

Late terminations of pregnancy – an obstetrician’s perspective

David Ellwood

THE RECENTLY REIGNITED DEBATE on abortion has raised many questions, including the number performed, the age of the women and indications for the procedure. Those on the “pro-life” side of the highly polarised participants have also focused attention on “late abortions”. There have been suggestions that there may be large numbers of late terminations of pregnancy being performed, in some cases close to full term, with no medical indication other than a woman’s choice not to continue the pregnancy. Indeed, the phrase “partial-birth abortion” which is sometimes used

by political activists on the pro-life side may lead the uninformed listener to conclude that this is something close to infanticide, being performed at a time when survival for the infant is a realistic possibility. What then is the real situation with late terminations in Australia?

The term “late termination” is understood by most obstetricians to mean one that is carried out at or above 20 weeks’ gestation. This legal watershed, beyond which the fetus attains a legal identity, often triggers a change in the decision-making process when a request for termination is made. This depends on the practice and laws that apply in various jurisdictions.

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Decision-making in Australian states

In Western Australia, an expert medical committee appointed by the health minister has the

legislated power to decide on whether or not a late termination can be performed. All of these procedures take place in that state's tertiary women's hospital and are done for reasons of severe fetal abnormality or serious maternal illness. In South Australia the law clearly permits termination up to, but not beyond, 28 weeks of gestation, and the decision is essentially one between a woman and her doctor. In practice though, the indications for later termination are the same as in Western Australia.

In both New South Wales and Victoria the law does not provide any guidance for practitioners about gestational age or indications for late termination. However, in both states the processes in the major public hospitals are similar in that some form of local ethics panel or "termination review committee" is used to examine the reasons why the request has been made and the indications for the procedure. In practice, late terminations in public hospitals are almost always for reasons of severe fetal abnormality, or where the mother has a life-threatening illness exacerbated by the pregnancy.

New South Wales Health has issued guidelines for hospitals about the nature of the local ethics panel and its composition. In Victoria, individual hospitals have chosen their own methods of managing the approval process. In the Australian Capital Territory, where abortion has been specifically excluded from the Crimes Act, the sole tertiary hospital carries out a small number of late terminations using a local ethics committee process which mirrors (and in fact predated) the NSW Health recommendations. In Queensland and Tasmania, access to later terminations within the public hospital system is very limited, and the procedure is generally not carried out above 22 weeks' gestation.

Methods

The methods used for late termination vary, depending on the indication (particularly the nature of the fetal abnormality), the gestation and the preferences of the individual practitioner and patient. The most commonly used method is induction of labour using prostaglandins. A surgi-

cal procedure such as dilatation and evacuation, although possible, is less likely to be used at gestations beyond 20 weeks due to technical difficulties caused by fetal size and a higher rate of complications. Very infrequently, the method of choice may be either hysterotomy or caesarean section, if there are valid obstetric reasons for choosing this approach. In many cases, the birth of an intact fetus is preferable so that comprehensive post-mortem pathology can help to confirm the antenatal diagnosis. This kind of information is essential for later counselling in regard to future pregnancies. The various laws and court decisions that guide practice in late termination do not really provide any direction as to the method that should be used, and some practitioners have expressed concern about the lack of legal clarity.

How many late terminations are done?

What is known about numbers of late terminations performed around the country? In theory (and in law), all of the post-20-week procedures should be registered as both births and perinatal deaths. In practice it can sometimes be difficult to be certain if a stillbirth, for which the cause is recorded as a severe fetal abnormality, was the result of an active procedure of termination or if the fetus had died before labour was induced. The Victorian state collection of perinatal statistics has reported on the numbers of perinatal deaths due to fetal abnormality which are the result of termination of pregnancy, even though some of these would have occurred anyway.¹ In 2003, the number reported was 116, which represents 0.18% of all births in that state. They also reported on late terminations that were done for maternal conditions including serious physical illness and psychosocial indications. These numbered 103 in 2003, and virtually all were done in the private sector for maternal psychosocial indications. Including these, the rate for the state rises to 0.35%.

South Australia has reported on all terminations carried out between 1994 and 2000, and the rate of late terminations was about 2% of all terminations in 2002. As there were 5417 termi-

nations and over 18 000 births, this equates to a rate of 0.6% of all births. In Western Australia, the state's tertiary hospital has reported carrying out 219 late terminations in the first 5.5 years since legislation was introduced, which represents an average of 40 each year or 0.16% of all births.² Nationally, nearly all of these late terminations are at less than 28 weeks' gestation (with the great majority at less than 24 weeks) and for reasons of severe fetal abnormality that is likely to result in either major handicap or perinatal death, except for the cases referred to in Victoria. Later terminations (after 28 weeks) are extremely rare. If these data from individual states and territories are amalgamated, an estimate of the numbers of late terminations each year might be somewhere between 0.1% and 0.6% of all births, which is between 250 and 1500 late terminations each year. Due to the numbers being skewed by the larger populations in the eastern states, at least one of which (Victoria) has a high rate, the national number is likely to be higher than the lowest estimate and is probably somewhere between 500 and 1000.

Access to services

From the patient's perspective there are some significant issues. Access to late termination varies from state to state, and within the larger states the extent to which this service is available depends on the individual practitioners within hospitals. For example, in metropolitan Sydney the availability of late termination, even in cases where the reasons are unlikely to be questioned by most obstetricians, is restricted to a small number of the larger hospitals. It could be argued that this is a highly specialised type of clinical service and that it should be restricted to a small number of expert units, but in that case there should be a recognised state-wide service with equitable access for all. While access to prenatal diagnostic services has improved considerably over the past decade there are still problems for women in rural and remote areas, and this often leads to later diagnosis of fetal abnormalities and a subsequent request for late termination.

The other very difficult issue for patients is that in all jurisdictions except South Australia the final decision about whether or not the termination can proceed is left up to an independent body. This is a real impediment to patient autonomy, even though it may be seen as a necessary step to ensure that all health professionals are accepting of the decision to proceed with a late termination. There is also a potential privacy issue that could be raised, with patients not wishing to have personal information discussed by a committee whose members are not directly involved in their care. Consistency in approach and unambiguous national guidelines would help to reduce the possibility of arbitrary decisions being made which are different between states.

Conclusion

This article has looked at the issue of late terminations from the perspective of obstetricians working in major tertiary hospitals. It is likely that the bulk of these procedures in Australia are carried out in this setting, using the resources of the fetal medicine units for accurate diagnosis and counselling before patients, their doctors and relevant committees making decisions about late termination. However, some of these procedures are also carried out in private clinics, where the methods and indications are likely to be different.

Many of those on the pro-life side of the debate have called for some form of national collection of data on the numbers and indications for late terminations. Based on the analysis presented above, it is highly probable that the figures would confirm that the numbers in the public sector are small and the indications are almost always compelling medical reasons to do with the fetal prognosis. In this regard, it can be argued that obstetricians and other health professionals have played a significant and responsible role in the regulation of late termination, ensuring that clinical practice is in line with the community's expectations and the ethical standards of the profession. It should be acknowledged that there are often significant maternal risks associated with continuing a pregnancy in the face of certain

major fetal abnormalities. If access to late terminations were limited by more restrictive abortion laws, increasing maternal morbidity arising from pregnancies with a very poor prognosis for the infant is likely — an outcome that is in no-one's best interests.

References

- 1 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity. Annual report for the year 2003, incorporating the 42nd survey of perinatal deaths in Victoria. Melbourne, 2004.
- 2 Dickinson J. Late pregnancy termination within a legislated medical environment. *Aust N Z J Obstet Gynaecol* 2004; 44: 295-7. □

Abortion in Australia: a legal misconception

Kerry Petersen

Abortion is a procedure and practice which has been universally practised in some form since the beginning of recorded history. While deliberate terminations of pregnancy are reported throughout history, all races, cultures and religious groups have sharply divergent and frequently irreconcilable opinions on this highly controversial subject.¹

ABORTION IS A CONTROVERSIAL and complex issue for which there is no black and white legal solution. Attitudes towards abortion span a broad spectrum, but opinion polls show that most Australians approve of women having the right to make decisions about abortion and there is little support for introducing restrictive laws.^{2,3,4} The attitudes of parliamentarians mirror those of the general public and cut across party lines. Many politicians are reluctant to become involved in the public debate and hide behind the so-called conscience vote in parliaments, although it is not entirely clear why this subterfuge is regarded as acceptable. Nevertheless, periodically some politicians raise the issue for ideological or other reasons.⁵

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The power to regulate abortion comes under the jurisdiction of the states and territories and contemporary laws vary from state to state even though their common provenance is the UK statute, the Offences Against the Person Act 1867 (amended by Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990, s.37). This statute was passed in an era when abortion was a taboo subject, and the procedure was unsafe and accompanied by high mortality and morbidity rates. This law framed the offence as an “attempt” to make it easier to prove beyond reasonable doubt, and it was transported to Australian states around the turn of the twentieth century with other criminal laws. The following three offences, which are derived from that 1867 Act, continue to underpin contemporary abortion laws in most Australian jurisdictions:

- The attempt to procure an *unlawful* miscarriage by the pregnant woman
- The attempt to procure an *unlawful* miscarriage (by another person, whether or not the woman is pregnant)
- Supplying the means to procure an *unlawful* abortion knowing there is an intention to procure a miscarriage unlawfully (whether she is pregnant or not).

In practice, medical termination of pregnancy is widely available because of amending state