Endometritis, incomplete abortion/retained products of conception and mental health problems.
Manages complex cases that require medical or surgical abortion	• Recognises when a transcervical approach is not feasible and appropriately refers for hysterectomy or hysterotomy, in women with specific medical comorbitities, uterine or placental anomalies. • Communicates and works effectively with the MDT. • Identifies and manages immediate complications by inserting osmotic cervical dilators (e.g. vasovagal or false passage) or removal (e.g. hourglassing).
Manages post-abortion mental health	• Manages emotional difficulties and refers to appropriate health professional.

Evidence to inform decision	
• Mini-CEX • CbD • Reflective practice	• Local and deanery teaching • TO2 (including SO) • NOTSS • RCOG Learning • Participating in MDT simulation training • Leads critical incident review

Knowledge criteria
• How to recognise and manage the complications of surgical abortion (e.g. cervical laceration, uterine perforation, acute haemorrhage and a vasovagal episode) and medical abortion (e.g. retained placenta, acute haemorrhage and uterine rupture)

• How to recognise and manage delayed complications of medical and surgical abortion (e.g. endometritis, incomplete abortion/retained products of conception and mental health problems)

SECTION 2: PROCEDURES

Procedures marked with * require three summative competent OSATS.

Procedures	*Level by end of training*	*CIP 1*	*CIP 2*	*CIP 3*	*CIP 4*
Ultrasound examination of early pregnancy complications*	5		X		
MVA*	5			X	
EVA*	5			X	
Dilation and evacuation for pregnancies for 13+6 and more weeks pregnant*	5			X	

SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES (GPCs)

Mapping to GPCs
Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking; diagnosis and management: consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control; and communicable diseases) Domain 3: Professional knowledge • Professional requirements • National legislative requirements • The health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • Patient safety • Quality improvement Domain 7: Capabilities in safeguarding vulnerable groups

SECTION 4: MAPPING OF ASSESSMENTS TO SPAC CiPs

SPAC CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor communicates and manages effectively to provide safe abortion care		X	X	X	X	X
2: The doctor has the ultrasound skills that are needed to provide safe abortion care	X	X		X	X	X
3: The doctor has the procedural skills that are needed to provide safe abortion care	X	X	X	X	X	X
4: The doctor can safely manage complications associated with abortion care	X	X	X	X	X	X

SECTION 5: RESOURCES (OPTIONAL)

1. Abortion Act 1967. London: HMSO [www.legislation.gov.uk/ukpga/1967/87/contents].
2. Darney PD, Sweet RL. Routine intraoperative ultrasonography for second trimester abortion reduces incidence of uterine perforation. *J Ultrasound Med* 1989 Feb;8(2):71-5.
3. Abortion (Northern Ireland) (No.2) Regulations 2020 https://www.legislation.gov.uk/uksi/2020/503/part/7/made
4. Department of Health. Abortion Notification Forms [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4063863].
5. Department of Health. *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health;* 2004.
6. Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit. Clinical Guidance. *Contraception after pregnancy* 2007 [www.fsrh.org/news/new-fsrh-guideline--contraception-after-pregnancy/].
7. Fox MC, Krajewski CM. Cervical preparation for second-trimester surgical abortion prior to 20 weeks' gestation: *SFP Guideline* #2013-4. Contraception 2014;89:75-84.
8. General Medical Council. *Consent guidance: patients and doctors making decisions together.* 2008.

9. Goldberg AB, Fortin JA, Drey EA, Dean G, Lichtenberg ES, Bednarek PH et al. Cervical Preparation Before Dilation and Evacuation Using Adjunctive Misoprostol or Mifepristone Compared With Overnight Osmotic Dilators Alone: A Randomized Controlled Trial. *Obstet Gynecol* 2015 Sep;126(3):599-609.
10. Grimes DA. The choice of second trimester abortion method: evolution, evidence and ethics. *Reprod Health Matters* 2008 May;16(31 Suppl):183-8.
11. Harris LH. Second trimester abortion provision: breaking the silence and changing the discourse. *Reprod Health Matters* 2008 May;16(31 Suppl):74-81.
12. Kelly T, Suddes J, Howel D, Hewison J, Robson S. Comparing medical versus surgical termination of pregnancy at 13-20 weeks of gestation: a randomised controlled trial. *BJOG* 2010 Nov;117(12):1512-20.
13. Kerns J, Steinauer J. Management of postabortion hemorrhage: November 2012 SFP Guideline #20131. Contraception. 2013 Mar;87(3):331-42.
14. Lichtenberg ES. Complications of osmotic dilators. *Obstet Gynecol Surv* 2004 Jul;59(7):528-36.
15. Medical versus surgical methods for first trimester termination of pregnancy. *Cochrane Database of Systematic Reviews* 2005;(1):CD003037.
16. Newmann S, Dalve-Endres A, Drey EA. Society of Family Planning. Clinical guidelines. Cervical preparation for surgical abortion from 20 to 24 weeks' gestation. *Contraception* 2008;77:308-14.
17. Okusanya BO, Oduwole O, Effa EE. Immediate postabortal insertion of intrauterine devices. *Cochrane Database of Systematic Reviews* 2010;(6): CD001777.
18. Paul M, Lichtenberg S, Borgatta L, et al. eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care.* 2nd ed. Chichester: WIley-Blackwell; 2009.
19. RCOG Presenting Information on risk. *Clinical Governance Advice* No. 7; 2008.
20. RCOG: Patient leaflet: *Information about abortion care*; 2012.
21. Renner R, Jensen JTJ, Nichols MDN, Edelman A. Pain control in first trimester surgical abortion. *Cochrane Database of Systematic Reviews* 2009;(2): CD006712.
22. Rowlands S, ed. *Abortion Care.* Cambridge: Cambridge University Press, 2014.
23. Statutory Instrument 2002 No. 887. The Abortion (Amendment) (England) Regulations 2002. London: HMSO; 2002 [www.legislation.gov.uk/uksi/2002/887/made].
24. Termination of Pregnancy for Fetal Abnormality in England, Scotland & Wales. *Report of a Working Party*. RCOG;2010 [www.rcog.org.uk/termination-pregnancy-fetal-abnormality-england-scotland-and-wales].