## Nurses and abortion

Vincent Argent and Lin Pavey have concluded, in an analysis of the House of Lords case *Royal College of Nursing v DHSS* [1981] 1 AC 800 ("the RCN case"), that without any change in the law, nurses can legally perform surgical induced abortion.[1] Their article contains some dangerous legal misconceptions.

The RCN case concerned the participation of nurses in prostaglandin-induced abortions. The House of Lords decided by a majority (3:2) that in certain circumstances nurses could participate.

The RCN case decided that for the procedure that the court was considering:

(a) Medical abortion is a process.
(b) The process may be effected by a team.
(c) Section 1(1) of the Abortion Act 1967 permits delegation to nurses of some acts which form part of the process. This includes acts that have a direct abortifacient effect.
(d) The process must be initiated by a registered medical practitioner, and must be under his control throughout, in the sense that anything done other than by him must be done pursuant to his instructions.
(e) What amounts to acceptable delegation may be determined by "accepted medical practice".

One of the judges in the majority, Lord Keith, expressly regarded the decision as one on its own facts. He said: "…it remains to consider whether, *on the facts of this case* the termination can properly be regarded as being "by a registered medical practitioner"[2] [emphasis my own]. This means that when considering an abortion procedure, unless one is dealing with precisely the procedure that the RCN case considered, it cannot be asserted that a majority of the House of Lords says that the procedure falls within Section 1(1).

Although the RCN case is an important statement of the meaning of Section 1(1), it leaves some important questions unanswered.

It is plain that "accepted medical practice" itself cannot be the correct test, unless it is to be read as "medical practice accepted by the courts". The main difficulty with making "accepted medical practice" the touchstone of appropriate delegation is that the Act itself puts obvious limits on the use of that idea. Suppose that it became the majority opinion amongst gynaecologists that all steps in an abortion should be performed by nurses. It would then, in a sense, be "accepted medical practice" that nurses should perform all steps. But that would be prohibited by the Act. It could not be *legally* accepted medical practice. Medical practice looks to the law to determine what is acceptable, not vice versa.[3] Any test that requires the law to defer entirely to medical practice in determining the correct construction of the Act must be a wrong test. Although in other areas of the law (notably clinical negligence), the law has great respect for the views of responsible medical practitioners, and is importantly (and often decisively) informed by those views, it has long been one of the pillars of medical law that the courts, not the profession, set the standard. If that is true of standard setting in the common law, still more should it be true of statutory construction.

So what must have been meant was "legally acceptable" medical practice. On the facts considered in the RCN case, it was found that the medical induction procedure was acceptable and accordingly fell within the boundaries of s. 1(1).

If it is legitimate to use accepted (or acceptable) medical practice as the arbiter of legality, it is strongly arguable that the relevant medical practice for the purposes of determining legality is the practice known about or envisaged by Parliament at the time of the enactment. As Lord Denning pointed out in the Court of Appeal, had Parliament intended to make the standard move with shifting medical practice, there were plenty of expressions available which would have had that effect. Surgical termination using modern methods was not amongst the procedures envisaged, and it was certainly not foreseen or foreseeable that it might be suggested that nurses might be significant operators in such procedures.

The dissenting views cannot merely be discounted. They emphasised, very powerfully, the need for great caution in the construction of the statute, and in particular the need for judges to be careful not to usurp the function of Parliament and engage in judicial legislation. The danger of such judicial legislation is particularly acute since it is a long time since the Abortion Act 1967 was enacted; abortion practice has changed immeasurably since Parliament debated and voted.

The RCN case draws no distinction in principle between medical and surgical abortion. But that does not mean that all acts which are done or it is envisaged might be done by nurses in the performance of surgical abortions fall within the boundaries of appropriate delegation. That is the basic error into which Argent and Pavey fall.

So: does the RCN case say that it is lawful for nurses to perform surgical abortion? No, it does not. The position in relation to nurses' involvement in procedures other than that specifically considered in the RCN case is wholly unclear. It would be very unsafe for anyone to act on the basis of the assertions in the Argent and Pavey article. If it is seriously proposed that nurses should perform surgical abortions then the matter should be considered again by Parliament. A ruling on the point by any court lower than the House of Lords is unlikely to give an answer sufficiently definitive to lay to rest the doubts of those affected by the issue.

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3 Note, for example, Bolitho v City and Hackney Health Authority [1998] AC 232; also the High Court of Australia in Rogers v Whitaker (1992) 109 ALR 625.

## Reply

Charles Foster's critique is useful and agrees that abortion law should be modernised. The Abortion Act 1967 does not reflect the realities of current clinical practice and the increasing role of nurses in the provision of abortion care.

The statute could be changed but a test case in the House of Lords or even a ruling from the Department of Health would suffice. Pro-choice and anti-abortion groups hold opposing views on how the law should be changed but it is important that a new approach reflects modern clinical need.

Foster does state that the RCN case draws no distinction in principle between surgical and medical abortion and this is, in fact, the hub of our argument. In other jurisdictions, nurses and other providers are already providing a safe surgical service. This will assume increasing importance in the UK where the Royal College of Obstetricians and Gynaecologists has recognised doctors' relative disinterest in providing this essential service to women.

Foster considers that accepted medical practice should by judged by the courts but we know that sensible judges do take a pragmatic view based on medical expert opinion.

The Abortion Act was designed to remove the mischief of unsafe abortion and it is now clear that a safe service can be run by nurses who are part of a team under the overall supervision of a medical practitioner.

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## Unsafe abortion in Nigeria

Each minute of every day, nearly 40 women undergo dangerous, unsafe abortions.[1] These unsafe abortions are often performed by unskilled providers or under unhygienic condition or both. Estimates based on figures for 2000 indicate that 19 million unsafe abortions take place each year and an estimated 68 000 women die as consequences of unsafe abortion, and almost all occur in developing countries.[2]

In Nigeria, as is also the case in most developing countries, unsafe abortion has assumed a serious public health problem, and induced unsafe abortion has been established as an important contributor to maternal morbidity and mortality. In Nigeria, induced abortion is a criminal offence both for the seeker and the provider. The penalty is 14 and 7 years jail sentences, respectively, for the provider and client. These penalties notwithstanding, induced unsafe abortions are still performed on a daily basis both by skilled and unskilled personnel. There are approximately 610 000 abortions performed in Nigeria annually with an abortion rate of 25.4 per 1000; of these, 60% are thought to be unsafe.[3] In Nigeria, unsafe abortion contributes up to 20% of maternal mortality, and those women that survive are faced with complications such as sepsis, vesicovaginal fistula, anaemia, ruptured uterus (sometimes ending in hysterectomy), amongst others.

Factors associated with this high morbidity and mortality from unsafe abortion in Nigeria include restrictive abortion law, activity of quacks and untrained providers, poor health-seeking behaviour of women, poor and inadequate post-abortion care facilities in health institutions, inadequate access to family planning counselling, information and services and poor socioeconomic status of Nigerian women.

This suffering and these deaths are preventable and the solutions are well known, available, practical and cost-effective, but they are too often neglected because of political and social constraints. The abortion law in force in Nigeria today is still the one adopted from the British colonial government of 1861. No reasonable amendment or modification has been made to keep apace with time. The existing abortion law prevents the institutionalisation of safe abortion practices and drives abortion underground, thereby encouraging the use of quacks and unqualified providers who cause distress and suffering to the women concerned. It also restricts counselling and training of health professionals on abortion-related issues.

Post-abortion care, an unfortunately neglected vital tool of the reproductive health care package for Nigerian women, should be seriously revisited, revitalised and promoted in Nigeria as a very important intervention strategy to deal with complications arising from unsafe abortions. Women who have unintended pregnancies should have ready access to reliable information and compassionate counselling. In all cases, women should have access to quality services for the management of complications of abortion. Where the law permits, there should be provision of quality standards for abortion providers.

The 1994 International Conference on Population and Development in Cairo, Egypt, at which Nigeria was a participant, agreed that in order to reduce the morbidity and mortality from

unsafe abortion, improved and expanded family planning services must be given the highest priority. Twelve years after the Cairo conference, the contraceptive prevalence in Nigeria is 7.3%.[5] This is worse for adolescents and unmarried women who are frequently excluded from contraceptive services. In many developing countries, lack of information on sexuality and contraception targeted at the adolescent population has often translated into a high prevalence of unwanted pregnancy. Thus, there is great need for the establishment of accessible and affordable youth-friendly centres, different from a hospital setting, where these vulnerable groups can go for care. Such centres should be equipped to offer services on family planning counselling and information, education on reproductive physiology and overall safer sex, and should be able to provide post-abortion care services. Also, regulations, policies and/or laws that restrict adolescents' access to such services should be revised.

In conclusion, the contribution of unsafe abortion to maternal mortality will be drastically reduced – if not completely eliminated – if specific and goal-directed actions are taken. Such actions include promoting women's rights, status and health; ensuring access to contraception; providing post-abortion care services, including counselling; putting referral systems in place; decriminalising abortion and changing laws where they are restrictive. All relevant agencies are called upon to initiate authentic programmes that will curb this carnage from unsafe abortion as part of the overall strategy for achieving the millennium development goal, not only in Nigeria but also in most developing countries of the world.

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## Cerazette and HRT

A general practitioner (GP) wrote into our service recently to ask if Cerazette® could be used as the progestogen part of hormone replacement therapy (HRT). I would be interested in the views of other Faculty members about this.

The progestogen-only pill (POP) has been used traditionally as part of HRT regimes, although is not licensed for this indication. It has always been postulated that from the perspective of contraception, as the additional oestrogen in the HRT, might 'undo' the mucus thickening effect of the POP, that when used as part of HRT the dose of POP should be doubled (or trebled). As the newer POP, Cerazette works by inhibiting ovulation1 in almost all cases, this should not be the case with Cerazette as part of an HRT regime.

In addition, I believe there have been studies of desogestrel as part of the HRT regime, but these were halted as a result of the 1995 pill scare and the venous thromboembolism issue with third-generation progestogens. A 1996 study by Saure *et al*.[2] was a randomised double-blind multicentre study of 310 women, comparing the effects of two sequential HRT preparations, containing either estradiol and norethisterone, or estradiol and desogestrel. Both regimes successfully alleviated menopausal symptoms, and there was no significant difference in bleeding patterns with the two combinations. There was no endometrial hyperplasia or atypia identified during the study.

My own view is that using Cerazette as the progestogen part of HRT should be acceptable practice. However, women of perimenopausal age do have much reduced fertility, and some would say that Cerazette, whilst it offers an additional choice of POP, could be regarded as 'contraceptive overkill'. We cannot, however, get away from the fact that the 12-hour rule for daily administration with Cerazette makes it considerably easier to take.

The question remains as to whether Implanon® could be used as part of an HRT regime. I feel it is unlikely this would be the case, but would be interested in readers' views on this subject.

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## Cytology sampling using brushes

I read with interest the letter from Dr Leng Neoh in the April 2007 issue of the Journal.[1]

I would like to question the technique of collecting a cervical cytology sample using the new liquid-based cytology (LBC) Cervex-Brush® described by the author. The National Health Service Cervical Screening Programme (NHSCSP) guidance[2] on taking samples for LBC recommends that the Cervex brush is rotated five times at the external cervical os 'clockwise only'. Perhaps the technique described by the author that involves rotating the brush at the cervical os five times clockwise and anti-clockwise may have inadvertently caused downward traction on the threads of the intrauterine device leading to its 'unintentional removal'. I do not see any benefit in using a Spencer Wells forceps as suggested by the author to minimise this risk. In fact, I wonder how one could rotate the Cervex brush with the Spencer Wells forceps near the external cervical os and that this technique may be a potential cause for inadequate sampling of the cervix.

I would appreciate readers' comments.

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## Cytology sampling using brushes

I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.[1]

As an experienced cervical sample taker I agree with Dr Neoh that when sampling the cervix using the Cervex-Brush® caution is required when the client has an intrauterine device or intrauterine system (IUD/IUS) *in situ* to ensure the clinician does not inadvertently remove the IUD during sampling.

However, I must point out that the plastic fronds of the brush are bevelled for *clockwise* rotation only.[2] The Cervex-Brush should be rotated *five times* in a clockwise direction and not, as stated by Dr Neoh, "five times clockwise and five times anti-clockwise". This is incorrect sampling and there is also more risk of the threads becoming tangled.

When presented with the above situation, my practice is to rotate the Cervex-Brush five times in a clockwise direction, but to do it in two stages, namely after rotating twice, stop, remove the brush from the cervix (but not from the vagina) and from any threads that may be starting to become entangled, and then continue sampling to complete the five rotations, ensuring the brush is repositioned at the same point on the cervix where the second rotation finished. I have found that although the threads may start to become entangled, it is easy to remove the brush from them without dislodging the IUD.

Using a Spencer Wells forceps as suggested by Dr Neoh is also an option but this requires some skill and may dislodge the IUD/IUS by the traction on the threads. This also necessitates having a ready supply of instruments.

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## Increase in IUD expulsions

It was with great interest, and a sense of *déja-vu*, that I read the recent correspondence concerning insertion problems with TT380 Slimline.[1–3]

Reading Dr Yadava's original letter in 1996[4] enabled me to identify the cause of the problems that I had been experiencing with insertion, and following my adoption of his modification (cutting the introducer tube shorter) I experienced no further problems.

It was unfortunate that the manufacturer (in this country at least[2,3,5]) was unwilling to modify the device, and that the apparent design problem has been passed on to newer devices.

In the light of this new evidence, I would like to reiterate my suggestion[6] that it might be appropriate for the Faculty to take up the matter with the manufacturer.

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