Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

NAME OF DOCUMENT	Termination of Pregnancy and/or fetal death
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FORMER REFERENCE(S)	Termination of Pregnancy (medical and surgical 1st, 2nd & 3rd trimester) – Admission Termination of Pregnancy – Framework Misoprostol and Mifepristone for Medical Termination of Pregnancy and or fetal Death
EXECUTIVE SPONSOR	Maternity Medical Co-Director
AUTHOR	A. Shand (Director of maternal fetal medicine) L. Gerhardy (Fellow maternal fetal medicine)
SUMMARY	Management of a woman requesting a termination of pregnancy including booking procedure process

Royal Hospital for Women (RHW)
CLINICAL BUSINESS RULE

Termination of Pregnancy and/or fetal death

1. BACKGROUND

Access to safe termination of pregnancy is an important part of maternity care and should be available to any woman (public or private) requesting termination of pregnancy (TOP).

This CBR aims to provide a pathway for the management of a woman requesting termination of pregnancy, within the Framework for Termination of Pregnancy New South Wales, and in accordance with the Abortion Law Reform Act 2019 (see appendix 1).

2. RESPONSIBILITIES

- Medical**,** Midwifery and Nursing staff will:
  - Provide comprehensive care to the woman in accordance with the Framework for Termination of Pregnancy New South Wales, and the Abortion Law Reform Act 2019

3. PROCEDURE

3.1 Equipment

- nil

3.2.0 Pre-procedure considerations

3.2.1 Clinical standards and legal requirements

≤ 22+0 weeks gestation:

- Ensure informed consent is gained by medical practitioner before TOP is performed (unless an emergency)
- Assess whether woman would benefit from counselling before performing TOP
- Organise counselling if required

≥ 22+1 weeks gestation:

- Ensure the following before TOP:
  - medical practitioner has obtained informed consent for the procedure
  - medical practitioner has provided all necessary information to the woman about access to counselling, including publicly-funded counselling
  - medical practitioner considers that in all the circumstances there are sufficient grounds for TOP to be performed. This assessment is to be made after considering:
    - all relevant medical circumstances
    - the woman's current and future physical, psychological and social circumstances, and the professional standards and guidelines that apply to the medical practitioner in relation to TOP, and
    - any advice received from the multi-disciplinary team, or hospital termination advisory committee (TAC) when convened
  - The practitioner has consulted with another specialist medical practitioner who also considers that in all the circumstances there are sufficient grounds for TOP to be performed

3.2.2 Termination advisory committee (TAC)

- Convening of the TAC is only required for woman requesting TOP ≥ 22+1 weeks gestation when two specialist medical practitioners cannot agree on the indication for the TOP or decide that further consultation is needed (see appendix 2)

3.2.3 Psychosocial support

- Offer counselling to any woman seeking TOP. This may be provided by a social worker, psychologist or a psychiatrist depending on the specific psychosocial needs of the woman
- Arrange review by a social worker at some point prior to commencement of TOP to ensure supportive counselling and information/resources are provided

3.2.4 Pre-termination assessment

- Consider and document in the medical record for any proposed TOP:
  - Confirmation of an intrauterine pregnancy
  - Determination of gestational age
  - Medical, obstetric, surgical and psychosocial history
  - In cases of a fetal anomaly, the diagnostic probability, and the prognosis for the fetus should be discussed
  - Blood group
  - Information should be provided on options for the pregnancy, methods of termination, and post-termination care
  - The woman's wishes regarding contact with the fetus/neonate following termination are to be clearly documented to ensure appropriate arrangements are made
  - Options for the fetal remains should be discussed (this discussion is often in conjunction with the social worker)
  - Investigations should be discussed including fetal autopsy, placental histology and blood tests, depending on gestation and circumstances
  - Information about contraceptive options, or preparation for future pregnancy
  - Sexually transmitted infection screening

3.2.5 Informed consent

- Ensure written consent is obtained by the treating medical practitioner before any TOP is performed, regardless of method of TOP
- Ensure for medical TOP that the woman is informed by the treating medical practitioner that there is potential for the neonate to be born exhibiting signs of life and the ramifications should this occur (if feticide has not been undertaken)

3.3.0 Method and process of TOP

- Advise that both surgical and medical termination of pregnancy can be offered to the woman, as both are safe options. The decision can be guided by woman's preference, gestational age, local clinician expertise and service capabilities

3.3.1 Medical TOP process and regime

- Discuss and consider medical TOP for any gestation of pregnancy.
- Offer feticide to a woman having a TOP at ≥ 22 weeks, and recommend feticide at gestations ≥ 24 weeks unless there is a lethal fetal anomaly
- Recommend mifepristone followed by misoprostol[1]
- Ensure woman is given accurate written information about treatment and side effects (see appendix 3)
- Prescribe mifepristone and misoprostol (prescribing of mifepristone must only be done by a medical practitioner who is registered as a mifepristone prescriber)
- Avoid mifepristone and misoprostol for the following contraindications:
  - Suspected ectopic pregnancy

- Known allergy to mifepristone or misoprostol or prostaglandins
- Bleeding disorders or concurrent anticoagulation therapy
- Concurrent corticosteroids
- Chronic or acute adrenal or hepatic failure
- Intrauterine Contraceptive Device in situ (to be removed before treatment)
- Inherited porphyria

Mifepristone and Misoprostol **outpatient** regimen (MS-2 Step)

- Recommend MS-2 Step for medical TOP at gestations ≤ 63 days
- Facilitate as an outpatient (within service capabilities) with composite pack which contains:
  - mifepristone 200mg and misoprostol 800mcg (MS-2 Step)
- Instruct the woman to take mifepristone 200mg orally, followed by 24-48 hours later by misoprostol 800mcg buccal or sublingual
- Follow up at 2-3 weeks should be arranged to confirm expulsion complete. This may be done with self-assessment (history of tissue passed, abdominal cramping, pain, vaginal bleeding), clinical examination, serum/urine β-hCG, or ultrasound[2]

Mifepristone and Misoprostol **inpatient** regimen

- Prescribe mifepristone 200mg orally as an outpatient.
- Instruct the woman to take Mifepristone orally 24-48 hours before planned admission for misoprostol
- Give written information as to when and where to return to hospital (see appendix 3)
- Arrange admission 24-48 hours after mifepristone[3]. On admission:
  - ensure adequate analgesia. Epidural is not contra-indicated in these circumstances [4]
  - arrange follow up with care givers (social work, genetics, maternal fetal medicine, perinatal loss clinic, general practitioner (GP)) as appropriate for gestation and situation
  - administer misoprostol as per table 1

Table 1 – Medical TOP medication regimens

	<13 weeks gestation	13-28 weeks gestation	29-34 weeks gestation	>34 weeks gestation
Misoprostol dose (after mifepristone) (this is the preferred method)	Initial dose: 800mcg vaginally Subsequent doses: 400mcg vaginally every three hours to a maximum of TWO further doses over 24 hours	400mcg vaginally every three hours to a maximum of FIVE doses over 24 hours	100mcg vaginally every four hours to a maximum of FIVE doses over 24 hours	100mcg vaginally every four hours to a maximum of FIVE doses over 24 hours OR Oxytocin infusion and consider artificial rupture of membranes after labour established
Misoprostol-only regimen (if mifepristone unavailable or contraindicated)	800mcg sublingually or vaginally every 3 hours to a maximum of THREE doses	400mcg vaginally every three hours to a maximum of FIVE doses over 24 hours.	100mcg vaginally every four hours to a maximum of FIVE doses over 24 hours	100mcg vaginally every four hours to a maximum of FIVE doses over 24 hours OR Oxytocin infusion and consider artificial rupture of membranes after labour established

- Recommend vaginal route for misoprostol administration (evidence suggest that this is the most effective route, though can be used sublingually, buccally, or orally[5])

- Ensure caution and use of clinical judgement when deciding the maximum number of doses of misoprostol in a woman with a previous uterine incision[5] (Uterine rupture is rare, however preparedness for emergency management of the same must be considered with later gestations[5])
- Consider the following if there is failure to deliver after the above regimens:
  - Rest overnight, recommence regimen the following day
  - Repeat dose of mifepristone after two days of misoprostol treatment
  -

3.3.2 Surgical TOP process

- Offer surgical TOP for gestation under 14 weeks (greater than 14 weeks gestation requires a medical practitioner with the relevant experience)
- Confirm viable intrauterine pregnancy prior to surgical TOP when gestation ≤ 7 weeks. Consider delaying procedure till after 7 weeks gestation unless there is a strong reason for performing procedure earlier
- Perform vacuum aspiration under 7 weeks gestation with appropriate safeguards to ensure complete abortion, including inspection of aspirated tissue and ultrasound guidance
- Ensure adequate cervical priming in preparation for surgical TOP (can decrease the length of the procedure, and may assist in reduction of complications such as incomplete abortion). The following regimens can be used:
  - Misoprostol 400 mcg sublingually 1-2 hours prior to the procedure
  - Misoprostol 400mcg vaginally or buccally 2-3 hours prior to the procedure
  - Mifepristone 200mcg orally 24-48 hours prior to procedure (mifepristone should only be used if misoprostol is not an option, as there is less evidence of efficacy compared with misoprostol[1,5])
- Recommend ultrasound guidance if greater than 14 weeks gestation. This can be requested via medical imaging or a skilled assistant can perform the ultrasound
- Ensure antibiotic prophylaxis is given in line with therapeutic guidelines
- Recommend group and hold for gestation ≥ 14 weeks

3.4.0 <u>Booking the admission for TOP</u>

- Avoid TOP on the weekend if possible, as fewer support staff are available for both woman and staff

3.4.1 Medical TOP

<u>Medical TOP <9 weeks gestation (i.e. <63 days gestation)</u>

- Manage as an outpatient with MS-2 step protocol (see below for protocol)

<u>Medical TOP at 9-15 weeks gestation</u>

- Complete a booking form and discuss with the Access and Demand Nurse Manager (ADNM) to make arrangements
- Prescribe and provide mifepristone to the woman to be taken 24-48 hours prior to the planned admission
- Admit to Macquarie ward on planned admission day

<u>Medical TOP ≥ 16 weeks gestation</u>

- Complete a booking form and discuss with Birth Unit to make arrangements
- Prescribe and provide mifepristone to the woman to be taken 24-48 hours prior to the planned admission
- Admit to Birth Unit on planned admission day

3.4.2 Surgical TOP

- Discuss with theatre bookings office to identify an appropriate theatre list for the procedure, and notify the clinician in charge of the list
- Complete Recommendation for Admission (RFA) and give to theatre bookings office
- Admit to Day surgery on day of procedure

3.5.0 <u>Post TOP care</u>

- Assess neonate immediately upon birth:

- If condition of the neonate warrants further specialist medical examination this should be arranged promptly. If signs of life evident, the neonate must be afforded the right of dignity, maintenance of privacy and physical comfort. If it is considered that no benefit would be conferred on the neonate by medical treatment, staff are under no duty to render futile treatment. Parents should be encouraged to be part of care where appropriate and agreeable

- Register the birth and death in NSW if:
  - the fetus/neonate is ≥ 20 weeks gestation, or weighs ≥ 400grams
  - shows signs of life at birth at any gestation
- Management of fetal remains:
  - Respect the woman's wishes regarding the fetus/neonate
  - Arrange viewing and handling of the fetus/neonate through social work or midwifery/nursing staff
  - Discuss autopsy depending on the gestation and circumstances, and sign consent if requesting
  - Discuss 'disposal' of the fetal remains. For registered stillbirths/TOP (e.g. burial, cremation), this is organised through a funeral director, which social work can help arrange. For those not required to be registered, this can be arranged through the hospital, or via a monthly cremation at the Eastern Suburbs Memorial Park, or private arrangements can be made, which social work can help arrange
- Administer anti-d for all rhesus negative woman having a surgical TOP and those having a medical TOP > 10 weeks gestation[7]
- Offer lactation suppression from 12-14 weeks gestation. Colostrum is produced as early as 12 weeks into a pregnancy[8,16]
- Recommend contraception. If requested or agreed to at time of TOP, make arrangements for same to occur
- Offer counselling to woman and family after procedure, informing of the support services available (PANDA, Lifeline, Beyond Blue or through social work)
- Document a discharge plan. It should include follow up arrangements and Midwifery Support Program (MSP) if appropriate. Notify the perinatal loss midwife on 0497631174 or by emailing SESLHD-BereavementRHW@health.nsw.gov.au where appropriate to organise follow up in the perinatal loss clinic

3.5 Conscientious objection

- Communicate with staff that have a conscientious objection that being involved in TOP is not required. However, they are required to inform the woman and refer them to another medical practitioner who does not have a conscientious objection (see appendix 4)

3.6 DOCUMENTAION

- Medical record
- Birth registration papers
- Termination of pregnancy notification form https://www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx

3.7 EDUCATIONAL NOTES

- When documenting birth in medical record apgars must be stated as zero, rather than "not observed". This is a ministry of health requirement
- Medical termination of pregnancy with combination mifepristone and misoprostol therapy has consistently been shown to be more effective than misoprostol alone across different gestations [1,5,9,10,11]. Mifepristone binds to progesterone receptors to reverse their inhibition of cervical softening and dilation, and uterine contraction. More importantly, it sensitises the myometrium to prostaglandins [5]. The maximum effect of mifepristone is achieved when prostaglandins are administered 24-48 hours after the mifepristone dose [3,5]. Combination mifepristone and misoprostol results in an increased abortion rate within 24 hours, reduced curettage rate for retained products, and reduced induction to abortion interval [5]. In women given Mifepristone pre-treatment, 97% will abort within 5 doses of prostaglandins[17]
- Prescribers of Mifepristone within Australia need to be registered with Marie Stopes International as registered prescribers.

3.8 RELATED POLICIES/PROCEDURES/CLINICAL PRACTICE CBR

- NSW Ministry of Health 2019 *Framework for Termination of Pregnancy in New South Wales*. PD2019_048
- Stillbirth and Fetal Deaths – Diagnosis, Delivery, Documentation and Transportation
- Feticide and Multi-Fetal Reduction

3.9 IMPLEMENTATION/COMMUNICATION/ EDUCATION PLAN

The revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

4. REFERENCES

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5. CULTURAL SUPPORT

- When clinical risks are identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.
- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

7. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
24.1.23	2	Endorsed at Maternity Local Operating Procedure Committee
16.2.23	2	Endorsed at RHW Safety and Quality Committee

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Appendix 1

SUMMARY OF ABORTION LAW REFORM ACT 2019

Under t*he Abortion Law Reform Act 2019* a medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant provided that informed consent has been given (unless, in an emergency, it is not practicable to obtain the patient's informed consent). Before performing a termination, a medical practitioner must assess whether it would be beneficial to discuss accessing counselling with the patient and if the practitioner assesses that it would be beneficial and the patient is interested in accessing counselling, provide all necessary information to the patient about access to counselling, including publicly-funded counselling.

In addition, under the Act, except in emergencies, a specialist medical practitioner may perform a termination on a woman who is more than 22 weeks pregnant if:

- The practitioner has obtained informed consent for the procedure
- The practitioner has provided all necessary information to the patient about access to counselling, including publicly-funded counselling
- The practitioner considers that in all the circumstances there are sufficient grounds for the termination to be performed. This assessment is to be made after considering:
    - all relevant medical circumstances
    - the patient's current and future physical, psychological and social circumstances, and the professional standards and guidelines that apply to the practitioner in relation to terminations, and
    - any advice received from the hospital advisory committee or multi-disciplinary team.
- The practitioner has consulted with another specialist medical practitioner who also considers that in all the circumstances there are sufficient grounds for the termination to be performed. The second practitioner must also consider
    - all relevant medical circumstances
    - the patient's current and future physical, psychological and social circumstances, and
    - other professional standards and guidelines that apply to the practitioner in relation to terminations.

Any registered health practitioner who is asked to advise about termination of pregnancy or perform, assist in or advise on a termination of pregnancy and who has a conscientious objection to termination of pregnancy must inform the person who made the request that they have a conscientious objection to the performance of a termination of pregnancy and in a timely fashion.

Appendix 2

TERMS OF REFERENCE - TERMINATION ADVISORY COMMITTEE

1. The Termination Advisory Committee (TAC) at RHW may be convened when a woman requests a termination of pregnancy at any gestation, on request of the treating specialist medical practitioner. The treating specialist medical practitioner may consult with the TAC where they identify a need. The provision of a TAC is not a mandatory component of the assessment of request, but serves to assist the treating practitioner in complex clinical situations. The TAC is neither a constituted ethics committee nor does it have clinical decision making ability. Its sole purpose is to provide the treating specialist medical practitioner with advice of a clinical or technical nature. Consultation and advice should be documented by the treating practitioner. This TAC may be by email or in person. Terminations of pregnancy should be conducted within the framework for termination of pregnancy in New South Wales. PD2019_048.
    a. **At equal to or under 22 weeks+0 days gestation**, the medical practitioner is not required to consult with the TAC. All women should be offered counselling.
    b. **At greater than 22 weeks gestation**, the specialist medical practitioner is not required to consult with the TAC, but should consult with another specialist medical practitioner who also considers that, in all the circumstances, there are sufficient grounds for the termination to be performed under the law (Appendix 1). Counselling should be provided. This may be a Social Worker, Psychologist or Psychiatrist depending on the specific psychosocial needs of the patient. The two specialist medical practitioners will decide whether the TAC should be consulted. **If both specialists agree on the indication for termination then there is no need to convene and consult the TAC**.
2. The multidisciplinary team may include experts in the areas of psychiatry or specialist mental health, maternal fetal medicine, neonatology and any other specialty relevant to the woman's and fetus(es) medical condition.
3. The Head of Department of Maternal Fetal Medicine is responsible for the governance of this committee, and in turn reports to the Co-Directors of Maternity and Executive Clinical Director.
4. The committee will usually be chaired by a Maternal Fetal Medicine Specialist. If this is not possible (for example when there is medical leave and the sole Specialist available is presenting the case), the Clinical Midwife Consultant High Risk Pregnancy will chair the meeting. In both cases, this will be in an administrative role.
5. Other clinicians as applicable who have been involved in the case may be invited to attend according to which staff members are most relevant to the case.
6. An expert in mental health always forms part of the TAC: this may be a Social Worker, Psychologist or Psychiatrist depending on the specific psychosocial needs of the patient.
7. The Treating Medical Practitioner makes an initial submission to convene the TAC. This submission is written on the RHW Individual TOP Committee Proforma including a list of members of the multi-disciplinary team consulted.
8. The Treating Medical Practitioner or the Fellow in Maternal Fetal Medicine (if they have been involved in the case) presents the case at the TAC.
9. The Administrative Officer of Maternal Fetal Medicine contacts members of the TAC by email or telephone to decide whether the meeting can be conducted by email consultation, or to arrange a suitable time and venue for the TAC to convene.
10. Members of the multi-disciplinary team who have consulted with the patient may make a written or verbal submission to the TAC, particularly if they are unable to be present.
11. The patient and/or her family may make a written submission to the TAC.
12. The TAC should aim to convene within two (2) business days of the request for termination of pregnancy.
13. Members of the multi-disciplinary team may participate in the TAC by telephone or videoconferencing.
14. The advice of the TAC is for the treating medical practitioner so that they are able to undertake an informed assessment of request for termination of pregnancy. If the committee/ treating practitioner requests further

input or information, the decision may be deferred and further specialist consultation or advice may be organised.

15. The treating medical practitioner will document the outcome of the termination review committee in the patient's medical record.

Developed: Submitted to Clinical Operations Committee by Medical Clinical Co-Director, Maternity Services Division
Implemented: 27 September 2010, Maternity Services Division
Reviewed: 16 July 2012, Medical Clinical Co-Director, Maternity Services Division and Midwifery Clinical Co-Director, Maternity Services Division
Approved: 14 August 2012, Maternity Services Division
Revised: 17 May 2020

Appendix 3

MIFEPRISTONE AND MISOPROSTOL INFORMATION FOR WOMEN

About the Medicines used to stop a pregnancy by inducing labour
There are several reasons why a pregnancy may be stopped early, including death of the fetus, serious medical conditions in the mother which make it unsafe for the pregnancy to continue, or serious abnormalities in the fetus. Mifepristone and Misoprostol are two medicines that are commonly used together to induce labour when a decision has been made to stop a pregnancy. The safety of mifepristone (formerly RU486) used with a prostaglandin (usually misoprostol) is well established.

This brochure is designed to provide some written information about the medicines used to stop a pregnancy following discussions with your doctor. Your doctor is happy to answer any questions you may have about the use of mifepristone and misoprostol.

About Mifepristone
Mifepristone is a tablet taken orally. Mifepristone works by blocking the pregnancy hormone progesterone which is needed to maintain a pregnancy. Because this hormone is temporarily blocked, the lining of the uterus begins to change. Also the cervix (neck of the uterus) softens and the uterus is more likely to contract and labour when the second medication misoprostol is given. Mifepristone decreases the time a woman may spend in labour from beginning induction of labour to the birth or miscarriage.

When all your questions are answered, and you have consented to stopping the pregnancy, your doctor will arrange for you to take the mifepristone tablets. The medication works best if there is 24-48 hours between taking the Mifepristone tablets and admission to hospital to start the induction of labour. Admission to the hospital is usually arranged for 24-48 hours after the Mifepristone medicine is taken.

Side effects from Mifepristone
Vomiting and headache can occur in 15-20% of women

A small percentage of women will also get period like cramping

There is a small chance (less than 0.5% or 1 in 200) that you may come into labour or miscarry during the 24-48 hours prior to your admission to hospital. If you have bright red bleeding, any cramping pain, think your waters have broken, have a fever, feel unwell or have any other concerns, please call the hospital for advice at any time.

Mifepristone may make you dizzy. Do not drive a car or operate machinery until you know how this medication affects you. It is recommended to have someone drive you home after taking the Mifepristone.

About misoprostol
Misoprostol is a tablet and can be given in three ways; placed under the tongue, taken by mouth or inserted into the vagina. How this medicine is given depends on each woman's situation and the hospital guidelines. Misoprostol stimulates the uterus to contract and induces labour with further softening and opening of the cervix resulting in miscarriage or birth. When mifepristone has previously been given, the uterus is more sensitive to the misoprostol and this helps shorten the time a woman may spend in labour.

Misoprostol tablets are given once you are in hospital and are administered every three to four hours with a maximum of five doses in 24 hours. Most women miscarry or give birth 6-9 hours after the first dose although sometimes it can take 24 hours or longer from the first misoprostol tablet.

Misoprostol is licenced in Australia for medical termination of pregnancy less than 63 days by the Therapeutic Goods Administration (TGA). Misoprostol is widely used around the world to induce labour or late miscarriage, however, the TGA of Australia does not license it for this purpose. This does not make it unsafe for use as international and local research has shown it is effective and safe for the induction of labour where there has been a fetal death or where the pregnancy needs to be stopped. Some women experience side effects from the

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Misoprostol tablets, most of which are mild. Some of the side effects are also related to the labour, miscarriage or birth.

Common side effects from misoprostol
Shivering, chills, nausea, vomiting, diarrhoea, hot flushes, headache, abdominal pain and low grade temperatures. Strong, sustained uterine contractions after repeated vaginal doses of misoprostol.

Rare side effects from labour and delivery
Heavy vaginal bleeding that may require a blood transfusion (about 1 in 100 women).

If the placenta does not come away after miscarriage or birth it may be necessary to have the placenta removed in the operating theatre under anaesthetic (about 1 in 5 women- this is less common with using Mifepristone and Misoprostol than Misoprostol alone, and is more common when a woman is less than 20 weeks than after 20 weeks gestation)

Infection may occur with any induced labour. About 3% of women require antibiotic treatment. This may be a later complication. If you have symptoms such as fever, nausea, chills, vomiting or diarrhoea or increased blood loss it is important that you ring the birth unit or Macquarie ward urgently and come in for assessment. Very rarely infection can be severe, so if after discharge home you feel unwell, it is important to see a doctor quickly.

Very rare side effects from labour and delivery
In women who have previously had a caesarean birth or uterine scarring, there are reports of rupture of the uterine scar (scar on the uterus) associated with Misoprostol induction of labour (risk of 1 in 1000). This is not unique to misoprostol and can occur whenever labour is induced in women with a scar on the uterus. This may be treated with unplanned major abdominal surgery, or sometimes a hysterectomy (removal of the uterus) will be required.

If you have any concerns, you can phone the hospital 24 hours a day
If you are 15 weeks pregnant or less, please call the Macquarie Ward on 02 9382 6298
If you are 16 weeks pregnant or more, please call the Birth Unit 02 9382 6100 or 0439869035

Pre-medication Date and Time: _____

Admission Date and Time: _____

Where to come : Please go to the reception desk in the main entrance of the Royal Hospital for Women. Following completion of some admission paperwork you will be admitted to your room in one of our wards.

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Appendix 4

CONSCIENTIOUS OBJECTION

Any registered health practitioner who is asked to perform, assist in or advise on a termination of pregnancy, and who has a conscientious objection to termination of pregnancy must inform the person who made the request that they have a conscientious objection to the performance of a termination of pregnancy and in a timely fashion. In addition, if a registered health practitioner is asked to perform a termination, or advise about the performance of a termination, the practitioner must, without delay:

1. give information to the woman on how to locate or contact a medical practitioner whom they believe does not have a conscientious objection to the performance of the termination; or
2. transfer the woman's care to another registered health practitioner, or health service provider, who can provide the requested service and does not have a conscientious objection to the performance of the termination.

A registered health practitioner who has a conscientious objection may meet this requirement by providing the woman with the details of a NSW Health supported information service. This service is able to provide information about medical practitioners who do not have a conscientious objection to the performance of termination; as well as general information and support services for reproductive and sexual health (up-to-date information for these services is available at www.health.nsw.gov.au/pregnancyoptions)

Public health organisations and approved health facilities have a duty of care to ensure that women seeking a termination 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 their conscientious objection. Public health organisations must ensure that no person, either patient or 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, nurses and other staff must perform a termination of pregnancy, or assist in the termination, in those rare emergency cases where it is necessary to preserve the life of the pregnant woman, regardless of their objection to termination of pregnancy.