Policy Directive

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Pregnancy - Framework for Terminations in New South Wales Public Health Organisations

Document Number PD2014_022

Publication date 02-Jul-2014

Functional Sub group Clinical/ Patient Services - Maternity
Clinical/ Patient Services - Medical Treatment

Summary This policy directive provides a framework to support the review and development of appropriate local protocols for terminations of pregnancy undertaken in public hospitals. It clarifies the assessment of need, consent and the responsibilities of each public health organisation in the provision of this procedure. All public health organisations that manage facilities in which terminations occur are to ensure they have in place protocols that are consistent with and address all the issues referred to in this policy directive.

Replaces Doc. No. Pregnancy - Framework for Terminations in New South Wales Public Health Organisations [PD2005_587]

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Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Hospitals

Audience All Clinicians in Maternity Services

Distributed to Public Health System, Divisions of General Practice, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 02-Jul-2019

Policy Manual Patient Matters

File No. H14/1016

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

POLICY STATEMENT

PREGNANCY - FRAMEWORK FOR TERMINATIONS IN NEW SOUTH WALES PUBLIC HEALTH ORGANISATIONS

PURPOSE

This Policy Directive provides a framework to support the review and development of appropriate local protocols for terminations of pregnancy undertaken in public hospitals. It clarifies the assessment of need, consent and the responsibilities of each public health organisation in the provision of this procedure. All public health organisations that manage facilities in which terminations occur are to ensure they have in place protocols that are consistent with and address all the issues referred to in this Policy Directive.

MANDATORY REQUIREMENTS

All NSW Public Health Organisations are to ensure they have in place protocols that are consistent with and address all the issues referred to in this Policy Directive.

IMPLEMENTATION

The Chief Executives of NSW Local Health Districts are ultimately responsible for the implementation of this Policy Directive within their services/facilities.

REVISION HISTORY

Version	Approved by	Amendment notes
July 2014 (PD2014_022)	Deputy Secretary Population and Public Health	Clarification on the assessment of need process and conscientious objection
May 2005 (PD2005_587)	Director General	Pregnancy-Framework for Terminations in New South Wales Public Health Organisations

ATTACHMENTS

1. Pregnancy - Framework for Terminations in New South Wales Public Health Organisations

Pregnancy - Framework for Terminations in New South Wales Public Health Organisations

NSW GOVERNMENT Health

PROCEDURES

Issue date: July - 2014

PD2014_022

CONTENTS

1 BACKGROUND

1.1 About this document

This Policy Directive provides a framework to support the review and development of appropriate local protocols for terminations of pregnancy undertaken in public hospitals. It clarifies the assessment of need, consent and the responsibilities of each public health organisation in the provision of this procedure. All public health organisations that manage facilities in which terminations occur are to ensure they have in place protocols that are consistent with and address all the issues referred to in this Policy Directive including the use of health care interpreters where required or requested.

1.2 Key definitions

In this document the term:

must – indicates a mandatory action required by a NSW Health Policy Directive, law or industrial instrument; and

should – indicates an action that should be followed unless there are justifiable reasons for taking a different course of action.

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 Births, Deaths and Marriages Registration Act 1995.

1.3 Related Documents

This Policy Directive should be read in conjunction with the following Policy Directives:

- Client Registration Policy PD2007_094
- Coroners Cases and the Coroners Act 2009 PD2010_054
- Death - Extinction of Life and the Certification of Death - Assessment PD2012_036
- Consent to Medical Treatment - Patient Information PD2005_406
- Human Tissue-Use/Retention Including Organ Donation, Post-Mortem Examination and Coronial Matters PD2005_341
- Infection Control PD2007_036
- Deaths - Review and Reporting of Perinatal Deaths PD2011_076
- Deceased Persons In Health Facility Mortuaries & Management of Health Facility Mortuaries PD2007_017
- Perinatal Data Collection (PDC) Reporting and Submission Requirements PD2010_072
- Congenital Conditions Register - Reporting Requirements PD2012_055
- Health Care Records - Documentation and Management PD2012_069
- Genetic Testing PD2007_066

- Interpreters - Standard Procedures for Working with Health Care Interpreters PD2006_053.

2 LEGAL CONTEXT

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

2.1 Criminal Law[1]

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 registered medical practitioner
- 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
- In the circumstances, the operation is not out of proportion to the danger intended to be avoided.

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.

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.

[1] see Sections 82 to 84 of the Crimes Act

2.3.1 Adult patient

The law imposes on a medical practitioner a duty to his/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. Negligence may be established where the standard of care falls below that which could be reasonably expected in the circumstances.

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, the child 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 the burden of medical treatment is such that it would not benefit the child, because of pre-viability of the child, prematurity, or the effect of a disease or condition - then a medical practitioner is under no duty to render overburdensome treatment. Healthcare professionals have an obligation to work together with families to make compassionate decisions. Conversely, where the likelihood of treatment will be of benefit, there is an obligation to render life-saving medical treatment.

2.4 Coroners Act

"Death" in the Coroners Act 2009 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 Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054).

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.

Before considering consent to the termination, consideration needs to be given to the immediate and future implications of the range of genetic tests available to pregnant

women. Testing may benefit women and their families in a number of ways but it may also create dilemmas for the woman being tested and other members of their families that 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 woman being tested has given full consideration to these issues. All testing should be carried out with the consent of the woman being tested. The woman must be provided with comprehensive information as to the purpose of the test or the procedure and the possible implications and consequences of those results, before being asked to give consent. Careful consideration should be given to the way results are conveyed to ensure this is done sensitively.

Certain results must be reported to the NSW Register of Congenital conditions as set out in PD2012_055 *Congenital Conditions Register - Reporting Requirements*. Where there is prenatal diagnosis using amniocentesis, chorionic villus sampling or fetal blood sampling it is recommended that where possible women 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 affected 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.

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 screening alone, or in combination with ultrasound, 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. 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 such screening before agreeing to have it done.

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 the medical practitioner provides counselling, documentation of the counselling must be included in the medical record.

3.2 Assessment of Need

The decision for termination of pregnancy is one between an individual woman and her treating practitioner.

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

1. The woman's physical and psychological condition
2. Accurate assessment of gestational age

3. In cases of birth defect, the diagnostic probability
4. In cases of birth defect, the 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:

- <13 weeks gestation - The assessment of need is to be undertaken by the treating medical practitioner in consultation with the woman after appropriate counselling has been offered.
- 13 - 20 weeks gestation - The assessment of need is to be undertaken by the treating medical practitioner in consultation with the woman after appropriate testing and counselling has been offered and the results / reports provided to the treating practitioner. The treating practitioner may need to consult further with other relevant specialists as part of the assessment.
- > 20 weeks gestation - In the assessment of need the treating practitioner should seek appropriate consultation and advice as dictated by the individual clinical scenario. Such consultation and advice should be documented by the treating practitioner. In some circumstances the Local Health Districts may provide opportunity for a case conference or multidisciplinary team, with a mix of skills and experience to provide advice to the treating medical practitioner so that he/she is able to undertake an informed assessment of need for termination of pregnancy. The provision of a case conference or multidisciplinary team is not a mandatory component of the assessment of need but serves to assist the treating practitioner in complex clinical situations. The multidisciplinary team may include experts 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' condition.

  Such a multidisciplinary team is neither a constituted ethics committee nor does it have clinical decision making ability. Its sole purpose is to provide the treating medical practitioner with advice of a clinical or technical nature.

  If the clinical decision is made by the treating medical practitioner that a termination is to occur up to 22 weeks gestation, this service should be provided within the facility. If the clinical decision is made between a woman and a treating medical practitioner that a termination is required after 22 weeks gestation and the facility is not in a position to offer a termination as outlined in this policy, the treating practitioner must provide appropriate information and refer the woman to another facility within their tiered maternity network which does have the expertise and capacity to undertake this procedure.

3.3 Patient Information/Consent

Written consent of the woman is to be obtained by the treating medical practitioner before a pregnancy termination is performed. Hospital protocols should give guidance to clinicians on providing appropriate patient information. Women 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 woman of any material risks to her physical or mental health from the proposed termination. Where applicable, the woman 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 woman. 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 woman may choose to discuss the matter with other family members).

The requirements for valid consent are:

1. The person must have the capacity to give consent
2. The consent must be freely given
3. 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
4. The patient must be informed in broad terms of the procedure that is intended, in a way the patient can understand.

Capacity to give consent implies that the person must be able to comprehend and retain relevant information, and understand the implications sufficiently to reach a decision about termination. Examples of patients who are not considered as having this capacity would include: a child under the age of fourteen, and some people affected by mental illness, intellectual disability or cognitive impairment (PD 2005_406).

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.

3.3.1 Consent form

The Policy Directive *Consent to Medical Treatment - Patient Information* (PD2005_406) Section 34: *Consent for procedures that a medical practitioner does not "recommend"*, provides an alternatively worded consent form for some procedures, such as termination of pregnancy. This is in recognition that some medical procedures, such as terminations of pregnancy are performed which may not be "recommended" by a medical practitioner, or whereby a medical practitioner may feel uncomfortable about recommending the procedure. Public health organisations may adopt the alternatively worded consent form as in PD2005_406 - Section 34.

4 PROCEDURE

4.1 Clinical protocols

Clinical protocols are to be in place for all forms of termination procedures and should include the provision of counselling for staff if required. These protocols should incorporate the roles and responsibilities of the relevant professional groups and relevant product information including prescribing, administration, indication of use, contraindications, precautions, adverse reactions and drug interactions.

4.2 Conscientious objection

Any medical practitioner who is asked to advise a woman about termination of pregnancy, or perform, direct, authorise or supervise a termination of pregnancy, and who has a conscientious objection to termination of pregnancy must:

1. Inform the woman that they have a conscientious objection and that other practitioners may be prepared to provide the health service she seeks; and
2. Take every reasonable step to direct the woman to another health practitioner, in the same profession, who the practitioner reasonably believes does not have a conscientious objection to termination of pregnancy.

The term 'direct' is to be understood in its ordinary sense, that is, to direct or point to another source, rather than the requirement of a written referral as part of an ongoing working relationship. It may be as simple as directing the woman to another practitioner who they know has no such objection. This is to ensure that women receive timely, accurate information from a professional who does not hold an objection to the health service she seeks.

Any health practitioner having a conscientious objection to termination of pregnancy should notify their manager in a timely manner of his/her conscientious objection. Public health organisations must ensure that no staff member is disadvantaged because of a conscientious objection to termination of pregnancy.

The exception to this is termination of pregnancy in emergency situations. Medical practitioners, midwives and nurses must perform a termination of pregnancy in those rare emergency cases where it is necessary to preserve the life of the pregnant woman, regardless of their objection to abortion.

5 POST-PROCEDURE ISSUES

5.1 Woman

Clinical guidelines should be in place regarding immediate postpartum care. These should include clinical observations and frequency required, and management of 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 accord with her wishes. 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, funeral arrangements and birth registration.

Counselling is to be offered to the woman, and as appropriate to the family, after the procedure. Information should also be provided regarding support services available. A discharge plan should be developed.

5.2 Fetus/Child

5.2.1 Post-procedure 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.

Where a child is born alive but medical consensus is that treatment (other than palliative treatment) would be over burdensome and of negligible benefit to the child (futile), whether due to pre-viability, prematurity, the effect of a disease or condition or some other reason, the medical practitioner has no legal obligation to provide that treatment. Healthcare professionals have an obligation to work together with families to make compassionate decisions.

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. If the gestational age is less than 20 weeks or the weight is less than 400 grams then no birth or death registration is required.

All live births and all deaths following a live birth must be registered.

5.2.3 Appropriate disposal/ transfer

Local guidelines should be developed for the appropriate transfer and disposal of the fetus and products of conception following termination of pregnancy.

5.2.4 Notification to Ministry of Health

Birth, perinatal death and birth defects are category 1 conditions under the *Public Health Act 2010* requiring notification to the Ministry of Health.

6 RECORDS MANAGEMENT

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 woman the following information should also be documented:

1. 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.

2. 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.