Policy Directive

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

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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.
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This Policy Directive may be varied, withdrawn or replaced at any time.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.

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

1. Introduction

This Policy Directive supersedes Policy Directive PD2005_567 (previously circular 2000/64), which provided a framework to support the review and development of appropriate local protocols for terminations of pregnancy undertaken in public hospitals. This Policy Directive clarifies the assessment of need, consent and the responsibilities of each Area Health Service in the provision of this procedure.

All Area Health Services 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. There are a number of relevant Departmental Policy Directives that should be incorporated into local protocols and these are referred to throughout this Policy Directive. 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.

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.

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 Policy Directive 2005_138 (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/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 Policy Directive 2005_352 (Circular 2004/23) e.g death occurring under unusual circumstances or where a medical practitioner has not certified a cause of death. *Refer to Policy Directive 2005_352 (Circular 2004/23) "Coroners' Cases and Amendments to Coroners Act 1980" and Policy Directive 2005_488 (Circular 99/92) "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 the medical practitioner provides counselling, 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. The AHS has an obligation to provide a 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 for need of termination of pregnancy. 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's medical condition.

If the clinical decision is made by the treating medical practitioner that a termination is to occur up to 22 weeks gestation, this service is to be managed within the Area Health Service (AHS).

If the clinical decision is made by the treating medical practitioner that a termination is required after 22 weeks gestation and the AHS is not in a position to offer a termination as outlined in this policy, the AHS must provide appropriate information and refer the patient to a facility which does have the expertise and capacity to undertake this procedure.

To ensure a timely referral for women, the referral process should be based on the provision of an Area Health Service (AHS) agreement or Memorandum of Understanding (MOU) to be established with the other AHS as an issue of priority. The Area Health Service (AHS) agreement or Memorandum of Understanding (MOU) should include an agreed process for undertaking the required multidisciplinary assessment of need for the procedure.

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 Policy Directive 2005_406 (Circular 2004/84) "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:
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; and
4. the patient must be informed in broad terms of the procedure that is intended, in a way the patient can understand.

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 2005_406 (Circular 2004/84) "Patient Information and Consent to Medical Treatment"* - 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 the Policy Directive 2005_406 (*Circular 2004/84)* -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 all staff. 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

In the circumstances where staff have a conscientious objection to participate in terminations of pregnancy or administer any abortifacient agents there is an obligation to transfer the care of the patient to another medical specialist (or health professional) on site or at another AHS facility. Any staff that have concerns should contact their manager.

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 as appropriate to the family after the procedure. Information should also be provided regarding support services available. Refer also to *Policy Directive 2005_341* (*Circular 2004/)1- Use and Retention of Human Tissue Including Organ Donation, Post-mortem Examination and Coronial Matters*.

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 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 *Policy Directive 2005_ 247* (*Circular 02/45) 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 Policy Directive 2005_117 (Circular 98/4) Midwives Data Collection and 2005_543 (99/55) NSW Midwives Data Collection Form MR44/PR16.

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 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.

Refer to Policy Directive 2005_127 (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.

Robyn Kruk
Director-General

ANNEXURE 1

Testing for Genetic Disorders

Reference should be made to Guideline 2005_012 (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 tests 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 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 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 Guideline.

Where there is prenatal diagnosis using amniocentesis, 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 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 (and other factors, refer page 9 and 10 of the Guideline).

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 Guideline).

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 Guideline.