The Role of the GP

Before Referring

- Confirm the woman is pregnant with a positive pregnancy test
- Be prepared to discuss the options available to her: continuation of pregnancy, adoption or referral for consideration for a termination of pregnancy. If appropriate **allow time**, for her to consider these options and bring her decision to a further consultation
- If a woman seeks an early medical termination then refer promptly as it needs to be performed at less than nine weeks gestation. An ultrasound scan should be arranged as soon as possible to confirm gestational age. If the pregnancy is very early, a serum bHCG is also very helpful.
- Women should be made aware of the availability of free professional counselling which can be arranged when contact is made with the clinic
- Be prepared to discuss the different methods of termination available (discussed later in this document).

Under New Zealand law, a fully informed consenting woman may access a termination regardless of age. Young women under 16 do not need to inform their parents or seek parental consent.

A woman does not need the consent of her partner before having a termination.

Religious / Moral Conflict

It is not the role of general practitioners to discuss their own personal views about termination. If a general practitioner is not able to refer personally, then arrangements must be made for the woman to be seen as soon as possible by another doctor in the area

If any doctor has difficulty giving advice or referring a woman for consideration for termination because of moral or religious belief, and they know that this conflict might affect the advice and treatment provided, then this must be explained to the patient. The patient should be told that they have the right to see another doctor, and have information about access to alternative services readily available to them.

The Medical Council of NZ "Good Medical Practice" makes these points:[2]

- Respect the right of patients to make an informed choice about their care
- Make sure your personal beliefs do not influence your patient's care
- Respect and protect confidential information.

Ideally a practice should state clearly in the practice information leaflet, any website and in the practice premises if there are doctors who have a conflict that might interfere with their ability to refer for consideration for termination of pregnancy or provide contraceptive advice.

Making the Referral

If the woman requests referral for consideration for a termination of pregnancy, the referral should include:

- Relevant obstetric, gynaecological, medical, surgical, social, psychiatric history, and include contraception used at time of conception
- First antenatal bloods
- For very early gestations of pregnancy (under six weeks) a BHCG is very useful
- STI screening and treatment (see box page 6) and smear if appropriate

  Ensure copies of the results will be sent to the clinic that you are referring to

Assess gestation as accurately as possible by history (using LMP) and by examination. Arrange an urgent scan if the woman seeks an early medical termination to confirm that gestation is under nine weeks, and intra-uterine

Encourage the woman to return to you for follow-up post termination and to discuss ongoing contraception.

At the clinic, the woman will see nurses, counsellors if required, and two registered certifying consultants. If the woman's referring doctor is a certifying consultant then she will only need to see one more certifying consultant at the clinic.

The certifying consultants will go over any relevant medical, surgical and psychiatric history with the woman. They will do a routine pre-op assessment and examination and assess her legal eligibility for a termination. If one certifying consultant declines certification, the woman is entitled to be referred to other certifying consultants for further consideration of her legal eligibility.

Once the woman has two certificates she may proceed to termination.

Claiming under Section 88

Claiming for First Trimester Non-LMC termination services under the Section 88 Maternity Services Notice

To make a claim for funding for termination of pregnancy services, a Provider has to be authorised by the Ministry of Health under the Primary Maternity Services Notice 2007 ('the Notice') pursuant to Section 88 of the Public Health and Disability Act 2000.

An 'authorised' General Practitioner is able to claim a fee under the Non-LMC First Trimester Module of the Notice of $150 for assessment, care, advice and referral in relation to termination of pregnancy and $40 for the post termination follow-up consultation.

If you are not an 'authorised' provider at the time of the consultation you will not be able to claim retrospectively. You will need to make a decision whether or not to charge the patient.

To become an authorised maternity provider you will need to contact Ministry of Heath Sector Service Directorate and complete an application form. Once the application has been approved, you will be issued with a Payee number, Agreement number and a Section 88 Maternity Advice Notice.

You can contact the Sector Services Directorate by:

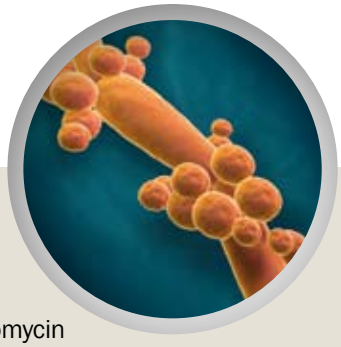
Phone: 0800 281 222

Post: Sector Services,
Private Bag 1942,
Dunedin

Follow-Up Post Termination

It is an important role of the referring general practitioner to arrange follow-up post termination. It is recommended the follow-up include:

- Assessment and management of any complications arising from the termination, that may include excessive bleeding, pain, discharge, or fever
- Contraception (in almost 55% of terminations no contraception was used and in 35% of cases there has been a previous termination)
- Offer free post termination counselling for woman who may have problems come to terms with having had an abortion. Referral to free post abortion counselling can be arranged by contacting the termination clinic



Screening and Treatment of Sexually Transmitted Infection

Screening for *Chlamydia trachomatis* is imperative. In a 2005 study, 7.7% of women tested positive pre termination of pregnancy.[3] Untreated Chlamydia is associated with significant post-op morbidity, including endometritis, salpingitis and pelvic inflammatory disease.

A endocervical swab for a PCR test for Chlamydia is the gold standard as there is a high false negative rate with urine tests for Chlamydia in women.

Screening for *Neisseria gonorrhoea* is mandatory and should be done on a separate endocervical swab then transported to the laboratory as soon as possible. There is approximately a 50% loss of viable organisms if it takes more than 24 hrs before the sample gets to the laboratory.

Most laboratories are able to check for other infections such as Trichomonas vaginalis and Bacterial vaginosis on the same swab, if not then send a third swab (high vaginal).

If any swabs come back as positive for infection, it is important that the GP make contact with the woman and arrange for immediate treatment for both the woman and her partner(s).

Treatment for Chlamydia: Azithromycin 1 g stat (certified condition)

Treatment for Gonorrhoea: If penicillin susceptible use Amoxycillin 3 g and Probenecid 1 g stat . If Ciprofloxacin susceptible use Ciprofloxacin 500 mg stat. If Ciprofloxacin resistant use Ceftriaxone 250 mg IM.

When treating Gonorrhoea infection, treatment regimens should include treatment for Chlamydia as well, as co-infection is common.

Treatment for Bacterial vaginosis/*Gardnerella vaginalis* / Trichomonas (both confirmed or indeterminant): Ornidazole 1.5 g stat, or tinidazole 2 g stat or Metronidazole 2 g stat or 400 mg tds for 7 days

Some clinics consider giving treatment for Group B Streptococcus agalactiae where cultured. Contact your local clinic for advice.

Advise the woman not to have sexual intercourse until she has been seen at clinic as re-infection can cause unnecessary delays in any procedures.

Contraception

General practitioners, sexual health clinics and family planning clinics play a major role in the provision of advice and access to contraception.

In the 2007 Abortion Supervisory Committee report, women accessing a termination reported using the following methods of contraception at the time of conception:

- 54.8% No method
- 26.7% Condoms
- 13.4% Oral contraceptives
- 2% Natural Family Planning
- 1.2% Morning After Pill
- 1.1% Intrauterine Device
- 0.5% Injection (Depo-Provera)

While most women will be prescribed appropriate contraception at the time of accessing termination services, it is recommended that contraception is again fully discussed with the woman when she returns for her post termination follow-up check. Recall systems can be valuable for ensuring contraception is maintained.

Future Reproductive Outcome There is no evidence of an association between induced termination and subsequent ectopic pregnancy, placenta praevia or infertility. There may be a slight increase in the risk of subsequent late miscarriage or preterm labour in those woman who have had five or more abortions but study results are not consistent.

Psychological sequelae Some studies suggest a very small increase in rates of self-harm and mental health illness among women who have had a termination but these findings do not imply a causal association and may reflect continuation of pre-existing conditions.

Statistics

- Approximately one in five pregnancies is terminated (in New Zealand and worldwide). In the UK one third of women will have had one termination of pregnancy before the age of 45.
- In New Zealand, 18,380 terminations were performed in 2007.[1]
- The termination rate has been relatively stable over the past decade and is similar to Australia and USA.
- The termination rate is highest amongst women aged 20–24 years with the median age of 25 years – this has stayed the same over the last twenty years.
- In 2007, most terminations (65%) were a woman's first termination. The majority of terminations were performed during the 9th–11th week of gestation. The risk of complications is less when terminations are performed at early gestations.
- Only 0.3% of terminations happen after 20 weeks gestation.
- 98–99% of all terminations in New Zealand are granted on the basis of serious danger to the mental health of the woman. Similar statistics are found in the UK.