

## Termination review committees: are they necessary?

Nicole L Woodrow

*In Victoria, decisions regarding late termination of pregnancy no longer involve just pregnant women and their clinicians. At two major women's hospitals, committees now govern the decision-making process for approval of a late termination of pregnancy. The legal and ethical implications of clinical decision-making by committee need to be widely debated. (MJA 2003; 179: 92-94)*

DECISION-MAKING PROCESSES for termination of pregnancy after 20 weeks' gestation have recently changed in Victoria. Most late terminations of pregnancy are conducted in the public sector at two major centres for obstetrics and gynaecology: the Royal Women's Hospital, and Monash Medical Centre. Before June 2000, in response to a request for a late termination of pregnancy, the clinicians managing the woman's pregnancy would meet and attempt to reach a consensus as to the appropriateness of a termination in her circumstances. Following the reporting of a late termination of pregnancy to the Victorian Coroner,<sup>1</sup> Monash Medical Centre and the Royal Women's Hospital each decided to create a termination review committee (TRC) to deal with the decision-making (Box). The role of each committee is to receive referrals from obstetricians regarding requests for late termination of pregnancy from pregnant women, and to decide whether the request should be approved.

### Clinical decision-making by committee

There is a growing belief in the medical community that doctors can no longer make important clinical decisions in isolation. This is particularly evident where clinicians have diverse views about the appropriateness of a late termination. The major dilemmas are whether a clinician views the status of the fetus as secondary to the mother's interests, or whether the fetus is a separate entity with rights that can be in conflict with the rights of the pregnant woman.

Clinical decision-making by committee can perform several roles, and these depend on whose interests the committee is intended to serve.

### Expert ethical and legal guidance

A committee may provide expert guidance in areas in which clinicians need assistance, predominantly in clinical ethics and the law, where clinical requests would be assessed in line with current standards. By obtaining appropriate expert guidance, a TRC may protect the community against possible poor ethical or legal decisions by clinicians.

### Liability

A committee may accept the bureaucratic responsibility for the care of the patient, including liability. The clinicians become absolved of legal liability for the decision about a late termination. This would serve the interests of doctors, who give up their clinical autonomy to the committee, and are not responsible for the decisions made by the committee in patient care.

An attempt has been made by the Royal Women's Hospital TRC to recognise this role (Guidelines for the termination of pregnancy. Royal Women's Hospital, Melbourne, intramural communication). The Royal Women's Hospital guidelines for termination of pregnancy state that "staff will be strongly supported by the Hospital in patient care which is in accordance with these guidelines." However, "staff will be strongly supported" is a weak legal statement to take on legal liability. It is doubtful whether a doctor can absolve himself or herself from legal responsibility. Nevertheless, many clinicians feel supported by ethics committees in making these difficult decisions. They feel it is helpful if a TRC shares with them the responsibility for the decision-making.

### Avenue of appeal

A committee may act as an avenue of appeal for the pregnant woman. That is, if the clinician disagreed with the woman's position, she could seek another opinion. In this case, the committee would be set up to serve the interests of the pregnant woman. If the committee came to a different conclusion, it would be required to facilitate a second opinion — either within the hospital, in another hospital, privately or interstate. However, the Victorian TRCs do not act as an avenue of appeal for pregnant women in their current structure. It is the decision of the obstetrician to put forward her case; the pregnant woman has no right to do so herself.

In the case of pregnant women denied a termination by a TRC, it is unclear how to offer a second opinion. Obtaining a second opinion outside the major teaching hospitals is not necessarily straightforward. The pregnant woman may have to request the second opinion of her own volition. Although not impossible, it is unlikely that a doctor in Victoria (or perhaps even interstate) would proceed against the decision of a TRC, even if he or she thought the woman had an ethical and legal reason for a late termination. It may be in the pregnant woman's best interests to inform her of this before the case is put before a TRC. Pregnant women can

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then exercise their autonomy to pursue private or interstate options before these become “closed”.

### **Public accountability**

A committee may act to provide public accountability as well as an educative role for clinicians. Public accountability would require that the committee have appropriate representation from the community. The committee would need to publish its cases or make them accessible to clinicians for general examination. Clinical decision-making, whether by a committee or by clinicians, should be publicly accountable. Clearly, this is not the current role of the Victorian TRCs.

### **Ethical considerations of clinical decision-making by committee**

#### **Interests**

Whose interests does a TRC serve? The major concerns that have been expressed about ethics committees can be levelled at TRCs.<sup>2</sup> If a committee is set up to serve the interests of the hospital, then it tends to err on the side of “conservative” decision-making. In late terminations, where the law is unclear, this is to be expected, but this may not be in the interests of pregnant women.

A committee could also come under the influence of a particular constituency or lobby group, which might not serve the best interests of either pregnant women or clinicians. This would depend on how members (and their delegates) are co-opted on to the committee, and whether any external process assesses the committee.

#### **The pregnant woman's autonomy and a TRC**

Who is ultimately responsible for a decision? In Victoria, a pregnant woman has no explicit right to demand a review by a TRC, even if she is aware of the inside workings of the process. She cannot attend personally to put her case forward, nor is she able to send a patient advocate, or even a clinician of her choice, to review the process. It must also be remembered that the obstetrician presenting the case may not agree with the woman's decision for a termination, but may bring the case to a TRC anyway.

This raises several issues about patient autonomy and informed consent. All the woman's preferences and circumstances are heard second-hand. How strongly her preferences are advanced will depend on the communication from the obstetrician. Should an obstetrician who disagrees with the patient's preference inform the woman before he or she attends a TRC? As a legal question, this may be extending the disclosure principle to its limit, as patients have no right to *demand* that a procedure should be provided. However, from an ethical viewpoint, a lack of disclosure may restrict a pregnant woman's autonomy to seek other options.

Most members of a TRC do not meet the pregnant woman who is making the request for a termination. This “arm's length” approach may undermine the autonomy of the pregnant woman to argue her case.

### **Termination review committees in Melbourne, Victoria**

#### **Why were they formed?**

The Royal Women's Hospital Executive created a termination review committee in June 2000, following widespread publicity of a controversial late termination of pregnancy. The hospital created a set of guidelines for late termination to be referred to the TRC as “hospital policy”. The TRC was formed to ensure that hospital administration approved all late terminations performed within the hospital. The hospital administration believed that this was the best way to protect itself, clinicians and patients from possible poor decision-making by doctors.

A TRC was also formed at Monash Medical Centre in July 2000. The initiative came from clinicians who wished to formalise the process that was already in place for approving a late termination of pregnancy. The clinicians believed that a formal process would improve communication with the hospital administration and lawyers, and ensure all options were explored before a late termination was performed.

#### **What are the terms of reference of the committees?**

The committees deal with the decision-making for approval of all terminations of pregnancy at or after “viability” (22–24 weeks' gestation) to be performed within the hospital. Their role is to assess a request for a termination in line with their interpretation of current Victorian law. The committees are also responsible for ensuring adequate consultation, counselling and documentation before the approval of a late termination.

#### **Who are the members?**

Royal Women's Hospital: A member of the executive (eg, Chief Executive Officer, Executive Director [medical or nursing]), a neonatal paediatrician, two medical divisional directors, one nursing divisional director, and the obstetrician managing the pregnancy. Delegates may be used in some cases. The committee may co-opt non-voting members with relevant clinical, legal and ethical skills.

Monash Medical Centre: The clinicians involved in the woman's care (obstetrician, ultrasonologist, geneticist, paediatrician, labour ward midwives, resident staff) and a general practitioner practising outside the hospital. Opinion may be sought from a member of the hospital executive and the hospital lawyer.

#### **How do the committees make decisions?**

Initially, the pregnant woman has a consultation with her clinicians. After comprehensive counselling, she may request a termination of pregnancy. Requests for termination may be in the setting of an obstetric complication, a medical or psychiatric illness, or a fetal abnormality. The clinicians meet to decide if they believe that the request should be upheld and if this requires approval from a TRC. The referral to a TRC comes from the obstetrician, not from the pregnant woman.

In arriving at a decision, the TRC needs to compare the consequences for the pregnant woman if she has a termination, if she continues the pregnancy and cares for the child, or if she gives up the child for adoption.

Other considerations include the extent and severity of a fetal abnormality, and the physical, psychological and social circumstances of the pregnant woman.

At the TRC, an attempt is made at consensus, but if necessary, decisions are made by majority vote. The clinician is bound by the decision of the committee.

The Monash Medical Centre model differs from the Royal Women's Hospital model in that opinion from the hospital executive and lawyer is consultative rather than prescriptive in nature. The final decision is made by the pregnant woman, her clinicians and an independent GP.

Both committees can be convened and decisions made within days of a request being put forward.

### Anonymity of the members

The Royal Women's Hospital TRC insists on anonymity for its members. The hospital administration is concerned that if names of the members of the TRC were available outside the hospital, members risked being victimised and stalked, as occurred with a former senior consultant in the 1970s (Review of Royal Women's Hospital TOP [termination of pregnancy] Working Party. Notes of meeting number 1. 17 October 2000, intramural communication).

The inconsistency in this defence of anonymity is that the doctor performing the termination of pregnancy is not anonymous, nor are the doctors counselling the pregnant woman. It could be argued that the people most at risk of a political act of violence are the clinicians, not the members of the Royal Women's Hospital TRC. The ethical difficulty is who takes the responsibility for the decision-making if committee members are anonymous. An attempt is made to offer support to the clinician by the Chairman of the Royal Women's Hospital TRC "signing off" on the patient's chart.

### Third-party considerations

The Royal Women's Hospital TRC considers the "desires of the father, other children and familial circumstances" in evaluating the appropriateness of a termination. Third-party considerations for termination of pregnancy have no standing in Australian law. The countries which do have "third-party authorisation" for terminations of pregnancy (eg, Morocco, which requires a husband to authorise his wife's abortion) are considered to have the most restrictive laws on abortion.<sup>3</sup> How can a TRC consider the desires of the father or other children without asking them for their opinion? Does this contravene our privacy laws and our commitment to our patient's privacy? The intention of this clause is unclear, but I have reservations that our care for pregnant women may be harmed by third-party considerations.

### Conclusion

While we are waiting for a legal solution, women will continue to attend clinicians requesting late termination of pregnancy. Further research needs to be performed on the

impact that clinical decision-making by committees has on the effective care of pregnant women. In particular, we need to review the psychological effects on women who were denied a termination by a TRC.

Clinicians need support in making controversial and difficult ethical decisions. Clinical ethics committees can provide support and advice, particularly in clinical ethics and the law, but should they take over clinical decision-making? This alienates both the pregnant woman and the clinicians, and may lead to inappropriate clinical care. The committee must not erode the doctor-patient relationship, which provides a framework for mutual decision-making. It is the setting where patients make many of their difficult quality-of-life decisions. Each case is unique and there is no right answer when a pregnant woman asks, "Doctor, what would you do?". We live in a pluralistic society with diverse views on abortion. Why should the decision of a committee, which bears no long-term responsibility for the unborn child, prevail over an informed, conscientious, pregnant woman, especially when there is no sound legal basis for the committee's decision-making?

### Competing interests

None identified.

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