LETTERS TO THE EDITOR

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 (RCN case), that 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) 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 really be said to have been carried out by being a registered medical practitioner”2 [emphasis my own]. This means that when considering an abortion procedure, unless one is dealing with procedures specifically mentioned in the RCN case, it cannot be asserted that a majority of the House of Lords says that the procedure falls within Section 1(1), (d) of the Abortion Act 1967. 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 poses 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. More generally, was the law to do what is acceptable, not vice versa. 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 that 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. It might be suggested that nurses might be significant operators in such procedures.

The dissenting views cannot merely be discounted. Statute can be given powerful, 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. It is not necessary to involve in procedures other than that specifically considered in the RCN case is wholly unclear. It would be very unsafe for anyone to attempt to carry out any abortion by anyone other than a doctor. Argent and Pavey article. If it is seriously proposed that nurses should perform surgical abortions then the matter should be considered again by both the RCN and the 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.

Charles Foster, MA(Cantab), MRCVS
Barrister, Outer Temple Chambers, London, UK.

References
2 Royal College of Nursing v DHSS [1981] 1 AC 800; p. 805.
3 Note, for example, Bolilto v City and Hackney Health Authority [1998] AC 232; also the High Court of Australia in Rogers v Whitaker [1990] 10 ALR 625.

Reply

Charles Foster’s critique is useful and agrees that abortion laws are still stuck in the 1960s. 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 states that the RCN case draws no distinction between surgical and medical abortion and this, in fact, the hub of our argument. In other jurisdictions, nurses and other providers are already providing a safe surgical service, so it is not surprising that the 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 modern medical practice.

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.

Vincent Argent, BRCOG, LLB
Consultant Obstetrician and Gynaecologist (Lead in Sexual Health), Addenbrooke’s Cambridge University Teaching Hospital, Cambridge, UK. E-mail: vargent11@aol.com

Lin Pavey, RCN
Member of RCN Nurses Working in Termination of Pregnancy Network

Unsafe abortion in Nigeria

Each minute of every day, nearly 40 women around the world die from unsafe abortion. Each year, an estimated 56 million unsafe abortions are performed, with 15 million performed under unhygienic conditions or both. This has contributed up to 20% of maternal mortality, and almost all occur in developing countries.1

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 sentence, respectively, on conviction to rig the abortionist and the client.

This regulation is at times useful to prevent illegal abortionists from exploiting women and children. There are an 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.2 In Nigeria, unsafe abortion constitutes a direct cause 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, and services and too few professional providers. This lack of service and financial resources makes it impossible for most women to have a safe abortion.

Unsafe abortion in Nigeria is a direct cause of maternal mortality. It is a neglect tool of the reproductive health system that is currently in use in Nigeria, a country that has a long history of the British colonial government of 1861. No reasonable amendment or modification has been made to keep pace with time. The existing abortion legislation produced a situation where 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.

In conclusion, post-abortif abortion is an unfortunately neglected vital tool of the reproductive health care package for Nigerian women, should be seriously revisited, revitalised and promoted in Nigeria. A well regulated, effective 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 present, laid a strong foundation in order to reduce the morbidity and mortality from abortion.221

©FFPRHC J Fam Plann Reprod Health Care 2007: 33(3)
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%. 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 is the main cause. 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 centres, both 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 effective 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 curtail 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.

Perpetus Chudi Ikewe, MBBS, FWACS
Department of Obstetrics and Gynaecology,
Eleme State University Teaching Hospital,
Ahalikati, Nigeria.
E-mail: drogoperps@yahoo.com

References

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 chance of POP should be doubled (or trebled). As the newer POP, Cerazette works by the dose of POP should be doubled (or trebled).

Cytology sampling using brushes
I read with interest the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

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) states that for LBC samples for LBC recommends that the cervix is brushed five times at the external cervical os ‘clockwise only’. However 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.

Anagha A Nadgir, MBChB, MRCOG, FFPI
Associate Specialist, Contraception and Sexual Health Service, Middlesex Hospital, PCT, North Ormesby, Middlesbrough, UK.
E-mail: anagha.nadgir@nhs.net

References

Cytology sampling using brushes
I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

As an experienced cervical sample taker I agree with Dr Neoh that when sampling the cervix using the Cervex-Brush® causes 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 brushes are bevelled for clockwise rotation only. 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 much easier to remove them from 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 by the traction on the threads. This also necessitates having a ready supply of instruments.

Suzanne Jones, BGN
Lead Nurse, Abacus Clinics, Liverpool, UK. E-mail: suzanne.jones@liverpoolpct.nhs.uk

References

Increase in IUD expulsions
It was with great interest, and a sense of déjà-vu, that I read the recent correspondence concerning inserter problems with the LCB Mirena® IUD.

Reading Dr Yadava’s original letter in 1996* enabled me to identify the cause of the problems that I had been experiencing with insertion, and following my advice to Dr Neoh that when sampling the brush from them without dislodging the IUD


I experienced no further problems. It was unfortunate that the manufacturer (in this country at least?) did not agree with my suggestion and so be modified by 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 that it might be appropriate for the Faculty to take up the matter with the manufacturer.

Robert J T Jarvis, MFFP
General Practitioner, The Surgery, Ladhum, Norfolk, UK. E-mail: rj.jarvis@binternet.com

References

222