

**GUIDANCE ON THE TERMINATION OF PREGNANCY IN  
NORTHERN IRELAND**

**Within the scope of this Guidance and the law in Northern Ireland, each Health & Social Services Trust must ensure that its patients have access to termination of pregnancy services.**

**1. Purpose of guidance**

- 1.1 The purpose of this guidance is to outline the law relating to termination of pregnancy in Northern Ireland and to identify good medical practice. Since the lawfulness of any proposed termination will always ultimately depend upon the exercise of clinical judgment it is not possible to provide universally applicable rules which prescribe for every case. Whether or not a pregnancy is terminated is a difficult decision and sensitivity is always required. Each case requires careful assessment within the law as outlined in this guidance.

**2. Current Termination of Pregnancy Law**

- 2.1 The law relating to termination of pregnancy in Northern Ireland is different from that in England, Wales and Scotland. In particular the Abortion Act 1967 does not extend to Northern Ireland and the grounds on which abortion may be carried out here are more restrictive than those in England, Wales and Scotland.

*Northern Ireland*

- 2.2 In Northern Ireland, the law relating to the termination of pregnancy is contained in sections 58 and 59 of the Offences Against the Person Act 1861, and in section 25(1) of the Criminal Justice Act (Northern Ireland) 1945 as those provisions have been interpreted to date by the courts. The legislation has been interpreted and explained by the

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Northern Ireland Courts in a series of cases decided in the High Court in the 1990s and, more recently, in a decision of the Court of Appeal in 2004. Similar legislation applied in England, Wales and Scotland before 1967 and was interpreted in the leading English case of *R-v-Bourne* (1939). The *Bourne* decision, although an English case, remains highly relevant to Northern Ireland, and has been consistently applied in Northern Ireland cases. Further detail and relevant extracts from the law relating to abortion in Northern Ireland are provided at Annex A.

### *England, Wales and Scotland*

- 2.3 Abortion law in England, Wales and Scotland is governed by the Abortion Act 1967. This Act was amended by the Human Fertilisation and Embryology Act 1990 which led to the limiting of its application to pregnancies which have not exceeded the 24<sup>th</sup> week.
- 2.4 Further detail and relevant extracts from the law pertaining to abortion in England, Wales and Scotland are provided at Annex B.

### *Legal principles*

- 2.5 The law governing the termination of pregnancy in Northern Ireland at present is to be found in the legislation mentioned in paragraph 2.2 and in the cases where that legislation has been interpreted by the courts. It may be summarised in the following principles:
- (i) operations in Northern Ireland for the termination of pregnancies are unlawful unless performed in good faith for the purpose of preserving the life of the mother;
  - (ii) the 'life' of the mother in this context has been interpreted by the courts as including her physical and mental health;

- (iii) a termination will therefore be lawful where the continuance of the pregnancy threatens the life of the mother, or would adversely affect her physical or mental health;
- (iv) the adverse effect on her physical or mental health must be a 'real and serious' one, and must also be 'permanent or long term';
- (v) in most cases the risk of the adverse effect occurring would need to be a probability, but a possibility might be regarded as sufficient if the imminent death of the mother was the potentially adverse effect;
- (vi) it will always be a question of fact and degree whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy in a particular case.

2.6 For that reason, before it would be lawful to perform any operation in Northern Ireland for the termination of a pregnancy, there must either be (1) a threat to the life of the mother, or (2) a risk of real and serious adverse harm to her long term or permanent health. In any other circumstance it would be unlawful to perform such an operation.

2.7 It is also important to emphasise that, unlike the situation in England, Wales and Scotland, the risk of fetal abnormality is not recognised as a separate ground for termination of pregnancy in Northern Ireland. It will only be lawful to terminate a pregnancy in the case of actual or possible fetal abnormality if the continuance of the pregnancy threatens the life of the mother, or would adversely affect her physical or mental health. As in other cases, the adverse effect on the mother's physical or mental health must be a real and serious one, and must also be permanent or long term.

- 2.8 It will always be for the medical practitioner responsible for the care of the woman to decide, as a matter of professional clinical judgment, whether the perceived effect of non-termination is sufficiently grave to warrant terminating the pregnancy. As with any exercise of clinical judgment, there will be occasions where this will be a difficult decision.
- 2.9 Termination of pregnancy beyond the time at which a child is 'capable of being born alive' is governed by the Criminal Justice Act (NI) 1945, which provides a statutory defence against the offence of child destruction where the act which caused the death of the child was done in good faith for the purpose of preserving the life of the mother. Exactly the same principles (see paragraph 2.5) apply in such a case. In other words the legal justification for carrying out a termination of pregnancy in Northern Ireland is exactly the same both before and after the time at which a child is capable of being born alive. This follows from the *Bourne* decision and its application to the Northern Ireland legislation. The 1945 Act does not prescribe a time period beyond which a child is 'capable of being born alive'. This would therefore be a matter of evidence in the event of a prosecution in Northern Ireland.
- 2.10 It is important for practitioners to appreciate that anyone who unlawfully performs a termination of pregnancy is liable to criminal prosecution with a maximum penalty of life imprisonment. A person who is a secondary party to the commission of such an offence is liable on conviction to the same penalty. For this reason (unless in circumstances of emergency) a joint assessment (although not itself a legal requirement) is usually recommended (see section 3 below).

Consent

- 2.11 It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing personal care. This principle reflects the right of individuals to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by the person and action by their regulatory body. Employing bodies may also be liable for the actions of their staff. While there is no statute here setting out the general principles of consent, case law ('common law') has established that touching an individual without valid consent may constitute the civil or criminal offence of battery. Further, if health or social care professionals fail to obtain proper consent and the individual subsequently suffers harm as a result, this may be a factor in a claim of negligence against the health or social care professionals and staff involved. Poor handling of the consent process may also result in complaints from individuals through the HPSS complaints procedure or to regulatory bodies.
- 2.12 With consent to termination of pregnancy, as with consent for other medical procedures, there are certain criteria which must be met in order for the consent to be valid. The woman must have sufficient competence to understand the procedure and its alternatives in broad terms and to make a decision. It is also important that consent must be voluntary and the decision must be made on the basis of sufficient, accurate information.
- 2.13 The Department has produced *A Reference Guide to Consent for Examination, Treatment or Care* (March 2003). It provides guidance on the law relating to consent. This document is publicly available on the DHSSPS website - [www.dhsspsni.gov.uk/](http://www.dhsspsni.gov.uk/). Practitioners are strongly advised to read this guidance before carrying out any termination procedure. Particular attention is drawn to the chapters

on adults without capacity ('incapable adults') and on children and young people. These chapters explain the circumstances in which a referral should be made to the court for a ruling before a medical procedure or treatment is undertaken, and the circumstances in which it may be appropriate to apply to the court to over-ride the refusal of consent by a young person. Practitioners should be aware that court referrals have been considered necessary and have been made in some cases where termination of pregnancy has been the issue: see in particular the Northern Ireland cases of *Re AMNH*, *Re SJB* and *Re CH* (Appendix A).

### **3. Assessment**

- 3.1 An assessment by two doctors who share prior knowledge of the woman and her clinical circumstances can give added weight to a clinical decision and is recommended. For example, if a woman has a severe cardiac condition it would usually be appropriate to consult with a cardiologist. Assessment of the woman by a single doctor may be sufficient to satisfy him/herself that a termination of pregnancy is indicated. However, except in circumstances of emergency, it will usually be prudent to seek a second medical opinion. All assessments and findings should be recorded in the patient notes.
- 3.2 Where mental health issues are the primary consideration, assessment by at least two different doctors is always recommended. Ideally one of the assessing doctors should be someone who has prior professional knowledge of the woman (eg GP/consultant obstetrician/gynaecologist/geneticist/psychiatrist).
- 3.3 Generally, a psychiatrist should be involved if there is a past history of severe and enduring mental illness. When mental illness is the indication, it is unlikely that a termination of pregnancy will be considered unless that illness has been pre-existing, severe and enduring. However, there may be exceptional situations when the

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mental health of a woman with no prior history of mental illness needs to be assessed by a specialist mental health practitioner, to assist in her overall assessment and management.

- 3.4 In circumstances where the pregnancy is likely to cause adverse effects on the mother's mental health which are real, serious, long term or permanent, those medical practitioners who have experience in managing mothers in these situations may well be best placed to assess the long term likely impact on the mother's mental health.
- 3.5 If there is any doubt about the mental competence of the woman to give informed consent or that she may have a learning disability, then an assessment of her mental ability should be undertaken by a specialist in this field. If the patient is under 18 years old a consultant in child & adolescent psychiatry should be involved in the assessment. See the Department's Reference Guide to Consent for Examination, Treatment or Care.
- 3.6 Assessment of mental state should be completed in a timely manner and without undue delay and the findings recorded in clinical notes. Where medical practitioners are making an assessment of a patient's recent mental state, this should include consideration of her:
- Current mental state;
  - Current treatment, with specific reference to any psychotropic medication;
  - Past mental health history, specifically including suicidality (serious attempts with definite intent, as far as can be established);

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- Family mental health history, specifically including a history of suicides;
- Enquiry as to the circumstances of conception;
- Support structures within and without family;
- History of previous pregnancies, with particular reference to mental health issues, which arose during pregnancy and in the post natal period.

3.7 The assessment of the patient's mental state should be made by a GP, consultant obstetrician/gynaecologist/psychiatrist. The practitioner performing the termination must be personally satisfied with the adequacy of the assessment and the evidence presented before proceeding to carry out the termination of pregnancy.

#### **4. Moral/Ethical issues**

4.1 Some staff may have a conscientious objection to termination of pregnancy on moral and/or religious grounds. No-one can compel staff to actively participate in performing a termination and the right to object on grounds of conscience should be recognised and respected except in circumstances where the woman's life is in immediate danger and emergency action needs to be taken. Health and Social Services Trusts should also have appropriate arrangements in place to accommodate such requests from staff. However staff with a conscientious objection cannot opt out of providing general care for women undergoing termination of pregnancy. The personal beliefs of staff should not prejudice patient care.

4.2 The General Medical Council's (GMC's) *Good medical practice* (May 2001) states that a doctor registered with the GMC is under a duty 'to

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make sure that his/her personal beliefs do not prejudice his/her patients' care.' A breach of this duty would be a disciplinary offence. This guidance is publicly available on the GMC website – <http://www.gmc-uk.org>

- 4.3 The Nursing and Midwifery Council (NMC) *Code of professional conduct: standards for conduct, performance and ethics* (November 2004) refers to conscientious objection at paragraph 2.5 and indicates that, “you must report to a relevant person or authority, at the earliest possible time, any conscientious objection that may be relevant to your professional practice. You must continue to provide care to the best of your ability until alternative arrangements are implemented.” This guidance is publicly available on the NMC website - [www.nmc-uk.org/](http://www.nmc-uk.org/)
- 4.4 The British Medical Association (BMA) has published guidance on the law and ethics of abortion in England Scotland and Wales and Northern Ireland. This guidance is publicly available on the BMA website - [www.bma.org.uk/](http://www.bma.org.uk/).
- 4.5 The BMA document advises that, “doctors with a conscientious objection to abortion should make their views known to the patient and enable the patient to see another doctor without delay if that is the patient’s wish.” It also states that, “general practitioners with a conscientious objection, who are working in a group practice, may ask a partner to see patients seeking termination.” The doctor will, however, have responsibility for the woman’s care until someone else takes it over.
- 4.6 The Royal College of Obstetricians and Gynaecologists (RCOG) has also produced an evidence-based Clinical Guideline, *The Care of Women Requesting Induced Abortion* (September 2004). Section 3.4 of this guideline provides advice on professionals' rights in relation to conscientious objection to abortion. This document is publicly available on the RCOG website - [www.rcog.org.uk/](http://www.rcog.org.uk/)

## **5. Good practice issues**

- 5.1 All healthcare professionals especially those working in maternity and gynaecology units should be familiar with the legal framework relating to termination of pregnancy in Northern Ireland and be aware of when termination of pregnancy can legally be provided.
- 5.2 When termination of pregnancy is considered appropriate within the Northern Ireland legal framework, adequate information, support and counselling by appropriately trained staff should be available for the woman both before and after the termination of pregnancy.

### Women considering a termination

- 5.3 Any woman considering a termination should be treated sensitively and in a non-judgmental way. Efforts should be made to explore the woman's concerns and expectations and to establish what kind of support she is getting or may expect to receive from her partner, family, social services, work colleagues or school/college authorities. It is important to discuss any difficulties she foresees if she continues with the pregnancy as well as any concrete measures that can be taken to help her particular situation. A woman should be given information about alternatives to termination such as continuing with the pregnancy, adoption, etc.

### Confidentiality

- 5.4 The BMA guidance on the law and ethics of abortion in England Scotland and Wales provides information on confidentiality. The following paragraphs 5.5 - 5.8 are taken from the BMA guidance:

### Adults

- 5.5 Patients have a right to expect that doctors will not disclose any personal health information to a third party without consent. Women

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seeking termination of pregnancy are likely to be particularly concerned about the confidentiality of this information and doctors should be sensitive to this.

- 5.6 “Sometimes doctors are asked to remove information about previous terminations from a patient's medical records. The BMA advises doctors to be very wary of removing relevant medical information from a patient's record, especially if further consultations or treatment have arisen on the basis of this information. To remove relevant medical information may make the doctor's later decisions appear unsupported and could also be detrimental to the future care of the patient”.
- 5.7 “If the doctor consulted is not the patient's own general practitioner, the woman should be encouraged to consent to information being provided to her GP. If, however, she refuses to consent to the sharing of this information her wishes should be respected.”

Minors

- 5.8 “The duty of confidentiality owed to a person under 16 is as great as the duty owed to any other person. An explicit request by a patient that information should not be disclosed to particular people, or indeed to any third party, must be respected except in the most exceptional circumstances, for example, where the health, safety or welfare of some person would otherwise be at serious risk. There are exceptions where the child is a ward of court, or is in care and these should be noted.”
- 5.9 Paragraph 18 of the GMC's *Good medical practice* (May 2001) states that, “You must treat information about patients as confidential. If in exceptional circumstances there are good reasons why you should pass on information without a patient's consent, or against a patient's wishes, you must follow our guidance on [Confidentiality: Protecting and](#)

[Providing Information](#) and be prepared to justify your decision to the patient, if appropriate, and to the GMC and the courts, if called on to do so.”

*Recording of clinical decisions*

5.10 There should be consistency in the recording of clinical decisions which should show a full and clear rationale behind the decision to carry out a termination including any consultation with other medical professionals. The record should show that the decision is supported by appropriate information and counselling about the options and implications and that the woman has understood and given her informed consent to the termination.

## **6. Service arrangements**

6.1 Information should be available for both women and healthcare professionals on the choices available within the service and on routes of access to the service.

6.2 Access to services should be ensured for women with special needs. For example, as appropriate, special arrangements should be made for non-English-speaking women and those with speech and hearing impairment.

6.3 Any woman considering induced termination of pregnancy should have timely access to clinical assessment.

6.4 Appropriate information and support should be available for those who consider but do not proceed to termination of pregnancy.

6.5 Service arrangements should be such that:

- Where possible, all women can undergo the termination within 7 days of the decision to proceed being agreed.
- As a minimum standard, all women can undergo the termination

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within 2 weeks of the decision to proceed being agreed.

- As a minimum standard, no woman need wait longer than 3 weeks from when she initially seeks assessment/advice to the time of her termination.
- Women admitted for termination of pregnancy should be cared for with great sensitivity in the most appropriate ward/location.
- Women having second-trimester terminations by medical means should be cared for by an appropriately experienced midwife or nurse. Ideally, they should have the privacy of a single room.

6.6 Clinical management guidance is included at Annex C. These reflect the RCOG Guideline: *The care of women requesting induced abortion, September 2004*.

## **7. Providing Information to Women**

7.1 Verbal advice should be supported by accurate, impartial printed information that the woman considering termination can understand and may take away to consider further before the procedure.

7.2 Information for women and professionals should emphasise the duty of confidentiality by which, as for any form of health care, all concerned with the provision of induced termination are bound.

7.3 Clinicians involved with termination of pregnancy should be aware of the risk of possible complications and sequelae of termination and should discuss these with the woman so that she can give informed consent, recording discussions on a proforma similar to those used in 'Consent of Examination, Care and Treatment'.

**RELEVANT EXTRACTS FROM THE LAW ON ABORTION IN NORTHERN IRELAND**

**Offences Against the Person Act 1861**

1. The grounding statute in Northern Ireland is the Offences Against the Person Act 1861 which contains in sections 58 and 59 the criminal offence of unlawfully procuring a miscarriage:

*“58. Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable...”*

*“59. Whosoever shall unlawfully supply or procure any poison or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to procure the miscarriage of any woman, whether she be or not be with child, shall be guilty of as misdemeanour, and being convicted thereof shall be liable...”*

**Criminal Justice Act (Northern Ireland) 1945**

2. Section 25 (1) of the Criminal Justice Act (Northern Ireland) 1945 also provides:

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*“...any person who, with intent to destroy the life of a child then capable of being born alive, by any wilful act causes a child to die before it has existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to imprisonment for life. Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.”*

**The Bourne case 1939**

3. The Bourne case, *R v Bourne* [1939] KB 687, centred on an obstetrician who was charged with having procured the miscarriage of a fourteen-year old girl contrary to section 58 of the 1861 Act. The girl was pregnant as the result of a rape. The obstetrician had attested that, having made an examination of the girl, he had concluded that the continuance of the pregnancy would severely affect her mental health.
4. In his charge to the jury, Mr Justice Macnaghten referred to section 1 (1) of the Infant Life (Preservation) Act, 1929 and pointed out that the proviso (that a person shall not be guilty of an offence if he acted in good faith to preserve the mother’s life) did not appear in section 58. However, he went on to say:

*“...but the words of that section (i.e. section 58 of the 1861 Act) are that any person who “unlawfully” uses an instrument with intent to procure miscarriage shall be guilty of felony. In my opinion the word “unlawfully” is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in section 1 sub-section 1, of the Infant Life (Preservation) Act, 1929, and that section 58 of the Offences against the Person Act, 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso.”*

5. What this means is that a person who procures an abortion in good faith for the purpose of preserving the life of the mother shall not be guilty of an offence.
6. In terms of what is meant by “preserving the life of the mother”, Mr Justice Macnaghten said this:

*“...those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.”*

#### **Cases in the Northern Ireland High Court during the 1990s**

7. In 1993, the Northern Ireland High Court heard the first of a series of cases which began to circumscribe the nature of lawful terminations. All of the cases involved individuals who were unable to consent for themselves by reason of diminished mental competence or age.
8. The 1993 case of *Re K* concerned a fourteen year old minor who was a ward of court. The Northern Health and Social Services Board sought an order permitting a termination of the pregnancy on the basis of the minor’s statements that she would commit suicide if the pregnancy was not terminated. Having heard medical evidence that “...to allow the pregnancy to continue to full term would result in her being a physical and mental wreck”, the judge found that a termination in such circumstances would be lawful.
9. In the 1994 case of *Re A.M.N.H.*, the pregnant woman was severely mentally handicapped and a ward of court. There was medical

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evidence that the continuation of the pregnancy would adversely affect the woman's mental health. The judge held that abortion is lawful where the continuation of the pregnancy would adversely affect the mental or physical health of the mother. However, he said that the adverse effects must be real and serious. He found in the case that the termination of the woman's pregnancy would be lawful.

10. The 1995 case of *Re S.J.B.* involved a seventeen-year-old severely handicapped girl who was made a ward of court. On the basis of medical evidence presented to the court, the judge held that a termination of the pregnancy would be lawful.
11. The case of *Re C.H.*, also decided in 1995, concerned a sixteen-year-old girl who was a ward of court. She stated that she wished to have her pregnancy terminated and threatened to commit suicide if she was forced to continue with her pregnancy. On the basis of medical evidence, the judge held that it would be lawful for the pregnancy to be terminated.
12. In 2004 the Northern Ireland Court of Appeal, on a judicial review application brought by the *Family Planning Association for Northern Ireland*, considered the law relating to termination of pregnancy in Northern Ireland and ruled that the Department should issue these Guidelines.

**RELEVANT EXTRACTS FROM THE LAW ON ABORTION IN ENGLAND,  
WALES AND SCOTLAND**

**Abortion Act 1967**

1. Section 1 (1) of the Abortion Act 1967 states that a registered medical practitioner may lawfully terminate a pregnancy, in a NHS hospital or on premises approved for this purpose, if two registered medical practitioners are of the opinion, formed in good faith:
  - (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
  - (b) that the termination is necessary to prevent the grave permanent injury to the physical or mental health of the pregnant woman; or
  - (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
  - (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.”

**CLINICAL MANAGEMENT AND SERVICE ARRANGEMENTS  
FOR NORTHERN IRELAND**

**1. Pre-termination management**

**The termination of pregnancy decision**

- 1.1 Clinicians caring for women considering termination of pregnancy should aim to identify those who require more support in decision making than can be provided in the routine clinic setting, for example those with a psychiatric history. Care pathways for additional support, including access to social services, should be available.

**Blood tests**

- 1.2 Pre-termination assessment should include:
- Measurement of haemoglobin concentration
  - Determination of ABO and rhesus blood groups with screening for red cell antibodies
  - Offer of ante natal screening in line with National Screening Committee recommendations including screening for Hepatitis B, Syphilis and HIV and Rubella immunity.

**Ultrasound scanning**

- 1.3 There should be access to scanning, as it can be a necessary part of pre-termination assessment, particularly where gestation is in doubt or where extra uterine pregnancy is suspected. However, ultrasound scanning is not considered to be an essential prerequisite of termination in all cases.
- 1.4 When ultrasound scanning is undertaken, it should be in a setting and manner sensitive to the woman's situation. It is inappropriate for pre-termination scanning to be undertaken in the routine antenatal clinic.

**Risk of complications**

1.5 The patient should be advised of the risk of the following complications:

- Haemorrhage – the risk is low – around 1 in 1000 at less than 13 weeks and 4 in 1000 at more than 20 weeks.
- Uterine perforation at the time of surgical termination is moderate – the risk is 1–4 in 1000.
- Uterine rupture – the risk is less than 1 in 1000.
- Cervical trauma – the risk of damage to the external cervical os at the time of surgical termination – 1 in 100.
- Failed termination and continuing pregnancy – all methods of first-trimester termination carry a small risk of failure to terminate the pregnancy, thus necessitating a further procedure. The risk for surgical termination is around 2.3 in 1000 and for medical termination between 1 and 14 in 1000.

1.6 The following sequelae should also be mentioned:

- Post-termination infection – genital tract infection, including pelvic inflammatory disease of varying degrees of severity, occurs in up to 10% of cases. The risk is reduced when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening.
- Breast cancer – induced termination is not associated with an increase in breast cancer risk.
- Future reproductive outcome – there are no proven associations between induced termination and subsequent ectopic pregnancy, placenta praevia or infertility. Termination of pregnancy may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery.
- Psychological sequelae – some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had a termination compared with women who give birth and to nonpregnant women of similar age. It must be borne in mind that

these findings do not imply a causal association and may reflect continuation of pre-existing conditions.

### **Prevention of infective complications**

1.7 Termination of pregnancy care should encompass a strategy for minimising the risk of post-termination infective morbidity. Patients should be considered for antibiotic prophylaxis.

1.8. The following regimens are suitable for peri-termination prophylaxis:

- metronidazole 1 g rectally at the time of termination plus
- doxycycline 1 00 mg orally twice daily for 7 days, commencing on the day of termination

OR

- metronidazole 1 g rectally at the time of termination plus
- azithromycin 1 g orally on the day of termination.

## **2. Termination procedures**

2.1 As a minimum, clinicians should be able to provide a termination of pregnancy by one of the recommended methods for each gestation band.

### **Surgical method**

2.2 Conventional suction termination should be avoided at gestations below 7 weeks.

2.3 Conventional suction termination is an appropriate method at gestations of 7–15 weeks, although, in some settings, the skills and experience of practitioners may make medical termination more appropriate at gestations above 12 weeks.

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- 2.4 During suction termination, the uterus should be emptied using the suction curette and blunt forceps (if required) only. The procedure should not be completed by sharp curettage.
- 2.5 Suction termination may be performed under local or general anesthesia. Consideration should be given to making this option available, particularly for low-gestation procedures.
- 2.6 If conscious sedation is used in place of general anesthesia to reduce the pain and anxiety associated with surgical termination, it should be undertaken only by trained practitioners and in line with Department of Health guidance "*Conscious sedation in termination of pregnancy*". This guidance is available from [www.doh.gov.uk](http://www.doh.gov.uk).
- 2.7 For first-trimester suction termination, either electric or manual aspiration devices may be used, as both are effective and acceptable to women and clinicians. Operating times are shorter with electric aspiration.
- 2.8 Cervical preparation is beneficial prior to surgical termination and should be routine if the woman is aged under 18 years of age or at a gestation of more than 10 weeks.
- 2.9 Termination regimens containing misoprostol are not licensed within manufacturers' summaries of product characteristics. European Community regulations permit doctors to prescribe unlicensed regimens and permit pharmacists to dispense and nurses to administer medicines prescribed outside of a product license. Women should be informed if a prescribed treatment is unlicensed.
- 2.10 Based on available evidence, the following regimen appears to be appropriate for cervical preparation prior to first - or second-trimester surgical termination. This advice is based on considerations of efficacy, adverse-effect profile and cost:

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Misoprostol 400 micrograms (2 x 200-microgram tablets) administered vaginally, either by the woman or a clinician, 3 hours prior to surgery.

**Medical methods**

- 2.11 Misoprostol (a prostaglandin E1 analogue) is suitable for all termination procedures for which the E1 analogue gemeprost is conventionally used (that is, early medical termination, cervical priming, mid-trimester medical termination).
- 2.12 Based on current evidence, the following arrangement appears to be appropriate for mid-trimester medical termination.

Misoprostol 600mg vaginally, then misoprostol 600mg orally 3-hourly to a maximum of 5 oral doses.

**General**

- 2.13 Some women will require analgesia after surgical termination or during and after medical termination. Requirements for analgesia vary and there is no benefit in routine administration of prophylactic analgesics. Services should make available a range of oral and parenteral analgesics in order to meet women's needs.

**3. Aftercare**

**Rhesus prophylaxis**

- 3.1 Anti-D immunoglobulin G (250 iu before 20 weeks of gestation and 500 iu thereafter) should be given, by injection into the deltoid muscle, to all nonsensitised RhD negative women within 72 hours following termination, whether by surgical or medical methods.

**Post-termination information and follow up**

- 3.2 Following termination of pregnancy, women must be given a written account of the symptoms they may experience and a list of those that would make an urgent medical consultation necessary. They should be given a 24-hour telephone helpline number to use if they feel worried about pain, bleeding or high temperature. Urgent clinical assessment and emergency gynaecology admission must be available when necessary.
- 3.3 Each woman should be offered, or advised to obtain, a follow-up appointment within 2 weeks of the termination.
- 3.4 On discharge, each woman should be given a letter that includes sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications.
- 3.5 Referral for further counselling should be available for the small minority of women who experience long-term post-termination distress. Risk factors are ambivalence before the termination, lack of a supportive partner, a psychiatric history or membership of a cultural group that considers termination of pregnancy to be wrong.
- 3.6 Care should be taken to ensure that any women who presents with symptoms or complications following a termination of pregnancy, regardless of where it was carried out, has access to appropriate treatment and counselling where required.

**Contraception following termination**

- 3.7 Future contraception should be discussed before discharge following termination. The chosen method of contraception should ideally be initiated immediately following termination.
- 3.8 Intrauterine contraception can be inserted immediately following a first - or second-trimester termination of pregnancy.

- 3.9 Sterilisation can be safely performed at the time of induced termination. However, combined procedures are associated with higher rates of failure and of regret on the part of the woman.