NSW HEALTH DEPARTMENT

CIRCULAR

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FRAMEWORK FOR TERMINATIONS OF PREGNANCY IN NEW SOUTH WALES PUBLIC HOSPITALS

1. Introduction

This framework is designed to support the review and development of appropriate local protocols for terminations of pregnancy undertaken in public hospitals. All public health organisations which manage facilities in which terminations occur are to ensure that they have in place protocols which are consistent with and address all the issues referred to in this framework. There are a number of relevant Departmental circulars which should be incorporated into local protocols. They are referred to throughout this document. Please note that the definitions used for the purposes of public health data collections such as the NSW Midwives Data Collection, may differ from reporting requirements under the NSW Registration Act.

2. Legal Context

The legal framework in relation to termination of pregnancy is set out below.

2.1 Criminal Law (see Sections 82 to 84 of the Crimes Act)

In New South Wales, the law on termination is governed by the NSW Crimes Act 1900 as interpreted by relevant case law. In summary, termination is lawful if:

- the procedure is performed with the consent of the woman and by a legally qualified medical practitioner ; and
- the medical practitioner procuring the termination has an honest belief based on reasonable grounds that the procedure is necessary to preserve the woman from serious danger to her life, or physical or mental health. These grounds may be medical, economic or social ; and
- in the circumstances the operation is not out of proportion to the danger intended to be avoided.

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2.2 Births, Deaths and Marriages Registration Act

Under the Births, Deaths and Marriages Registration Act 1995 ("the Registration Act") there is a requirement to register all births.

2.2.1 Stillbirth

"Birth" includes "stillbirth", which means the birth of a "stillborn child" (a fetus of at least 20 weeks gestation or, if the gestational age is not known, having a body mass of at least 400 grams at birth). If the gestational age of the fetus is not accurately known, the weight of the fetus becomes relevant. When notice of a stillbirth is given, the responsible person must also give a doctor's certificate certifying the cause of fetal death. No registration of "death" is required in respect of stillborn children.

2.2.2 Neonatal birth and death

A child born alive, irrespective of gestational age, must be registered as a birth- see section 12 of the Registration Act. If the child subsequently dies it must be registered and notified to the Registrar together with the cause of death in accordance with the Registration Act or alternatively reported to the Coroner. *Refer to circular 98/114 Register of Deaths*

2.3 Duty of Care

This section outlines the legal responsibilities in relation to both adult and child patients in the context of terminations of pregnancy. Both the civil and criminal law is relevant.

2.3.1 Adult patient

The law imposes on a medical practitioner a duty to his or her patient to exercise reasonable care and skill in the provision of professional advice and treatment. Appropriate and adequate information must be provided to patients in order for the patient to make an informed choice about treatment.

In relation to the actual performance of the termination, a duty of care is owed to the patient and the standard of reasonable care and skill required is that of a medical practitioner experienced in that area of practice. Where the standard of care falls below that which could be reasonably expected in the circumstances, negligence may be established.

2.3.2 Child

For the purposes of this section "child" refers to a child who has been expelled or removed from the mother's womb alive. It should be noted that a fetus *in utero* is not recognised as a separate legal entity. However, once a fetus has been expelled or removed from the mother's womb, and is born alive, he/she has the legal status of a person whose rights exist independently of the rights of the parents.

Where a child is born alive and a responsible body of medical opinion considers that no benefit would be conferred on the child by medical treatment, whether it be because of pre-viability of the child, his/her prematurity or the effect of a disease or condition, a medical practitioner is under no duty to render futile treatment. Where the converse situation applies, there is an obligation to render life saving medical treatment.

2.4 Coroners Act

"Death" in the Coroners Act 1980 should be construed in the same way as "death" in the Registration Act. The delivery of a fetus that "exhibits no sign of respiration or heartbeat, or other sign of life" which does not include a stillbirth after expulsion from the womb is not a "death" for the purposes of the Coroners Act. A fetus becomes a person if after expulsion or extraction from the mother and before being determined to be dead, signs of life are exhibited.

The reporting obligations are set out in the Coroners Act and Circular 99/57 e.g death occurring under unusual circumstances or where a medical practitioner has not certified a cause of death. *Refer to Circular 99/57 "Coroners' Cases and Amendments to Coroners Act 1980" and Circular 95/57 "Assessment of the Extinction of Life and the Certification of Death".*

3. Pre-Procedure Issues

3.1 Counselling

All women seeking a termination of pregnancy are to be offered counselling. This counselling does not replace but is additional to any genetic counselling that may be indicated. Information on testing for genetic disorders is attached as Annexure 1.

Evidence of pre termination counselling from an appropriately qualified health care professional must be documented as having been offered and a copy of the counsellor's report provided to the treating medical practitioner. Where counselling is provided by the medical practitioner, documentation of the counselling must be included in the medical record.

3.2 Assessment of Need

For all proposed terminations the following criteria should be considered and documented:

- patient's physical and psychological condition
- assessment of gestational age
- in cases of birth defect diagnostic probability
- in cases of birth defect prognosis for the fetus

Except where there is an imminent threat to the life or physical health of a woman necessitating a termination as a matter of urgency the following process is to be followed:

1st trimester - The assessment of need is to be undertaken by the treating medical practitioner in consultation with the patient after appropriate counselling has occurred.

2nd Trimester – In the case of *pre-20 weeks gestation* the assessment of need is to be undertaken by the treating medical practitioner in consultation with the patient after appropriate testing and counselling has occurred and the results/reports provided to the attending practitioner. The attending practitioner may need to consult further with other relevant specialists as part of the assessment.

In the case of *post 20 weeks gestation* a multidisciplinary assessment will be necessary convened by the treating medical practitioner and including expertise in the areas of psychiatry or specialist mental health, fetal medicine, neonatology and the other specialty or specialties relevant to the woman's and fetus's medical condition. Following this assessment the relevant clinical department head is to be advised if the treating medical practitioner is to undertake the procedure. If termination procedures are not conducted at the receiving hospital (or are not conducted at the gestational age in question), the woman will be offered appropriate information and counselling and referred to a service which does have the expertise and capacity for the treatment she is considering.

3.3 Patient Information/ Consent

Written consent of the patient is to be obtained by the treating medical practitioner before a pregnancy termination is performed.

Refer to Circular 99/16 "Patient Information and Consent to Medical Treatment".
Hospital protocols should give guidance to clinicians on providing appropriate patient information. Patients must be provided with sufficient information about the treatment options, benefits, possible adverse effects or complications, and the likely result if the treatment is not undertaken, in order to be able to make their own decision about undergoing the termination.

A medical practitioner has a legal duty to warn a patient of any material risks to her physical or mental health from the proposed termination.

Where applicable the patient is to be informed of the potential for the infant to be born exhibiting signs of life and the ramifications should this eventuate.

Consent to the proposed procedure must be obtained from the patient. Only the consent of the pregnant woman is required before a termination may be performed (not the consent of other family members, even though on many occasions the patient may choose to discuss the matter with other family members).

The requirements for valid consent are:
- Firstly the person must have the capacity to give consent;
- Secondly, the consent must be freely given;
- Thirdly, the consent must be specific and is valid only in relation to the treatment or procedure for which the patient has been properly informed and has agreed to; and
- Finally, the patient must be informed in broad terms of the procedure which is intended.

The woman's wishes regarding contact with the fetus/child following termination should be documented to ensure appropriate arrangements are made where requested by the woman.

4. Procedure

4.1 Clinical protocols

Clinical protocols are to be in place for all forms of termination procedures. These protocols should incorporate the roles and responsibilities of the relevant professional groups. Counselling should be readily available for all staff.

4.2 Conscientious objection

Staff are not required to participate in terminations of pregnancy or administer any abortifacient agents. Any staff who have concerns should contact their manager. For more general information please see circular 83/348 - Employment, Discrimination and Religious Conviction.

5. Post Procedure Issues

5.1 Woman

Clinical guidelines should be in place regarding immediate postnatal care. These should include maternal clinical observations and frequency required, and guidelines for clinical emergencies.

The medical practitioner responsible for the care of the woman should be informed of the completion of the procedure, the condition of the woman and, where relevant, the child. The woman should also receive appropriate post procedure information.

The woman's wishes regarding the fetus should be respected and arrangements for viewing and handling of the fetus should be ensured. If an autopsy is considered appropriate the woman’s consent should be sought.

The woman must be informed of any further requirements that may be necessary, and provided with assistance in fulfilling these, for example providing, funeral arrangements and birth registration.

Counselling is to be offered to the mother and family after the procedure and parents are to be informed of support services available.

A discharge plan should be developed.

5.2 Fetus/Child

5.2.1 Examination and care

Examination of the fetus/child should occur immediately upon delivery.

Where a medical termination of pregnancy results in a fetus/child showing signs of life it is important that staff involved are aware of their responsibilities and duty of care toward the child. This includes assessment of the condition of the child at birth, and any abnormalities present. If upon examination the condition of the child warrants further specialist examination staff should immediately consult a neonatologist.

If it is considered that no benefit would be conferred on the child by medical treatment, whether it be because of pre-viability of the child, his/her prematurity or the effect of a disease or condition, staff are under under no duty to render futile treatment. Where the converse situation applies, there is an obligation to render life saving medical treatment.

Any child born with signs of life as a result of a termination of pregnancy, irrespective of gestation or condition, must be afforded the right of dignity, maintenance of privacy and physical comfort whilst signs of life exist. Parents should be encouraged to be part of this care.

5.2.2 Registration requirements

The requirements of the Registration Act are to be fulfilled. Refer to Section 2 of this document.

In the case of a stillbirth where it is unclear whether the gestational age is less than 20 weeks at the time of delivery the fetus is to be weighed. If the weight is 400 grams or greater the fetus must be registered as a stillbirth.

All live births and all deaths must be registered.

5.2.3 Appropriate disposal/ transfer

Guidelines should be developed for the appropriate transfer and disposal of the fetus and products of conception following termination of pregnancy. These should be in accordance to Circular 99/87 Infection Control Policy, section 8 'Management of Clinical Waste'.

5.2.4 Notification to Department of Health

Birth, perinatal death and birth defects are category 1 conditions under the Public Health Act 1991 requiring notification to the Department of Health.

Refer also to Departmental Circular 98/4 Midwives Data Collection and 99/55 NSW Midwives Data Collection Form MR44/PR16.

6. RECORDS MANAGEMENT

Refer to Circular 98/59 "Principles for Creation, Management, Storage and Disposal of Health Care Records" and NSW Health "Information Privacy Code of Practice", Second Edition, December 1998

Health professionals are required to keep accurate health care records of patients.

In addition to routine clinical notes concerning the care and treatment of the patient the following information should also be documented:

- Gestational Age/weight

Gestational age is to be recorded where known. The method used to calculate the gestational age should be documented. If appropriate, weight should be recorded.

- Signs of life following a medical termination

Where a medical termination is performed the extent and duration of any signs of life should be recorded and what actions were taken.

Michael Reid
Director-General

ANNEXURE 1

Testing for Genetic Disorder

Reference should be made to Circular 97/48 called "Guidelines for Testing for Genetic Disorders"

Before considering consent to the termination, consideration needs to be given to the implications of the range of testing eg ultrasound available to pregnant women.
Testing may benefit individuals and their families in a number of ways but it may also create dilemmas for the individual being tested and other members of their families which need sensitive management. Pre test and post test counselling is an essential element of genetic testing. Each test has distinct advantages, disadvantages and limitations and should only be used after the individual being tested has given full consideration to these issues. All testing should be carried out with the consent of the person being tested. The person must be provided with comprehensive information as to the purpose of the test or the procedure and the possible implications of the results, and consequences of those results, before being asked to give consent. Careful consideration should be given to the way results are conveyed.

Certain results must be reported to the NSW Birth Defects Register as set out in the Circular.

Where there is prenatal diagnosis using amniocentensis, chorion villus sampling and fetal blood sampling it is recommended that where possible patients are counselled face to face at least one day before the procedure. Counselling should address a clear and simple explanation of the probability of an effected fetus, explanation of the process of the procedure, options to be considered if the result is abnormal, acknowledgment of the individual nature of decisions about continuing or terminating the pregnancy and methods of termination of pregnancy (and other factors, refer page 9 and 10 of the Circular).

Ultrasound has become a routine part of prenatal care. Parents may not have given consideration to the prospect of an adverse result. When an abnormality is detected, care should be taken to provide counselling and emotional support to minimise the impact of the result on the woman and her family.

Maternal serum testing is an optional and voluntary prenatal test for women of any age, which, when combined with age and other factors, can provide an assessment of risk for Down syndrome and other abnormalities such as neural tube defects. The test alone does not identify any birth defect. An increased risk result indicates the need to consider definitive prenatal diagnostic tests such as amniocentesis. It is important that women consider all aspects of this blood test before agreeing to have it done. (Refer page 13 and 14 of Circular).

Neural tube defects include anencephaly, spina bifida and encephalocele. Serum Alpha Fetoprotein Testing is a voluntary and optional prenatal test which gives a risk assessment for neural tube defects. Issues to be discussed with patients are set out on page 16 of the Circular.