Report 13

October 2019

South Australian Law Reform Institute

Abortion: A Review of South Australian Law and Practice

The **South Australian Law Reform Institute** was established in December 2010 by agreement between the Attorney-General of South Australia, the University of Adelaide and the Law Society of South Australia Incorporated. It is based at the Adelaide University Law School.

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SALRI publications are available to download free of charge from the SALRI webpage under *Publications: Reports and Papers*.

Suggested citation:

John Williams, David Plater, Anita Brunacci, Sarah Kapadia and Melissa Oxlad, *Abortion: A Review of South Australian Law and Practice* (South Australian Law Reform Institute, Adelaide, 2019)

Table of Contents

Terms of Reference **1**
Glossary of Terms **3**
Preface **10**
Recommendations **24**

Part 1 – Introduction and Background
1.1 The South Australian Law Reform Institute 37
1.2 Background and Terms of Reference 38
1.3 Methodology and Consultation 40
1.4 Findings 51

Part 2 – Abortion: An Overview of Consultation
2.1 The Big Picture 53

Part 3 – The Law in South Australia
3.1 Historical Development of the Law in South Australia 79
3.2 Current Law in South Australia 82
3.3 The Law in Other Australian Jurisdictions 86
Table 1 – Regulatory approaches to abortion in Australian jurisdictions 88
3.4 Notes on the Law in Other Jurisdictions 93
3.5 Case Law: The Common Law Context 94
3.6 Safety of the Woman as Catalyst for Law Reform 98
3.7 Recent Attempts at Reform 106

Part 4 – Incidence of Termination
4.1 Overview 113
4.2 National Statistics 114
4.3 South Australian Statistics 116

Part 5 – Criminal Offences
5.1 Criminality Generally 118
5.2 Abortion and the Criminal Law 119
5.3 SALRI's Observations and Conclusions 133
5.4 The Role and Actions of the Woman 134
5.5 The Role and Actions of Medical Practitioners 139
5.6 SALRI's Observations and Conclusions 142

Part 6 – The Role and Rationale of a Residual Offence
6.1 Residual Offences Generally 145
6.2 Would there be a Gap to Rely on Health Law? 148
6.3 Offences if a Medical Practitioner Procures an Illegal Abortion 149
6.4 Offences if a Layperson Procures Mifepristone 152
6.5 Submissions 152
6.6 SALRI's Observations and Conclusions 157

Part 7 – Clinical Practice in South Australia

7.1 Regulation of Health Professionals 160
7.2 Guidelines for Practice 162
7.3 Who can Provide Abortion Medication and Services? 164
7.4 Extended Scope of Practice for Health Practitioners 166
7.5 Education and Training 167
7.6 Submissions 168
7.7 SALRI's Observations and Conclusions 174

Part 8 – Medical Abortions

8.1 Overview 176
8.2 Professional Standards and Clinical Guidelines 177
8.3 Certification Requirements 178
8.4 Risks and Complications 179
8.5 Medicare Item Number 185
8.6 SALRI's Observations and Conclusions 186

Part 9 – Facilities

9.1 The Current Position 188
9.2 Appropriate Facilities 190
9.3 Medical Abortion and the Prescribed Hospital Requirement 191
9.4 SALRI's Observations and Conclusions 192

Part 10 – Criteria for lawful terminations

10.1 The Current Position 193
10.2 Grounds for Termination 193
10.3 Submissions 201
10.4 SALRI's Observations and Conclusions 207

Part 11 – Late term abortion

11.1 Preliminary Consideration 211
11.2 Current Developments 211
11.3 Gestational Limits and Criteria for Late Term Abortions 217
11.4 Second Medical Practitioner (or Specialist) or Ethics Panel or Committee 222
11.5 Submissions 225
11.6 SALRI's Observations and Conclusions 238

Part 12 – Counselling

12.1 The Role and Purpose of Counselling 243
12.2 Who Can Provide Counselling Services? 245
12.3 Should Counselling be Optional or Mandated? 248
12.4 Submissions 250
12.5 Other Counselling-Related Issues 263
12.6 SALRI's Observations and Conclusions 278

Part 13 – Disability

13.1 Introduction 282
13.2 Current Law 283
13.3 Other Issues 285
13.4 The Notion of Disability 287

13.5 Prenatal Screening 291
13.6 Eugenics 296
13.7 Abortion on the Basis of Disability and International Human Rights Law 298
13.8 The Role of Counselling 302
13.9 The Role of Genetic Counselling 307
13.10 Submissions 309
13.11 Late Term Abortion and Gestational Limits in the Context of Disability 313
13.12 SALRI's Observations and Conclusions 318

Part 14 – Gender Selective Abortion

14.1 Submissions to SALRI and the NSW Legislative Council Committee 320
14.2 SALRI's Observations and Conclusions 330

Part 15 – Access and Availability

15.1 Metropolitan and Regional Access 332
15.2 Residency 338
15.3 Telehealth 340
15.4 Patient Assistance Transport Scheme (PATS) 343
15.5 Submissions 344
15.6 SALRI's Observations and Conclusions 348

Part 16 – Aboriginal Practice

16.1 Aboriginal Population in South Australia 351
16.2 Culturally Sensitive Access to Services 352
16.3 Aboriginal Health Generally 353
16.4 Expanding the Role and Use of Data 354
16.5 Submissions 355
16.6 SALRI's Observations and Conclusions 356

Part 17 – Conscientious Objection and Referral

17.1 Rights and Duties of Medical Practitioners 357
Table 2 – Summary of key conscientious objection and referral principles promoted in the policies of Australia's peak health bodies 360
17.2 Should a Conscientious Objector be Obliged to Provide a Referral? 366
17.3 What Constitutes an Effective Referral? 370
Table 3 – Spectrum of referral approaches in Australian Jurisdictions 370
17.4 Views of the VLRC and QLRC 374
17.5 Possible Misuse of Conscientious Objection 377
17.6 Submissions 380
Table 4 – Breakdown of submissions on conscientious objection 381
17.7 SALRI's Observations and Conclusions 390

Part 18 – Safe Access Zones

18.1 Current Law 398
18.2 Nature of the Behaviour Involved 398
18.3 Recent High Court Decisions and Constitutional Implications 400
18.4 Logistics Declaration or Defined in Law and Size and Operation 411
Table 5 – Summary of safe access zone legislation within Australia 413
18.5 Submissions 414
18.6 SALRI's Observations and Conclusions 429

Part 19 – Consent, capacity and coercion

19.1 Informed Consent 438
19.2 Capacity 443
19.3 Reproductive Coercion 446
19.4 Definition of 'Domestic Abuse' 453
19.5 SALRI's Observations and Conclusions 455

Part 20 – Data Collection and Use

20.1 Data Collection in South Australia 457
20.2 Expanding the Role and Use of Data 458
20.3 Submissions 459
20.4 SALRI's Observations and Conclusions 461

Part 21 – Incidental

21.1 Use of Gendered Terms 463
21.2 Child Concealment 465
21.3 Consequential Amendment to 'Harm and Serious Harm'? 467
21.4 SALRI's Observations and Conclusions 469

Part 22 – Abortion Law Reform Act 2019 (NSW)

22.1 Recent Developments 471
Table 6 – Summary of proposed amendments to the Reproductive Health Care Reform Bill 2019 (NSW) 479

Appendix A - Consultation Questions 490
Appendix B - YourSAy Online Engagement Report 493
Appendix C - Health Practitioner Regulation National Law (South Australia) Act 2010 (SA), s 116 496
Appendix D - *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) Schedule 3 497
Appendix E - Patient Assistance Transport Scheme – Application Form: Section 1 500
Appendix F - Patient Assistance Transport Scheme – Application Form: Section 2 501
Appendix G - Patient Assistance Transport Scheme – Application Form: Section 3 502
Appendix H - Patient Assistance Transport Scheme – Application Form: Section 4 503
Appendix I - Australian peak health bodies and associations: policy excerpts 504
Appendix J - Summary of the law regarding conscientious objection in Australian jurisdictions 509
Appendix K - State-based Australian health departments: excerpts of policies / guidelines 511
Appendix L - Key referral principles in policies of international health bodies 514
Appendix M - International health bodies and associations: policy excerpts 516
Appendix N - Certificate and Notice (in the prescribed form) 521
Appendix O - Bibliography 524

Terms of reference

On 28 February 2019, the South Australian Law Reform Institute (SALRI) was formally asked by the South Australian Attorney-General, the Hon Vickie Chapman MP, to inquire into and report in relation to the topic of abortion, with the aim of modernising the law in South Australia and adopting best practice reforms. SALRI was requested to undertake proper investigation and provide recommendations for reform based on best clinical practice in this area and taking guidance from other jurisdictions in considering the most suitable way to achieve proper reform of abortion laws in South Australia.

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Acknowledgements

This Report was written by Professor John Williams, Dr David Plater, Anita Brunacci, Sarah Kapadia and Dr Melissa Oxlad with valuable input from the students of the 2019 Law Reform course at the University of Adelaide, namely Joshua Aikens, Jesse Beckinsale, Lesley Jayasuriya, Kershlin Krishna, Ben Stocks, Tina Tran, and especially Olga Pandos, Jade Porter and Genevieve Williams.

Louise Scarman, Olivia Jay, Holly Nicholls and Joshua Aikens provided proofreading and editorial assistance.

SALRI acknowledges the valuable contribution to this Report of Associate Professor Bernadette Richards, Professor Ian Symonds and Stephen McDonald.

SALRI also acknowledges, and relies upon, the extensive previous research on this topic and, in particular, upon the work of and submissions to the Victorian Law Reform Commission (Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) and Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008)); the Queensland Law Reform Commission (Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017)) and Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018)). SALRI also acknowledges the recent work of the New Zealand Law Reform Commission (New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018)) and the Northern Territory Department of Health (Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016)). SALRI also notes the Health Care (Health Access Zones) Amendment Bill 2019 (SA). SALRI, in particular, notes the *Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 (NSW)) and the work of, and submissions to, the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019).

SALRI is grateful for the many insightful submissions received in relation to this reference.

SALRI would also like to acknowledge the support of the Attorney-General's Department in providing funding to undertake this reference.

Disclaimer

This Report deals with the law as it was on 2 October 2019 and may not necessarily represent the current law.

Any views expressed in this Report are those of the South Australian Law Reform Institute and no other agency.

Glossary of Terms

SALRI is aware that the use of some terminology in the context of abortion is contentious[1] and has, wherever possible, elected to use the terminology most commonly identified by medical practitioners in this area. SALRI accepts that some parties may disagree with some of the terms and definitions used throughout this Report.

SALRI uses the term 'woman' to refer to someone needing an abortion. SALRI intends no disrespect by this and has adopted the approach of the South Australian Abortion Action Coalition, which noted to SALRI:

> People needing abortions are referred to in this submission as women and the vast majority of abortions are provided to people who identify as women. SAAAC acknowledges that other people who do not identify as women can need access to abortion. Trans-men, gender queer and others of diverse gender identities who do not necessarily identify as women, can and do get pregnant and require abortion care.

SALRI has also avoided (as far as possible) problematic and value laden terms such as 'pro-life' or 'pro-choice' or 'pro-abortion' or 'anti-abortion'. Many descriptions abound to characterise the various positions held by groups and individuals involved in the abortion regulation debate. SALRI, drawing on the VLRC approach,[2] characterises groups and individuals according to their stance on decriminalisation, and refers to supporters or opponents of the decriminalisation of abortion.

The following key terms are used in this Report:[3]

1969 South Australian Act	*Criminal Law Consolidation Amendment Act 1969* (SA) (No 109 of 1969).
2016 Queensland Parliamentary Committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry Into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016).
2017 Queensland Parliamentary Committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017).

[1] See also Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 8–10 [2.14]–[2.18].

[2] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 5.

[3] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) i–ii; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 5. The terminology in this area is not simple. The South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists, for example, preferred the term 'termination of pregnancy (TOP)' as the preferred term over 'abortion', due to the latter being 'freighted with emotional and political associations that can contribute to clouding of reasoned debate.'

2018 South Australian Bill	Statutes Amendment (Abortion Law Reform) Bill 2018 (SA).
2019 NSW Act	*Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 (NSW)).
Aboriginal	A person identifying as Aboriginal, Torres Strait Islander or both.
Aboriginal health worker[4]	A person who provides primary health care for Aboriginal and Torres Strait Islander clients.
Abortion[5]	A deliberately induced miscarriage by medical or surgical means, does not include spontaneous miscarriage.
ACCHS	Aboriginal Community Controlled Health Service.
AHPRA	Australian Health Practitioner Regulation Agency.
AMA	Australian Medical Association.
AMA (SA)	Australian Medical Association (South Australia).
CEDAW	*Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 1 March 1980, 1249 UNTS 13 (entered into force 3 September 1981).
CLCA	*Criminal Law Consolidation Act (1935)* SA.
Clinical Geneticist	A physician who has undergone speciality training in genetics after professional general training in Adult Medicine or Paediatrics (and occasionally other disciplines such as psychiatry, obstetrics and gynaecology, ophthalmology).[6]
Clinical Genetics Service	A service which provides healthcare for individuals or family members who are affected by, or at risk of developing a genetic disorder, in order to ensure early and accurate clinical and laboratory diagnosis, risk estimation, genetic counselling, and appropriate management and surveillance recommendations.

[4] See further below Part 16, especially n 1628.

[5] There is debate as to whether 'termination' or 'abortion' is preferable. SALRI adopts the suggestion of Professor Ian Symonds, Dean of Medicine at the University of Adelaide, that 'abortion' is now the preferable term and is used by the RANZCOG. See Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Abortion' (RANZCOG Statements and Guidelines, March 2019) <https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Abortion-(C-Gyn-17)Review-March-2019.pdf?ext=.pdf>.

[6] See Eric Haan, 'The Clinical Geneticist and the "New Genetics"' (2003) 178(9) *The Medical Journal of Australia* 458.

Conscientious Objection	A refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner's personal beliefs, values or moral concerns. (It does not include a refusal to perform a procedure on medical grounds).[7]
Counselling	A focused, interactive process through which the woman voluntarily receives support, information and non-directive guidance from a trained person; counselling is more than just information provision.[8]
CRC	*United Nations Convention on the Rights of the Child,* opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).
CRPD	*Convention on the Rights of Persons with Disability,* opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008).
Emergency	Treatment which is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman.
Fetal abnormality	A genetic or other condition identified in a fetus which, in some cases, may make the fetus unviable and, in other cases, may indicate the fetus will be born with a genetic condition or disability.[9]
Fetus[10]	An unborn human more than eight weeks after conception.

[7] A conscientious objection is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination and occurs when a health practitioner, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards. Health practitioners are entitled to have their own personal beliefs and values as are all members of the community and it is acceptable for a health practitioner to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection. However, a refusal by a health practitioner to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the practitioner's skills or scope of practice, illegal or where the practitioner believes the patient has impaired decision-making capacity. See also Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019), <https://ama.com.au/position-statement/conscientious-objection-2019>.

[8] See World Health Organization, *Clinical Practice Handbook for Safe Abortion* (2014); World Health Organization, *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception* (2015).

[9] SALRI, drawing on the VLRC, uses the term 'fetal abnormality' because it is used by medical practitioners to describe a positive test or indication for certain genetic or other conditions. SALRI does not wish to imply that a fetus which is diagnosed with such conditions is in any way 'abnormal'. See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 5. This is a complex area: at 44–46 [3.86]–[3.95]. See below Part 13.

[10] The spelling **fetus** is the preferred spelling in the medical world, regardless of location, and as such has been adopted by SALRI. SALRI acknowledges that the spelling **foetus** is still often used by lay-people. However, the spelling fetus is the etymologically correct one as it derives from the Latin term 'fetus' meaning 'offspring'. See Daniel J Bell et al, 'Fetus vs Foetus' (Web Page) <https://radiopaedia.org/articles/fetus-vs-foetus>. SALRI has followed the approach of the VLRC. 'We use the spelling of fetus without the o, despite this being common usage in Australia. This is not a preference for the American spelling, but rather recognition of the word's derivation from the Latin word fetus and its widespread use in medical literature. While there are several descriptions used in medical literature to refer to the fetus, depending on the different stages of pregnancy, we use the term fetus exclusive of all other term': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 5.

Genetic Counselling	A communication process, which aims to help individuals, couples and families understand and adapt to the medical, psychological, familial and reproductive implications of the genetic contribution to specific health conditions.[11]
Genetic Counsellor	An allied health professional who has completed specialised training through a clinical Master of Genetic Counselling.[12]
Gestation	The period of fetal development inside the womb between conception and birth.
Gestational limit	A restriction on when certain procedures, including an abortion can be carried out, imposed by either legislation or clinical practice.
Health practitioner	A person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) to practice in the health profession. Includes medical practitioners, nurses and midwives, pharmacists, psychologists, Aboriginal and Torres Strait Islander health practitioners and Chinese medicine practitioners.
ICCPR	*International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
ICESCR	*International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).
Late term abortion	Abortion which occurs after 22 or 24 weeks' gestation.
MBA	Medical Board of Australia.
MBS	Medicare Benefits Schedule.[13]
Medical abortion	The use of pharmaceutical drugs to induce an abortion. Most commonly mifepristone (also known as RU486) and misoprostol (referred to in combination as MS-2 Step).
Medical Practitioner	A person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) to practice in the medical profession (ie: a physician or surgeon). Medical Practitioners are also classified as Health Practitioners.

[11] Human Genetics Society of Australasia, *Definition of Genetic Counselling* (Web Page) <https://www.hgsa.org.au/asgc/definition-of-genetic-counselling>.

[12] Human Genetics Society of Australasia, *Genetic Counsellor Training Certification and Regulation in Australia and New Zealand* (Web Page) <https://www.hgsa.org.au/resources/genetic-counselling>.

[13] Department of Health, 'What is the MBS and Medicare? *Medical Services Advisory Committee* (Web Page, 20 July 2016) <http://www.msac.gov.au/internet/msac/publishing.nsf/Content/Factsheet-03>.

Midwife	Person registered under the Health Practitioner Regulation National Law to practice in the midwifery profession, other than as a student. A midwife is a type of 'health practitioner'.
Miscarriage	The spontaneous or unplanned expulsion of the fetus before it is able to survive independently (also referred to as spontaneous abortion/spontaneous termination).
Morning After Pill	A contraceptive pill that is effective up to approximately 72 hours after intercourse.
MS-2 Step	The use of mifepristone (also known as RU486) and misoprostol to cause a medical abortion.
Neonatal	A period of one month after birth.
NSW Legislative Council Committee	Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019).
Nurse	A person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) to practice in the nursing profession, other than as a student. A nurse is a type of 'health practitioner'.
Parliamentary Committee	Except where otherwise specified, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, which considered the: • Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (Qld) and aspects of the laws governing termination of pregnancy in Queensland (the 'first Bill' and 'Inquiry'); and • Health (Abortion Law Reform) Amendment Bill 2016 (Qld) (the 'second Bill').
PBS	Pharmaceutical Benefits Scheme.[14]
Perinatal	The period between 20 weeks gestation and 28 days after birth.
Pharmacist	Person registered under the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) to practice in the pharmacy profession, other than as a student. A pharmacist is a type of 'health practitioner'.
QLRC	Queensland Law Reform Commission.

[14] Department of Health, 'About the PBS', *Pharmaceutical Benefits Scheme* (Web Page, 1 July 2019) <http://www.pbs.gov.au/info/about-the-pbs#What_is_the_PBS>.

QLRC Consultation Paper	Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017).
QLRC Report	Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0004/576166/qlrc-report-76-2018-final.pdf>.
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
Referral	The duty of a health practitioner to transfer the care of a patient who is seeking care which the health practitioner is unable or unwilling to provide, so that the patient is then able to access the care that they seek, without judgement or moral objection, and without having the patient's access to such care impeded, by the health practitioner.[15]
Reproductive coercion	A behaviour that interferes with the autonomous decision-making of a woman, with regard to reproductive health.[16]
Safe Access Zone	A defined area around a premises that provides abortion services in which certain types of conduct are prohibited.
SALRI	South Australian Law Reform Institute.
Stillbirth	The birth of a fetus without any signs of life which may have otherwise been expected to be able to survive independently (ie after 28 weeks gestation).

[15] SALRI adopts the explanation of Dr Roach of RANZCOG to the NSW Legislative Council Committee as to the role and scope of referral. 'The first place I would start is that there is an extraordinary irony in all of this which is that people who are talking about their own conscientious objection or their own conscience are actually making judgements on the conscience of others, particularly the women who are choosing to have an abortion or not. I do not think they recognise that or are aware of that. They sit back on their own morality while judging the morality of others. The statement that we made and we stand by is that we respect the conscience of our members, we respect the conscience of each person in society and that they should be aware of their own and they should live by that. However, we chose to be doctors, we were not made to be doctors. We chose to be doctors. In choosing to be doctors we have a duty of care to the patient and if the patient seeks our care and we are unable to deliver that care, and there are other reasons why we cannot deliver it, we might not have experience in that area, we might not have a skill in that area. **If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well**': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, Uncorrected Transcript, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

[16] Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371. 'Reproductive coercion is defined as behaviour that interferes with the autonomous decision-making of a woman, with regard to reproductive health… Specifically, this may take the form of birth control sabotage (such as removing a condom, damaging a condom, removing a contraceptive patch, or throwing away oral contraceptives), coercion or pressure to get pregnant, or controlling the outcome of a pregnancy (such as pressure to continue a pregnancy or pressure to terminate a pregnancy': at 371. Another definition is: 'Reproductive coercion is any interference with a person's reproductive autonomy that seeks to control if and when they become pregnant, and whether the pregnancy is maintained or terminated. It includes sabotage of contraceptive methods and intervention in a woman's access to health care': Elizabeth Price et al, 'Experiences of Reproductive Coercion in Queensland Women' (2019) *Journal of Interpersonal Violence* (advance), 1. See also below [19.3.1]–[19.3.34].

Surgical Abortion	A procedure where the contents of a women's uterus are surgically removed to terminate a pregnancy.
Termination of pregnancy / TOP (also referred to as Termination)	Deliberately induced miscarriage by medical or surgical means. See also Abortion.
Terms of Reference	The letter of referral from the Attorney General to SALRI dated 28 February 2019.
UDHR	*Universal Declaration of Human Rights,* GA Res 217A (III), UNGAOR, UN Doc A/810 (10 December 1948).
Viability	The time at which a fetus, if born, is said to be capable of existing independently. This is commonly taken to be between 22 weeks (Queensland) and 24 weeks (Victoria).
VLRC	Victorian Law Reform Commission.
VLRC Report	Victorian Law Reform Commission *Law of Abortion* (Report No 15, March 2008) <http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Abortion_Report.pdf>
WHO	World Health Organisation.
Woman	This includes a person with internal female reproductive organs.[17]

[17] This definition is used for the purpose of this report only and is not intended to be a definition of the term 'woman' generally. See also below [21.1.1]–[21.1.13].

Preface

Background

Abortion raises significant legal, health, ethical, policy and practical questions. Often these questions are answered by recourse to deep personal beliefs. It is, therefore, unsurprising that abortion and its regulation in South Australian law has elicited a wide range of responses and submissions to this review. While on some matters there has been a large degree of consensus, on other issues the views and positions of respondents are diametrically opposed to each other.

The South Australian Law Reform Institute (SALRI) acknowledges the sincerity and conviction of the various differing views expressed to it and that there is no simple, universal or straight-forward position. In making its recommendations SALRI has carefully considered the Terms of Reference that frame this review, the origins and operations of the current South Australian law, interstate law, the reviews undertaken in comparable jurisdictions, available research, its many consultation responses and submissions as well as contemporary medical practice and procedures.

SALRI has framed its recommendations on the foundational premise that women have autonomy and, in the context of this review, should be free to make their own informed decision as to whether or not they seek an abortion.

Consistent with its Terms of Reference, SALRI has concluded that, as far as possible, certain wider and often profound issues urged upon SALRI by various parties to consider as part of its review are simply beyond SALRI's remit. As noted by the Catholic Archdioceses of Adelaide and Port Pirie to SALRI in their submission:

> SALRI's terms of reference clearly state that their brief is not about preventing or precluding abortion. Complex moral questions (ie such as when human life begins) fall outside of its terms of reference. SALRI acknowledges that abortion is 'a sensitive topic that gives rise to sincere, strong and often competing views'. Because it is an issue that 'raises various sensitive, legal, medical and ethical implications', SALRI considers abortion to be a matter of 'personal ethics upon which individual minds are free to differ'. The Church recognises that SALRI is not determining whether abortion should or should not occur but is testing what regulations, legislation and appropriate medical controls could or should be in place around the provision of abortion procedures.

On 5 December 2018, the Statutes Amendment (Abortion Law Reform) Bill 2018 (SA) was introduced by the Hon Tammy Franks MLC in the South Australian Legislative Council as a Private Members Bill.[18] Ms Franks explained that 'this Bill provides that abortion should be removed from our criminal laws and regulated like any other health service'.[19]
Ms Franks explained the rationale of her Bill as follows:

> … because our current abortion law, which was written in 1969 and was once progressive and leading the nation, is no longer fit for purpose. It acts as a barrier to the provision of best health care, a barrier to that care for women living in rural and remote areas, who are particularly disadvantaged, a barrier to women who are new to living in this state and have not been resident for the required two months, and a barrier to the medical profession, who deal with matters of

[18] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2420–2428.

[19] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2421. See further South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2779–2782.

> health care every day, none of which, except for abortion, are placed within the criminal code, as this issue is.[20]

These, and other matters, have been recurring themes in the discussion of reform to the law in South Australia for many years and changes to legislative arrangements interstate, especially in Victoria,[21] Queensland[22] and the Northern Territory[23], have been debated and introduced. Bills were introduced in New South Wales to decriminalise abortion on 1 August 2019[24] and in New Zealand on 8 August 2019,[25] to reclassify abortion as a health issue rather than as a crime. There have also been recent developments in Western Australia.[26] Moreover, there have been considerable ongoing discussions within the community in relation to abortion.[27]

Referral from Attorney-General

On 26 February 2019, the South Australian Attorney-General, the Hon Vickie Chapman MP, announced that she had asked SALRI 'to consider changes to the State's abortion laws with a view to improve access and modernise the practice in the State and with a view to making abortion a regulated medical procedure under health legislation as opposed to a criminal law issue'.[28] The Attorney-General acknowledged Ms Franks' advocacy on this issue but noted her view that the Private Members Bill was 'too broad and failed to adequately regulate [the relevant] medical

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[20] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2420. See also South Australia, *Parliamentary Debates*, Legislative Council, 30 May 2018, 281–282; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2776–2791.

[21] *Abortion Law Reform Act 2008* (Vic).

[22] *Termination of Pregnancy Act 2018* (Qld). See also Ben Smee, 'Queensland Parliament Votes to Legalise Abortion', *The Guardian* (online), 17 October 2018 <https://www.theguardian.com/australia-news/2018/oct/17/queensland-parliament-votes-to-legalise-abortion>.

[23] *Termination of Pregnancy Law Reform Act 2017* (NT). See also Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016).

[24] *Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 (NSW)). See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6; New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 1–7; Alexandra Smith, 'Abortion Bill Introduced as Hundreds Protest Outside NSW Parliament', *Sydney Morning Herald* (online, 1 August 2019) <https://www.smh.com.au/politics/nsw/abortion-bill-introduced-as-hundreds-protest-outside-nsw-parliament-20190801-p52cv4.html>. The NSW Bill is now in force as the *Abortion Law Reform Act 2019* (NSW).

[25] Abortion Legislation Bill 2019 (NZ). See also Eleanor Roy, '"Time for Change": New Zealand unveils Bill to Legalise Abortion', *The Guardian* (online) 5 August 2019, <https://www.theguardian.com/world/2019/aug/05/new-zealand-unveils-bill-to-legalise-abortion>. The New Zealand Law Commission had suggested a similar approach as in Victoria and Queensland. See New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018).

[26] Government of Western Australia: Department of Health, *Safe Access Zones: Proposals for Reform in Western Australia* (Discussion Paper, April 2019).

[27] See, for example, Rebecca Puddy, 'Adelaide's Catholic Archdiocese wants to stop "Radical" Changes to Abortion Laws', *ABC News* (online, 15 February 2019), <https://www.abc.net.au/news/2019-02-15/catholic-church-to-send-letter-on-abortion-law-reform/10816294>; AAP, 'SA Abortion Law Reform under Fire', *news.com,.au* (online, 27 February 2019), <https://www.news.com.au/national/breaking-news/sa-abortion-law-reform-under-fire/news-story/3810830a3aa4534c0be02a41351975b7>; Judith Ireland, 'Labor Pledges to Tie Hospital Funding to Abortion Services', *Sydney Morning Herald* (online), 6 March 2019, <https://www.smh.com.au/politics/federal/labor-pledges-to-tie-hospital-funding-to-abortion-services-20190305-p511uk.html>; Amy Greenbank, 'Labor Promises Free Abortions, Pushes to Decriminalise Procedure in Federal Election Pitch', *ABC News* (online), 6 March 2019, <https://www.abc.net.au/news/2019-03-06/labor-promises-free-abortions-if-it-wins-government-at-election/10873612>.

[28] Vickie Chapman, 'Law Reform Institute to Consider Abortion Law Reform' (Press Release, 16 February 2019) <https://www.agd.sa.gov.au/newsroom/law-reform-institute-consider-abortion-law-reform>.

procedures'. The Attorney-General further noted that wide consultation was appropriate and that in her view a referral to SALRI was the most appropriate way 'to determine how South Australian laws could best be updated and brought in line with those in other jurisdictions, particularly considering regional access and investigating the current outdated criminal law'.[29]

On 28 February 2019, the Attorney-General formally wrote to SALRI in respect of its Terms of Reference.

The Attorney-General noted that over 40 years have now passed since the present abortion laws were first enacted in South Australia. Since that time, there have been significant changes to clinical practice including medical termination methods and modern health service provision. The Attorney-General raised that, as a result of these developments, there is now a concern that South Australia's abortion laws no longer reflect best modern clinical practice and may act as a barrier to equality of access to health services. The Attorney-General observed that it is appropriate that the relevant law is modernised to bring it in line with current clinical practice and to improve the efficiency of health service provision and access, particularly for women in regional, rural and remote areas. In particular, SALRI was asked to investigate and make recommendations for reform based on best clinical practice in this area and, with guidance from other jurisdictions, consider the most suitable way to achieve proper reform of abortion laws in South Australia.[30]

The SALRI review is governed by its Terms of Reference from the Attorney-General as set out below. For clarity, it should be noted that the prevention, or preclusion, of abortion services in South Australia is outside the scope of the Terms of Reference.

Further, SALRI is not considering the complex moral question of when life begins, as it does not fall within the scope of its Terms of Reference.[31] SALRI acknowledges the current fundamental legal premise that 'legal personhood' does not acquire until birth (although this premise is questioned).[32] 'The common law principle that a fetus is not a person, with legal rights, until born', as the VLRC noted, 'is a fundamental part of our legal system'.[33] 'The common law has always taken the view that legal personhood — possession of the legal rights and protections held by all people — does not arise until a fetus becomes a person by being "born alive".' [34] A number of submissions to SALRI, citing various grounds, would not agree with the legal position. However, it is beyond the scope of this review for SALRI to revisit or question this fundamental premise of both civil and criminal law.[35]

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[29] Ibid.

[30] Letter from the Attorney-General to SALRI, 28 February 2019.

[31] The question of the precise status of a fetus and if it is a 'person' and any legal rights or recognition raises complex moral, philosophical, theological, medical and legal questions and is beyond the scope of this review. See further Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 149–157 [B.15]–[B.86]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 269–274.

[32] See, for example, Kristen Savell, 'Is the "Born Alive" Rule Outdated and Indefensible?' (2006) 28(4) *Sydney Law Review* 625. The rule is especially questioned in light of medical advances that mean fetal viability is now 24, or 22 or even 20 weeks. See further below Part 11.

[33] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 97 [7.13].

[34] Ibid 158 [C.5]. See also *R v Hutty* [1953] VLR 338, 339; *Attorney General (Qld) ex rel Kerr v T* (1983) 46 ALR 275, 277; *R v Iby* (2005) 63 NSWLR 278.

[35] See also *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70 (9 December 2010), [139] (Peek J).

The Attorney-General's Terms of Reference to SALRI were as follows:

Referral

I therefore seek the Institute's consideration of a referral in relation to the topic of abortion, with the aim of modernising the law in South Australia and adopting best practice reforms.

Scope

The Institute is asked to inquire into and report on recommendations on:

1. The effectiveness of current law, practices and services in South Australia relating to the medical termination of pregnancy, in particular the availability and safety of services, based on advice and information from SA Health; and

2. How the current legal position may be amended to:

    i. remove offences relating to the medical termination of pregnancy pursuant to Division 17 of the CLCA;

    ii. make recommendations for legislative reform based on best clinical practice for the lawful regulation of medical termination of pregnancy;

    iii. ensure reasonable availability and access to safe medical termination of pregnancy services.

3. Any other relevant matters.

In providing advice and recommendations for legislative reform, SALRI is asked to have regard to the following:

- the termination of pregnancy should be treated as a health care issue rather than as a criminal matter;
- existing practices and services in South Australia concerning termination of pregnancy including those provided by medical practitioners, counsellors and support services;
- existing legal principles relating to termination practices in South Australia;
- the South Australian Government's commitment to modernise and ensure safe and reasonable access to termination services for all women; [36]
- the law should be consistent with contemporary clinical practice and health regulation, including reasonable and safe access to termination services; and
- the law should achieve reasonable consistency with other Australian jurisdictions and international jurisdictions that have modernised their laws relating to termination.

[36] This is a major consideration for SALRI, especially in relation to regional, rural and remote access. Proper access for regional, rural and remote communities is important so as not to disadvantage women living in those communities. See further below Part 15.

SALRI is aware that abortion is a complex issue that has a variety of legal, medical and ethical implications.[37] As academics, Kate Galloway and Jemima McGrath, have noted: 'Abortion is a touchstone for social, ethical, and religious norms.'[38] Conversations regarding abortion often give rise to sincere, deeply felt and often conflicting views and it is impossible to reconcile the competing views that are held in this area.[39] SALRI notes that, on occasion and throughout Australia, the debate about abortion has been marked by intemperate, even extreme, language.[40] However SALRI commends the interested parties and overwhelming majority of community members who provided their input to SALRI as part of this reference for doing so in a constructive and considered manner.

SALRI has had the opportunity to undertake extensive independent and multidisciplinary research and consultation with interested parties and the community in relation to this reference and has received over 3000 online responses and submissions.[41] SALRI expresses its appreciation to all who contributed to this important reference and particularly acknowledges and thanks the many individuals who shared deeply personal and often explicit accounts of their own experiences. The responses, submissions and accounts that SALRI received have been carefully taken into account in the drafting of this Report and its recommendations.

SALRI acknowledges and relies upon the extensive previous research on this topic and, in particular, upon the work of and submissions to the Victorian Law Reform Commission (Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) and Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008)) and the Queensland Law Reform Commission ((Queensland Law Reform Commission, *Review of Termination of Pregnancy*

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[37] 'No issue in bioethics has attracted more public attention, passionate opinion, and ink than abortion': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 148 [B.8].

[38] Kate Galloway and Jemima McGrath, 'Reproductive Justice: a Framework for Abortion Law Reform' (2018) 43(4) *Alternative Law Journal* 295, 296.

[39] 'Some people have strong ethical views about abortion. Those views range from absolute opposition to abortion in all circumstances to respect for women's autonomy, and various points in between': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 148 [B.1]. The VLRC noted that some parties supported decriminalisation. 'They characterised abortion as a matter between a woman and her doctor, with autonomy as the fundamental principle that the law should respect. The Paediatric State Committee, Royal Australasian College of Physicians, stated '[a]ny departure from this principle risks compromise to the health and rights of the woman concerned'. Autonomy was also strongly argued by community groups, health organisations and disability organisations, which 'saw no place for the criminal law in regulating what they considered was a woman's personal decision': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 72 [5.9]–[5.10]. However, the VLRC noted that others 'took an alternative view, stressing a moral opposition to abortion and a belief that abortion should remain a crime. This view was also expressed by various Catholic organisations. Many submitters argued that abortion is potentially harmful to women and that autonomy is a hollow promise': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 72 [5.11].

[40] See, for example, the emotive criticism directed at the Hon Tammy Franks. See South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2427–2428; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2777–2779.

[41] These consisted of 2885 YourSAy online survey responses and about 340 further submissions ranging from a single sentence to hundreds of pages. SALRI also conducted five roundtable discussions with interested parties and organisations in Adelaide, and further meetings were conducted in Whyalla, Port Augusta, Ceduna and Port Lincoln, as well as individual and small group meetings with metropolitan, rural and interstate medical and health practitioners and experts in this area.

Laws (Consultation Paper, WP No 76, December 2017) and Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018)). SALRI also acknowledges the work of the New Zealand Law Reform Commission (New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law (*Ministerial Briefing Paper, October 2018)) and the Northern Territory Department of Health (Department of Health (NT), *Termination of Pregnancy Law Reform: Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016)). SALRI has also had regard to the Health Care (Health Access Zones) Amendment Bill 2019 (SA) introduced to the South Australian Parliament on 26 September 2019.[42] SALRI has also had regard to the Abortion Legislation Bill 2019 (NZ). SALRI has had particular regard to the *Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 (NSW))[43] and the August 2019 Report of (and submissions to) the NSW Legislative Council Standing Committee on Social Issues.[44]

The present law

The present law relating to abortion in South Australia dates to 1969 and is based on the UK *Abortion Act 1967*. The present law in South Australia provides that an abortion is lawful and a person is not guilty of performing an unlawful abortion if the pregnancy of a woman[45] is terminated by a qualified medical practitioner in a case where they and one other medical practitioner are of the opinion, formed in good faith after both have personally examined the woman, that:

1. The continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or

2. That there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, 'the child would suffer from such physical or mental abnormalities as to be seriously handicapped'.

In determining whether the continuance of a pregnancy would involve the risk of injury to the physical or mental health of a pregnant woman, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.[46]

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[42] See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478 (Hon Tammy Franks MLC); South Australia, *Parliamentary Debates*, House of Assembly, 26 September 2019, 7501–7504 (Ms Cook).

[43] See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6; New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 1–7.

[44] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019). Given SALRI's extensive consultation prior to the introduction of the NSW Bill on 1 August 2019, it was impracticable to embark on a fresh round of consultation on issues raised by the 2019 NSW Act. Rather SALRI has paid careful regard to the submissions and comments from interested parties in relation to the 2019 NSW Act and has also had regard to the NSW parliamentary debate.

[45] SALRI uses the term 'woman' to refer to someone needing an abortion. SALRI intends no disrespect by this and has adopted the approach of the South Australian Abortion Action Coalition (SAAC) which noted to SALRI: 'People needing abortions are referred to in this submission as women and the vast majority of abortions are provided to people who identify as women. SAAAC acknowledges that other people who do not identify as women can need access to abortion. Trans-men, gender queer and others of diverse gender identities who do not necessarily identify as women, can and do get pregnant and require abortion care.' See above vii.

[46] *CLCA* s 82A(3). This provision draws on the common law in this area which recognises broadly similar defences. See *R v Bourne* [1939] 1 KB 687. See also *R v Davidson* [1969] VR 667; *R v Wald* (1971) 3 DCR (NSW) 25; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

The 1969 South Australian Act, whilst well-intentioned (if not radical)[47] at the time, has failed to keep up with various changes in clinical practice, medical knowledge and community attitudes. One example is that the 1969 Act predates the now widespread use of early medical abortion[48] and the present law contemplates abortions would only be performed on a surgical basis which is no longer the case. Another example is that the 1969 Act reflects the then prevailing model that the doctor should be the gatekeeper to medical treatment whilst modern law and practice now emphasises the need to respect patient autonomy and patient centred care.[49] The approach of the 1969 Act to disability is also at odds with modern attitudes and practices.[50]

SALRI is of the view that the present law relating to abortion in South Australia is outdated in various respects and no longer reflects contemporary clinical practice or medical advances, and undermines the autonomy of women. Further, its current operation has an adverse effect on both patients and health staff and acts as a barrier to equitable and effective access by women in rural, regional, remote and Aboriginal[51] communities. The present law needs to be updated to align more closely with contemporary clinical practice and professional protocols.[52] Aspects of the present law which are particularly problematic, such as the requirement for any abortion (whether medical or surgical) to take place at a 'prescribed hospital', the need for two medical practitioners to 'personally' examine a patient and agree an abortion is appropriate, the two month residency requirement and the criteria for when an abortion can be carried out (especially on the grounds of disability or 'fetal abnormality') should be removed. Controversial issues to be considered also include the difficult question of late term abortions and the general upper limit of 28 weeks, the role and operation of conscientious objection (including the absence of any formal requirement for referral) and the absence in South Australia of safe access zones to protect both patients and staff from intimidation, harassment and obstruction at premises providing abortions[53] (including the concern of unregulated groups or individuals).[54]

SALRI concurs with the approach of the Northern Territory in that:

> … a comprehensive, contemporary approach requires robust legislation for gestations across all phases of pregnancy. Contemporary legislation requires: evidence based practice by health professionals who make decisions about when, how and where to implement treatment according to an assessment of the health and wellbeing of the woman within a framework of professional

[47] South Australia was the first State where Parliament liberalised, or at least clarified, the law of abortion whilst other jurisdictions such as Victoria and New South Wales left it to the courts to liberalise the law.

[48] See below Part 8.

[49] Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283, 294–296. 'Today, the importance of respecting patient autonomy pervades the professional guidance available to doctors… doctors… have a duty to work in partnership with patients': at 295.

[50] See further Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207.

[51] SALRI, reflecting a strong theme in its consultation, aims to ensure that Aboriginal communities are not disadvantaged. As the South Australian Abortion Action Coalition rightly noted regarding the effects of present law and practice: 'Aboriginal women are disproportionately resident in rural and remote locations and so disproportionately affected.' See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 28–29 [2.72], 56 [3.30], 73 [3.91]. See further below Part 16.

[52] See below Part 7.

[53] See further Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317. See further below Part 18.

[54] See below n 82.

practice guidelines; an approach to consent for termination of pregnancy that is in line with consent for other medical procedures; provisions for both conscientious objection and referral to another practitioner who can provide appropriate services; and provisions for safe access zones in the vicinity of treatment facilities.[55]

Recommendations

Based on the results of its extensive consultation[56] and research, and reflecting its Terms of Reference and underlying principles,[57] SALRI has made a number of recommendations for reform to law and practice including:

1. Abortion should be treated as a health issue rather than as a criminal law matter and women's autonomy and best health care should be respected and promoted.
2. Issues surrounding abortion should be largely (though not totally)[58] removed from the criminal law, especially the *Criminal Law Consolidation Act 1935* (SA) (*CLCA*) and placed in health law and practice.[59]
3. Sections 81, 82 and 82A of the *CLCA* should be repealed and replaced with the appropriate provisions as recommended in either a standalone Act or the most suitable Act.
4. There should be a statutory review of any new law relating to abortion five years after its commencement, given the ongoing medical, clinical and other developments in this area.
5. The woman involved (whether as a principal or assisting) in an abortion or attempted abortion should be exempted from criminal liability in relation to that procedure.

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[55] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016) 2.

[56] SALRI's consultation included 2885 YourSAy online survey responses and about 340 further submissions, ranging from a single sentence to hundreds of pages. It is material, though not necessarily conclusive, that SALRI's consultation found strong (though not universal) support for reform of the present law regarding abortion. The overwhelming theme of the YourSAy online survey responses favoured the relaxation of the present law (though there were differences in how far any reforms should go). Of the other submissions received by SALRI, about 225 supported reform (though again there were differences in how far any reforms should go) and about 100 opposed reform (of which many called for a total or near total ban on abortion).

[57] The QLRC, for example, was 'guided by a number of key principles', including the following:

'Generally, termination should be treated as a health issue rather than as a criminal matter;

Women's autonomy and health (including access to safe medical procedures) should be promoted, recognising that: at the earlier stages of pregnancy, a woman's autonomy has greatest weight, and termination is lower risk and safe for the woman; at the later stages of pregnancy, the interests of the fetus have increasing weight, and termination involves higher risk for the woman and creates more complex issues;

The law should align with international human rights obligations relevant to termination of pregnancy laws, including enabling reasonable and safe access to termination services;

The law should be consistent with contemporary clinical practice and health regulation; and

The law should achieve reasonable consistency with other Australian jurisdictions that have modernised their laws relating to termination': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) v, 5–6.

[58] SALRI supports the retention, as exists in all other Australian jurisdictions, of a residual offence to cover procedures (both surgical and medical) involving unqualified persons, though exempting both the woman concerned and health practitioners. See below Part 6. SALRI also supports the introduction of safe access zones (and associated offences) around locations where abortions are provided. See further below Part 18.

[59] It is important to note that, even the total removal of all issues surrounding abortion from the criminal law, would not leave this area unregulated as it will still be subject to a comprehensive framework of health law and practice, and professional protocols and guidelines.

6. The medical or other health practitioners involved (whether as a principal or assisting) in an abortion or attempted abortion should be exempt from criminal liability in relation to the procedure. Any breach of their clinical or professional roles should be treated as a professional or disciplinary issue.
7. In light of the apparent inadequacy of the law in this area and the need to ensure the safety of women,[60] SALRI recommends that a new offence should be added to either a new standalone Act or the most suitable Act to cover the residual situation and provide that an unqualified person who performs an abortion, or who assists in the performance of an abortion, commits an offence.
8. Appropriate health practitioners, beyond medical practitioners, should have the ability to take part in abortion procedures, subject to national health law and practice, and evolving changes in clinical practice and service delivery. This has particular benefits for access for regional, rural, remote and Aboriginal communities and is a means of 'futureproofing' this area.[61]
9. The ACT approach[62] is to be preferred, namely where an abortion is lawful at all gestational stages with the woman's consent, and if performed by an appropriate health practitioner. This approach respects a woman's autonomy, placing decision-making responsibility with the woman and service availability with the medical (or health) profession.[63]
10. In the alternative to the ACT approach, to provide that up to 24 weeks gestation an abortion may be undertaken with the woman's consent, and if performed by an appropriate health practitioner. However, after 24 weeks gestation for an abortion to be performed it requires the first medical practitioner to consult with at least one other medical practitioner[64] (whilst still recognising the autonomy of the woman) and for both practitioners to agree that it an abortion is medically appropriate.[65] The additional presence and approval of two medical practitioners after 24 weeks reflects current clinical practice[66] and also 'recognises that

[60] SALRI notes that there are existing health laws (such as holding out to be health practitioner), including criminal laws (such as assault or causing harm or serious harm), to deal with unqualified persons and the effects of their actions. However, these either may not apply and/or are arguably inadequate. See further below Part 6.

[61] The current law provides for abortion to be dealt with solely by a medical practitioner. However, SALRI wishes to ensure that the law can evolve with clinical practice and procedure without the need for further legislative reform. In this way, the reference to 'health practitioners' throughout SALRI's Recommendations acknowledges the evolving clinical landscape (which includes potential changes to the nature of the health work force). This particularly relates to prescribing rights, which may impact who can perform and assist in an abortion in the future, including the provision of MS-2 Step.

[62] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT). This is also the model proposed in the Statutes Amendment (Abortion Law Reform) Bill 2018 (SA).

[63] It should be noted that this approach does not leave the subject of abortion unregulated as a comprehensive framework of health law and practice and professional guidelines and protocols still apply.

[64] This would not preclude consultation if considered helpful with other health practitioners or others such as social workers, but this would be an issue for operational and clinical practice.

[65] This is an adaption of the law in Queensland and Victoria, and in the 2019 NSW Act, but with no specific legislated criteria for when an abortion can be carried out.

[66] RANZCOG, for example, recognises the complexities associated with late term abortions and supports a process by which late term abortions can be lawfully performed. RANZCOG further submits 'that involvement of at least two doctors is reasonable… This may include, but not be limited to, feto-maternal medicine specialists, neonatologists, geneticists, social workers and mental health specialists'. See Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Submission No 39 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019)

terminations at this later stage often involve disadvantage, distress, complexities and higher risks to the pregnant woman'.[67]

11. Any criteria governing the circumstances when a woman can access abortion, such as, for the protection of her life or physical or mental health (or indeed any other grounds) are likely to operate to undermine the woman's autonomy and are restrictive, arbitrary and ultimately unworkable and should not be included in any new law.[68]
12. The specific ground under the present law of allowing an abortion on the grounds of disability or 'fetal abnormality' is inappropriate and potentially discriminatory and should not appear in any new law.[69]
13. The approach in Victoria and Queensland, and in the *Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 (NSW))(hereafter '2019 NSW Act'), that abortion is permissible if a medical practitioner considers that the abortion 'should, in all the circumstances be performed' received very little support in SALRI's consultation and was viewed as problematic.[70]
14. The issue[71] of gender selective abortion has been raised with SALRI. However, there is little indication this is an issue in South Australia and any legislative prohibition on gender selective abortion is unnecessary, as well as likely to be unenforceable.[72]
15. A requirement for an abortion (whether early or late term) to be approved by a specialist medical practitioner or a panel or committee is inappropriate and undermines patient autonomy. It also creates an increased barrier to access for regional, rural, remote and Aboriginal communities.

<https://www.parliament.nsw.gov.au/lcdocs/submissions/64875/0039%20The%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Obstetricians%20and%20Gynaecologists.pdf>.

[67] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

[68] See further below Part 10.

[69] This is a complex and sensitive area. See Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207. Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 44–46 [3.86]–[3.95]; Carole Petersen, 'Reproductive Justice, Public Policy, and Abortion on the Basis of Fetal Impairment: Lessons from International Human Rights Law and the Potential Impact of the Convention on the Rights of Persons with Disabilities' (2015) 28(1) *Journal of Law and Health* 121. See further below Part 13.

[70] This approach received very little support in SALRI's consultation for either early or late term abortions (though some parties in favour of the decriminalisation reluctantly accepted it as a fallback position if their preferred approach was not accepted). Medical practitioners in regional, rural and remote locations particularly raised that this version made them feel like the decision maker for the procedure; a role they were neither equipped nor keen to undertake. It is also questionable what this approach actually achieves in practice. The terminology was described to SALRI as so vague and subjective as to be almost meaningless. See below [10.4.10]–[10.4.11], [11.6.9].

[71] See further Aisha Dow, 'The "Missing Girls" never born in Victoria', *The Age* (online, 12 August 2018) <https://www.theage.com.au/national/victoria/the-missing-girls-never-born-in-victoria-20180811-p4zwxe.html>.

[72] This emerges from both SALRI's consultation and the input of the AMA and others to the 2019 NSW Act. See, for example, Michael McGowan, 'NSW Abortion Law Backers unlikely to support calls for Sex Selection Ban', *The Guardian* (online, 15 August 2019) <https://www.theguardian.com/world/2019/aug/15/nsw-abortion-law-backers-unlikely-to-support-calls-for-sex-selection-ban>; Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>; Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 8–10 [2.14]–[2.18]. 47–49 [3.106]–[3.113]. See further below Part 14.

16. The present rebuttable upper limit of 28 weeks for an abortion set out in s 82A of the *CLCA* has been overtaken by advances in medical science in that a child is now capable of being born alive (although signs of life does not necessarily denote viability) and surviving from 24 or even 22 weeks. However, an upper limit for a lawful abortion is inappropriate, and no upper limit should be included in any new law[73] (highlighting that any such procedures are very rare and are only undertaken after careful consideration by all parties and in the most compelling circumstances).[74]
17. The requirements in the present law that an abortion can only take place at a 'prescribed' hospital, that it involves the 'personal' examination by two medical practitioners and a two month residency requirement in South Australia are outdated and should be removed. These restrictions impede equitable and effective access, especially for regional, rural, remote and Aboriginal communities.
18. Recognition of the particular issues confronting the Aboriginal community and persons with disability in relation to abortion and specific operational changes are required to address their potential vulnerabilities.
19. Acknowledging the role and value of telehealth in the South Australian context, especially to improve service delivery for regional, rural, remote and Aboriginal communities.
20. Data relating to abortions in South Australia should continue to be collected, but in a de-identified format.[75]
21. The conscientious objection to decline to perform an abortion[76] should be explicitly recognised for health practitioners in South Australian law. However, it should be limited to those health practitioners directly involved in the procedure (except in an emergency situation).[77]
22. Consistent with the position interstate and existing professional guidelines, a health practitioner who holds a conscientious objection to the performance of an abortion or offering advice in regard to a potential abortion must provide timely referral (without seeking to impede or influence the woman's decision)[78] to a willing health practitioner or health service. Although referral has a specialist medical meaning, in this context referral is intended to mean either 'transferring the [patient's] care or providing information to the

[73] SALRI recognises that, as emphasised in consultation (especially involving professional associations and health practitioners), late term procedures after 20 weeks (let alone 28 weeks) are very rare and are better governed by clinical and professional practice. See further below Part 11.

[74] The most common example for a late term abortion being undertaken is where a major fetal abnormality is identified late in gestation. See further below Parts 11 and 13.

[75] The South Australian data relating to abortion dates back to 1969 and is widely viewed as a valuable, if not unique, research resource. Parties both supportive and opposed to the decriminalisation of abortion supported continuing collection of this data. However, there were real concerns over privacy and confidentiality. See below Part 20.

[76] A refusal by a medical practitioner to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the medical practitioner's skills or scope of practice, illegal or where the practitioner believes the patient has impaired decision-making capacity.

[77] This already exists in both South Australia and interstate and is included in health practice and professional guidelines. SALRI considers that explicit legislative provision will supplement and support such guidelines.

[78] SALRI, in its consultation, has heard multiple accounts of the inappropriate use of conscientious objection by some health practitioners to impose their views on patients and dissuade them from seeking an abortion. See also Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1. See also below [17.5.1]–[17.5.15].

patient so that she is then able to access the care that she seeks'.[79] SALRI accepts that referral may raise issues for health practitioners who hold a genuine conscientious objection to abortion,[80] however, both a woman's right to terminate a pregnancy and a medical practitioner's right to freedom of conscience should be respected and balanced. The suggested approach, which explicitly recognises conscientious objection, but also requires referral, represents a considered approach to balancing the rights of both the woman and the practitioner, while ensuring the autonomy of the woman is protected.[81]

23. There is a real need for safe access zones (and associated offences) around premises where abortion services are provided in South Australia to protect the privacy, welfare and dignity of both staff and patients from harassment, obstruction and intimidation[82] and to avoid the situation of South Australia attracting unregulated protesters.[83] Any such law should be based on the law in Victoria as recently upheld by the High Court of Australia.[84]
24. Impartial and non-directional counselling (including genetic counselling) in the context of abortion is beneficial and should be available if desired but it should be for the woman concerned to decide on undertaking any counselling, including who she chooses to see or not see. It is inappropriate to require mandatory counselling or mandatory referral to counselling.[85]

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[79] Evidence to Standing Committee on Social Issues, NSW Legislative Council, 15 August 2019, Uncorrected transcript, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists). See also above n 15. SALRI adopts the comments of Dr Roach as a sound guide for both the role and scope of conscientious objection and referral.

[80] This point was emphasised to SALRI in consultation by Dr Elvis Šeman and Dr Antonia Turnbull and some faith groups and NGOs. See further, for example, Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85.

[81] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 114 [8.27]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 145 [4.140]–[4.141], 148 [4.154]; Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900. SALRI also considers that legislative provision is warranted and it is inappropriate, especially in light of the draft Commonwealth Religious Discrimination Bill, to leave these issues to professional guidelines. See also below [17.7.7].

[82] SALRI notes that the situation in South Australia may not be as extreme as previously existed in Victoria. SALRI acknowledges from the material presented to it that certain groups and individuals, notably 40 Days for Life, conduct themselves with relative restraint. However, as was accepted by the group in question, there are clearly other individuals and groups that are opposed to abortion and are not part of 40 Days for Life that are also involved in the vicinity of the Woodville clinic and do not appear to share their restraint. SALRI has heard accounts of inappropriate conduct, including harassment, videotaping and obstruction. SALRI is of the view that safe access zone laws are necessary to protect the privacy, welfare and dignity of both staff and patients from harassment, obstruction and intimidation. See further below Part 18.

[83] There are both interstate and even international dimensions to protests outside abortion providers in Australia. South Australia is the only jurisdiction, apart from Western Australia, which does not have legislated safe access zones around abortion providers. Western Australia is in the process of formulating such laws. Concerns were raised to SALRI that if South Australia is the only State without these protections, South Australian clinics could be particularly targeted by interstate and overseas protestors. SALRI was provided examples of international anti-abortion protestors already having travelled to South Australia for this purpose. See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4866, 4869 (Hon Tammy Franks MLC).

[84] *Clubb v Edwards* [2019] HCA 11, (2019) 366 ALR 1.

[85] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 126 Rec 5. See further at: 118–126 [8.60]–[8.140].

25. Any counselling should be provided within professional health settings by appropriately trained counsellors who are members, or eligible for membership, of their relevant health professional body.[86]
26. Any suggestions of mandated information[87] or waiting periods[88] for a woman to undergo an abortion should not be introduced.
27. There are valid concerns over reproductive coercion and this should be explicitly acknowledged as a form of domestic violence,[89] but any new specific offence of coercion to undertake an abortion or not undertake an abortion is not recommended at this stage.[90]
28. Any further requirement to establish or record in law for informed consent by a woman to have an abortion is unnecessary, as this is already an integral aspect of health law and practice.[91]
29. Various operational changes and consequential changes.

The specific detail of these recommendations are found in the body of the Report.

Acknowledgements

This has proved to be a major reference into a complex and sensitive area of modern law and practice and I would particularly like to note the valuable contribution to the consultation, research and writing of this Report by Dr David Plater (SALRI Deputy Director), Ms Anita Brunacci (SALRI Lead Researcher and family lawyer), Ms Sarah Kapadia (SALRI Researcher), Dr Melissa Oxlad of the University of Adelaide, Ms Olivia Jay (SALRI Researcher) and Mr Stephen McDonald of the South Australian Bar. Input by SALRI's Advisory Board Members is also acknowledged.

I would especially like to acknowledge the valuable contribution of students from the 2019 Law Reform class at the University of Adelaide who have contributed so much to the necessary research and background work for a Report of this magnitude and complexity. I would also like to acknowledge the diligent contribution of Ms Louise Scarman (SALRI Admin Officer) in proofreading and editing this Report, the support of the Attorney-General's Department of South Australia in providing funding for this reference and the technical support of SA Health.

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[86] Parties both supportive and opposed to the decriminalisation raised concerns to SALRI over the 'impartiality' and 'independence' of abortion related counselling and claims of pressure upon women to either have or not have an abortion. SALRI acknowledges the concerns about the ambiguity that exists in the promotion and advertising of abortion-related counselling services. Given the varying attitudes to abortion held by counselling service providers, SALRI also suggests that counselling services should be required to be transparent about their underlying views when advertising and offering counselling services related to abortion in order to enable women to make an informed decision about any counselling she may or may not choose to undertake. See below [12.5.24]–[12.5.50].

[87] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 116–117 [8.39]–[8.59], 118 Rec 4; New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 142–143 [9.6]–[9.10].

[88] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 126–127 [8.141]–[8.154], 127 Rec 6; See New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 143–145 [9.11]–[9.17]

[89] SALRI's consultation and research raised the issue of 'abortion coercion' or 'reproductive coercion' as a form of domestic violence and as a real concern. It is important to note that this concern arises in relation to both coercion to undertake and **not** undertake an abortion. See Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 382–383. See further below [19.3.1]–[19.3.34].

[90] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 137 [8.237]–[8.242], 137 Rec 16.

[91] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Rogers v Whitaker* (1992) 175 CLR 479.

Lastly, I wish to acknowledge the many thousands of South Australians who actively participated in the consultation process that greatly assisted SALRI in informing this Report.

Professor John Williams
Director, South Australian Law Reform Institute
October 2019

Recommendations[92]

PART 1 – INTRODUCTION

Recommendation 1

SALRI recommends that abortion should be treated as a health issue rather than as a criminal law matter and a woman's autonomy and best health care should be respected and promoted.

PART 2 – ABORTION: AN OVERVIEW

Recommendation 2

SALRI recommends that there is a review of the operation and effectiveness of any new law in South Australia in relation to abortion five years after its commencement, given the ongoing medical, clinical and other changes in this area.

PART 5 – CRIMINAL OFFENCES

Recommendation 3

SALRI recommends that abortion should be largely (though not totally)[93] removed from the criminal law, especially the *Criminal Law Consolidation Act 1935* (SA), and placed in health law and practice.[94]

Recommendation 4

SALRI recommends that sections 81, 82 and 82A of the *Criminal Law Consolidation Act 1936* (SA) should be repealed and replaced with the appropriate provisions recommended below in a standalone Act or the most suitable Act (though not the *Criminal Law Consolidation Act 1936* (SA)).[95]

Recommendation 5

SALRI recommends that any new law in South Australia should provide that a woman who consents to, assists in, or performs an abortion on herself does not commit an offence (either in the criminal law or relevant health law).

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[92] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) vii–xiv.

[93] SALRI supports the retention, as exists interstate, of an offence to cover procedures (both surgical and medical) involving unqualified persons, though excepting both the woman concerned and health practitioners. SALRI also supports the introduction of safe access zones (and associated offences) around abortion providers.

[94] It is important to note that, even the total removal of all issues surrounding abortion from the criminal law, would not leave this area unregulated as it will still be subject to a comprehensive framework of health law and practice and professional protocols and guidelines.

[95] SALRI understands the *Health Care Act 2008* (SA) may be unsuitable.

Recommendation 6

SALRI recommends that any new law in South Australia should provide that it should not be possible for a woman to be charged as an accessory to an unlawful abortion performed upon her by an unqualified person.

Recommendation 7

SALRI recommends that a woman should not be liable to any legal sanction if she knowingly permits a health practitioner to perform an abortion upon her.

Recommendation 8

SALRI recommends that, to avoid any doubt, any new offence in South Australia should not extend to the performance of an abortion or assisting in the performance of an abortion by a medical or health practitioner within the scope of their practice.

Recommendation 9

SALRI recommends that, to avoid any doubt, any new law in South Australia should provide that, in deciding any issue about a health practitioner's[96] professional conduct in relation to the performance of an abortion or assisting in the performance of an abortion, regard may be had to all of the circumstances surrounding the procedure, including any issue as to authorisation and scope of practice.

PART 6 – THE ROLE AND RATIONALE OF A RESIDUAL OFFENCE

Recommendation 10

SALRI recommends that a new offence should be added to the Health Care Act 2008 (SA) or the most appropriate Act (though preferably not the Criminal Law Consolidation Act 1936 (SA)) to provide that an unqualified person who either performs, or who assists in the performance of, an abortion, commits a crime.[97]

Recommendation 11

SALRI recommends that, for the purposes of the new proposed offence in Recommendation 10 above, an 'unqualified person' should be defined to mean, in relation to performing an abortion or assisting in the performance of an abortion, a person who is not a health practitioner.[98]

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[96] The current law provides for abortion to be dealt with solely by a medical practitioner. However, SALRI wishes to ensure that the law can evolve with clinical practice and procedure without the need for further legislative reform. In this way the reference to 'health practitioners' throughout SALRI's Recommendations acknowledges the evolving clinical landscape (which includes potential changes to the nature of the health work force). This particularly relates to prescribing rights which may impact who can perform and assist in an abortion in the future, including the provision of MS-2 Step.

[97] SALRI notes that there are existing laws, including criminal laws, to deal with unqualified persons and the effects of their actions, however, these are arguably inadequate. See further below Part 6.

[98] For the purposes of the new offence, SALRI suggests an 'unqualified person' means: in relation to performing an abortion — a person who is not a medical practitioner; and in relation to assisting in the performance of an

Recommendation 12

SALRI recommends that the new offence proposed in Recommendation 10 should be a major indictable offence with a maximum penalty of seven years imprisonment.[99] Proceedings for any such offence should only be able to be instituted by, or with the consent of, the Attorney-General or the Director of Public Prosecutions.

PART 7 – CLINICAL PRACTICE IN SOUTH AUSTRALIA

Recommendation 13

SALRI recommends that the present requirement for two medical practitioners to personally examine the patient does not account for current clinical practice, including telehealth and other remote forms of consultation, and should be removed.

Recommendation 14

SALRI recommends that any new law in South Australia should clarify that the performance of an abortion should not necessarily be confined to a medical practitioner but should (subject to national health law and practice) refer to a health practitioner.

Recommendation 15

SALRI recommends that any new law in South Australia should provide that a health practitioner may assist another health practitioner to perform an abortion, in the scope of their health practice. A reference to assisting in the performance of an abortion by a health practitioner includes dispensing, supplying or administering a medical abortion drug.

Recommendation 16

SALRI recommends that Recommendation 15 should not apply to an abortion that the assisting medical or health practitioner knows, or ought reasonably to know, is being performed outside the scope of a health practice.

abortion — a person who is not a medical practitioner or health practitioner (including a nurse, midwife or pharmacist) providing the assistance in the practice of their respective occupation. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, June 2018) ii, n 10.

[99] Ibid x Rec 3.10; 111–12 [3.278]

PART 8 – MEDICAL ABORTIONS

Recommendation 17

SALRI recommends that the present additional Commonwealth administrative requirements[100] relating to the authorisation and/or registration of medical and other health practitioners to prescribe or dispense MS-2 Step should be removed.[101]

Recommendation 18

SALRI recommends that the Commonwealth should add a Medicare identification number for appointments related to both abortion consultations and abortion procedures, as well as the dispensing of MS-2 Step for pharmacists, to reflect the work involved in these appointments and to better collect appropriate data sets.

PART 9 – FACILITIES

Recommendation 19

SALRI recommends that the present requirement in South Australia that an abortion can only be carried out or administered at a 'prescribed hospital' does not account for current clinical practice and should be removed.

PART 10 – CRITERIA FOR LAWFUL TERMINATIONS

Recommendation 20

SALRI recommends that, whatever option is adopted, any new law in South Australia should not provide any specified criteria for access to lawful abortion.[102]

Recommendation 21

SALRI recommends that, consistent with Recommendation 2, the relevant law in South Australia should be amended, consistent with general health law and practice, to provide that an abortion can be undertaken at any gestational stage with the involvement of one health practitioner.[103]

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[100] SALRI acknowledges the overwhelming agreement received from health practitioners in this area who noted that the additional requirements for proscribing and dispensing MS-2 Step are more onerous than for other medications which have more severe side effects for the patient and are more likely to cause harm if incorrectly proscribed.

[101] SALRI further notes the comments of regional, rural and remote service providers who noted to SALRI that the time required to satisfy these requirements, when the procedure may only be sought by a small number of women in any year, is sometimes considered to be not worthwhile and therefore the service is not available in the area despite health practitioners being present who would otherwise be willing and able to assist.

[102] In Queensland and Victoria (and included in the 2019 NSW Act), a late term abortion is permissible if two medical practitioners consider that the abortion 'should, in all the circumstances be performed'. This approach, whether for early or late term abortions, received very little support in SALRI's consultation. Medical practitioners in regional, rural and remote locations particularly raised that this version made them feel like the decision maker for the procedure; a role they were neither equipped nor keen to undertake. It is also questionable what this approach actually achieves in practice. The criteria is so vague and subjective so as to be next to meaningless.

[103] SALRI notes that, under this approach, abortion at any stage in gestation is lawful with a woman's consent and if performed by a health practitioner. This approach places decision-making responsibility with the woman and

PART 11 – LATE TERM ABORTION

Recommendation 22

SALRI recommends that the present rebuttable upper limit of 28 weeks for an abortion set out in s 82A of the *Criminal Law Consolidation Act 1936* is inappropriate and no upper limit for a lawful abortion should be provided for in any new law.[104]

Recommendation 23

SALRI recommends that, in the alternative to Recommendation 21, the relevant law in South Australia should provide that up to 24 weeks gestation[105] an abortion can be performed by one health practitioner but, after 24 weeks gestation, consistent with Recommendation 2 and recognising the woman's autonomy, an abortion may be performed by a medical practitioner, but only after that medical practitioner has consulted with another medical practitioner and both are of the view that the proposed procedure is medically appropriate.[106]

Recommendation 24

SALRI recommends that a health practitioner may, in an emergency, perform an abortion on a woman at any time if the health practitioner considers it is necessary to perform the procedure to save the woman's life or, in the case of multiple pregnancy, another fetus.

Recommendation 25

SALRI recommends that any new law in South Australia should not include a requirement for an abortion (including a late term abortion) to be approved by a second specialist medical practitioner (such as a gynaecologist) or a panel or committee.

PART 12 – COUNSELLING

Recommendation 26

SALRI recommends that any new abortion law in South Australia should not contain mandated information provisions.[107]

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service availability with the health profession. This approach is reflected in the law in the ACT and in the 2018 South Australian Private Members Bill.

[104] SALRI recognises that, as emphasised in SALRI's consultation (especially involving professional associations and health practitioners), any such late term procedures are very rare and are better governed by clinical and professional practice.

[105] SALRI notes there was no consensus, including amongst medical practitioners, on this question and 22 weeks was also identified as a valid point in time. See further below Part 11.

[106] This version is an adaption of the approach that exists in Queensland and Victoria and is included in the 2019 NSW Act, but without the criteria as to why an abortion may be performed.

[107] This recommendation is not intended to impede patients continuing to receive the product disclosure material for medication and information as to the treatments to be performed and potential side effects as would be provided with any other medical prescription or surgical procedure. It is also not intended to impede the provision of culturally appropriate information.

Recommendation 27

SALRI recommends that there should not be any further requirements beyond existing general health law and practice in any new law in South Australia for informed consent by the woman to have an abortion.[108]

Recommendation 28

SALRI recommends that any new law in South Australia should not contain a compulsory delay or waiting period before an abortion may be lawfully performed.[109]

Recommendation 29

SALRI recommends that high-quality, impartial and non-directive counselling should be available to any woman who chooses to access it and that any such counselling should be provided within professional health settings by appropriately trained counsellors who are members, or eligible for membership, of their relevant health professional body.

Recommendation 30

SALRI acknowledges the benefit of impartial and non-directional counselling in the context of abortion, but it should be for the woman concerned to decide on receiving or undertaking any counselling and who she chooses to see, or not see. SALRI recommends any new law should not contain a requirement for mandatory counselling or mandatory referral to counselling.

Recommendation 31

SALRI acknowledges concerns about the ambiguity that exists in the promotion and advertising of abortion-related counselling services. Given the varying attitudes to abortion held by counselling service providers, SALRI recommends that counselling services should be required to be transparent about their underlying views when advertising and offering counselling services related to abortion, in order to enable the woman to make an informed decision about any counselling she may or may not choose to undertake.

Recommendation 32

SALRI supports the notion that counselling services should be culturally sensitive, appropriate and competent for all cultural groups. In particular, SALRI recommends that counsellors providing abortion-related counselling to Aboriginal women have undertaken cultural awareness training, are sensitive to cultural and contextual factors, and the values systems and authority structures of Aboriginal communities, and provide services in a flexible manner so as to meet the cultural needs of Aboriginal women who may choose to access high-quality, impartial and non-directive counselling.

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[108] Informed consent is already an integral aspect of health law and practice in South Australia to the performance of any medical procedure, including an abortion. Any specific legislative requirement for informed consent to abortion is unnecessary, if not unhelpful. See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Rogers v Whitaker* (1992) 175 CLR 479.

[109] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 8, rec 6.

PART 13 – DISABILITY

Recommendation 33

SALRI recommends that the present disability specific provision in s 82A of the *Criminal Law Consolidation Act 1935* (SA) as to when a lawful abortion is available should be removed, and should not be included in any new law.

Recommendation 34

SALRI recommends that access to a clinical genetics service should be available to all women where there is a family history of genetic conditions or where fetal abnormality has been detected through prenatal screening where a genetic cause is possible. It should be for the woman concerned to decide on undertaking any genetic counselling however, and SALRI therefore recommends any new law should not contain a requirement for mandatory genetic counselling or a mandatory referral to a clinical genetics service. The promotion and provision of genetic counselling could be further enhanced through:

a. the development or amendment of current medical frameworks and/or guidelines relating to the effective and timely referral to a clinical genetics service, endorsing best clinical practice;
b. raising community awareness about clinical genetics services and the role of a genetic diagnostics and counselling service;
c. increasing access for all pregnant women to information about clinical genetics services and how to access such services; and
d. ensuring adequate resources are available to meet a likely increase in clinical genetic diagnostics and counselling service requests arising from changes to guidelines/frameworks and greater community understanding of such services.

Recommendation 35

SALRI supports inclusive and accessible health care for all, as well as principles of autonomy. As such, SALRI recommends that counsellors providing abortion-related counselling to women with disabilities should be knowledgeable about disability awareness to ensure a sensitive, safe and inclusive environment for women with disabilities who may choose to access high-quality, impartial and non-directive counselling.

PART 14 – GENDER-SELECTIVE ABORTION

Recommendation 36

SALRI notes that any suggestion of gender selective abortion raises concern, but any legislative prohibition on gender selective abortion is unnecessary, as well as likely to be unenforceable, and therefore recommends that there should be no legislative prohibition in South Australia on gender selective abortion.[110]

[110] See also Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019)

PART 15 – ACCESS AND AVAILABILITY

Recommendation 37

SALRI recommends that the present requirement that a woman must have been resident in South Australia for a period of two months prior to the procedure serves no useful purpose and should be removed.

Recommendation 38

SALRI recommends that where a surgical abortion is unable to be performed due to a lack of service provision in a woman's local area and she is unable to access an early medical abortion due to:

a. her stage of gestation; and/or
b. it being counter indicated as assessed by her treating health practitioner;

then the woman should be eligible to access the Patient Assistance Transport Scheme (PATS) to travel to the nearest location where the surgical abortion can be performed.

Recommendation 39

SALRI notes the benefit of telehealth medicine to address rural, regional and remote access issues in relation to abortion and recommends that any new law in South Australia should not prevent or restrict the use of telehealth medicine when appropriate, based on current clinical practice and procedures.

Recommendation 40

SALRI recommends that the SA Health website be maintained on an ongoing basis so as to provide South Australians with reliable and impartial information on abortion procedures and access to abortion services, including contact information for advisory services, counselling support and medical centres.

PART 16 – ABORIGINAL PRACTICE*

Recommendation 41

SALRI notes the particular issues in South Australia relating to Aboriginal communities and recommends that practitioners who prescribe MS-2 Step, or hospitals which undertake abortion procedures, should have access to pamphlets, literature or referral sources which can be supplied to Aboriginal women to ensure they have access to culturally appropriate information and support.

<https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>.

Recommendation 42

SALRI recommends that all health services, including hospitals and specialist clinics, ensure that staff have undertaken cultural awareness training to ensure a culturally safe environment for Aboriginal women attending the service.[111]

PART 17 - CONSCIENTIOUS OBJECTION AND REFERRAL[112]

Recommendation 43

SALRI recommends that conscientious objection on the part of a health practitioner, in relation to performing an abortion or assisting in the performance of an abortion, should be respected and explicitly included in any new law and therefore no medical or heath practitioner should be under a duty to perform or assist in performing an abortion, save for a medical emergency.[113]

Recommendation 44

SALRI recommends that conscientious objection should be restricted to individuals who are directly performing an abortion or assisting in the performance of an abortion, and it should not apply to other parties such as administrators, corporate services staff or to any provision of after care.

Recommendation 45

SALRI recommends that any new law in South Australia should provide that a health practitioner who holds a conscientious objection to performing or assisting in the performance of an abortion, making a decision about whether an abortion should be performed on a woman or offering advice in relation to the potential performance of an abortion, must provide timely transfer of care or provide information to the patient regarding a willing health practitioner or health service.

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[111] See also Recommendation 32 relating to culturally sensitive counselling and Recommendation 61 relating to collection of data on Aboriginality.

[112] SALRI adopts the explanation of Dr Roach of RANZCOG to the NSW Legislative Council Committee as a sound guide as to its recommendations for the role and scope of both conscientious objection and referral. 'In choosing to be doctors we have a duty of care to the patient and if the patient seeks our care and we are unable to deliver that care, and there are other reasons why we cannot deliver it, we might not have experience in that area, we might not have a skill in that area. **If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well**': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, Uncorrected transcript, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists). See also above n 15.

[113] SALRI considers that, in relation to abortion, explicit legislative provision is preferable to supplement and support the existing references to conscientious objection that already appears in health law and practice and professional protocols in relation to health procedures generally.

Recommendation 46

SALRI recommends that any new law in South Australia should make it clear that if a health practitioner has a conscientious objection in relation to an abortion (or potential abortion), then that health practitioner is required to:

a. disclose their conscientious objection to the person; and
b. if the request is made by the woman, effectively transfer the care of the woman, or provide her information by either:
    i. transferring care to another health practitioner who, to the first practitioner's knowledge, can provide the requested service and does not hold a conscientious objection to the performance of the abortion; or
    ii. providing information on a health service provider at which, to the first practitioner's knowledge, the requested service can be provided by another health practitioner who does not have a conscientious objection to the performance of the abortion.[114]

Recommendation 47

SALRI recommends that a health practitioner's refusal to provide or participate in treatment or a procedure must be done in a way to minimise disruption to patient care and must never be used to intentionally impede a patient's access to an abortion.[115]

Recommendation 48

SALRI recommends that any new law in South Australia should provide that, in deciding any issue about a health practitioner's professional conduct, regard may be had as to whether the practitioner contravenes the provisions in Recommendations 45, 46 and 47 above.

PART 18 – SAFE ACCESS ZONES

Recommendation 49

SALRI recommends that any new law in South Australia should include safe access zone provisions around premises where abortion services are provided and that the purpose of these provisions is to protect the safety and welfare, and respect the privacy and dignity, of people accessing the services and employees or other persons who need to access those premises in the course of their duties or responsibilities.

Recommendation 50

SALRI recommends that any new law in South Australia should provide that a place will be within the safe access zone of premises at which the service of providing an abortion is ordinarily undertaken if it is in the premises or not more than the prescribed distance from an entrance to the premises.

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[114] See also Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019) <https://ama.com.au/position-statement/conscientious-objection-2019>.

[115] See also New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 67.

Recommendation 51

SALRI recommends that any new law in South Australia should provide that the prescribed distance is 150 metres.

Recommendation 52

SALRI recommends that any new law in South Australia should provide that the operation of the safe access zone is not limited to the hours of operation of the premises and should be 24 hours a day and seven days a week, with no exceptions.

Recommendation 53

SALRI recommends that safe access zones should be automatically established by legislation and not be by Ministerial decree.

Recommendation 54

SALRI recommends that a new offence be established in South Australia to provide that it is an offence to engage in prohibited conduct in the safe access zone for an abortion services premises and 'prohibited conduct' should be defined to mean intimidation, obstruction, impeding access, harassment or other conduct that relates to abortions or could reasonably be perceived as relating to abortions and would be visible or audible to another person entering, leaving or in the premises; and would be reasonably likely to deter a person from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, an abortion.

Recommendation 55

SALRI recommends that a new offence should be established in South Australia to provide that it is an offence for a person to make, publish or distribute a restricted recording of another person without the other person's consent and without reasonable excuse. A 'restricted recording' should be defined to mean an audio or visual recording of a person while the person is entering, leaving or in an abortion services premises, and which contains information that identifies, or is likely to lead to the identification of, the person being recorded.[116]

Recommendation 56

SALRI recommends that there should be a maximum penalty of one year's imprisonment and/or an appropriate fine for each of the offences in Recommendations 54 and 55 above.

PART 19 – CONSENT, CAPACITY AND COERCION

Recommendation 57

SALRI recommends that any new law in South Australia relating to abortion should not include a new specific anti-coercion offence.

[116] See, for example, *Termination of Pregnancy Act 2018* (Qld) s 16.

Recommendations 58

SALRI acknowledges that reproductive coercion is a form of family violence and recommends that 'reproductive coercion' should be added to the definition of family violence in s 8 of the *Intervention Orders (Prevention of Abuse) Act 2009* (SA)[117] and/or elsewhere.

Recommendation 59

SALRI recommends that no incidental changes are necessary in South Australia to the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity, consent to medical treatment for minors[118] or the regulation of health practitioners, public hospitals and health services and licensed private health facilities.

PART 20 – DATA COLLECTION AND USE

Recommendation 60

SALRI acknowledges the value of the data previously collected by SA Health relating to abortions in South Australia and recommends the collection of data continue with the following changes:

a. Data collected must not include names and addresses of patients;
b. Identification of Aboriginality should be collected;
c. Collection of data should be permitted to occur in either hard copy or electronic form as directed by SA Health and should not require signatures of health practitioners involved in the procedure, so as to allow the data to be reported to SA Health by administration staff where appropriate.
d. Data should be able to be utilised in the same manner, and with the same ethical and legal approval, as all other data sets collected by SA Health or other relevant agency.

Recommendation 61

SALRI recommends that historical data collected by SA Health prior to any legislative changes be de-identified and permitted to be used[119] in the same manner, and with the same ethical and legal approval, as other data sets held by SA Health. SALRI further recommends that the annual Report to Parliament should be discontinued and replaced with such annual data to be made public in an appropriate manner.

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[117] SALRI notes that in its consultation and research the issue of 'abortion coercion' or 'reproductive coercion' was raised as a form of domestic violence and as a real concern. It is important to note that this concern applies to both coercion to undertake and not undertake an abortion. See also Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: a Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371. See also below [19.3.1]–[19.3.34].

[118] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

[119] SALRI acknowledges the concerns raised by some parties in its consultation in relation to the use of historical data collected without a patient's explicit consent. However, the benefit of the comparison over time in regard to the prevalence of abortion procedures, reason for the procedure including identified fetal abnormalities is considered by SALRI to be sufficient to outweigh this concern.

PART 21 – INCIDENTAL

Recommendation 62

SALRI recommends that gendered terms such as 'woman' in the present law should be replaced.[120]

Recommendation 63

SALRI notes that the offence of child concealment falls outside SALRI's terms of reference and recommends that the offence of child concealment in s 82 of the *Criminal Law Consolidation Act 1936* (SA) should be separately considered by the Attorney-General's Department in consultation with interested parties.

Recommendation 64

SALRI recommends that no change to the law in South Australia is necessary to the definition of 'harm' or 'serious harm'[121] in s 21 of the *Criminal Law Consolidation Act 1936* (SA) to cover the situation of harm or the loss (other than in the course of a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers any other harm.[122]

Recommendation 65

SALRI recommends that consequential amendments to other South Australian laws should be made where necessary and desirable in light of the repeal of ss 81, 82 and 82A of the *Criminal Law Consolidation Act 1936* and the potential introduction of the new offence in Recommendation 10 relating to the performance of an abortion by an unqualified person.

Recommendation 66

SALRI recommends that, for the avoidance of any doubt, any common law offence relating to abortion should be abolished.

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[120] See also South Australian Law Reform Institute, *Discrimination on the Grounds of Sexual Orientation, Gender, Gender Identity and Intersex Status in South Australian Legislation* (Audit Paper, September 2015) 40 [1.4]. See further below [21.1.1]–[21.1.13].

[121] SALRI notes the existing concepts and definitions of 'harm' or 'serious harm' to the woman would cover this situation. 'Serious harm' means— (a) harm that endangers a person's life; or (b) harm that consists of, or results in, serious and protracted impairment of a physical or mental function; or (c) harm that consists of, or results in, serious disfigurement: CLCA s 21.

[122] See also *R v King* (2003) 59 NSWLR 472.

Part 1 – Introduction and Background

1.1 The South Australian Law Reform Institute

1.1.1 The South Australian Law Reform Institute (SALRI) is an independent non-partisan law reform body based at the Adelaide University Law School that conducts inquiries—also known as references—into areas of law. The areas of law are determined by the SALRI Advisory Board and may also be at the request of the Attorney-General of South Australia. SALRI examines how the law works in South Australia and elsewhere (both in Australia and overseas), conducts multidisciplinary research and consults widely with the community, interested parties and experts. Based on the research and consultation that it conducts during a reference, SALRI then makes reasoned recommendations to the State Government so that the Government and Parliament can make informed decisions about any changes to relevant law and/or practice. SALRI's recommendations may be acted upon and accepted by the Government and Parliament. However, any decision on accepting a recommendation from SALRI is entirely an issue for the Government and/or Parliament.

1.1.2 When undertaking its work, SALRI has a number of objectives. These include identifying law reform options that would modernise the law, fixing any problems in the law, consolidating areas of overlapping law, removing unnecessary laws, or, where desirable, bringing South Australian law into line with other States and Territories.[123]

1.1.3 SALRI was established in December 2010 under an agreement between the Attorney-General of South Australia, the University of Adelaide and the Law Society of South Australia Incorporated.[124] It is based at the University of Adelaide Law School. SALRI is assisted by an expert Advisory Board.

1.1.4 SALRI is based on the Alberta law reform model that is also used in Tasmania[125] and is linked to the Law Reform elective course at the University of Adelaide. The work of the Law Reform class plays a valuable role to inform and support SALRI's work (including this reference).

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[123] The benefit of national uniform, or at least consistent, laws was raised in consultation by various parties such as the Australian College of Nursing, Family Planning Alliance Australia and Beth Wilson AM, the former Victorian Health Services Commissioner. 'A consistent national approach in this respect and in relation to access to and regulation of abortion generally, is desirable': Law Society of South Australia, Submission to the South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice,* 'Review of Abortion Laws in South Australia', 31 May 2019, 6 [35], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>. The importance and value of a national uniform, or at least consistent, approach is especially evident in a complex issue such as abortion that has interstate dimensions and involves overlapping and concurrent responsibilities of both the Commonwealth, States and Territories. See, for example, Caroline de Costa et al, 'Abortion Law Across Australia — A Review of Nine Jurisdictions' (2015) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 109, 111; Patrick Ferdinands, 'How the Criminal Law in Australia Has Failed to Promote the Right to Life for Unborn Children: a Need for Uniform Criminal Laws on Abortion across Australia" (2012) 17(1) *Deakin Law Review* 77. Concerns have been raised that a lack of uniformity undermines the abortion laws of jurisdictions such as NSW where the procedure remains criminalised, because 'it allows 'forum shopping' across jurisdictions to circumvent the practical effect of existing criminal laws proscribing abortion': at 77. The fear of 'abortion tourism' has also been raised. See Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, NSW Parliamentary Research Service, Parliament of New South Wales, 2017) 14.

[124] *Law Society of South Australia* (Web Page) <https://www.lawsocietysa.asn.au/>.

[125] See Kate Warner, 'Institutional Architecture' in Brian Opeskin and David Weisbrot (eds), *The Promise of Law Reform* (Federation Press, 2005) 55, 62–4, 68.

1.1.5 SALRI is grateful to the Attorney-General's Department for providing funding to undertake this important reference.

1.2 Background and Terms of Reference

1.2.1 It is crucial to note that SALRI's remit is governed by its relevant Terms of Reference. A number of parties in consultation expressed their frustration at SALRI's remit,[126] but SALRI's present reference is not an unrestricted examination of all the issues and options that may arise in relation to abortion. Rather SALRI is governed by its relevant Terms of Reference.

1.2.2 On 5 December 2018, the Statutes Amendment (Abortion Law Reform) Bill 2018 (SA) was introduced by the Hon Tammy Franks MLC in the South Australian Legislative Council as a Private Members Bill.[127] Ms Franks explained that 'this Bill provides that abortion should be removed from our criminal laws and regulated like any other health service'.[128]

1.2.3 On 26 February 2019, the South Australian Attorney-General, the Hon Vickie Chapman MP, announced that she had asked SALRI 'to consider changes to the State's abortion laws with a view to improve access and modernise the practice in the State and with a view to making abortion a regulated medical procedure under health legislation as opposed to a criminal law issue'.[129] The Attorney-General acknowledged Ms Franks' advocacy on this issue but noted her view that the Private Members Bill was 'too broad and failed to adequately regulate [the relevant] medical procedures'.[130] The Attorney-General observed that wide consultation was appropriate and her view that a referral to SALRI was the most appropriate way 'to determine how South Australian laws could best be updated and brought in line with those in other jurisdictions, particularly regional access and investigating the current outdated criminal law.'[131]

1.2.4 On 28 February 2019, the Attorney-General formally wrote to SALRI in respect of its Terms of Reference. The Attorney-General noted that, since the present abortion laws were introduced in South Australia in 1969, there have been significant changes to clinical practice including medical termination methods and modern health service provisions. The Attorney-General raised that, as a result of these developments, there is now a concern that South Australia's abortion laws no longer

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[126] A number of groups opposed to the decriminalisation of abortion such as the Adelaide Centre for Bioethics and Culture, 40 Days for Life, Pregnancy Help SA, Cherish Life Australia, the Canberra Declaration, the Right to Life Association of South Australia, the Lutheran Church, the Australian Christian Lobby and Advocates International raised their frustration at SALRI's remit. Several groups noted: 'However, any consideration of legislative reform must consider the ethical issues that underlie any law reform in relation to abortion.' Others were blunter. One retired academic, for example, argued: 'It is most regrettable and unfortunate that the tide of 'progressive' thinking from all too many doctors and lawyers regarding this matter has consistently turned its back on any suggestion that the law might be altered to make reconsideration of facilitating abortion, and prevention of this loss of life, a priority. As is typical, your 'review' is only dealing with issues of going further in the current unsatisfactory direction.' A clergyman argued: 'Whether abortion is right or wrong is outside your terms of reference, but thereby your enquiry is seriously biased. You are dealing with an abortion as an established fact, and something we must all accept. A great many people, however (myself included), do not accept abortion in any form at all.' However, a number of parties such as Catholic Archdioceses of Adelaide and Port Pirie expressly recognised that SALRI's terms of reference are limited as detailed by the Attorney-General.

[127] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2420–2428. See also South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2776–2791.

[128] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2421.

[129] Vickie Chapman, 'Law Reform Institute to consider Abortion Law Reform (Press Release, 16 February 2019) <https://www.agd.sa.gov.au/newsroom/law-reform-institute-consider-abortion-law-reform>.

[130] Ibid

[131] Ibid.

reflect best modern clinical practice and may act as a barrier to equality of access to health services. The Attorney-General observed it is appropriate that the relevant law is modernised to bring it in line with current clinical practice and to improve the efficiency of health service provision and access, particularly for women in regional, rural and remote areas.[132] SALRI was particularly requested to investigate and make recommendations for reform based on best clinical practice in this area and, with guidance from other jurisdictions, consider the most suitable ways to achieve appropriate reform of South Australia's abortion laws.[133]

1.2.5 SALRI's full Terms of Reference, as set out on 28 February 2019 by the South Australian Attorney-General, the Hon Vickie Chapman MP, are as follows:

> **Referral**
>
> I therefore seek the Institute's consideration of a referral in relation to the topic of abortion, with the aim of modernising the law in South Australia and adopting best practice reforms.
>
> **Scope**
>
> The Institute is asked to inquire into and report on recommendations on:
>
> 1. the effectiveness of current law, practices and services in South Australia relating to the medical termination of pregnancy, in particular the availability and safety of services, based on advice and information from SA Health; and
>
> 2. how the current legal position may be amended to:
>
> i. remove offences relating to the medical termination of pregnancy pursuant to Division 17 of the CLCA;
>
> ii. make recommendations for legislative reform based on best clinical practice for the lawful regulation of medical termination of pregnancy;
>
> iii. ensure reasonable availability and access to safe medical termination of pregnancy services.
>
> 3. Any other relevant matters.
>
> In providing advice and recommendations for legislative reform, SALRI is asked to have regard to the following:
>
> the termination of pregnancy should be treated as a health care issue rather than as a criminal matter;

[132] This is a major consideration for SALRI, especially in relation to rural, regional and remote access in South Australia. See also below Part 15. In 2016, 672 women who resided in country South Australia had an abortion. Only 85 of those (12.6%) were able to have an abortion in their country area, with the rest needing to travel to the metropolitan area for the service. Of those that had an abortion in the city, 21% (141 of the 672) had a medical abortion and so ideally could have been offered the service closer to home. This leads to costs incurred for travel and accommodation (generally for two nights) for country women, including social costs of leaving supports and family responsibilities. Proper regional, rural and remote access is important so as not to disadvantage women living in these areas. The closure of Tasmania's main abortion provider, for example, forces women to travel to Melbourne, having particular impact on low income women. See Sue Bailey, 'Tasmanian women face big costs if they travel interstate for abortions', *Sydney Morning Herald* (online, 8 March 2018) <https://www.smh.com.au/national/tasmanian-women-face-big-costs-if-they-travel-interstate-for-abortions-20180308-p4z3il.html> Rhiannon Shine, 'Abortion Rally at Tasmanian Parliament ups pressure on Hodgman Liberal Government', ABC News (online, 24 May 2018) <https://www.abc.net.au/news/2018-04-28/abortion-rally-at-parliament-ups-pressure-on-state-government/9707190>.

[133] Letter from the Attorney-General to SALRI, 28 February 2019.

existing practices and services in South Australia concerning termination of pregnancy including those provided by medical practitioners, counsellors and support services;

existing legal principles relating to termination practices in South Australia;

the South Australian Government's commitment to modernise and ensure safe and reasonable access to termination services for all women;

the law should be consistent with contemporary clinical practice and health regulation, including reasonable and safe access to termination services; and

the law should achieve reasonable consistency with other Australian jurisdictions and international jurisdictions that have modernised their laws relating to termination.

1.3 Methodology and Consultation

1.3.1 SALRI is committed to inclusive and accessible consultation with the South Australian community and all interested parties, including, but not confined to, the legal profession and experts. Such genuine and inclusive consultation is integral to modern law reform. As Neil Rees has observed:

> Effective community consultation is one of the most important, difficult and time consuming activities of law reform agencies … community participation has two major purposes: to gain responses and feedback and to promote a sense of public 'ownership' over the process of law reform … consultation often brings an issue to the attention of the public and creates an expectation that the government will do something about the matter …[134]

1.3.2 This reference has involved extensive multidisciplinary research and consultation with interested parties, experts and the community.[135] This Report draws on research and consultation undertaken both in person in Adelaide and at various regional locations, and via a range of online methods, traditional written submissions and in person meetings.

1.3.3 The preparation of this Report has involved several stages. SALRI conducted background research and initial consultation, following which a number of plain English 'Fact Sheets' on the key issues were prepared.[136] SA Health also provided technical support.

1.3.4 SALRI conducted Expert Forums with representatives of interested parties and groups at the University of Adelaide on 16 May 2019 (faith groups), 20 May 2019 (the disability sector), 7 June 2019 (the medical and legal sectors in the morning and parties supportive of the decriminalisation of abortion in the afternoon) and 12 June 2019 (faith groups and NGOs) to discuss some of the key issues in relation to this reference. These meetings were attended by a number of experts and representatives of the legal, medical and academic sectors, as well as representatives from faith groups,

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[134] Neil Rees, 'The Birth and Rebirth of Law Reform Agencies' (Paper Presented at the Australasian Law Reform Agencies Conference, Vanuatu, 10–12 September 2008) <http://www.lawreform.vic.gov.au/sites/default/files/ALRAC%2BPaper%2B_NeilRees.pdf>. See also Roslyn Atkinson, 'Law Reform and Community Participation' in Brian Opeskin and David Weisbrot (eds), *The Promise of Law Reform* (Federation Press, 2005) 160–174; Michael Kirby, 'Changing Fashions and Enduring Values in Law Reform' (Speech delivered at the Conference on Law Reform on Hong Kong: Does it Need Reform?, The University of Hong Kong, Department of Law, 17 September 2011) <http://www.alrc.gov.au/news-media/2011/changing-fashions-and-enduring-values-law-reform>.

[135] SALRI made it clear throughout its consultation that it could not provide any individual advice or guidance and if any party in consultation had any doubt about their position or the reference raised issues of sensitivity for them, they should seek legal advice or counselling support about their concerns and any issues or implications for them.

[136] See South Australian Law Reform Institute, 'Abortion: A Review of South Australian Law and Practice', *YourSAy* (Web Page, 19 April 2019) <https://yoursay.sa.gov.au/decisions/abortion/about>.

community groups, the disability sector and not for profit groups. The Expert Forums were conducted under the Chatham House rule.[137]

1.3.5 These roundtables proved to be helpful and constructive meetings and though consensus was not reached (unsurprisingly given the issues and views involved), broad agreement was expressed on many issues. A number of the groups and attendees at the Forums also provided individual submissions.[138] SALRI is grateful to all parties who attended the Forums. At the request of various participants who requested privacy, a list of attendees and/or invitees will not be published.

1.3.6 Similar Expert Forums were also conducted in regional locations with SALRI visiting Whyalla and Port Augusta on 7–8 May 2019, Ceduna on 28–29 May 2019, Port Lincoln on 20 June 2019 and Murray Bridge on 28 June 2019. During these visits, SALRI spoke to a large number of medical practitioners, other health practitioners (including nurses, midwives, pharmacists and Aboriginal health workers), hospital administrators and others. Given pressures in time and resources, it was not possible for SALRI to visit other rural and regional locations. The venues chosen were identified to reflect a representative range of rural, regional and remote communities and were important given the matters of availability and access were specific points in the Terms of Reference.

1.3.7 SALRI spoke in person to several interested parties and experts who were unable to attend the Expert Forums including Dr Elvis Šeman and Dr Antonia Turnbull.[139] SALRI also visited the Pregnancy Advisory Centre in Woodville and separately met with various medical and health practitioners working in regional, rural, remote and metropolitan areas. SALRI also met with the AMA(SA) and RANZCOG.

1.3.8 In conjunction with the Expert Forums, SALRI also utilised the Government's YourSAy platform, not as an opinion poll, but rather as an opportunity to seek the views of the community on specific issues.[140] SALRI also utilised other means (such as contacting a wide range of potential interested parties directly) and invited any interested parties and members of the community to utilise the YourSAy website by providing online comments, taking part in an online feedback form and/or providing written submissions. Plain English 'Fact Sheets' on the key issues and a supporting background paper were made available on the YourSAy website. The online survey was created on Friday 19 April 2019 with assistance from the YourSAy team using SurveyMonkey software and was open for six weeks. The online survey closed on Friday 31 May 2019. It consisted of ten areas for comment and participants were given possible questions to guide their considerations in these areas.[141] The questions were broadly based on those used by the QLRC.[142] The areas of comment were linked to information in the Fact Sheets. Interested parties or individuals responded to the survey on an anonymous basis.

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[137] SALRI invited a wide range of legal, medical, health, community, faith and disability groups reflecting a diverse range of perspectives as well as experts to attend these roundtables. It was not possible to invite individual members of the public to attend.

[138] Several of the parties who attended these meetings also provided written follow up submissions and comments.

[139] SALRI also carefully considered various material and references provided by Dr Šeman and Dr Turnbull.

[140] See South Australian Law Reform Institute, 'Abortion: A Review of South Australian Law and Practice', *YourSAy* (Web Page, 19 April 2019) <https://yoursay.sa.gov.au/decisions/abortion/about>.

[141] These questions can be found at Appendix A.

[142] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) v–vii.

1.3.9 The YourSAy site and supporting material also proved helpful to inform many parties and individuals of this reference and the key issues,[143] and to encourage them to get in touch with SALRI directly in writing. A total of 2885 online responses were received from the online survey with many respondents providing helpful clarification of their views.

1.3.10 SALRI received subsequent submissions or comments from a total of approximately 340 individuals, agencies or interested parties.[144] These submissions were received in the form of written submissions, email correspondence or, for organisations only and a number of experts, meetings by phone or in person (or a combination of these means). Some parties made multiple submissions.

1.3.11 In light of the sensitivity of the subject and the logistics involved,[145] SALRI did not meet in person with any members of the general community. SALRI formed the view that given the high number of submissions from the public it would not be feasible to meet with all persons who may wish to do so and it would create a perceived bias to meet only with some individuals and not all.

1.3.12 To help guide the in-person discussions with interested parties, SALRI addressed three broad examples for potential reform, drawing on the models presented by the VLRC,[146] although SALRI is not restricted to recommend any one model.

1.3.13 SALRI is aware that abortion is an issue which raises sincere and deeply held views and SALRI has had careful regard to all the various views expressed to it in consultation in the preparation of this Report. Though it is not possible, with a complex topic such as abortion, to reconcile or accept all those views, SALRI has been struck by the generous participation and thoughtful contributions of the many individuals and organisations who contributed in the preparation of this Report. SALRI is particularly grateful for the insightful input to this reference of individuals who have shared personal and often explicit accounts of their experiences under the present law and practice.[147]

1.3.14 This reference was significant in that a number of further issues were identified in consultation and research. SALRI liaised with various parties and with relevant experts from South Australia, interstate and internationally in relation to follow up or technical issues that arose in the preparation of this Report.

1.3.15 SALRI has carefully considered and taken into account all responses, submissions and comments received as part of this reference as well as the role and operation of relevant law and practice in other jurisdictions (both in Australia and overseas), relevant law reform and government reports and academic research and commentary.[148]

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[143] See results in *YourSAy Online Engagement Report — Abortion: A Review of South Australian Law and Practice 15 April 2019 – 31 May 2019* reproduced at Appendix B.

[144] These submissions ranged from a single sentence to tens or even hundreds of pages in length with multiple attachments. Some submissions were also significantly similar.

[145] Given the high level of community interest in this reference, it would have been impracticable for SALRI to speak with every interested member of the public who wished to do so.

[146] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 6–7.

[147] Given the nature of this reference and the private experiences that parties have sometimes referred to in their survey responses and submissions, SALRI has not referred to any individual by name and uses a de-identified form of identification, unless a party expressly agreed to be referred to by name. SALRI has referred to groups and experts by name unless that group or expert has asked to be referred to in a de-identified form.

[148] SALRI notes that its recommendations have been guided by a number of key principles, including its terms of reference and that:

1. Generally, abortion should be treated as a health issue rather than as a criminal matter;

1.3.16 SALRI paid particular regard to the work (the timing of any Reports permitting) of other jurisdictions, especially Victoria,[149] the Northern Territory[150] and Queensland[151] who have reviewed their laws and practices relating to abortion relatively recently. SALRI paid regard to the work of the New Zealand Law Reform Commission[152] and the resulting Abortion Legislation Bill (2019) introduced to the New Zealand Parliament on 8 August 2019. SALRI has also had regard to the Health Care (Health Access Zones) Amendment Bill 2019 (SA) introduced to the South Australian Parliament on 26 September 2019.[153] SALRI paid particular regard to the *Abortion Law Reform Act 2019* (NSW) (introduced as the Reproductive Health Care Reform Bill 2019 to the NSW Parliament on 1 August 2019)[154] and the 27 August 2019 Report of (and submissions to) the NSW Legislative Council Standing Committee on Social Issues (hereafter, NSW Legislative Council Committee).[155] Careful consideration was given in this Report as to how any potential legislative reforms in South Australia will interact with developments in both Australia and overseas.[156]

1.3.17 Consistent with its Terms of Reference, SALRI has concluded that, as far as possible, certain wider and often profound issues urged upon SALRI by various parties to consider as part of its review are simply beyond SALRI's remit. As noted by the Catholic Archdioceses of Adelaide and Port Pirie to SALRI in its submission:

> SALRI's terms of reference clearly state that their brief is not about preventing or precluding abortion. Complex moral questions (ie such as when human life begins) fall outside of its terms of reference. SALRI acknowledges that abortion is 'a sensitive topic that gives rise to sincere, strong and often competing views'. Because it is an issue that 'raises various sensitive, legal, medical and ethical implications', SALRI considers abortion to be a matter of 'personal ethics upon which

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> 2. Women's autonomy and best health care (including effective access to safe medical procedures) should be promoted, recognising that, at the earlier stages of pregnancy, abortion is lower risk and safer for the woman and at the later stages of pregnancy, abortion involves greater sensitivities and complications, especially higher risk for the woman and greater complexity;
> 3. The law in South Australia should align with relevant international human rights obligations, including enabling reasonable and safe access to abortion services;
> 4. The law in South Australia should be consistent with contemporary clinical practice and health regulation; and
> 5. The law in South Australia should achieve reasonable consistency with other Australian jurisdictions that have modernised their abortion laws, notably Victoria and Queensland (see *Abortion Law Reform Act 2008* (Vic); *Termination of Pregnancy Act 2018* (Qld)).

[149] *Abortion Law Reform Act 2008* (Vic).

[150] T*ermination of Pregnancy Law Reform Act 2017* (NT). See also Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016).

[151] *Termination of Pregnancy Act 2018* (Qld).

[152] New Zealand Law Reform Commission, Alternative Approaches to Abortion Law (Ministerial Briefing Paper, October 2018).

[153] See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478 (Hon Tammy Franks MLC); South Australia, *Parliamentary Debates*, House of Assembly, 26 September 2019, 7501–7504 (Ms Cook). See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4849– 4875. See further below Part 18.

[154] See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6; New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 1–7.

[155] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019). Given SALRI's extensive consultation prior to the introduction of the NSW Bill on 1 August 2019, it was impracticable to embark on a fresh round of consultation on issues raised by the 2019 NSW Act. Rather SALRI has paid careful regard to the submissions and comments from interested parties in relation to the 2019 NSW Act and has also had regard to the NSW parliamentary debate.

[156] Such work cannot be simply adopted in a South Australian context where South Australia has its own unique circumstances.

> individual minds are free to differ'. Abortion under prescribed circumstances has been a 'given' in SA since 1969 … While the Catholic Archdiocese of Adelaide opposed this legislation 50 years ago, and continues to oppose abortion … the reality of abortion in SA cannot be ignored. The Church recognises that SALRI is not determining whether abortion should or should not occur but is testing what regulations, legislation and appropriate medical controls could or should be in place around the provision of abortion procedures.

1.3.18 SALRI is not examining the highly involved question of when life starts. This is, as Professor Paul Babie of the Law School at the University of Adelaide rightly noted to SALRI, a complex moral, medical, legal and theological question that is beyond this law reform reference (and probably beyond any law reform reference) to resolve, and one on which opinions inevitably differ and any *agreed* answer has eluded (and will continue to elude) the most erudite of scholars, lawyers, physicians, philosophers and theologians.[157]

1.3.19 SALRI also acknowledges, consistent with judicial reasoning,[158] the fundamental premise that life is not legally recognised under Australian domestic law until a child is born.[159] 'The common law principle that a fetus is not a person, with legal rights, until born', as the VLRC noted, 'is a fundamental part of our legal system'.[160] This approach has been confirmed in various contexts, including in the abortion case of *Attorney General (QLD) ex rel Kerr v T*, where Gibbs CJ stated 'a fetus has no rights of its own until it is born and has a separate existence from its mother'[161] and as Gillard

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[157] See further Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 148–157; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 89–94. It is also an issue that has troubled law reform agencies. The QLRC, for example, refrained from the notion of a fetus having legal 'rights' but accepted that a fetus has 'interests' and 'that, as the fetus develops, its interests are entitled to greater recognition and protection': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 94 [3.181]. See also at 6 [1.29], 61–62 [3.48], 62–63 [3.52]–[3.53], 274 [18]; *R v Woolnough* [1977] 2 NZLR 508, 516–517. The Australian Lawyers' Alliance also 'acknowledges that as a pregnancy progresses and a foetus becomes viable, there is greater community support for considering the interests of an unborn baby'. This approach does seem somewhat at odds with the fundamental 'born alive' rule.

[158] See, for example, *R v Poulton* (1832) 5 C & P 329; *R v Hutty* [1953] VLR 338; *In the Marriage of F* (1989) 96 FLR 118; *Tremblay v Daigle* [1989] 2 SCR 53; *Burton v Islington Health Authority* [1993] QB 204, *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245; *R v F* (1996) 40 NSWLR 245; *Winnipeg Child and Family Services (Northwest Area) v G* (1997) 152 DLR (4th) 193; *R v Iby* (2005) 63 NSWLR 278; *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70 (9 December 2010), [22]–[26] (Anderson J), [81]–[102], [121]–[139] (Peek J); *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27 [21], [24], [94] and [305]–[306].

[159] This point was aptly summarised by the VLRC. 'The law has found it impossible, in numerous different contexts, to recognise a fetus as an entity with interests which are both separate and separable from those of a pregnant woman … The common law has always taken the view that legal personhood — possession of the legal rights and protections held by all people — does not arise until a fetus becomes a person by being "born alive". A fetus cannot be the victim of any form of homicide. Over 50 years ago Justice Barry observed in a murder trial that, "legally a person is not in being until he or she is fully born in a living state" and this occurs "when the child is fully extruded from the mother's body and is living by virtue of the functioning of its own organs". This rule was recently confirmed by the NSW Court of Criminal Appeal in *R v Iby* [(2005) 63 NSWLR 278.]': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 158 [C3], [C5]. SALRI cannot better this summary of the law.

[160] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 97 [7.13].

[161] (1983) 46 ALR 275, 277. See also *In the Marriage of F* (1989) 96 FLR 118, in which the applicant sought an injunction to restrain his estranged wife from terminating her pregnancy. Lindenmayer J dismissed the application, affirming that there are no common law rights that would support the husband's application. Specifically, the court concluded that the so-called 'right to procreate' claimed by the applicant did not extend to giving him a right to force his wife to continue her pregnancy against her wishes, even if it was not clear that the proposed abortion would be legal: at 122, applying *Paton v BPAS Trustees* [1979] 1 QB 276, 279 (Sir George Baker P). He also concluded that, because a fetus lacks legal personality and cannot have rights until it is born, a fetus has no common law rights that can be enforced by an applicant on its behalf: at 122. Justice Lindenmayer did acknowledge, however, that the Family Court had jurisdiction to grant the injunction sought: at 125. His Honour concluded that it would not be 'proper' to grant the applicant husband an injunction in this case as granting the injunction would force the

J has similarly pointed out: 'Legal personality begins at birth and ends with death.'[162] SALRI acknowledges that this rule is sometimes contentious and has been questioned,[163] especially in light of medical advances as to the age and circumstances in which a child, if born, is capable of existing independently.[164] However, it is beyond the scope of this review for SALRI to reconsider such a fundamental rule which has application in both a civil[165] and criminal[166] law context.[167] As Lord Mustill observed: 'It is sufficient to say that is established beyond doubt for the criminal law, as for the civil law … that the child *en ventre sa mère* does not have a distinct human personality, whose extinguishment gives rise to any penalties or liabilities at common law.'[168]

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respondent to proceed with a pregnancy she did not want, and to give birth to a child she did not want and which she might resent, which he felt cast doubts on both her will and capacity to carry out her functions as a mother. Granting the injunction would also compel the respondent 'to do something in relation to her own body which she does not wish to do', which would be 'an interference with her freedom to decide her own destiny'. He acknowledged that refusing the injunction could be said to allow the respondent 'to interfere with the destiny of the intended child,' but said that this objection was answered by his finding that the fetus had no legal right to be born which the court could protect. He also acknowledged that refusing the injunction could be said to allow the respondent to override her husband's 'interest in having his intended offspring born', but answered this objection by saying that, in the circumstances of this case, that interest was 'subordinate to the legitimate interest of the wife in being left free to decide a matter which affects her far more directly than it does the husband': at 127; see also *Tremblay v Daigle* [1989] 2 SCR 53.

[162] *Yunghanns v Candoora No 19 Pty Ltd* [1999] VSC 524, [82].

[163] See, for example, *R v Iby* (2005) 63 NSWLR 278, 288 [63]–[64]; Kristen Savell, 'Is the "Born Alive" Rule Outdated and Indefensible?' (2006) 28(4) *Sydney Law Review* 625; Elizabeth Chloe Romanis, 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' [2019] *Medical Law Review* (advance), 1. A number of submissions to SALRI, such as from the Australian Christian Lobby and Advocates International, also questioned the rationale and continued validity of the rule. See also St Thomas More Society, Submission No 16 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) [49]–[51], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64850/0016%20St%20Thomas%20More%20Society.pdf>.

[164] There is no one settled age but this is commonly taken to be between 22 (Queensland) and 24 weeks (Victoria). See further below Part 11.

[165] 'The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil rule of this country … and is, indeed, the basis of the decisions in those countries where law is founded on the common law, that is to say, in America, Canada, Australia and, I have no doubt, in others': *Paton v BPAS Trustees* [1979] 1 QB 276. 279 (Baker P). See also *In the Marriage of F* (1989) 96 FLR 118; *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70 (9 December 2010), [22]–[26] (Anderson J), [81]–[102], [121]–[139] (Peek J).

[166] See, for example, *R v Poulton* (1832) 5 C & P 329; *R v Hutty* [1953] VLR 338; *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245; *R v F* (1996) 40 NSWLR 245; *R v Iby* (2005) 63 NSWLR 278.

[167] SALRI agrees with the views of Peek J in this context. 'I consider that enough has been said to demonstrate that all of these [civil and criminal law] matters are interlinked in such a close and interactive way that if it be thought that substantial change should be made, it is a matter for the legislature and, with respect, only after the most thorough and broad ranging review of all of these areas': *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70 (9 December 2010), [139]. See also: 'The task of properly classifying a fetus in law and in science are different pursuits. Ascribing personhood to a fetus in law is a fundamentally normative task. It results in the recognition of rights and duties — a matter which falls outside the concerns of scientific classification. In short, this Court's task is a legal one. Decisions based upon broad social, political, moral and economic choices are more appropriately left to the legislature': *Tremblay v Daigle* [1989] 2 SCR 53.

[168] *Attorney General's Reference (No 3 of 1994)* [1998] AC 245, 261. The rule has some qualifications (see, for example, *Watt v Rama* [1972] VR 353; *V v G* (1980) 2 NSWLR 366) but it remains a fundamental premise of Australian law. As the VLRC notes: 'The common law has demonstrated its usual pragmatism by devising fictions to create limited exceptions to the general rule that only a person born alive can have interests protected by law. The fictions have been used in circumstances where the application of this general rule would produce an unjust result and the outcome has been supported by the woman in question': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 158 [C7]. However, in the few areas where the common law has acknowledged that

1.3.20 Not only is abortion a complex topic, but it is one that arouses strong and often conflicting opinions. As academics, Kate Galloway and Jemima McGrath noted, 'Abortion is a touchstone for social, ethical, and religious norms.'[169] The topic, as the Australian College of Nursing noted to SALRI, 'is contentious and divisive amongst the general population and the health professional community'. SALRI is acutely aware that the issue is polarising and gives rise to sincere, strongly held and divergent views that are difficult, if not impossible, to reconcile.

1.3.21 Some parties took a very direct view and told SALRI that abortion in all forms is unethical and should be totally prohibited. As already acknowledged, submissions such as these, while sincerely held, fall outside of the scope of SALRI's Terms of Reference.

1.3.22 SALRI further notes the sincerity of the conflicting views that it has received in its consultation and YourSAy contributions and through its research. SALRI had careful regard to all the views that it has received, but it is ultimately impossible to reconcile these views. SALRI reiterates that precluding all forms of abortion in South Australia is **not** within its Terms of Reference. SALRI also notes that the strong result of both its consultation and research does not support this position.[170] While it was urged upon SALRI, the so called 'heartbeat' model proposed by several parties such as Cherish Life Australia, Pregnancy Help Australia, 40 Days for Life and at the 16 May 2019 roundtable has also not been considered by SALRI. The 'heartbeat' model is based on recent developments in the United States which would prevent any abortion after a fetal heartbeat is said to be detected, typically at about six weeks.[171] Any such highly restrictive model is outside SALRI's Terms of Reference. In its operation, it would represent a severe restriction, if not reversal, of the current law in South Australia.

1.3.23 SALRI notes the practical reality that some form of abortion is an established feature of all Australian jurisdictions and this reference is premised on the basis that a suitably regulated form of abortion will continue to be lawful in South Australia. As Professors Millbank and Stuhmcke said to SALRI in another context, the 'horse has already bolted'.[172]

1.3.24 A strong (though far from universal) theme expressed to SALRI is that the State should not assume an interventionist approach in an area such as abortion and that by having criminality as the starting premise it creates a stigma which undermines a woman's reproductive autonomy and is also at odds with providing women with comprehensive and safe options for medical assistance. There has been strong (though not universal) support in SALRI's consultation for the foundational premise that women have autonomy, and should be free to make their own informed decision as to whether or not they seek an abortion. This premise is largely accepted by SALRI.

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a fetus has an interest that merits legal attention, 'in those cases the courts made it clear that legal rights do not accrue until birth': at 158 [C5].

[169] Kate Galloway and Jemima McGrath, 'Reproductive Justice: a Framework for Abortion Law Reform' (2018) 43(4) *Alternative Law Journal* 295, 296.

[170] See further below Part 2.

[171] Associated Press, 'Ohio Governor Severely Restricts Abortion in Move against *Roe v Wade*', *The Guardian* (online, 13 April 2019) <https://www.theguardian.com/us-news/2019/apr/12/ohio-governor-abortion-signs-heartbeat-law>; Jessica Glenza, 'Doctors' Organisation: calling Abortion Bans "Fetal Heartbeat Bills" is Misleading', *The Guardian* (online, 5 June 2019) <https://www.theguardian.com/world/2019/jun/05/abortion-doctors-fetal-heartbeat-bills-language-misleading>.

[172] David Plater, Madeleine Thompson, Sarah Moulds, John Williams and Anita Brunacci, *Surrogacy: A Legislative Framework: A Review of Part 2B of the Family Relationships Act 1975 (SA)* (South Australian Law Reform Institute, Report No 12, October 2018) 77 [7.5.40].

1.3.25 SALRI, in accordance with the Terms of Reference and existing models across Australia,[173] has focused on a framework for a suitable system of abortion in South Australia (albeit with an underlying premise that this is a personal decision and personal autonomy and rights to privacy in regard to medical treatment must be balanced) and, though various parties in consultation have raised these options, has not examined nor sought to formally or effectively preclude any form of abortion in South Australia. This option does not accord with SALRI's Terms of Reference and is also inconsistent with interstate law and practice, community expectations and the rights of the individual.[174] They are therefore outside the scope of this Report.

1.3.26 The *Criminal Law Consolidation Amendment Act 1969* (SA) (hereafter '1969 South Australian Act'), whilst at the time a progressive (and even radical) step,[175] has failed to keep up with clinical, scientific and other changes. One example is that the 1969 Act predates the now widespread use of medical abortion.[176] The present law contemplates abortions only being conducted on a surgical basis and this is no longer the case. Another example is the approach to disability featured in the 1969 Act, which is at odds with modern attitudes and practices.[177]

Broad examples for potential reform

1.3.27 SALRI has looked at a number of options for potential reform, including, although not exclusively, those presented by the VLRC.[178]

1.3.28 **Example A** would retain but seek to clarify and update the present law in the *CLCA* (supplemented by judicial rulings in other parts of Australia)[179] on the legality of abortion. Under this approach an abortion is lawful with the woman's consent, and when an appropriate health practitioner or practitioners determines that an abortion is necessary because of a risk of harm to the woman's physical or mental health if the pregnancy continued. This approach casts the medical practitioner as the 'gatekeeper' and provides that abortion must be a necessary and proportionate response to the risk of physical or mental harm faced by a pregnant woman. Case law supplements the range of factors impacting on a woman's physical or mental health that may be taken into account when determining risk of harm. These are economic, social, or medical matters that may arise during pregnancy, or later.

1.3.29 **Example B** provides for a two-staged approach to regulation, with different rules and procedures for early and later term abortions. The stages at which different rules should apply is difficult to identify with different views. It is often linked to the notion of fetal viability. Late term abortions are defined in Victoria, for instance, as those where the pregnancy has exceeded 24 weeks gestation, which was said by the VLRC to accord with current clinical practice.[180] In Queensland (and in the recent NSW Act), it is 22 weeks. Abortions before the relevant gestation period are regulated in the same way as any other medical procedure. The only requirements are the woman's consent and that the procedure be performed, or supervised, by an appropriate health practitioner. Once a pregnancy passes the relevant stage, abortion would only be lawful if a medical practitioner (or two medical practitioners) determined that it was necessary to prevent risk of physical or mental harm to

[173] See further below [3.2.1]–[3.2.21], [3.3.1]–[3.3.30].

[174] See below Parts 2 and 3.

[175] Other jurisdictions such as NSW and Victoria left change to the law to the courts and not Parliament.

[176] MS-2 Step is the most common protocol for a medical abortion. See below Part 8

[177] See further below Part 13.

[178] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 6–7. See further at: 85–93.

[179] See *R v Davidson* [1969] VR 667; *R v Wald* (1971) 3 DCR (NSW) 25.

[180] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 6, 90.

the woman if the pregnancy continued (or some other criteria such as 'appropriate in all the circumstances'). Risk of harm can be formulated in various ways. Example B also encompasses the situation where there are no criteria, but differing procedures arise at different stages of gestation such as a need for the approval or at least involvement of two medical practitioners after 22 or 24 weeks.

1.3.30 **Example C** is often called the 'on request' model[181] and would regulate abortion in the same way as any other medical procedures. Under this approach, abortion would be lawful at all gestational stages with the woman's consent, and if performed by an appropriate health practitioner. This approach places the decision-making responsibility with the woman, and service availability with the medical (or health) profession. This is essentially the model that exists in the Australian Capital Territory.[182] It is also the approach proposed in the Statutes Amendment (Abortion Law Reform) Bill 2018 (SA) (hereafter '2018 South Australian Bill'). This approach does not leave the subject of abortion unregulated as a comprehensive framework of health law and practice and professional guidelines and protocols still apply.[183]

1.3.31 As previously noted, these examples are broad categorisations and involve overlap and numerous variations. They are provided to outline the various approaches to regulation in this area.

1.3.32 SALRI has had careful regard to the general principles outlined by the Attorney-General. It also notes the general principles outlined and taken into account by other law reform agencies and organisations during consultation.[184] The QLRC, for example, was 'guided by a number of key principles', including the following:

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[181] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 38 [124]–[125].

[182] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT).

[183] As the South Australian Abortion Action Coalition note: 'All health procedures, practices and services are closely controlled and regulated by government, industry and professional bodies, and breaches are dealt with seriously. In this way, existing health law, regulations, codes of practice, clinical protocols and institutional policies and procedures provide a comprehensive regulatory framework that protects patients, promotes good quality and safety in health care and ensures accountability. There are more than 20 health statutes in South Australia, and nearly 70 Commonwealth statutes, covering virtually every aspect of health, aged and disability care and public health.'

[184] Other groups have also outlined the guiding principles. Advocates International, for example, argued 'The Five Cs', namely care for women, care for babies, care for children in the womb, care for families and care for life. Dr Sarah Moulds at the University of South Australia suggested any model should 'recognise that laws that criminalise abortion threaten women's basic rights to life, health, equality and bodily autonomy, recognise women as capable of making decisions about their own bodies, improve access to safe medical abortion, provide safe access zones around abortion services, impose an obligation on health practitioners to refer where a conscientious objection is held and remove the requirement for parental consent for girls who are competent to provide consent.' The Human Rights Law Centre drew SALRI's attention to:

'Principles to guide abortion law reform inquiries:

- The law should promote the health, equality, dignity and autonomy of pregnant people, in particular the freedom to choose what happens to their bodies.
- The law should promote equal access to quality and safe health care across urban, regional and remote parts of South Australia.
- The law should be clear and regulate abortion as a healthcare matter rather than a criminal matter.
- The law should be consistent with public health standards and regulation and allow for the evolution of clinical practice.
- The law should align with international human rights obligations relevant to abortion, including safe access to abortion services.
- The law should be gender-inclusive in recognition of the fact that people who identify as transgender or gender diverse may also experience pregnancy.'

> Generally, termination should be treated as a health issue rather than as a criminal matter;
>
> Women's autonomy and health (including access to safe medical procedures) should be promoted, recognising that: at the earlier stages of pregnancy, a woman's autonomy has greatest weight, and termination is lower risk and safe for the woman; at the later stages of pregnancy, the interests of the fetus have increasing weight, and termination involves higher risk for the woman and creates more complex issues;
>
> The law should align with international human rights obligations relevant to termination of pregnancy laws, including enabling reasonable and safe access to termination services;
>
> The law should be consistent with contemporary clinical practice and health regulation; and
>
> The law should achieve reasonable consistency with other Australian jurisdictions that have modernised their laws relating to termination.[185]

1.3.33 SALRI is of the view that, having regard to its research, consultation and contemporary clinical practice and interstate law, the present law relating to abortion in South Australia is outdated in various respects and no longer reflects contemporary clinical practice or medical advances. Its current operation further undermines the autonomy of women and has an adverse effect on both patients and health staff and acts as a positive barrier to fair and effective access by women in rural, regional, remote and Aboriginal[186] communities. The present law is outdated and needs change to align more closely with contemporary clinical practice and professional protocols.

1.3.34 Aspects of the present law such as the requirement for any abortion (whether medical or surgical) to take place at a 'prescribed hospital', the need for two medical practitioners to 'personally' examine a patient and agree an abortion is appropriate, the two month residency requirement, the criteria for when an abortion can be carried out (especially the present disability specific criteria), the difficult question of late term abortions and the general upper limit of 28 weeks,[187] the role and operation of conscientious objection and the absence of any formal requirement for referral and the absence in South Australia of safe access zones to protect both patients and staff at premises providing abortions from intimidation, harassment and obstruction are all problematic.

1.3.35 The present law is also problematic in that it reflects the paternalistic model that the medical practitioner should be the gatekeeper to medical treatment that, whilst prevailing in 1969, is at odds with modern law and practice that now emphasises the need to respect patient autonomy and the concept of patient centred care.[188]

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[185] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) v. See also at: 5–6.

[186] SALRI, reflecting a strong theme in its consultation, is keen to ensure that Aboriginal communities are not disadvantaged. As the South Australian Abortion Action Coalition noted of the effects of present law and practice: 'Aboriginal women are disproportionately resident in rural and remote locations and so disproportionately affected.' The Institute for Urban Indigenous Health Ltd similarly cautioned the QLRC 'against any restrictions that inequitably disadvantage Aboriginal and Torres Strait Islander women, including those that might place practical limitations on the availability and accessibility of termination services': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 56 [3.30]. See further below Part 16.

[187] See below Part 11.

[188] Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283, 294–296. 'Today, the importance of respecting patient autonomy pervades the professional guidance available to doctors… doctors… have a duty to work in partnership with patients': at 295. See also *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11, [81]: 'Social and legal developments ... point away from a model of the relationship between the doctor and patient based upon medical paternalism.'

1.3.36 The lack of decision making afforded to the woman under the medical gatekeeper model was widely criticised in SALRI's consultation (though some parties opposed to the decriminalisation of abortion viewed it as necessary). The Human Rights Law Centre observed that the present law in South Australia puts medical practitioners in the position of 'gatekeeper' over women's access to abortion as women are required to obtain approval from two medical practitioners. 'In doing so, women are effectively told that they cannot be trusted to make decisions about their bodies and lives.' The Human Rights Law Centre said any new law 'should be framed in a way that respects the autonomy of women and their right to control what happens to their body'.

1.3.37 It was often submitted to SALRI that the present law in South Australia regarding abortion is at odds with modern health law and practice which respects the autonomy of patients and their ability to make their own medical decisions in consultation with practitioners.[189] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (hereafter 'RANZCOG') emphasised the need for the woman to have the autonomy to decide on her treatment, explaining:

> RANZCOG supports a woman's right to abortion on request and believes the law should recognise this right. The decision about whether to have a termination of pregnancy should be made by the woman in consultation with her treating health practitioner in the same way that decisions about all other health services are made. The existing South Australian law, which requires a doctor to determine whether abortion is legally justified in each case, is now outdated and should be changed.

1.3.38 Professor Sheldon and her eight UK colleagues[190] noted that the legal requirement for two medical practitioners to certify the need for an abortion 'is grounded in the assumption that doctors, rather than women, are best placed to decide whether an abortion is justified'.[191] This was viewed as outdated.[192] As Professor Sheldon noted: 'Modern medicine has shifted fundamentally away from "doctor knows best" paternalism: today patients are routinely trusted, and indeed expected, to make important decisions for themselves.'[193]

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[189] The Australian Health Practitioner Regulation Agency Code of Conduct and the Australian Medical Association's Code of Ethics facilitate and promote autonomy in decision-making and also providing referral advice. See, for example, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Code of Conduct, March 2014) 6 [2.1.4]—[2.1.5] <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>; Australian Medical Association, *AMA Code of Ethics* (Code of Conduct, 2016) 1 [2.1.5], 5 [3.3] <https://ama.com.au/sites/default/files/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016.pdf>.

[190] Professor Marie Fox of the University of Liverpool, Professor Emily Jackson of the London School of Economics, Professor Jonathan Herring of Oxford University, Professor Jean McHale of the University of Birmingham, Professors Nicky Priaux and Professor Muireann Quigley of the University of Birmingham and Professor Rosamund Scott of Kings College London.

[191] Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) *Oxford Journal of Legal Studies* 334, 345.

[192] The present criminal prohibitions reflect a time that 'in matters sexual was almost unimaginably different from ours', when 'our society was only on the brink of the beginnings of the modern world': *R (Smeaton) v Secretary of State for Health and Others* [2002] EWHC 610 (Admin), [332]. The present laws dates from a period before women had the right to vote and when a woman's authorship of a treatise on contraceptive methods was deemed sufficient reason to remove a child from her custody! See *Re Besant* (1878) 11 ChD 508.

[193] Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) *Oxford Journal of Legal Studies* 334, 345. Professor Sheldon observed that in no other medical context — including those where treatment decisions may impact on fetal health and survival — are pregnant women treated as a legal exception to this proposition. A woman has a legal right to decline a Caesarean Section, even where one is believed necessary for her own health and the wellbeing of her baby. See *St George's Healthcare NHS Trust v* S [1988] 3 WLR 936; *Re MB (Adult, Medical Treatment)* [1997] 38 BMLR 175. In *Montgomery*, which concerned the informed consent of a pregnant woman, a seven judge UK Supreme Court noted that social and legal developments 'point away from a

1.3.39 There has been strong (though not universal) support in SALRI's consultation for the foundational premise that women have autonomy, and should be free to make their own informed decision as to whether or not they seek an abortion. This premise is largely accepted by SALRI.

1.3.40 SALRI concurs with the approach of the Northern Territory:

> … a comprehensive, contemporary approach requires robust legislation for gestations across all phases of pregnancy. Contemporary legislation requires: evidence based practice by health professionals who make decisions about when, how and where to implement treatment according to an assessment of the health and wellbeing of the woman within a framework of professional practice guidelines; an approach to consent for termination of pregnancy that is in line with consent for other medical procedures; provisions for both conscientious objection and referral to another practitioner who can provide appropriate services; and provisions for safe access zones in the vicinity of treatment facilities.[194]

1.3.41 SALRI is aware that abortion is a complex issue that gives rise to a variety of legal, medical and ethical implications.[195] Conversations regarding abortion often give rise to sincere, deeply felt and often conflicting views and it is impossible to reconcile the competing views that are held in this area.[196] SALRI notes that on occasion and throughout Australia the debate about abortion has been marked by intemperate, even extreme, language [197] and SALRI commends the interested parties and overwhelming majority of community members who provided their input to SALRI for doing so in a constructive and considered manner.

1.4 Findings

1.4.1 SALRI acknowledges the sincerity and conviction of the various and many differing views expressed to it and reiterates that there is no simple, universal or straight-forward position. In making its recommendations, SALRI has carefully considered the Terms of Reference that frame this review, the origins and operations of the current South Australian law, interstate law, the reviews undertaken

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model of the relationship between the doctor and patient based upon medical paternalism', towards an approach that treats patients 'so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices': *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [81].

[194] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016) 2.

[195] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 148 [B.8].

[196] 'Some people have strong ethical views about abortion. Those views range from absolute opposition to abortion in all circumstances to respect for women's autonomy, and various points in between': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 148 [B.1]. The VLRC noted that some parties supported decriminalisation. 'They characterised abortion as a matter between a woman and her doctor, with autonomy as the fundamental principle that the law should respect. The Paediatric State Committee, Royal Australasian College of Physicians, stated '[a]ny departure from this principle risks compromise to the health and rights of the woman concerned'. Autonomy was also strongly argued by community groups, health organisations and disability organisations, which saw no place for the criminal law in regulating what they considered was a woman's personal decision': at 72 [5.9]–[5.10]. However, the VLRC noted that others 'took an alternative view, stressing a moral opposition to abortion and a belief that abortion should remain a crime. This view was also expressed by various Catholic organisations. Many submitters argued that abortion is potentially harmful to women and that autonomy is a hollow promise': at 72 [5.11].

[197] See, for example, the emotive criticism directed at the Hon Tammy Franks. See South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2427-2428; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2777–2779.

in comparable jurisdictions, available research, its many consultation responses and submissions as well as contemporary medical practice and procedures.

1.4.2 SALRI accepts the foundational premise that women have autonomy and, in the context of this review (consistent with wider health law and practice), should be free to make their own informed decision as to whether or not they seek an abortion. SALRI has framed its recommendations on this basis.[198]

1.4.3 SALRI is of the view that abortion should be treated as a health issue rather than as a criminal law matter and a woman's autonomy and best health care should be respected and promoted.

1.4.4 SALRI suggests that abortion should be largely (though not totally)[199] removed from the criminal law, especially the *CLCA,* and placed in health law and practice.[200] To this end, ss 81, 82 and 82A of the *CLCA* should be repealed and replaced for clarity with the appropriate provisions, as recommended in this Report, in a standalone Act or the most suitable Act.[201]

1.4.5 Recommendation

Recommendation 1

SALRI recommends that abortion should be treated as a health issue rather than as a criminal law matter and a woman's autonomy and best health care should be respected and promoted.

[198] See below Part 5, especially Recommendations 2, 3, and 4.

[199] SALRI supports the retention, as exists interstate, of an offence to cover procedures (both surgical and medical) involving unqualified persons, though excepting both the woman concerned and health practitioners. See below Part 6. SALRI also supports the introduction of safe access zones (and associated offences) around abortion providers. See below Part 18.

[200] It is important to note that, even the total removal of all issues surrounding abortion from the criminal law, would not leave this area unregulated as it will still be subject to a comprehensive framework of health law and practice and professional protocols and guidelines.

[201] SALRI understands that the *Health Care Act 2008* (SA) may not be a suitable Act.

Part 2 – Abortion: An Overview of Consultation

2.1 The Big Picture

2.1.1 Abortion is not a new practice or issue.[202] Indeed, as an issue, abortion goes back centuries. As the VLRC observed:

> Abortion has been practised since the earliest times. Throughout history, moral, religious, and ethical considerations have been engaged in the debate about the role of law in abortion. At various times abortion has been punished, tolerated, or hidden but at all times, the practice has remained.[203]

2.1.2 'Abortion is a common procedure.'[204] It is estimated that approximately 1 in 4–5 (20–25%) women in Australia will have an abortion during their lifetime[205] (though the number in Australia has been decreasing over time).[206] It does not appear to be the case that the rate of abortion increases if the law is liberalised;[207] in fact the reverse appears be true.[208]

2.1.3 Further, as Dr Sarah Moulds of the University of South Australia (and others) noted: 'Restrictive abortion laws don't prevent abortions; but lead to worse health outcomes for women and they threaten women's basic rights to life, health, equality and bodily autonomy'.[209]

2.1.4 'The question of when, if ever, performing an abortion will be morally justified is one that endlessly consumes many philosophers, theologians, feminists, social scientists and legal

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[202] The earliest surviving record of abortion law is over 3000 years old. Babylonian law provided that a woman who 'cast the fruit of her womb by her own act shall suffer impailment': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 142 [A.5]. The original Hippocratic Oath, as one party opposed to decriminalisation of abortion noted to SALRI, included: 'I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan: and similarly I will not give a woman a pessary to cause an abortion.'

[203] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 142 [A.1]. 'Women have always had abortions and will always continue to do so, irrespective of prevailing laws, religious proscriptions, or social norms': David Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, 1917. See further Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 142–147; Joseph Dellapenna, 'The History of Abortion: Technology, Morality and Law' (1978) 40(3) *University of Pittsburgh Law Review* 359.

[204] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 31 [2.1].

[205] Family Planning Alliance Australia noted to SALRI that reliable figures are elusive and there is no routine national abortion data collection in Australia. A 2003 national survey reported that 22.6% of women aged 16 to 69 had received an abortion at some time in their lives: Anthony Smith et al, 'Sex in Australia: Reproductive Experiences and Reproductive Health among a Representative Sample of Women' (2003) 27(2) *Australian and New Zealand Journal of Public Health* 204, 206. See also below [4.1.1].

[206] Allison Branley and Sophie Scott, 'The Rate of Abortion in Australia is Lower Than You Think', *ABC News* (online, 13 December 2017) <https://www.abc.net.au/news/2017-12-13/the-rate-of-abortion-in-australia-is-lower-than-you-think/9250122>.

[207] Rosana Peiro et al, 'Does the Liberalisation of Abortion Laws Increase the Number of Abortions? The Case Study of Spain' (2001) 11(2) *European Journal of Public Health* 190. It is noted that what increases is unsafe abortions if abortion is criminalised. See Anibal Faundes and Iqbal Shah, 'Evidence Supporting Broader Access to Safe Legal Abortion' (2015) 131(1) *International Journal of Gynecology and Obstetrics* 556. See also below [4.1.2].

[208] Anibal Faundes and Iqbal Shah, 'Evidence Supporting Broader Access to Safe Legal Abortion' (2015) 131(1) *International Journal of Gynecology and Obstetrics* 556.

[209] See also, for example, David Grimes et al, 'Unsafe Abortion: the Preventable Pandemic' (2006) 368 *The Lancet* 1908.

commentators.'[210] There has been a vast amount of Australian academic[211] and law reform[212] consideration of abortion since the enactment of the 1969 South Australian Act[213] and the landmark *Davidson* ruling[214] in the same year that effectively liberalised (but did not decriminalise) abortion in Victoria and other States.[215]

2.1.5 To say that the subject of abortion has attracted (and continues to attract) extensive attention, debate and scrutiny is an understatement. As the VLRC observed:

> No issue has attracted more public attention, passionate opinion, and ink than abortion. Abortion is an ethical issue primarily because it involves ending the life of a fetus. It therefore raises challenging questions about the status of a fetus and the interrelationship between a pregnant woman and a fetus .... Historically the debate pits opponents of abortion against those who argue that abortion is a matter of personal choice for the woman contemplating it. One line of argument

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[210] Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998).

[211] See, for example, John Finnis, 'Abortion and Legal Rationality' (1970) 3(4) *Adelaide Law Review* 431; John Miller, 'Medical Abortion in South Australia: A Critical Assessment of Early Complications' (1973) 1(17) *Medical Journal of Australia* 825; Louis Waller, 'Any Reasonable Creature in Being' (1987) 13(1) *Monash University Law Review* 37; Natasha Cica, 'The Inadequacies of Australian Abortion Law' (1991) 5(1) *Australian Journal of Family Law* 37; Lynda Crowley-Cyr, 'A Century of Remodelling: The Law of Abortion in Review' (2000) 7(3) *Journal of Law and Medicine* 252; Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229; Lachlan de Crespigny and Julian Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201**;** Talina Drabsch, 'Abortion and the Law in New South Wales' (Briefing Paper No 9/05, Parliamentary Research Service, Parliament of New South Wales, August 2005); Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207; Patrick Ferdinands, 'How the Criminal Law in Australia Had Failed to Promote the Right to Life for Unborn Children: A Need for Uniform Criminal Laws on Abortion Across Australia' (2012) 17(1) *Deakin Law Review* 43; Jenny Morgan, 'Abortion Law Reform: The Importance of Democratic Change' (2012) 35(1) *University of New South Wales Law Journal* 142; Heather Douglas, Kirsten Black and Caroline de Costa, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20(3) *Journal of Law and Medicine* 560; Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105; Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41; Caroline de Moel-Mandel and Julia Shelley, 'The Legal and Non-Legal Barriers to Abortion Access in Australia: a Review of the Evidence' (2017) 22(2) *European Journal of Contraception and Reproductive Health Care* 114.

[212] See, for example, Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998); Nicolee Dixon, 'Abortion Law Reform: An Overview of Current Issues' (Research Brief No 2003/9, Parliamentary Library, Parliament of Queensland, 2003); Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008); Department of Health (NT), *Termination of Pregnancy Law Reform: Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016); Tiana Legge, *Policy Recommendations for Immediate Consideration by Governments of Australia* (White Paper, Women and Babies Support International Ltd, 2018); Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016); Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017); Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017); Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76); Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, June 2018); Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019).

[213] *Criminal Law Consolidation Amendment Act 1969* (SA) (No 109 of 1969).

[214] *R v Davidson* [1969] VR 667. See also below [3.6.15]–[3.6.18]. See also *R v Wald* (1971) 3 DCR (NSW) 25.

[215] See *R v Wald* (1971) 3 DCR (NSW) 25. See further below Part 3.

is based on a belief that the fetal interests are paramount, the other is based on the view that a woman's autonomy is paramount.[216]

2.1.6 There were many divergent views and reasoning expressed in SALRI's consultation. As was also found by the VLRC: 'Some people have strong ethical views about abortion. Those views range from absolute opposition to abortion in all circumstances to respect for women's autonomy, and various points in between.'[217] It is unrealistic to expect that consensus can be reached in this area. As the Model Criminal Code Officer's Committee observed: 'The criminal law in relation to abortion is the hottest of political, social and religious issues about which it is simply impossible to reach anything like consensus.'[218] Though abortion is a subject that gives rise to sincere and often strongly held views, SALRI reiterates the fact that most submissions were constructively expressed.[219]

2.1.7 A significant number of groups and individuals opposed any relaxation in the present law,[220] and, indeed, argued that abortion should either be totally prohibited or, at least, greatly restricted. This view was also expressed by many of the attendees at SALRI's roundtable with faith groups on 16 May 2019 and with faith groups and NGOs on 12 June 2019. A number of medical and health practitioners, notably Dr Šeman and Dr Turnbull,[221] also expressed this view. A limited number of

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[216] Victorian Law Reform Commission, *Law of Abortion*, Report No 15 (2008) 148 [B8].

[217] Ibid 148 [B.1].

[218] Model Criminal Code Officers Committee, *Chapter 5: Non-Fatal Offences against the Person* (Discussion Paper) (1996) 81.

[219] There were a few exceptions. One party declared: 'This is a very controversial topic with a very human element. However, most of you are probably legal eagles and paper pushers and not all too concerned about the human element … It's not just fuddy duddy old Boomers protecting the unborn, it's vegan Millennials like myself.' One party argued: 'Penalties should apply to both the man and the woman for failure to use a contraceptive ... Far too many abortions are occurring. We are killing off healthy babies and keeping sick ones alive. This is against the law of nature and breeds a sick race. We now fill a workforce with foreigners because our people are not having babies.' Another party argued: 'Each mother needs to understand that they are loved by God and He will care and provide for them through His faithful servants. All women be given a copy of relevant scripture early on in their pregnancy and again when they present for an abortion — they choose to read it or ignore it — they need to be shown the truth as it is written — denying them this choice is taking away their rights from them. In addition it should be a requirement that pregnant women considering an abortion be informed of what happens to the baby in the process of the procedure via a truthful video description from a Dr who has undergone these procedures, just as women who chose to keep their babies are shown birthing videos of what to expect. Repeat offenders be required to have implant contraception reviewed annually just as an irresponsible driver loses their licence to drive for a period of time. They also need to be given the opportunity to hear the truth from the Gospel each time they return, so they can choose for themselves to be forgiven, repent and be redeemed.' One group argued: 'We are horrified that any person should believe they have the right to murder babies. You know that a fetus is a HUMAN BEING from the time of conception. So now Australians are becoming so degraded that they can murder fetus's in the womb … Next you will be doing as the Aboriginal people of the Pilbara and Murchison did just over 150 years ago — eating the newborn just because it is nice juicy meat — better than Kangaroo. I have evidence of this in Daisy Bates autobiography. We cannot believe that our society could stoop to such low places. Instead of murder why not nurture young people to refrain from having sex until they have a life partner to whom they are committed and with whom they will have a real genuine love relationship (not just a sex one). This will bring boundaries, discipline and relationship back into our society that is crumbling fast and we will no longer be called "the lucky country". If you were born in Australia before 1960 you were raised on the Judeo/Christian Ethics — when you destroy these you suffer the consequences which we are experiencing now.'

[220] These individuals and groups included Dr Elvis Šeman and Dr Antonia Turnbull, Anna Walsh at Notre Dame University Australia, the Adelaide Centre for Bioethics and Culture, 40 Days for Life, Advocates International, the Australian Christian Lobby, Birthline Pregnancy Support Inc, the Canberra Declaration, Cherish Life Australia, the Christian Legal Centre, Concerned Women's Collective, Family Voice Australia, Genesis Pregnancy Support Inc, Pregnancy Help Australia Ltd, the Right to Life Association of South Australia and Women's Forum. Only a few respondents to SALRI's online survey stated that the current legislative framework should remain unchanged.

[221] The submission of Dr Šeman and Dr Turnbull to SALRI was endorsed by 39 medical and health practitioners in a personal capacity.

online survey responses also outlined this view. It was often argued to SALRI that life begins at conception and should be legally recognised and protected from this stage.[222] SALRI acknowledges the sincerity of these views but reiterates that any such approach is outside its Terms of Reference.

2.1.8 Despite these submissions, SALRI is of the view that, having regard to its extensive research (including interstate law and contemporary clinical practice) and consultation, such an approach is not supported by the medical profession or the wider community.

2.1.9 Overall, it is important to note that a wide range of views were expressed to SALRI by groups and individuals who opposed any relaxation in the present law. There was no single approach.[223]

2.1.10 Some groups and individuals took an absolute approach and argued that abortion should be totally prohibited. As one party submitted: 'I plead with you to consider that human life begins at conception. Clinically, or medically induced, abortion at any time after conception, is murder.' Another party similarly asserted: 'Abortion is an unacceptable practice and is not justified on any grounds.' Another argued: 'I believe that abortion is the murder of a living human.' One submission stated that abortion is 'unnecessary' and 'more counselling and support is required … and adoption is a much better option'.[224]

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[222] Family Voice Australia, for example, argued: 'Human life begins at conception: The science is clear as to when human life begins.' Another submission argued: 'Human life begins at conception. Clinical or medially induced abortion, at any time after conception, is murder.' The Lutheran Church argued: 'We concur with elementary biology that human life begins at conception. This is when a new life with its own unique genetic code is formed.' The UK-based Christian Legal Centre also presented this position to SALRI. This view was challenged by others in SALRI's consultation. The Church of the Flying Spaghetti Monster Australia argued: 'The fact is, scientifically, we simply do not know when sentience begins. The beginning of sentient life is purely a religious, spiritual or personal opinion. Differing religions have differing opinions on when sentient life begins. Different people have different opinions on when sentient life begins. Whilst we do have a lot of knowledge of the viability of a fetus to stay alive once it no longer has its maternal life support system in place … at what point the fetus becomes sentient is completely unknown and entirely a matter of opinion.'

[223] Some of the reasons offered were less than convincing. A retired midwife claimed: 'There are many other glaring reasons for outlawing abortions. A high abortion rate produces a higher risk of invasion, because there are not enough young people in the defence services. It is very sad that many people in the above services are female. Are they as strong as men? ***No***. Also, women think emotionally, men think with reason. I know who I would have preferred in our defences, men only. When it was decided that the Australian population was too low (of course abortion was one of the causes) we imported workers. Most of them are socially or intellectually incompatible with born Australians. Our country is better off with ***born*** Australians. Why are women filling so many of men's jobs? Because of the Marxists who want Australia to have a much lower population so they can invade us.' Another party argued; 'Abortion is not in the interests of society which must pay the price. The high reported rate of 100,000 Australian babies aborted each year has disrupted the age demography of Australia so there are not enough taxpayers to care for our elderly. We kill so many of babies conceived in Australia that the proportion of Australians born overseas is increasing and now is 26.3%. We need to maintain the proportion of Australians raised in Australia to maintain our identity.'

[224] Many parties such as Advocates International, the Lutheran Church, Genesis Pregnancy Support Inc, Pregnancy Help Australia, Pregnancy Help SA and Cherish Life Australia raised adoption to SALRI as a preferable alternative to abortion. SALRI does not doubt the sincerity of the suggestion but this does not appear a realistic alternative and adoption is now very rare. As SA Health notes: 'Adoption is better than abortion[?] Fact: This view claims that since there are so few children available for adoption then women with unwanted pregnancies should be encouraged to relinquish their offspring for adoption. For many women the choice to have an abortion is because they do not want to be pregnant, or continue to be pregnant, or to give birth or to relinquish a child. In an Australian study, "We Women Decide", women who had relinquished a baby for adoption spoke of the pain and ongoing feelings about this decision and this is in contrast to having no regret following an abortion.' SALRI also notes the VLRC's comments. 'Adoption is no longer common. When it does occur, it is an open process, with a stronger emphasis upon agreed contact and exchange of information than historic adoption processes. If abortion is denied some women may feel that they are forced to continue with unwanted pregnancy, go through birth, and then enter a relationship with a child with the attendant societal expectations that brings': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 39–40 [3.53]–[3.54]. Dr Erica Miller cogently noted to

2.1.11 One clergyman argued:

> A great many people, however (myself included), do not accept abortion in any form at all. Failing the total banning of abortion, I would argue for the most restrictive laws possible, as to who can perform them, until what time in the pregnancy etc. It should be discouraged as a practice, and more positive solutions encouraged, such as helping the mother keep the baby, or adoption.

2.1.12 Other parties took a near absolute approach and asserted that abortion should only allowed in very narrow, typically life-threatening situations.[225] One party stated: 'Abortion should be allowed in situations of dire necessity related to health issues.' Woman should not be allowed access to lawful abortion at any stage of a pregnancy in the view of 40 Days for Life 'except when the life of the woman is clearly at grave risk'. Another party argued: 'I think that an embryo deserves to live, has a sacrosanct Right to live. The only two exceptions should be: anencephaly and other severe deformities. Perhaps occasionally, where a mother has been raped and the woman feels too traumatised to cope with the result.'[226]

2.1.13 Cherish Life Australia argued that any relaxation of the law is unnecessary and misplaced and abortion should be confined to 'cases of high risk of maternal mortality'. It explained:

> Abortion is already highly accessible in SA under the current legal framework. No woman has ever been convicted, and there is a provision for free legal abortions up to 28 weeks (which in our opinion is excessive and wrong). Any further liberalisation of abortion laws in South Australia we at [Cherish Life Australia] are strongly adverse to. Removing all restraint from abortion access, would undoubtedly lead to more dead babies and more women harmed, as has been the case in other states where all restraint from abortion was removed.[227]

2.1.14 Other groups and individuals, whilst not supportive of relaxation of the present law, took another approach. One party accepted that abortion should be allowed in 'exceptional circumstances' and urged SALRI to 'resist the temptation to swing to the extreme right or left, instead cater for a common sense middle ground if abortion is needed to save the mother's life/health'. Another party said: 'While we appreciate that under certain circumstances an abortion may be necessary, in general we think that the present abortion law gives too much freedom to a mother to terminate a life that in most cases, she has be active in generating.' Another person argued:

> I submit that, in reforming abortion law in South Australia, is appropriate and necessary to retain Divisions 17 and 18 of the *CLCA* to provide due recognition of the value of human life and the gravity of killing a human being without lawful reason. Penalties should be reviewed and modernised. The appropriateness of imposing criminal sanctions on the pregnant woman should be reviewed. With medical advances, the viability is now less than 28 weeks; the law should reflect this. However, any reform that fails to recognise the humanness and value of the unborn child will create a precedent for deemed non-personhood. Such a law would not be ultimately good for the citizens of South Australia.

SALRI: 'Anti-choice activists look at adoption as an alternative to abortion. This proposed solution sidesteps the ethical issue of forced pregnancy and birth. Local adoption is very rare in Australia and the open adoption practiced in Australia today encourages ongoing relationships between birth parents and their adopted children … Thus a maternal relationship is established even when the child is adopted.'

[225] See also below [10.3.22]–[10.3.24], [10.4.3]. See further Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 81 [3.125], 82 [3.129].

[226] See also below [10.2.20]–[10.2.25], [10.3.25]–[10.3.27], [10.4.5].

[227] The relaxation of abortion laws does not appear to have led to an increased rate of abortions. See below [2.2.1], [4.2.1]–[4.2.2].

2.1.15 SALRI, while recognising the above views, notes that there was extensive support in its consultation for the present law to be relaxed and to remove (or at least largely remove) abortion from the criminal law.[228] This was the very strong view expressed by professional medical and health associations[229] and at SALRI's roundtable sessions with the disability sector on 20 May 2019, medical and legal sectors on 7 June 2019 and groups supportive of the decriminalisation of abortion on 7 June 2019. This was also the strong (though not universal) view to emerge in SALRI's regional visits to Whyalla, Port Augusta, Ceduna, Port Lincoln and Murray Bridge and discussions with medical and other health practitioners and providers. This was also the position expressed of the majority of the rural general practitioners consulted.

2.1.16 The overwhelming view in the online YourSAy responses was in favour of relaxation of the present law, though views differed as to the extent of any changes. Over half of all respondents supported the complete removal of any offences relating to abortion from the criminal law.[230] Typical of this view was this submission: 'Abortions should be free, readily available and void of stigmatisation.' Another said: 'Abortion should be governed by clinical guidelines and best evidence based medical practice.' Another said: 'The removal of the legal stigma is likely to enhance access, reliability of services and best health care outcomes.'

2.1.17 This view also strongly (though not universally) emerged in the 340 odd written and other submissions SALRI received. These submissions ranged from a single sentence to hundreds of pages. SALRI found in the submissions strong (though not universal) support for reform of the present law regarding abortion. Of the 340 odd submissions received by SALRI, about 225 supported reform

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[228] The individuals and groups advocating this approach included Dr Niki Vincent (the Commissioner for Equal Opportunity), Dr Susie Allanson, Professor Emerita Margaret Allen at the University of Adelaide, Dr Jane Baird, Associate Professor Barbara Baird at Flinders University, Professor Caroline de Costa, Dr Erica Millar, Dr Caroline de Moel-Mandel at Deakin University, Professor Margaret Davies at Flinders University, Professor Heather Douglas of the University of Queensland, Associate Professor Catherine Kevin at Flinders University, Dr Erica Miller at LaTrobe University, Dr Sarah Moulds at the University of South Australia, Mark Rankin at Flinders University, Dr Damien Riggs at Flinders University, Dr Margie Ripper at Flinders University, Professor Sally Sheldon of the University of Kent, Professor Ben White and Professor Lindy Willmott of the Australian Centre for Health Law Research, Beth Wilson AM, the Australian College of Midwives, the Australian College of Nursing, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian Nursing and Midwifery Federation (SA Branch), the Australian Lawyers' Alliance, Australian Lawyers for Human Rights, the Australian Medical Association (SA), the Australian Women's Health Network, the Castan Centre for Human Rights Law, Children by Choice, the Coalition of Women's Domestic Violence Services SA, the Church of the Flying Spaghetti Monster Australia, Fair Agenda, Family Planning Alliance Australia, Family Planning Welfare Association of the Northern Territory, the Greens (SA), Human Rights Law Centre, International Planned Parenthood Federation, the Law Society of South Australia, Marie Stopes Australia, the Pregnancy Advisory Centre, Public Health Association of Australia, Queensland Advocacy Inc, Reproductive Choice Australia, the Royal Australasian College of Physicians, Royal Australian and New Zealand College of Psychiatrists, the South Australian Abortion Action Coalition (itself consisting of various groups), the South Australian Council for Civil Liberties, the South Australian Rainbow Advocacy Alliance, the majority of the SA Branch of the Australian Local Government Women's Association Committee, the Southgate Institute for Health, Society and Equity at Flinders University, Women's Electoral Lobby Australia, Women Lawyers' Association of South Australia Inc, the Women's International League for Peace and Freedom, YWCA Australia, a number of lead clinicians and a leading health provider.

[229] RANZCOG considers that 'termination of pregnancy is an important health issue, and, as a medical procedure, should not form part of the criminal law'. See Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Position Statement: Official Statement on the Infant Viability Bill (Victoria)' (Media Statement, 25 May 2016) <https://www.ranzcog.edu.au/media/statements/1719-official-statement-on-theinfant-viability-bill-victoria-from-the-royal-australian-and-new-zealand-college-of-obstetricians-and-gynaecologists.html>.

[230] Some respondents supported retaining residual offences relating to unqualified health practitioners performing abortions and a smaller number supported offences relating to gestational periods. See below Parts 6 and 11.

(though there were differences in how far any reforms should go) and about 100 opposed reform (of which many called for a total or near total ban on abortion). The remainder expressed no view.

2.1.18 One submission, echoing a theme reflected by many, simply stated: 'I support the decriminalisation of abortion in South Australia.' Another party, also echoing a theme reflected by many, argued: 'Abortion should be completely removed from the criminal law, there should be no new law specific to abortion introduced into health law — with one exception: there should be safe access zones.' Mark Rankin concisely outlined: 'Abortion must be removed from the criminal law. In terms of abortion law reform, this is really all that is required.'[231] One submission said: 'I strongly believe that abortion should never be a criminal law issue. It is the woman's right to choose.'

2.1.19 The Greens (SA) also favoured the decriminalisation of abortion: 'Women need — and deserve — to be trusted to know what is best for them, to be recognised as the experts in their own personal lives and situations. They deserve reproductive rights, and these rights should not be curtailed.' The Hon Tammy Franks MLC submitted to SALRI that abortion should be wholly removed from the criminal law, citing 'the stigma and the chilling effect' of the present law. The Southgate Institute of Health, Society and Equity also advocated for the complete removal of abortion from the *CLCA*, noting this 'will enable it to be regulated under health law, policies and ethics; will strengthen the capacity of the health system to provide good quality abortion care; and enable continuing improvements in women's reproductive health care, in keeping with modern medical practice'.[232]

2.1.20 Professor Sally Sheldon of the University of Kent and eight UK colleagues submitted to SALRI that the present law in both England and South Australia is outdated and unhelpful and the 'current legal restrictions on women's decision making in the context of abortion are an anachronistic anomaly in the context of health law frameworks which have otherwise moved emphatically to recognise the right of competent patients to reach their own health care decisions'.[233]

2.1.21 The South Australian Abortion Action Coalition also favoured the complete removal of abortion from the criminal law and treating it purely as health issue, explaining:

> Legislative reform is an opportunity to remove the legislative stigmatisation of abortion. While the impact of such a move is difficult to measure there is no doubt that the normalisation of this health procedure can create an environment for provision that can better meet the challenges in accessing safe abortion information and services.

2.1.22 One experienced nurse and midwife, including in the Aboriginal community health sector, informed SALRI:

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[231] See also Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229; Mark Rankin, 'Recent Developments in Australian Abortion Law: Tasmania and the Australian Capital Territory' (2003) 29(2) *Monash University Law Review* 316; Mark Rankin, 'The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law?' (2011) 13(2) *Flinders Law Journal* 1; Mark Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35 *Sydney Law Review* 1; Mark Rankin, 'Abortion Law in New South Wales: The Problem with Necessity' (2018) 44(1) *Monash University Law Review* 32.

[232] The submission was written by Professor Judith Dwyer on behalf of the Southgate Institute for Health. Society and Equity at Flinders University on the request of Professor Fran Baum Director and is endorsed by the Southgate Institute.

[233] Professor Sheldon noted that the present criminal prohibitions, enshrined in English law in 1861 and later replicated in South Australia, 'reflect the archaic, highly conservative norms of mid-Victorian Britain towards gender, sexuality and fertility control. They date from a time before women had the right to vote and when a woman's authorship of a treatise on contraceptive methods was deemed sufficient reason to remove a child from her custody!' See *Re Besant* (1878) 11 ChD 508.

> As part of my work role I have listened to lots of stories of pregnancies some planned, others unplanned from women who are from metropolitan, rural and remote areas. If a woman decides to have an abortion, it is important that it's a respectful caring health system that cares for her health wherever she lives. I strongly believe this health pathway will be enhanced if the health procedure of abortion is regulated by health care law.

2.1.23 A Year 12 student commented:

> The fact that there are such specific standards for you to pass to undergo an abortion makes me feel uneasy. I believe that all women should have the right to choose what they want to do with their bodies. With the laws changing in America many females, myself included are fearing that the laws will change and tighten down in Australia. I believe that what you are doing is very powerful and has the ability to change so many females' lives for the better.

2.1.24 One party submitted:

> I write as a member of the South Australian community very concerned about current abortion laws that deny a woman the right to make decisions about her own healthcare. I believe all South Australians deserve to feel safe and in control of their lives; and to be able to legally access the healthcare they need. I write to express my strong support for reform that provides for safe and legal access to abortion; and protects patients from harassment and intimidation at clinics.

2.1.25 There were personal accounts in favour of reform.[234] One individual described:

> I am a young woman who fell pregnant two years ago while in the midst of leaving a very unstable and unhappy relationship. An abortion was the kindest step to take in the long run, despite being an extremely difficult and emotionally wrought decision to make at the time. It is a decision of health, ultimately: long-term health. What will be the healthiest option for the pregnant individual in question? Abortion should thus be treated as any other healthcare: regulated objectively, without any moral projection upon the parties involved and provided on the basis of a persons informed consent.

2.1.26 Another party said she supported the full decriminalisation of abortion and had personal experiences related to this topic and knew that if she had not been provided with the option to abort 'a previous pregnancy due to horrific circumstances surrounding the pregnancy and how I came to be pregnant, it would have had catastrophic consequences for me and my mental health and well-being.[235]

2.1.27 A strong theme highlighted in consultation by parties in favour of the decriminalisation of abortion was the fundamental importance of autonomy and the woman's capacity to make her own

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[234] There were also personal accounts against reform. One response described: 'I was 16 when I had an abortion at 20 weeks. I have been haunted my entire adult life by that decision. It was so easy to access. I didn't have to consult a parent, I was bussed to Sydney for the procedure and flown back to Adelaide afterwards. The government stepped in and facilitated the killing of my unborn child. I was a child myself. EVERY woman I know who has had an abortion is broken by it. Women are suffering because of this barbaric practice.'

[235] Another submission commented: 'I support full decriminalisation. I do not believe there should be any new laws in relation to abortion. I personally have needed to have abortions in my earlier life, when my life was chaotic, and I would not have been able to properly care for a child. I have since had a daughter, later in life, when I was in a much better position to love and care for her, and am very happy. I haven't been affected negatively in a psychological way by having the earlier abortions. I feel that having children at that earlier stage of life would have had a hugely detrimental effect on me, and on the child.' Yet another submission noted: 'Women must have the final say over their bodies and ultimately their futures. I believe abortion services should be legal and available to anyone who chooses to do so. There is much to say on this topic and so many examples of situations that it is simply not ok to proceed with a full term pregnancy. Women and girls are raped and continue to be raped, both in and out of marriages. As someone who has accessed termination services myself, I can unequivocally state that this was necessary for my well-being and determined my future in the direction that I was best for me at the time.'

decisions in relation to abortion and criticism of the medical 'gatekeeper' model to access an abortion.[236] As one submission commented: 'Women's autonomy to make their own decisions about their bodies must be respected, supported and protected'.

2.1.28 The Castan Centre for Human Rights Law emphasised the need for women to have the autonomy to decide on their medical treatment. They submitted that the law should avoid

> a situation in which the medical profession is empowered to determine whether an individual woman is able to access abortion services. By adopting such an approach, doctors become the gatekeepers to legal abortion; it is doctors rather than pregnant women who are empowered to determine whether a pregnancy may be terminated. Such an approach entrenches the power imbalance between women and their doctors, removes from women the ability to decide what is in their own best interests, and renders women beholden to the medical profession for allowing them to access abortion services … by giving such power to the medical profession, the law constructs 'women seeking abortion as supplicants, who must go cap in hand to request permission to terminate their pregnancies. Refusals may result in women carrying unwanted pregnancies to term; they will certainly result in later terminations'.[237]

2.1.29 There was also a diversity in views between those parties in favour of the decriminalisation of abortion. Some parties, notably the Southgate Research Institute, the South Australian Abortion Action Coalition, Dr Erica Millar and the Women Lawyers' Association of South Australia Inc, favoured the ACT approach and argued for the total removal of abortion from the criminal law and making it purely a question for health law and practice (supplemented by professional guidelines) and that specific provision for abortion is unnecessary. Other parties such as AMA(SA), Professor Caroline de Costa and Professor Carol Portmann preferred an intermediate approach and favoured the retention of some restrictions (notably for late term abortions)[238] and/or specific provision for abortion in the law in certain contexts such as any residual offence for abortions by unqualified persons[239] and/or specific legislative provision for conscientious objection and/or effective referral.[240]

2.1.30 A diversity of views were expressed to SALRI by faith groups,[241] as was also found by the VLRC,[242] the QLRC,[243] the NSW Legislative Council Committee[244] and even the original 1969 South

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[236] See also above [1.3.35]–[1.3.39].

[237] See also Sally Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in Jo Bridgeman and Susan Mills (eds), *Law and Body Politics* (Dartmouth Publishing, 1995) 105, 119. Professor Sheldon reiterated this view in consultation to SALRI.

[238] See below Part 11.

[239] See further below Part 6.

[240] See further below Part 17.

[241] It is important to note that the views expressed by faith groups are not necessarily shared by all of their members. One law graduate, for example, told SALRI she identifies as a Christian but disagrees with the position of her Church and believes that a woman's autonomy is integral and abortion should be available on request.

[242] The VLRC noted that the Catholic Archdiocese of Melbourne and other Catholic organisations 'maintained strong opposition to decriminalisation whilst the Anglican Diocese of Melbourne submitted that 'we believe abortion is a serious moral issue, but we do not believe abortion should remain a matter for criminal law' and 'our consensus view is the gradualist position which argues that while the embryo/fetus is fully human from the time of conception, it accrues moral significance and value as it develops': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 73 [5.13]. See also at 73 [5.12]–[5.18], 148–157.

[243] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 64 [3.57]–[3.58], 74–75 [3.96].

[244] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 10–11 [2.19]–[2.24], 12–14 [2.31]–[2.40].

Australian parliamentary debate.[245] There are nuances within the Christian and other faiths, which were clearly highlighted in the various consultation processes.[246]

2.1.31 The Catholic Archdioceses of Adelaide and Port Pirie noted to SALRI their compassion but opposed any relaxation in the present law and reiterated their position that life begins and should be respected from conception. They observed:

> While some may consider abortion a mere medical procedure, we must unequivocally assert that it is a medical procedure that by definition ends the life of a fetus, a life which the Church firmly believes is an unborn child — a unique individual whom we strongly believe should be protected and loved, not terminated and discarded.[247]

2.1.32 The Lutheran Church in its submission to SALRI outlined its belief that life begins at conception and should be legally protected and objected to removing abortion from the criminal law.

> Pressure to liberalise abortion law is based on an individualistic (or egoistic) ethics that doesn't adequately consider the impact of one's choices on others. The idea that individuals should be allowed to cause the death of another human merely because the life of that human might inconvenience them goes too far in the direction of radical autonomy and too far away from our duty of care to others. We have a significant proportion of people in our society for whom ethical egoism is their default moral framework, which hinders their capacity to live well with others.

2.1.33 The Uniting Church took a different approach.[248] At SALRI's 12 June 2019 roundtable it was noted:

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[245] This diversity in the view of abortion amongst religious groups was also shown in the 1960s. In their 1969 Report of the Commission on Abortion, the Methodist Church of Australasia remarked that 'an attempt to arrive at a Christian attitude to abortion gets no direct help from the Bible; ie it is nowhere said that abortion is prohibited, nor is it said that it can be allowed in any or all circumstances': Methodist Church of Australasia, *Report of the Commission on Abortion* (1969) 4. In consultation, the Presbyterian Church of South Australia supported the 1969 Bill, submitting that 'it would appear that on certain well established therapeutic and eugenic grounds abortion may be the action necessary before God and in responsibility to him': General Council of the Presbyterian Church of South Australia, *Report and Recommendations re Revision of Legislation Relating to Abortion* (1969) 4. The Anglican Church stated that although 'there can be no question of the Church of England tolerating the practice of abortion as morally defensible in itself', therapeutic abortion in the situation where the mother's health or sanity was threatened would not be contrary to the Church's teachings: LEW Renfrey, *Statement on Abortion Supplied to 'The News',* 13 June 1968. The Catholic Church's position was that 'any direct abortion whatsoever, even if it is performed in the presence of a manifest therapeutic indication to save the mother by its means, when otherwise she together with the child would perish, is immoral and forbidden by divine law': 'Abortion: Moral Issues' [1968] 1(12) *Medical Journal of Australia* 499.

[246] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 73 [5.11]–[5.13]. This also emerged in the comments of the leaders of Christian, Jewish and Islamic faith groups to the NSW Legislative Council Committee. See Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 10–11 [2.19]–[2.24], 12–14 [2.31]–[2.40].

[247] The Archdiocese cited Pope Francis: 'Church's teaching is clear: human life is sacred and inviolable. Prenatal diagnosis for selective purposes should be discouraged with strength, because it is the expression of an inhuman eugenics mentality, which takes away the possibility of families welcoming, embracing and loving their weakest children.' See also Catholic Bishops of New South Wales, Submission No 20, Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64853/0020%20Catholic%20Bishops%20of%20New%20South%20Wales.pdf>.

[248] See also Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 14 [2.39]–[2.40]; Lisa Martin, 'NSW Abortion Law Reform: Uniting Church Breaks Religious Ranks to Back Decriminalisation', *The Guardian* (online, 4 August 2019), <https://www.theguardian.com/world/2019/aug/04/nsw-abortion-law-reform-united-church-breaks-religious-

> … that there is great diversity of opinion among Uniting Church members. However, while members fully respect the sacredness of life and advocate for the rights of both the woman and the unborn child, the Uniting Church supported a woman's ultimate decision whether to procure an abortion or continue with a pregnancy … the issue of abortion should be taken as a social and not a criminal one.

2.1.34 The Anglican Church did not make a formal submission to SALRI, but the Anglican Church Diocese of Sydney submitted to the NSW Legislative Council Committee that 'the catchcry of 'decriminalisation' has had the power of any mantra that skates over the details'. The Anglican Church Diocese observed:

> While it may be true that I and many leaders of faith communities, consider abortion to be a last resort only when the health of the mother is threatened, I recognise that many in the community consider abnormalities or chromosomal deficiency in the unborn child to be sufficient reason to terminate the pregnancy. I also recognise that for nearly 50 years this has been the practice in NSW.[249]

2.1.35 Dr Karen Walker, the President of the Baptist Churches of South Australia, stated that she not does dispute the central consideration of a woman's right to choose, but these rights do not stand in isolation and 'other stakeholders such as society and the unborn child also have rights that must be considered'. Dr Walker commented that, whilst she supported the decriminalisation of early abortion and legal access for women considering early abortions, she was not supportive of 'the weakening of professional oversight and accountability in managing abortions or the unrestricted extension of abortion to any gestation'.

2.1.36 There are similar nuances within the Jewish faith.[250] A Rabbi noted to SALRI their thoughts:

> I appreciate this is a complex and fraught area of law … In considering the Jewish position, it may be helpful to know that our core text, the first five books of the Bible, does not consider the fetus to be a separate life until it is born. This idea is bolstered in another one of our core books the Talmud, which is quite clear in saying that any measures may be taken concerning the fetus in order to protect the life of the mother. These texts allow considerable flexibility in how we approach the topic of abortion, and there is a wide range of opinions in the community. In general, the Progressive Jewish community will tend to side with the welfare of the mother over the life of

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ranks-to-back-decriminalisation>; Alexandra Smith, 'Churches Divided over Bill to Decriminalise Abortion', *Sydney Morning Herald* (online, 4 August 2019) <https://www.smh.com.au/politics/nsw/churches-divided-over-bill-to-decriminalise-abortion-20190803-p52djw.html>.

[249] Anglican Church Diocese of Sydney, Submission No 34 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64870/0034%20Anglican%20Church%20Diocese%20of%20Sydney.pdf>. Different views were expressed to the NSW Legislative Council Committee by representatives of the Anglican Church: Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 10, [2.20], 11 [2,24].

[250] The VLRC's consultation revealed nuances in views across the Jewish faith. 'The Orthodox view is that abortion should be prohibited where there is no adequately compelling competing ethical goal, for example to save the mother's life or preserve the woman's physical or mental health. Rabbi Aviva Kipen, from the Bentleigh Progressive Synagogue, noted that in Jewish law abortion is allowed in specific circumstances where there is a risk to the physical or mental health of the mother or her ability to parent other children. She also argued that in a multicultural and secular society, the traditions of one faith should not be entrenched in law at the expense of other faiths' views. In supporting decriminalisation, she felt that people can still live by their religious traditions without disturbing the moral agency of others. The Jewish Community Council considered it one of Australia's achievements that one religious doctrine does not determine the behaviour of all': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 73 [5.15]–[5.17].

> the fetus. As a Progressive community, we respect our ancient texts but also incorporate contemporary understandings of women's rights over our own bodies. I personally believe that the state would serve women and families best by allowing blanket access to abortion, with women making these decisions in consultation with their families and medical practitioners.

2.1.37 A variety of differing emphases to abortion also emerged at both the faith sector roundtable on 16 May 2019 and the faith sector/NGOs roundtable on 12 June 2019.

2.1.38 Various parties in SALRI's consultation made reference to public opinion or surveys in relation to issues associated with abortion law and practice in support of their proposals. The Australian College of Nursing, for example, helpfully consulted with a targeted group of their South Australian members and found that the majority of respondents agreed that abortions 'should be lawful on request up to 22 weeks, but it depends on the specific case of each woman and fetus including the woman's physical, social, emotional and psychological wellbeing and the health of the fetus.' Other parties cited various surveys and studies to SALRI.[251]

2.1.39 SALRI means no disrespect, but it does not intend to comment upon, or examine, the many surveys or polls in this area in any detail as this aspect is outside of its Terms of Reference. SALRI considers that the surveys and studies as to public views on an issue as contentious as abortion are not necessarily wholly reliable, given the variety of questions and samples.[252] As the QLRC notes: 'Each survey has its own strengths and limitations, which affect its reliability.'[253] Such surveys are open to differing views and perceptions[254] and public support for abortion can be dependent on the circumstances under which an abortion is requested.[255] However, SALRI notes there is said to be wide and increasing public support in Australia for abortion, in at least some situations.[256] This is in line with

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[251] This included the Australian Christian Lobby, 40 Days for Life, a medical scientist, Cherish Life Australia, Family Voice Australia, the Right to Life Association of South Australia and a medical scientist opposed to the decriminalisation of abortion on the one side and on the other, YWCA Australia, the Australian Lawyers' Alliance, Marie Stopes Australia, the Hon Tammy Franks MLC and Dr Erica Miller.

[252] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 58, [4.3], 68 [4.81]. 'For example, some surveys may involve only a single question, limiting the interpretation of responses; some may involve multiple or more specific questions, but may have a limited number or sample of respondents; and some may involve leading questions, which could bias the results': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 45 n 208.

[253] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 45 [2.134].

[254] See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 58–69 [4.7]–[4.79]. 'The strongly expressed opinions of interest groups tend to dominate the public discourse about abortion, although public opinion is not limited to the views of the best organised or best resourced lobby groups': at 58 [4.3].

[255] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 51 [8.4.1]. The QLRC noted: 'For example, responses to the 2009 Australian Survey of Social Attitudes showed that 23% of Australians believe termination is "always wrong" where it is sought because "the family has a very low income and cannot afford any more children" (compared to 45% who believe it is not wrong); and 8% believe termination is "always wrong" where it is sought because "there is a strong chance of serious defect in the baby" (compared to 67% who believe it is not wrong)': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws*, Report 76 (June 2018) 46 [2.138]. Cherish Life Australia cited a 2018 Queensland survey to SALRI that found only 8% of respondents supported abortion on the ground of gender selection.

[256] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 45–46 [2.136]–[2.137]. See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 49–51 [8.4]; Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017) 4–5.

the results of SALRI's own consultation.[257] A NSW research study commented: 'The surveys of public opinion discussed in this paper suggest that the majority of Australians support lawful abortion, although support for abortion can be dependent on the circumstances under which abortion is sought.'[258] Dr Karen Walker of the Baptist Churches of South Australia noted 'that there is a consistent divide in opinion regarding the ease of access [to abortion]: two thirds have supported "easy access" while one third has consistently supported access "under special circumstances".'

2.1.40 In Queensland, the 2016 Parliamentary Committee reported:

> Recent surveys of attitudes towards abortion in Australia suggest that approximately 60% of the Australian population supports women being able to obtain an abortion readily, a substantial sized minority (between one quarter and one third) support abortion only in special circumstances and a smaller group (somewhere between 5 and 20%) believe abortion is never acceptable.[259]

2.1.41 Whilst community attitudes are obviously material and important, they may not be conclusive: 'Opinion surveys, no matter how robust, should not dictate law or policy.'[260] SALRI concurs with the view of the VLRC: 'Public attitudes have several implications for abortion law. They can inform legislators of the broad principles the law should be based upon, but do not settle the debate about the detail of the law.'[261]

2.1.42 Those making submissions to SALRI in favour of or against reform pointed to research that supported or denied views and implications for law reform concerning adverse physical or mental health effects associated with abortion, or absence thereof.

2.1.43 Parties such as Advocates International, the Australian Christian Lobby, the Right to Life Association and Dr Šeman and Dr Turnbull presented SALRI with much research said to suggest the negative physical and mental health implications associated with abortion. Other groups such as 40

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[257] It will be recalled of SALRI's 340 odd submissions; about 225 supported decriminalisation, about 100 opposed decriminalisation and the remainder expressed no opinion (confining their comments to technical issues)

[258] Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017) 58. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 51 [8.4.1]. One survey, for example, cited by the VLRC found that 82% of respondents said they would not allow abortion after 20 weeks for non-medical reasons: Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) [4.40]. Cherish Life Australia cited a 2018 Queensland survey to SALRI that showed 76% of respondents opposed abortion after 23 weeks. Cf Lachlan de Crespigny et al, 'Australian Attitudes to Early and Late Term Abortions' (2010) 193(1) *Medical Journal of Australia* 8 which suggests community opinion may be nuanced and supportive.

[259] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 48 [8.3.1]. In 2008, the VLRC drawing on various surveys, concluded: 'The available evidence provides general support for the following conclusions: A majority of Australians support a woman's right to choose whether to have an abortion. A subset of those supporters regard the right as capable of limitation, with restriction of choice based on factors such as gestational age and women's reasons for seeking the abortion. However, there is insufficient evidence to estimate the size of that subset. Several socio-demographic characteristics are associated with positive (and negative) views of abortion. For example, there is less support for abortion among persons with religious beliefs than among persons without religious beliefs; nonetheless, even among persons with religious beliefs, supporters remain in the majority': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 68 [4.82]. See also Alexandra Barratt et al, 'Knowledge of Current Abortion Law and Views on Abortion Law Reform: a Community Survey of NSW Residents' (2019) 43(1) *Australian and New Zealand Journal of Public Health* 88.

[260] Lachlan de Crespigny et al, 'Australian Attitudes to Early and Late Term Abortions' (2010) 193(1) *Medical Journal of Australia* 8, 12.

[261] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 57 [4.2].

Days for Life, Cherish Life Australia, Birthline Pregnancy Support Inc, the Canberra Declaration, the Concerned Women's Collective and Genesis Pregnancy Support Inc also raised what were said to be the adverse physical and mental health implications of abortion.[262] A particular theme highlighted to SALRI was what was said to be the negative mental implications associated with abortion and the supporting research.[263] Dr Šeman and Dr Turnbull, and several other health practitioners and various groups, such as the Australian Christian Lobby, Genesis Pregnancy Support Inc, Pregnancy Help Australia, Concerned Women's Collective, 40 Days for Life, and individuals, spoke of 'post-abortion

[262] An issue that was raised to SALRI in consultation by parties such as Advocates International, Family Voice Australia, Cherish Life Australia, the Right to Life Association of South Australia and individuals to support their opposition to decriminalisation of abortion related to the ability of a fetus to feel pain and its awareness and development. It was said that medical advances now show that a fetus from as little as three months can feel pain. As Advocates International stated: 'There is considerable evidence that the child in the womb is sentient and therefore experiences pain as early as 15 weeks and possibly earlier still.' See also, for example, Slobodan Sekulic et al, 'Appearance of Fetal Pain Could be Associated with Maturation of the Mesodiencephalic Structures' (2016) 11(9) *Journal of Pain Research* 103. This assertion was questioned by others in SALRI's consultation such as Reproductive Choice Australia and the Church of the Flying Spaghetti Monster Australia. 'Neither withdrawal reflexes not hormonal stress responses prove the existence of fetal pain, because they can be elicited by nonpainful stimuli and occur without conscious cortical processing. Fetal awareness of noxious stimuli requires functioning thalamocortical connections. Thalamocortical fibres begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks': Susan Lee et al, 'Fetal Pain: A Systematic Multidisciplinary Review of the Evidence' (2005) 294(8) *Journal of American Medical Association* 947. The 2004 House of Commons Science and Technology Committee looked at evidence on scientific and medical developments since the law was last amended in 1990, and found no evidence to indicate that fetuses are sentient, or consciously feel pain, especially before 24 weeks: Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967* (House of Commons Report No 12, Session 2006–07) 22–26. See also Stuart Derbyshire and Ann Furedi, '"Fetal pain" is a Misnomer' (1996) 313(7060) *British Medical Journal* 795; Stuart Derbyshire, 'Fetal Pain' (2010) 24(5) *Best Practice and Research Clinical Obstetrics and Gynaecology* 647; Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 60 [10.33]. Cf Terese Collett, 'Fetal Pain Legislation: Is it Viable?' (2002) 30(2) *Pepperdine Law Review* 161. The research in this area remains 'highly contested': New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 44 (Hon David Shoebridge). As with the issue of when life begins, any determinations on this issue are beyond the remit and outside of the terms of reference for SALRI. This is a medical issue which will likely impact best practice procedures and will develop with increased scientific knowledge over time.

[263] There is considerable literature. See, for example, Anne Speckhard and Vincent Rue, 'Postabortion Syndrome: An Emerging Public Health Concern' (1992) 48(3) *Journal of Social Issues* 95; Joel Brind et al, 'Induced Abortion as an Independent Risk Factor for Breast Cancer: a Comprehensive Review and Meta-Analysis' (1996) 50(5) *Journal of Epidemiology Community Health* 481; David Reardon and Jesse Cougle, 'Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A Cohort Study' (2002) 324(7330) *British Medical Journal* 151; David Fergusson, John Horwood, and Elizabeth Ridde, 'Abortion in Young Women and Subsequent Mental Health' (2006) 47(1) *Journal of Child Psychology and Psychiatry* 16; David Fergusson, John Horwood and Joseph Boden, 'Abortion and Mental Health Disorders: Evidence from a 30-year Longitudinal Study (2008) 193(6) *British Journal of Psychiatry* 444; Priscilla Coleman et al, 'Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey' (2008) 45(8) *Journal of Psychiatric Research* 1133; Priscilla Coleman et al, 'Corrigendum to "Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey"' (2009) 43(8) *Journal of Psychiatric Research* 770; David Fergusson, John Horwood and Joseph Boden, 'Reactions to Abortion and Subsequent Mental Health' (2009) 195(5) *British Journal of Psychiatry* 420; Natalie Mota, Margaret Burnett and Jitender Sareen, 'Associations Between Abortion, Mental Disorders, and Suicidal Behaviour in a Nationally Representative Sample' (2010) 55(4) *Canadian Journal of Psychiatry* 23; Priscilla Coleman, 'Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009' (2011) 199(3) *British Journal of Psychiatry* 180; Carlo Bellieni and Giuseppe Buonocore, 'Abortion and Subsequent Mental Health: Review of the Literature' (2013) 67(5) *Psychiatry and Clinical Neurosciences* 301; David Reardon, 'The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations and Research Opportunities' (2018) 6 *Open Medicine* 1, 8, 22.

grief' or 'post-abortion syndrome' as a demonstrated fact.[264] Groups and individuals opposed to the decriminalisation of abortion also highlighted to SALRI what were said to be considerable complications and risks associated with early medical abortion,[265] especially in a rural or remote context, and warned of the adverse health risks of the use of MS-2 Step.[266]

2.1.44 However, these views were widely challenged in SALRI's consultation. Various experts, medical and health practitioners as well as groups in favour of the decriminalisation of abortion presented SALRI with much research said to show no (or very limited)[267] physical or mental ill effects or implications associated with abortion.[268]

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[264] See further Anne Speckhard and Vincent Rue, 'Postabortion Syndrome: An Emerging Public Health Concern' (1992) 48(3) *Journal of Social Issues* 95. However, any such condition is questioned. 'The so called 'post-abortion traumatic stress syndrome' is not recognised by national or international bodies of psychiatrists': Sam Rowlands, 'The Decision to opt for Abortion' (2008) 34(3) *Journal of Family Planning and Reproductive Health Care* 175. See also Kirsten Black, 'Some women feel grief after an abortion, but there's no evidence of serious mental health issues', *The Conversation* (online, 26 April 2018) <http://theconversation.com/some-women-feel-grief-after-an-abortion-but-theres-no-evidence-of-serious-mental-health-issues-95519>. See also below [2.1.46].

[265] The SA Health statistic of a 9.8% 'complication rate' with medical abortions was repeatedly raised to SALRI to demonstrate what were said to be the unsafe implications of medical abortions, especially in a rural or remote context. See further below Part 8.

[266] See further below Part 8.

[267] There is extensive literature. See, for example, Frank Weston, 'Psychiatric Sequelae to Legal Abortion in South Australia' (1973) 1(7) *Medical Journal of Australia* 350; AC Gilchrist et al, 'Termination of Pregnancy and Psychiatric Morbidity' (1995) 167(2) *British Journal of Psychiatry* 243; Brenda Major et al, 'Psychological Responses of Women After First-Trimester Abortion' (2000) 57(8) *Archives of General Psychiatry* 777; Linda Pope, Nancy Adler and Jeanne Tschann, 'Postabortion Psychological Adjustment: Are Minors at Increased Risk?' (2001) 29(1) *Journal of Adolescent Health* 2; Billie Boneviski and Jane Adams, *Psychological Effects of Termination of Pregnancy: A Summary of the Literature: 1970–2000* (Newcastle Institute of Public Health, 2001); Gunner Erlandsson et al, 'Abortions and Breast Cancer: Record Based Case Control Study' (2003) 103(5) *International Journal of Cancer* 676; V Beral, et al, 'Breast Cancer and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83 000 Women with Breast Cancer from 16 Countries' (2004) 363(9414) *The Lancet* 1007; Vignetta Charles et al, 'Abortion and Long-Term Mental Health Outcomes: a Systematic Review of the Evidence' (2008) 78(6) *Contraception* 436; Julia Steinberg and Nancy Russo, 'Abortion and Anxiety: What's the Relationship?' (2008) 67(2) *Social Science and Medicine* 238; Katherine Henderson et al, 'Incomplete Pregnancy is not Associated with Breast Cancer Risk: The California Teachers Study' (2008) 77(6) *Contraception* 391; Brenda Major et al, 'Abortion and Mental Health: Evaluating the Evidence' (2009) 64(9) *American Psychologist* 863; Gail Robinson et al, 'Is there an "Abortion Trauma Syndrome"? Critiquing the Evidence' (2009) 17(4) *Harvard Review of Psychiatry* 269; Trine Munk-Olsen et al, 'Induced First Term Abortion and Risk of Mental Disorder' (2011) 364(4) *New England Journal of Medicine* 332; Julia Steinberg and Lawrence Finer, 'Examining the Association of Abortion History and Current Mental Health: a Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model' (2011) 72(1) *Social Science and Medicine* 72; National Collaborating Centre for Mental Health at the Royal College of Psychiatrists, *Induced Abortion and Mental Health: a Systematic Review of the Mental Health Outcomes of Induced Abortion, including their Prevalence and Associated Factors* (Review, December 2011); Julia Steinberg et al, 'Fatal Flaws in a Recent Meta-Analysis on Abortion and Mental Health' (2012) 86(5) *Contraception* 430; Julia Steinberg et al, 'Psychosocial Factors and Pre-Abortion Psychological Health: The Significance of Stigma' (2016) 150 *Social Science and Medicine* 167; Pam Belluck, 'Abortion Is Found to Have Little Effect on Women's Mental Health', *New York Times* (online, 14 December 2016) <https://www.nytimes.com/2016/12/14/health/abortion-mental-health.html>; Sarah Hovarth and Courtney Schreiber, 'Unintended Pregnancy, Induced Abortion, and Mental Health' (2017) 19(11) *Current Psychiatry Reports* 77; Nada Stotland and Angeka Shrestha, 'More Evidence That Abortion is Not Associated With Increased Risk of Mental Illness' (2018) 75(8) *JAMA Psychiatry* 775; Elizabeth Sullivan et al, *Report on the Lack of Association between Early Induced Abortion and Mental Health* (Report, Australian Centre for Public and Population Health Research, 2019).

[268] Indeed, some studies have found that abortion does not increase the risk of adverse mental health outcomes and may even lead to better mental health outcomes than the denial of abortion. See M Antonia Biggs et al, 'Women's Mental Health and Well-Being Five Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study' (2017) 74(2) *JAMA Psychiatry* 169; Diana Foster et al, 'A Comparison of Depression and Anxiety Symptom Trajectories between Women who had an Abortion and Women Denied One' (2015) 45(10)

2.1.45 There was repeated emphasis that abortion is a proper and very safe medical procedure.[269] The SA Health website, for example, notes: 'Fact: Abortions are very safe when performed by qualified practitioners. Reputable research confirms that continuing a pregnancy and going through childbirth has greater risk to a woman's health than having a first trimester abortion.'[270] There was also emphasis that medical abortion and the use of MS-2 Step, if properly administered and/or overseen by a qualified health practitioner, are safe and approved medical procedures.[271]

2.1.46 The particular assertion of adverse mental health outcomes associated with abortion was also challenged. The SA Health website, for example, notes:

> Fact: Unplanned pregnancy does cause emotional distress for some women, however research shows that for most women abortion causes no long lasting psychological consequences. Women who make their own clear decision about abortion generally find it a health enhancing experience. Having an abortion is not inherently traumatic; however, every step of the process to accessing abortion services can be made traumatic by judgmental or undermining treatment by others … A consistent opinion has emerged within the medical profession that the psychological effects of abortion are benign or positive and that serious adverse effects are rare. No reputable articles conclude there is any evidence to support the term nor condition of 'Post Abortion Syndrome'.[272]

2.1.47 The 2016 Queensland Parliamentary Committee noted: 'Ultimately, despite some variation in results, it is clear that there is no established causal relationship between abortion and mental health outcomes.'[273]

2.1.48 SALRI accepts this is a difficult area. There are differing results showing no (or very limited)[274] ill effects on the one hand or some negative effects on the other.[275] It may well be that, as the New Zealand Law Commission notes: 'These different findings may indicate that the impact

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Psychological Medicine 2073; Julia Steinberg, Charles McCulloch and Nancy Adler, 'Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication'(2014) 123(201) *Obstetrics Gynaecology* 263.

[269] The New Zealand Law Commission reported: 'In 2016, 99.6% of abortions performed in New Zealand did not lead to any complication. The most common complications were retained placenta or products, and haemorrhage, each occurring in 0.1% of cases': New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 49 [2.90].

[270] SA Health, 'Myths and Facts about Abortion' (Web Page, 24 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/myths+and+facts+about+abortion>.

[271] In a study of 233,805 medical abortions in the United States, 'significant adverse events and outcomes' were reported in 0.65% of cases. The majority of complications were incomplete abortions. See Kelly Cleland et al, 'Significant Adverse Events and Outcomes after Medical Abortion' (2013) 121(1) *Obstetrics Gynecology* 166. See further below Part 8.

[272] SA Health, 'Myths and Facts about Abortion' (Web Page, 24 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/myths+and+facts+about+abortion>. SA Health notes: 'Studies do highlight risk factors, which can increase the likelihood of a woman experiencing longer lasting emotional distress: women who did not make their own decision; women who have been or felt coerced/ pressured into having an abortion; women who hold strong cultural or religious beliefs that abortion is wrong and women who have a history of severe diagnosed mental health conditions'.

[273] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 58 [10.2.5].

[274] There is extensive literature. See, for example, National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health* (Report, December 2011). See also above n 267.

[275] There is considerable literature. Carlo Bellieni and Guiseppe Buonocore, 'Abortion and Subsequent Mental Health: Review of the Literature' (2013) 67(5) *Psychiatry and Clinical Neurosciences* 301, 307–308. See also above n 263.

abortion has on each woman is highly variable.'[276] As one author noted, much of the research is conflicting and of dubious reliability and/or potential bias.[277] The submission of the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists to SALRI insightfully observed: 'Large scale retrospective studies seeking to determine whether there is any link between TOP [Termination of Pregnancy] and later mental illness have shown conflicting results but are plagued by methodological limitations and the potential for political bias.'[278] It has been suggested that further long-term reliable longitudinal research is required.[279]

2.1.49 SALRI notes the conclusions of the QLRC, the World Health Organisation (WHO) and the VLRC.[280]

2.1.50 The QLRC noted that both medical and surgical terminations, 'when "performed by appropriately trained personnel under modern medical conditions", are safe and effective; side effects commonly include nausea, vomiting, pain and prolonged bleeding, but serious complications are rare.'[281] The QLRC accepted the research findings are inconsistent, but the evidence it had seen suggests that abortion does not increase the risk of subsequent ectopic pregnancy, placenta praevia or

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[276] See New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 50 [2.92].

[277] Brenda Major, 'Psychological Implications of Abortion: Highly Charged and Rife with Misleading Research' (2003) 168(10) *Canadian Medical Association Journal* 1257. 'Current data remain sparse, studies are small and methodologically flawed, and the conclusions are often intertwined with the political agendas of their authors and publishers': John Thorp et al, 'Long-Term Physical and Psychological Health Consequences of Induced Abortion: A Review of the Evidence' (2005) 72(1) *Linacre Quarterly* 44. The claim that abortion is linked to breast cancer, for example, appears highly dubious. The NSW Cancer Council, for example, observes: 'The topic of abortion generates passionate viewpoints in many people, which are often linked to personal religious or political beliefs, rather than reliance on scientific evidence … In summary, research evidence does not suggest that abortion increases the risk of breast cancer in women': Cancer Council, *Abortion Does Not Cause Breast Cancer* (Web Page, 2015) <https://www.cancercouncil.com.au/100629/cancer-information/general-information-cancer-information/cancer-questions-myths/medical-and-injuries/abortion-does-not-cause-breast-cancer/>. SA Health similarly notes: 'Fact: Abortion does not increase the chances of being diagnosed with breast cancer': SA Health, 'Myths and Facts about Abortion' (Web Page, 24 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/myths+and+facts+about+abortion>.

[278] The New Zealand Law Commission also noted that its research and consultation proved divided: New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 50 [2.92]–[2.93]. It quoted a 2008 study: 'Specifically, the results do not support strong pro-life positions that claim that abortion has large and devastating effects on the mental health of women. Neither do the results support strong pro-choice positions that imply that abortion is without any mental health effects. In general, the results lead to a middle-of-the-road position that, for some women, abortion is likely to be a stressful and traumatic life event which places those exposed to it at modestly increased risk of a range of common mental health problems': at 50 [2.92] quoting David Fergusson, John Horwood and Joseph Boden, 'Abortion and Mental Health Disorders: Evidence from a 30-year Longitudinal Study' (2008) 193(6) *British Journal of Psychiatry* 444, 450.

[279] See, for example, David Reardon, 'The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations and Research Opportunities' (2018) 6 *Open Medicine* 1, 22; Carlo Bellieni and Giuseppe Buonocore, 'Abortion and Subsequent Mental Health: Review of the Literature' (2013) 67(5) *Psychiatry and Clinical Neurosciences* 301, 308.

[280] See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 39–40 [7.2.4].

[281] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws*, Report 76 (June 2018), 31 [2.81] citing World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6]. The QLRC noted that complications may include a failed or incomplete termination, infection, cervical injury, haemorrhage, and uterine perforation or rupture. The risk of such complications was said to decrease with earlier gestations and clinician experience and the risk of maternal death is estimated at less than 1 in 100 000: at 31 [2.82].

infertility, although there is a possible increased risk of subsequent preterm birth or miscarriage in some cases. There did not appear to the QLRC to be a causal relationship between abortion and breast cancer and lawful and voluntary termination rarely causes negative psychological consequences in healthy women.[282]

2.1.51 The WHO concluded that 'the vast majority of women who have a properly performed induced abortion will not suffer any long-term effects on their general or reproductive health', explaining:

> Research shows no association between safely induced first-trimester abortion and adverse outcomes in subsequent pregnancies. Although second-trimester abortions have not been studied as extensively, there is no evidence of an increased risk of adverse outcomes in subsequent pregnancies. Sound epidemiological data show no increased risk of breast cancer for women following spontaneous or induced abortion. Negative psychological sequelae [consequences] occur in a very small number of women and appear to be the continuation of pre-existing conditions, rather than being a result of the experience of induced abortion.[283]

2.1.52 The VLRC observed that, whilst it is important not to denigrate the experience of some women who find abortion to have an emotional impact, this does not necessarily equate with psychological harm. The VLRC noted that it is 'generally recognised by health bodies that the vast majority of women do not suffer psychological harm from abortion', and some may even 'express feelings of relief afterward'.[284] The VLRC further commented:

> The Commission heard that forcing a woman to proceed with an unwanted pregnancy has a greater negative impact than abortion, even at later gestation. Adoption is no longer common.[285] When it does occur it is an open process, with a stronger emphasis upon agreed contact and exchange of information than historic adoption processes. If abortion is denied some women may feel that they are forced to continue with unwanted pregnancy, go through birth, and then enter a relationship with a child with the attendant societal expectations that brings.
>
> The Commission notes there are relatively few studies on outcomes for women who are forced to continue with unwanted pregnancies; however, several studies have found that such women have poorer psychological outcomes than those able to have an abortion. They show more signs of mental illness, emotional stress, guilt, and anxiety.[286] Women who carry unwanted pregnancies to term are more likely to smoke, to drink, to delay obtaining prenatal care and to give birth to low birth weight infants who they are less likely to breastfeed. They are more likely to be depressed

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[282] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 31, n 133. See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 25–27 (although this document appears to no longer be available on the RANZCOG website).

[283] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6.8]. See also: 'As in prior research, pre-abortion mental health emerged as the best predictor of post-abortion mental health and feelings about an abortion. Women with a prior history of depression may be predisposed to subsequent depression and regret, regardless of whether or not they have an unintended pregnancy and how they choose to resolve that pregnancy': Brenda Major et al, 'Psychological Responses of Women After First-Trimester Abortion' (2000) 57(8) *Archives of General Psychiatry* 777, 791–792. This appears a recurring theme.

[284] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 121 [8.86]. 'The overwhelming indication from the reviewed literature is that legal and voluntary termination of pregnancy rarely causes immediate or lasting negative psychological consequences in healthy women. When it does it is "mild and transient"': at 121, n 108, citing Billie Boneviski and Jane Adams, *Psychological Effects of Termination of Pregnancy: A Summary of the Literature: 1970–2000* (Newcastle Institute of Public Health, 2001) 3. See also above n 267.

[285] This is consistent with SALRI's research and consultation. See above n 224.

[286] National Health and Medical Research Council, An Information Paper on Termination of Pregnancy in Australia (1996) 26.

and unhappy after the birth than mothers with wanted children, and to spank and slap their children more frequently.[287]

Some studies have also found that poor outcomes extend to the child, who is more likely to have psychiatric problems, delinquency, and less education than other children.[288] Unwanted children have lower quality relationships with their mothers, show poorer social adjustment, school performance, and as adults appear more likely to have poor self-esteem, to engage in criminal behaviour, to be on welfare, and to obtain psychiatric services.[289]

2.1.53 The issue of abortion gives rise to significant human rights considerations, including under international human rights law.[290] Several international instruments are relevant to abortion laws, including:

A. The *Universal Declaration of Human Rights* ('UDHR');
B. The *International Convention on the Elimination of all forms of Discrimination Against Women* ('CEDAW');
C. The *International Covenant on Economic, Social and Cultural Rights* ('ICESCR');
D. The *International Covenant on Civil and Political Rights* ('ICCPR');
E. The *Convention on the Rights of the Child* ('CRC'); and[291]
F. The *Convention on the Rights of the Persons with Disability* ('CRPD').[292]

2.1.54 Each of these instruments has been ratified by Australia. It is settled that such instruments do not have direct legal effect on Australian domestic law[293] until given effect in either State or Commonwealth legislation. However, recourse may be had to relevant international law in the

[287] Australian Reproductive Health Alliance and Reproductive Choice Australia, *RU486/Mifepristone: A Factual Guide to the Issues in the Australian Debate* (2006) 17 <http://www.reproductivechoiceaustralia.org.au/resources>.

[288] National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) 26.

[289] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 39–40 [3.53]–[3.55]. See also National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) 17.

[290] See generally, Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 162–171; Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 19–25 [5.1]–[5.8]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 231–267; New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 51–60 [3.1]–[3.42].

[291] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 231 [1]. The role and effect of these international instruments was considered by the QLRC: at 231–267.

[292] See further below Part 13.

[293] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 232 [2]. See also *Bradley v Commonwealth (*1973) 128 CLR 557, 582 (Barwick CJ and Gibbs J); *Simsek v MacPhee* (1982) 148 CLR 636, 641–42 (Stephen J); *Koowarta v Bjelke-Petersen* (1982) 153 CLR 168, 211–212 (Stephen J); *Kioa v West* (1985) 159 CLR 550, 570–71 (Gibbs CJ); *Dietrich v The Queen* (1992) 177 CLR 292, 305 (Mason CJ and McHugh J).

interpretation of ambiguous or uncertain legislation or in the development of the common law.[294] Such instruments are also persuasive in guiding law reform considerations.[295]

2.1.55 These rights are open to conflicting emphasis in an abortion context. As the VLRC found:

> Many people stressed human rights as an important consideration; however, the arguments put forward depended on their view on abortion. Liberty Victoria, the Castan Centre for Human Rights Law, and others stressed privacy, equality, and health rights. In contrast, the Catholic Justice Agency argued that international human rights law confers rights upon the fetus. Still others argued that human rights law should confer fetal rights, as should domestic law.[296]

2.1.56 SALRI also found this conflicting emphasis in its submissions and consultation.

2.1.57 Submissions from both those in favour of and those against reform made reference to international human rights law as supporting their position. Parties[297] opposed to the decriminalisation of abortion raised what was said to be a 'right to life' under international human rights law,[298] extending even to the point of conception.[299] Groups and individuals in favour of reform raised what was said to be a general right, in at least some circumstances, to an abortion.[300]

2.1.58 Various parties, notably the Christian Legal Centre, suggested to SALRI that the *Convention on the Rights of the Child* applies, even from conception, to unborn children.[301] Family Voice Australia argued that art 6 of the *CRC* (which recognises 'that every child has the inherent right to life') applies to children, both before and after birth and 'any change to abortion laws in South Australia should give primary consideration to, and be consistent with, the rights of the child as enunciated in this

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[294] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 232 [2]. See also *Dietrich v The Queen* (1992) 177 CLR 292, 306 (Mason CJ and McHugh J), 321 (Brennan J), 337 (Deane J), 360 (Toohey J), 373 (Gaudron J); *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287–278 (Mason CJ and Deane J); *Mabo v Queensland [No 2]* (1992) 175 CLR 1, 41–42 (Brennan J); *Chu Kheng Lim v Minister for Immigration, Local Government and Ethnic Affairs* (1992) 176 CLR 1, 38. However, South Australia has a particular Act that precludes recourse to international law in administrative decision making; see the *Administrative Decisions (Effect of International Instruments) Act 1995* (SA).

[295] South Australian Law Reform Institute, *Discrimination on the Grounds of Sexual Orientation, Gender, Gender Identity and Intersex Status in South Australian Legislation* (Audit Paper, September 2015) 34–36 [66]–[71].

[296] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 73–74 [5.119].

[297] These parties included a party who trained as a social worker, the Christian Legal Centre, Cherish Life Australia, the Australian Christian Lobby, Advocates International, 40 Days for Life, Dr Šeman and Dr Turnbull, and Family Voice Australia.

[298] See also Piero Tozzi, Catholic Family and Human Rights Institute, *International Law and the Right to Abortion* (International Organisations Law Group Legal Studies Series No 1, 2010) 6, 7; Patrick Flood, 'Does International Law Protect the Unborn Child?' in Joseph Koterski (ed), *Life and Learning XVI: Proceedings of the Sixteenth University Faculty of Life Conference at Villanova University 2006* (University Faculty for Life, 2007) 3, 7–8, 9; Thomas Finegan, 'International Human Rights Law and the "Unborn": Texts and Travaux Préparatories' (2016) 25(1) *Tulane Journal of International and Comparative Law* 89, 116, 120–21; Rita Joseph, *Human Rights and the Unborn Child* (Martinus Nijhoff, 2009).

[299] This point was made by Family Voice Australia and Cherish Life Australia.

[300] This point was made by Professor Heather Douglas, Dr Sarah Moulds, the Australian Women's Health Network, the Human Rights Law Centre, Australian Lawyers for Human Rights, International Planned Parenthood, Marie Stopes Australia, the South Australian Abortion Action Coalition and the SA Council for Civil Liberties.

[301] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 247–248 [60]. See also Thomas Finegan, 'International Human Rights Law and the "Unborn": Texts and Travaux Préparatories' (2016) 25(1) *Tulane Journal of International and Comparative Law* 89, 116–117.

international instrument.'[302] The Right to Life Association South Australia said this reflects the 'shared view of the international community'.

2.1.59 The Christian Legal Centre argued that there is no 'right' to an abortion under international law. 'Advocates of abortion have created a false narrative that the termination of a pregnancy is a right. Internationally, this is not true.'[303] They argued that the 'right to life' is recognised from conception under international human rights law, notably (though not exclusively) the *CRC*. 'It can be clearly seen therefore that intergovernmental law, including its case-law, has been overwhelmingly in favour of recognising the personhood of the unborn child from conception; and no competing right to abortion has ever been developed in international law'.[304] The Christian Legal Centre concluded:

> An international consensus is beginning to emerge regarding the unborn child and their protection from conception. More states are amending their basic law or constitutional law to reflect this consensus. Intergovernmental courts, led by the Court of Justice of the European Union,[305] have become far bolder in defining the commencement of life from the fertilisation of the egg. No competing right to abortion can be found either in European or international law.

2.1.60 However, the view that international law recognises the 'personhood of the unborn child' child' is strongly contested, both to SALRI and elsewhere.[306]

2.1.61 Dr Erica Millar disagreed with the view that a fetus is a separate entity that requires legal protection and asserted that this rests on the unsupported assumption that there is an objective and scientific basis to 'fetal personhood'. Dr Millar argued: 'Fetuses always exist within a woman's body, and a woman always exists within her specific social space, a space that is not necessarily hospitable to pregnancy, birth, and the establishment of a new maternal relationship.'

2.1.62 The Human Rights Law Centre accepted in its submission to SALRI that a fetus has 'some interests' as a potential person,[307] 'however neither international law nor Australian law recognise a right to life in a fetus. This is because protecting a right to life before birth conflicts with human rights protections for women.'[308] The Human Rights Law Centre noted that the Australian Government said

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[302] SALRI does not propose to conduct an extended examination of the international human rights in this area and the differing interpretations. It is notable that there is no clear or simple answer.

[303] The Christian Legal Centre argued to SALRI: 'In recent years, intergovernmental bodies, including most notoriously the United Nations and the European Court of Human Rights, have tried to create a right to abortion by stealth. This agenda-based approach directly injures national sovereignty and does violence to genuine human rights dialogue.'

[304] See also Thomas Finegan, 'International Human Rights Law and the "Unborn": Texts and Travaux Préparatories' (2016) 25(1) *Tulane Journal of International and Comparative Law* 89, 116, 120–121; Rita Joseph, *Human Rights and the Unborn Child*, (Martinus Nijhoff Publishers, 2009) 14.

[305] *Oliver Brüstle v Greenpeace eV* (C-34/10) [2011] ECR I-9849, I-9871 [35]. This was trademark case.

[306] See, for example, Philip Alston, 'The Unborn Child and Abortion under the Draft Convention on the Rights of the Child' (1990) 12(1) *Human Rights Quarterly* 156, 178; Rebecca Cook and Bernard Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25(1) *Human Rights Quarterly* 1, 22–28.

[307] This is similar to the approach of the QLRC which, whilst refraining from the notion of a fetus having legal 'rights', accepted that a fetus has 'interests' and 'that, as the fetus develops, its interests are entitled to greater recognition and protection': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 94 [3.181]. See also at 6 [1.29], 61–62 [3.48], 62–63 [3.52]–[3.53], 274 [18].

[308] See *Vo v France* [2004] VIII Eur Court HR 67, 106 [80]. The drafters of the *International Covenant on Civil and Political Rights* rejected a proposal to extend the right to life to prenatal life: Bertrand G Ramcharan (ed), *The Right to Life in International Law* (Martinus Nijhoff, 1985) 54.

that the right to life under the *ICCPR* was 'not intended to protect life from the point of conception but only from the point of birth'.[309]

2.1.63 The QLRC explained that the approach taken to the *CRC* was to leave the question of rights before birth unaddressed, giving individual countries the flexibility to adopt their own position.[310] As the QLRC explained:

> However, none of those instruments explicitly extends the right to life to the fetus or unborn child. It is generally regarded that the right to life under those instruments applies from birth; whilst the fetus or unborn child may be entitled to some protections, it is left to individual countries to provide for any such protections in their domestic laws, provided they are not inconsistent with their other human rights obligations.[311] This is consistent with the position adopted under regional human rights treaties, including the *European Convention on Human Rights.*[312]

2.1.64 SALRI received various submissions arguing that international human rights law supports the case for decriminalisation for abortion and there is a right, in at least some circumstances,[313] to an abortion. The Law Society, for example, argued in favour of the decriminalisation of abortion, noting:

> [I]nternational human rights bodies have characterised laws generally criminalising abortion, as discriminatory and a barrier to women's access to health care. Furthermore, the decriminalisation of abortion is also consistent with a number of United Nations treaties, including: the *International Convention on the Elimination of all forms of Discrimination Against Women*; the *Universal Declaration of Human Rights*; *the International Covenant on Economic, Social and Cultural Rights*; and the *International Covenant on Civil and Political Rights*.[314]

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[309] Evidence to Joint Standing Committee on Treaties, Canberra, 16 June 2008 (Peter Arnaudo, Attorney-General's Department) <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommjnt%2F10940%2F0001;query=Id%3A%22committees%2Fcommjnt%2F10940%2F0002%22>.

[310] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 250 [67]. See also Philip Alston, 'The Unborn Child and Abortion under the Draft Convention on the Rights of the Child' (1990) 12(1) *Human Rights Quarterly* 156. This point was also made clear in an Australian context by the then Minister for Foreign affairs. 'Although a reference to the rights of the child "before as well as after birth", taken from the 1959 *United Nations Declaration on the Rights of the Child* does appear in the preamble of the draft convention, at the same time a statement in the travaux preparatoires — the preparatory materials — makes it clear that the contentious issue of the child's rights before birth is a question to be determined by individual state parties': Australia, *Parliamentary Debates*, Senate, 26 October 1989, 2313 (Gareth Evans, Foreign Minister).

[311] See, for example, Rebecca Cook and Bernard Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25(1) *Human Rights Quarterly* 1, 24; Philip Alston, 'The Unborn Child and Abortion under the Draft Convention on the Rights of the Child' (1990) 12 *Human Rights Quarterly* 156, 161, 177–178.

[312] Art 2(1) of the *ECHR* provides: 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.' However, art 2(1) does not provide any 'right to life' of an unborn child. As the European Court of Human Rights in *Vo v France* [2004] VIII Eur Court HR 67, 106–107 [80] commented: 'in the circumstances examined to date by the Convention institutions — that is, in the various laws on abortion — the unborn child is not regarded as a "person" directly protected by Article 2 of the Convention and … if the unborn do have a "right" to "life", it is implicitly limited by the mother's rights and interests. The Convention institutions have not, however, ruled out the possibility that in certain circumstances safeguards may be extended to the unborn child.'

[313] See, for example, *Re an Application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27. The majority held that the law in Northern Ireland is incompatible with the right to respect for private and family life, guaranteed by article 8 of the *ECHR*, insofar as it prohibits abortion in cases of rape, incest and fatal foetal abnormality. Lord Kerr and Lord Wilson also held that it is incompatible with the right not to be subjected to inhuman or degrading treatment, guaranteed by article 3 of the *ECHR*.

[314] Law Society of South Australia, Submission to the South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice,* 'Review of Abortion Laws in South Australia', 31 May 2019, 2 [8],

2.1.65 Another party submitted that 'safe, legal and easily accessible abortion is a human right … Abortion should be completely removed from the criminal law.' The Australian Women's Health Network made a similar point to SALRI, stating: 'A rights-based approach to health recognises women as the experts in their own lives.'

2.1.66 The Human Rights Law Centre argued to SALRI that the right of women to control if, and when, they have children is fundamental to their health and lives and that South Australia has a duty to guarantee safe access to abortion services and post-abortion care.[315] The Human Rights Law Centre asserted that laws which criminalise or restrict medical procedures needed by women discriminate against women and undermine basic rights to life, health and bodily autonomy.[316] Their conclusion (contrary to the views of the Christian Legal Centre) was 'the fundamental principles of equality and non-discrimination require that the human rights of a pregnant person — to life, health and bodily autonomy — be given priority over any interest in prenatal life'.[317]

2.1.67 Australian Lawyers for Human Rights asserted that the United Nations Committee on the Elimination of Discrimination against Women, the Special Rapporteur on the Right to Health, the Committee on Economic, Social and Cultural Rights and the Committee on the Rights of the Child 'have all declared access to safe and legal abortion is a fundamental human right for women and girls'.[318] They elaborated:

> Reproductive rights are recognised in multiple human rights instruments. They are protected by the rights to life (including the right not to die from preventable, pregnancy-related causes), health, personal freedom, security and integrity, privacy, equality and non-discrimination, consent in marriage and equality, to education and information, and the right to benefit from

<https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>. Various instruments may arise. Dr Sarah Moulds, for example, noted: Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights,* UN Doc E/C.12/GC/22 (2 May 2016), Committee on the Elimination of Discrimination Against Women, *General Recommendation No 35 on Gender-Based Violence Against Women* Un Doc CEDAW/C/GC/35 (26 July 2017), Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, 20th sess, UN Doc A/54/38/Rev 1 (1999) and Centre for Reproductive Rights, *Safe and Legal Abortion is a Woman's Human Right* (Briefing Paper, October 2011).

[315] Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights,* UN Doc E/C.12/GC/22 (2 May 2016) [28]. The UN Committee on the Elimination of Discrimination against Women, for example, has recommended the decriminalisation of abortion in all cases and noted that the abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services is a form of gender-based violence. See Committee on the Elimination of Discrimination Against Women, *General Recommendation No 35 on Gender-Based Violence Against Women* Un Doc CEDAW/C/GC/35 (26 July 2017).

[316] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, 20th Session, UN Doc A/54/38/Rev 1 (1999) [11]; United Nations Human Rights Committee, *Views: Communication No 2324/2013*, UN Doc CCPR/C/116/D/2324/2013 (9 June 2016) [7.9]–[7.11] ('*Mellet v Ireland*').

[317] See also UN Human Rights Committee, *CCPR General Comment No 28: Article 3 (The Equality of Rights Between Men and Women)* UN Doc CCPR/C/21/Rev.1/Add.10 (29 March 2000) [10]: 'When reporting on the right to life protected by article 6 … States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.'

[318] In February 2014, the CEDAW Committee, for example, stated; 'States parties [countries] should legalise abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe foetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. States parties [countries] should also remove punitive measures for women who undergo abortion': Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion,* (OHCHR Factsheet, 2015) <www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf>.

> academic/scientific progress … There is significant and consistent domestic and international jurisprudence that establishes that the right to life is not inconsistent with the provision of abortion services.[319]

2.1.68 There is support from international human rights Law bodies that the criminalisation of abortion could violate the right to life in certain circumstances. For example, the Human Rights Committee has commented that: 'States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk'.[320] This may go further, and preclude the criminalisation of abortion 'in a manner that runs contrary to [states'] duty to ensure that women and girls do not have to undertake unsafe abortions'.[321] However, the Committee noted that this does not extend to a general right to abortion on demand.[322]

2.1.69 International courts have also implied a right to an abortion in certain situations by finding breaches of the prohibition on cruel and degrading treatment where lawful abortions were denied under national law and practice. The Human Rights Committee and various courts have found violations of the freedom from cruel and degrading treatment where abortions were denied when the pregnancy was the result of rape,[323] the fetus had a severe impairment[324] or fatal abnormality[325] and where patients were intentionally denied medical services or experienced unsatisfactory medical

[319] Australian Lawyers for Human Rights also drew SALRI's attention to the Committee on the Elimination of Discrimination against Women which has said that 'it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women'. The Committee has also more recently requested that States 'remove punitive measures for women who undergo abortion' and has stated that the criminalisation of practitioners who provide abortion services also violates women's rights: Committee on the Elimination of Discrimination Against Women, *Concluding Observations on Peru*, UN Doc CEDAW/C/PER/CO/7-8 (24 July 2014), [36]; Committee on the Elimination of Discrimination Against Women, *Statement on Sexual and Reproductive Health and Rights: Beyond 2014 ICPD Review*, 57th sess (10–28 February 2014). Similarly, the Special Rapporteur on the right to health has argued that laws criminalising abortion 'infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health'. The Rapporteur has called on States to decriminalise abortion. See UN General Assembly, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011) 7 [21].

[320] Human Rights Committee, *General Comment No 36 on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life,* UN Doc CCPR/GC/36 (30 October 2018) [8].

[321] Ibid.

[322] Ibid.

[323] See, for example, Committee on the Elimination of Discrimination Against Women, *Views: Communication No 22/2009*, 50th sess, UN Doc CEDAW/C/50/D/22/2009 (25 November 2011) [9.2] (c) ('*TPF v Peru*'); *P v Poland* (European Court of Human Rights, Chamber, Application No 57375/08, 30 October 2012); *Re an Application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

[324] See, for example, *RR v Poland* [2011] III Eur Court HR 209; Committee on Economic, Social and Cultural Rights, *Concluding Observations on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories*, 42nd sess, UN Doc E/C.12/GBR/CO/5 (12 June 2009) 7 [25].

[325] See, for example, United Nations Human Rights Committee, *Views: Communication No 2324/2013*, UN Doc CCPR/C/116/D/2324/2013 (9 June 2016) ('*Mellet v Ireland*') United Nations Human Rights Committee, *Views: Communication No 1153/2003,* UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) ('*KL v Peru*'); *Re an Application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2108] UKSC 27.

treatment.[326] The underlying reasons of these decisions are the mental, emotional and physical anguish inflicted upon the vulnerable women in these cases by denying them access to a lawful abortion.[327]

2.1.70 The 2016 Queensland Parliamentary Committee noted that, although no international instrument contains an explicit reference to a 'right to abortion', several instruments do recognise certain rights as to sexual and reproductive health and family planning and establish associated legislative and service provision requirements for ratifying States.[328] The Committee further noted that international instruments:

> … while clearly recognising the right to life, are silent on whether the rights and protections conferred by the instruments are accorded to a fetus. 'Proposals to explicitly recognise the right to life of the unborn child [in international instruments] have been consistently rejected'[329]

2.1.71 SALRI does not propose to conduct an extended examination of the international human rights in this area and the differing interpretations. The 2016 Queensland Parliamentary Committee,[330] the VLRC,[331] the QLRC[332] and the New Zealand Law Reform Commission[333] have conducted such an examination. It is notable that there is no clear or simple answer. The effect of international human rights is open to differing interpretations and is ultimately inconclusive.[334] As the VLRC concluded: 'International human rights law does not preclude abortion and does not establish a right to life of the fetus. Nor does it guarantee a right to provision of abortion services beyond the general right to health which can be realised progressively.'[335]

2.1.72 SALRI is unable to express any firm findings on either the effects of abortion and, in particular, if and how abortion interacts with international human rights law. SALRI notes the wide diversity of views expressed in consultation, reflecting the incomplete and conflicting research in the area, about the effect of abortion on the parties and the complex human rights and other implications

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[326] See, for example, *RR v Poland* [2011] III Eur Court HR 209; *P v Poland* (European Court of Human Rights, Chamber, Application No 57375/08, 30 October 2012); United Nations Human Rights Committee, *Views: Communication No 1153/2003*, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) ('KL v Peru').

[327] *RR v Poland* [2011] III Eur Court HR 209, 239 [159]; *P v Poland* (European Court of Human Rights, Chamber, Application No 57375/08, 30 October 2012) [157]–[169]; United Nations Human Rights Committee, *Views: Communication No 1153/2003*, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) ('KL v Peru').

[328] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 20 [5.3].

[329] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 22 [5.6], quoting Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child' (1990) 12(1) *Human Rights Quarterly* 156, 178.

[330] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 19–25 [5.1]–[5.8].

[331] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 162–171.

[332] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 231–267.

[333] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 51–60 [3.1]–[3.42].

[334] See above n 312.

[335] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 171 [D.92].

arising. It has been suggested that further long-term reliable longitudinal research is required as to the effects, especially on mental health, of abortion.[336]

2.1.73 This position can, and should, be re-evaluated in the future in the light of ongoing medical advances and further research as to the physical and especially mental effects and implications of abortion as well as further international human rights developments and implications. It is partly for these reasons that SALRI sees the strong value of a future review to determine the role and operation of any changes in this area. SALRI has previously recommended such a review in the context of any surrogacy law reform, given the differing views as to its human rights implications and its effects (or not) on the parties involved, and medical and scientific advances.[337] Given the complexities and rapid medical and scientific advances in the area of abortion as well, SALRI suggests that there is a statutory review of the operation and effectiveness of any new law five years after its commencement.[338]

2.1.74 Recommendation

Recommendation 2

SALRI recommends that there is a review of the operation and effectiveness of any new law in South Australia in relation to abortion five years after its commencement, given the ongoing medical, clinical and other changes in this area.

[336] See, for example, David Reardon, 'The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations and Research Opportunities' (2018) 6 *Open Medicine* 1, 22–23. 'Further research is needed in this field, and it necessitates large longitudinal, prospective studies assessing the numerous contextual variables and potential confounders associated with having an elective abortion, and mental health status. Future research is needed to shed light on the mechanisms linking abortion to various disorders and to decipher the characteristics of women most prone to developing a particular mental health problem': Carlo Bellieni and Giuseppe Buonocore, 'Abortion and Subsequent Mental Health: Review of the Literature' (2013) 67(5) *Psychiatry and Clinical Neurosciences* 301, 308.

[337] David Plater, Madeleine Thompson, Sarah Moulds, John Williams and Anita Brunacci, Surrogacy: A Legislative Framework: A Review of Part 2B of the Family Relationships Act 1975 (SA) (South Australian Law Reform Institute, Report No 12, October 2018) 78–79 [7.5.46]–[7.5.47]. See also Surrogacy Bill 2019 (SA) cl 31.

[338] Such statutory reviews are a regular feature of South Australian legislation. See, for example, *Advance Care Directives Act 2013* (SA) s 62; *Assisted Reproductive Treatment Act 1988* (SA) s 21; Sonia Allan, *Report on the Review of the Assisted Reproductive Treatment Act 1988 (SA)* (Department of Health, South Australia, 2017). See also *Surrogacy Act 2019* (SA) s 31.

Part 3 – The Law in South Australia

3.1 Historical Development of the Law in South Australia

3.1.1 The origin of the laws against abortion are not entirely clear. It appears that abortion after 'quickening'[339] was a common law offence.[340] The criminal law traditionally took a dim view of abortion (at least from the 1800s).[341] Abortion has been regulated by statute in England since 1803.[342]

3.1.2 In Australia, the original laws relating to abortion were contained in each jurisdiction's criminal statute. Such laws were, and in part remain, based on ss 58–59 of the venerable United Kingdom *Offences Against the Person Act 1861* (UK).[343] Section 58 of the 1861 Act read as follows:

> Every Woman, being with Child, who, with Intent to procure her own Miscarriage, shall *unlawfully* administer to herself any Poison or other noxious Thing, or shall *unlawfully* use any Instrument or other Means whatsoever with the like Intent and whosoever, with Intent to procure the Miscarriage of any Woman whether she be or be not with Child, shall unlawfully administer to her or cause to be taken by her any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, shall be guilty of Felony ... and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for Life, or for any Term not less than Three Years, or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour, and with or without Solitary.

3.1.3 The offences relating to abortion in the *Offences Against the Person Act 1861* (UK) and its various Australian restatements (including South Australia, until amended by the 1969 changes) were to prove especially influential.

3.1.4 There have been major changes in the social and medical context since the passage of the 1969 South Australian Act. As the Attorney-General observed in her referral to SALRI:

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[339] The VLRC noted this meant 'the moment in pregnancy at which the first movements of the fetus are felt by the mother, usually in the fourth or fifth month': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 25 n 110.

[340] Louis Waller, 'Any Reasonable Creature in Being' (1987) 13(1) *Monash University Law Review* 37, 37–40. 'Four features of the common law may be noted: first, that the common law envisaged the commission of offences by both the woman carrying the "child" and others who took action resulting in its death; secondly, that those offences (constituting only "misprision" or "misdemeanour" and not felony) were not capital; thirdly, that no offence could be committed unless and until there was a "child"; and, fourthly, that for this purpose there had to be "quickening"': *R (Smeaton) v Secretary of State for Health* [2002] EWHC 610 (Admin), [83] (Munby J).

[341] See John Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (Cambridge University Press, 1988).

[342] See Louis Waller, 'Any Reasonable Creature in Being' (1987) 13(1) *Monash University Law Review* 37, 39–40.

[343] Earlier applicable English statutes included the *Miscarriage of Women Act 1803* (UK) (known as '*Lord Ellenborough's Act*'), *Lord Lansdowne's Act 1828* (UK) and *Offences Against the Person Act 1828* (UK). See Talina Drabsch, 'Abortion and the Law in New South Wales' (Briefing Paper No 9/05, Parliamentary Research Service, Parliament of NSW, August 2005) 14–15. Before the introduction of *Lord Ellenborough's Act*, it was not a crime under English common law to carry out an abortion before 'quickening', which was described by Blackstone as the time when 'the infant is able to stir in the mother's womb,' and which was generally around the 14th week of pregnancy: see William Blackstone, *Commentaries on the Laws of England* (Clarendon Press, 1765–69) vol 1, 125; Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber 1958) 144; Sir Edward Coke, *Institutes of the Laws of England* (1628–1644) pt 3, 50; Kerry Petersen, *Abortion Regimes* (Dartmouth Publishing, 1993) 19–21;

> The fact is that it's been four decades since our abortion laws were first enacted. Since then, there have been significant advancements in medical technology, and a significant shift in community attitudes.[344]

3.1.5 The law relating to abortion has remained unchanged since 1969 (at a time when unsafe and even dangerous surgical procedures by unqualified operators were a major problem),[345] and there have been various medical and scientific advances in this area since then.[346] For example, the way that abortion is managed by medical practitioners has changed in ways that were not contemplated in 1969 when no safe, effective, medication option was available and surgical abortion was the only method used by the medical profession. The present law, for example, requires any abortion in South Australia to be carried out in a prescribed hospital.[347] While in 1969, abortion was only a surgical procedure where hospitalisation would have been required, an abortion procedure can now be carried out using specific medication. This current law therefore especially impacts women living in rural and regional areas who may not have access to a prescribed hospital.[348]

3.1.6 The combination of the drugs mifepristone (also known as RU486) and misoprostol (collectively known as 'MS-2 Step') has radically changed the provision of abortion services.[349] The present laws were never designed with such drugs in mind.[350] Instead, the law dates back to a period when women could buy or acquire 'potions, purgatives, enemas, emetics and uterine douches prepared at home from the likes of oil of savine, oil of tansy, ergot of rye, pennyroyal, aloes and myrrh, or ready-mixed by amateur apothecaries'.[351] Some caused abortion and poisoned the woman herself, while others were neither poisonous nor effective, though no doubt they were profitable.

3.1.7 There were also major problems regarding abortion in terms of access and even police corruption.[352] As Heath and Mulligan explain of the background to the 1969 South Australian Act:

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[344] Vickie Chapman, 'Law Reform Institute to consider Abortion Law Reform' (Press Release, 16 February 2019) <https://www.agd.sa.gov.au/newsroom/law-reform-institute-consider-abortion-law-reform>.

[345] See further below [3.6.1]–[3.6.14].

[346] One illustration is the increasing use and sophistication of pre-natal testing. This has particular implications in the disability context. See below Part 13. Another illustration, in another context, was noted to SALRI by various parties opposed to the decriminalisation of abortion such as the Australian Christian Lobby, Cherish Life International and Advocates International. See above n 262.

[347] *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 5, sch 2.

[348] This issue was highlighted by the Hon Tammy Franks. 'This brings me to another issue that is very close to my heart, namely the disadvantage faced by women in rural and remote areas when trying to access abortion services. Advances in medicine and technology mean that under certain circumstances women today can access EMA using prescription medication. EMA has been commonly available in Australia since 2013 as an alternative to surgical abortion and it is widely regarded as safe and effective for early pregnancy up to nine weeks. In every other jurisdiction, this treatment can be accessed from GPs or community health centres or by telemedicine. However, under South Australia's current abortion laws, this is not possible because we have a prescribed hospital requirement. This means that women who qualify for an EMA must still complete two visits to a prescribed hospital 48 hours apart. There is no doubt that this further disadvantages women in regional or rural South Australia and is yet another area where South Australia is clearly lagging behind other jurisdictions': South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2791.

[349] See below Parts 9 and 15.

[350] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 55.

[351] Gideon Haigh, *The Racket: How Abortion Became Legal in Australia* (Melbourne University Press, 2008) 13.

[352] Board of Inquiry into Allegations of Corruption in the Police Force in Connection with Illegal Abortion Practices in the State of Victoria, *Report of the Board of Inquiry into Allegations of Corruption in the Police Force in Connection with Illegal Abortion Practices in the State of Victoria* (Report, 31 August 1971); Robyn Gregory, 'Hardly Her Choice: A History of Abortion Law Reform in Victoria' [2007] 19 *Women Against Violence* 62, 64–65.

> Even in the 1960s, sex education was rare and contraception was unreliable and difficult to obtain. High demand for abortion and the legal uncertainty surrounding the status of abortion services created an environment in which corruption and selective prosecution could thrive.[353]

3.1.8 There remain some jurisdictions in which abortion is either prohibited entirely or permitted only to save the woman's life.[354] However, in contrast, many jurisdictions provide that abortions are lawful in a wider range of circumstances. In the least restrictive jurisdictions, such as the ACT and Canada,[355] abortion is no longer the subject of specific criminal laws and is instead regulated as a health matter.[356]

3.1.9 Views are divided on the effect of the purported criminal law focus of the present laws in South Australia (and elsewhere in Australia) regarding abortion. Despite the criminal law restrictions around abortion, prosecutions were (and indeed remain) few and far between.[357] Such cases have tended to either be discontinued by the prosecution[358] or to not result in a conviction.[359] However, convictions for abortion related offences in Australia are far from unique,[360] not just in relation to

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[353] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 46.

[354] See, for example, Ireland, where abortion was, until recently, permitted only if there is a risk to the woman's life: *Protection of Life During Pregnancy Act 2013* (Irl) ss 7–9. 'Roughly 39% of the world's population lives in countries with highly restrictive laws governing abortion': Louise Finer and Johanna Fine, 'Abortion Law Around the World: Progress and Pushback' (2013) 103(4) *American Journal of Public Health* 585.

[355] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT); *R v Morgentaler* (1988) 1 SCR 30.

[356] France, China, Germany, Sweden, Norway, South Africa, China and Russia are examples.

[357] From 1994 to 2019, 12 people were prosecuted in NSW for abortion related offences. Four of these persons were found guilty. See Michael McGowan, 'NSW Abortion Law: The Decriminalisation Reform Bill Explained', *The Guardian* (online 19 August 2019) <https://www.theguardian.com/australia-news/2019/aug/19/nsw-abortion-law-the-decriminalisation-reform-bill-explained>.

[358] A 1975 NSW case, for example, involved an abortion on a 15½ year old without the knowledge or permission of her parents (this aspect would now be covered by *Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112*; see also *Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218*). The medical practitioner who had performed the abortion was charged with unlawfully procuring a miscarriage under s 83 of the *Crimes Act 1900* (NSW), and a nurse who worked at the clinic was charged with aiding and abetting. The medical practitioner had concluded the abortion was required to avert damage to the pregnant girl's mental and physical health without actually examining the patient herself, but solely in reliance on discussions the girl had had with the nurse. Both defendants were committed for trial, but the charges were subsequently dropped. A highly publicised Victorian abortion case in 2000 involved a late term abortion at 31 weeks with severe fetal disability where a medical practitioner was dismissed (though later reinstated), six medical practitioners were suspended and after an eight-year process (including a comprehensive police investigation) all were exonerated: ee Lachlan de Crespigny and Julian Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201.

[359] *R v Heath* (Victorian County Court, Southwell J, February 1972), cited in Kerry Breen, Vernon Plueckhahn and Stephen Cordner, *Ethics, Law and Medical Practice* (Allen & Unwin, 1997) 282 (not guilty); *R v McColdrick* (1986), cited in Stefania Siedlecky and Dianna Wyndham, *Populate and Perish: Australian Women's Fight for Birth Control* (Allen and Unwin, 1990) 99 (charges dismissed); *R v Bayliss* (1986) 9 Qld Lawyer Reps 8 (two medical practitioners were acquitted); *R v Brennan* [2010] QDC 329; see also Kerry Petersen, 'Abortion Laws and Medical Developments: A Medico-Legal Anomaly in Queensland' (2010) 18(3) *Journal of Law and Medicine* 594 (woman and her boyfriend acquitted in relation to a contemplated medical abortion).

[360] From 1994 to 2019, 12 people were prosecuted in NSW for abortion related offences. Four of these persons were found guilty. See Michael McGowan, 'NSW Abortion Law: The Decriminalisation Reform Bill Explained', *The Guardian* (online, 19 August 2019) <https://www.theguardian.com/australia-news/2019/aug/19/nsw-abortion-law-the-decriminalisation-reform-bill-explained>. See also below [5.2.13].

'rogue' medical practitioners,[361] but even the woman involved.[362] Additionally, the mere threat of prosecution is a significant factor.[363] SALRI often heard in consultation of the 'stigma' and 'chilling effect' on both patients and staff of the criminal law focus of abortion.[364]

3.2 Current Law in South Australia

3.2.1 The present specific offences in South Australia dealing with abortion in the *CLCA* date from 1969. As noted above, the present law is based on the UK *Abortion Act 1967*.[365]

3.2.2 The present law provides that anything done with intent to procure the miscarriage of a woman is unlawful unless authorised to be lawful. For the purpose of the present law, it is assumed that a fetus of 28 weeks gestation is capable of being born alive (though this presumption can be rebutted). The 28 weeks stage reflected the state of medical science when the present law was introduced in 1969.[366] An abortion is not lawful after 28 weeks unless it is necessary to save the mother's life.[367]

3.2.3 A summary of the relevant provisions of the *CLCA* are briefly discussed below.

Attempts to procure abortion or procure drugs etc to cause abortion

3.2.4 The present law prohibits a pregnant woman or 'any person' from unlawfully administering 'poison or other noxious thing or unlawfully us[ing] any instrument or any other means

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[361] There have been some examples. See *R v Smart* in 1981 where a Dr Smart was convicted in relation to a botched abortion he had performed on a 17 year old who had been seven months pregnant at the time and no other medical practitioner would agree to terminate the pregnancy. The evidence indicated that Smart had not asked her about the state of her physical or mental health and the medically unorthodox method that Smart had used to perform this abortion (suction curette, then forceps) had killed the fetus but failed to extract it, and had necessitated hospitalisation of the woman and the performance of emergency surgery on her); See also *R v Sood* [2006] NSWSC 1141, an obvious case of patently unsound medical practice where there was no examination and no questions were even asked of the patient: see Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69, 69–71. Even 'rudimentary' questions of the patient would have allowed the medical practitioner to escape conviction by raising her belief that the abortion was necessary for the patient's welfare: at 77.

[362] See *DPP v Lasuladu* [2017] NSWLC 11.

[363] The law in both Tasmania and Western Australia was modified after threats of prosecution. In November 2001, a medical student asked the police to investigate abortion practices at the Royal Hobart Hospital where abortions had been performed for over 30 years. Tasmanian medical practitioners said that they were not prepared to risk prosecution under unclear laws and refused to perform any further abortions. The law was changed as a result. See Nicolee Dixon, 'Abortion Law Reform': An Overview of Current Issues (Research Brief No 2003/9, Parliamentary Library, Parliament of Queensland, 2003) 29–31. A similar situation arose in Western Australia in 1998 when two Perth medical practitioners were charged but the case was dropped after the law in Western Australia was amended as a result: at 25–9; Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69, 74. See also below [5.2.13].

[364] See below Part 5.

[365] See generally Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283.

[366] Medical advances have overtaken this limit and the stage at which a fetus is capable of being born alive and surviving is now considered to be 24 weeks or 22 (or even 20) weeks. This has proved a problematic area. See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 95–109. See further below Part 11.

[367] The upper limit presumption of 28 weeks can be rebutted and as a fetus is now capable of being born alive and surviving from 24, or even as low as 22 weeks, there is a view in medical circles (reinforced, SALRI heard, by advice(s) from the SA Crown Solicitor's Office) that an abortion after 22, 23 or 24 weeks (SALRI heard various figures) is effectively unavailable in South Australia unless the mother's life is at risk. See further below Part 11, especially [11.2.5], n 1106.

whatsoever'[368] upon, respectively, herself or a pregnant woman with intent to procure an abortion. The maximum penalty imposed for this offence is (and remains) imprisonment for life.[369]

3.2.5 It is also a similar offence for a person to unlawfully supply or procure 'any poison or other noxious thing' or unlawfully use 'any instrument or thing whatsoever', knowing that it is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether or not she is pregnant. The maximum penalty for this offence is three years imprisonment. Anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised to be lawful.[370]

Immediately necessary to save life or prevent grave injury

3.2.6 It is not an offence for a qualified medical practitioner to terminate the pregnancy of a woman where the medical practitioner is of the opinion, formed in good faith, that the abortion is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman.[371]

Lawful or therapeutic abortion

3.2.7 Although unlawful abortion remains a serious criminal offence,[372] there is specific statutory provision for lawful or therapeutic abortion (unlike under the common law).[373]

3.2.8 Section 82A of the *CLCA* provides that an abortion is lawful when:

> two medical practitioners[374] form the opinion that either continuing the pregnancy would involve greater risk of injury to the physical or mental health of the woman, or involve greater risk to the life of the woman than termination; or
>
> there is a substantial risk that the child, if born would suffer from such physical or mental abnormality as to be seriously handicapped.[375]

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[368] The question of whether this provision extends to early medical abortion and the use of MS-2 Step is unclear. The overwhelming view SALRI received in consultation was that the use of MS-2 Step fell within this expansive provision and is therefore precluded under the present law. SALRI has proceeded on this assumption. This construction would accord with the original policy of the law and the 'mischief' it was aimed at: see *R v Farrow* (1857) 169 ER 961; *R v Turner* (1910) 4 Cr App R 203; *McAvoy v Gray* (1946) ALR 459. 460, where 'drug', 'poison' and 'noxious thing' are used interchangeably. However, there is a contrary view that 'poison or other noxious thing' should be read separately to 'any instrument or thing' and therefore unless MS-2 Step can be regarded as a 'poison or other noxious thing' (which it arguably is not), then early medical abortion would be within the current law. See *R v Lindner* [1938] SASR 413; Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 55–62. This was the view taken by the trial judge and seemingly the jury under the then similar Queensland provision in *R v Brennan* [2010] QDC 329. See also Kerry Petersen, 'Abortion Laws and Medical Developments: A Medico-Legal Anomaly in Queensland' (2010) 18(3) *Journal of Law and Medicine* 594. SALRI notes the uncertainty and lack of clarity of the present law (especially compounded by the far from clear s 82A of the *CLCA*) and it is inappropriate for such an important issue to be left unresolved.

[369] *CLCA* s 81(1)–(2).

[370] Ibid s 82.

[371] Ibid s 82A(1)(b).

[372] Ibid s 82A(1)(a).

[373] Until 2 October 2019, the common law still applied in New South Wales.

[374] 'The need for a second medical signature was intended as a check on rogue doctors, as well as offering protection to the doctor himself': Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283, 289.

[375] *CLCA* s 82A(1)(a)(i)–(ii). This ground of abortion under the present law is a sensitive and complex area. See Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 44–46 [3.86]–

3.2.9 When determining the risk to the woman's life, physical or mental health by continuing with a pregnancy, the medical practitioners may take into account 'the pregnant woman's actual or reasonably foreseeable environment'.[376] The problematic terms 'physical or mental abnormalities' and 'seriously handicapped' are not defined.

3.2.10 In urgent situations, where 'the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman', the opinion of only one medical practitioner is required for the abortion to be lawful.[377]

3.2.11 The treatment for the termination of the pregnancy is to be carried out in a hospital or a hospital of a class that is declared by regulation to be a prescribed hospital.[378] The rationale of this requirement was noted by Professor De Costa: 'In 1970 only surgical abortion was available anywhere in the world; the 1970 changes to the abortion law reflected that, and also required abortions to take place in licensed premises.'[379]

3.2.12 In an effort to prevent what was described at the time as 'abortion tourism',[380] when South Australia was the first state to legislate access to abortion, the 1969 changes provide that an abortion cannot be provided to a woman lawfully, if the woman has not resided in South Australia for a period of at least two months before the termination of her pregnancy.[381]

Child destruction

3.2.13 The offence of child destruction was originally established in England[382] to deal with lethal acts intentionally performed during childbirth where there was doubt about whether the child was born alive. Rather than having to establish live birth in order to convict a person of murder, manslaughter or infanticide, the offence of child destruction could be alternatively charged in cases of doubt.[383]

3.2.14 While it does not appear to have been the intention of the initial English legislation,[384] unlawfully terminating a pregnancy when a woman is carrying a child capable of being born alive falls

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[3.95]; Carole Petersen, 'Reproductive Justice, Public Policy, and Abortion on the Basis of Fetal Impairment: Lessons from International Human Rights Law and the Potential Impact of the Convention on the Rights of Persons with Disabilities' (2015) 28(1) *Journal of Law and Health* 121; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 83–85 [3.133]–[3.140], 98–99 [3.202]. See also below Part 13.

[376] Ibid s 82A(3). This provision draws on the common law in this area which recognises broadly similar defences. See *R v Bourne* [1939] 1 KB 687. See also *R v Davidson* [1969] VR 667; *R v Wald* (1971) 3 DCR 25; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

[377] Ibid s 82A(1)(b).

[378] This is problematic. See Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.234]–[3.235]. See further below Part 9.

[379] *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 5, sch 2. 'This provision was crafted to ensure that services were offered openly, only in those locations with the facilities necessary for their safe performance': Sally Sheldon (2016) 'British Abortion Law: Speaking from the Past to Govern the Future' 79(2) *Modern Law Review* 283, 307.

[380] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 52. With South Australia being the only State to have legislated on abortion in 1969, there was concern that women would travel to South Australia to have an abortion.

[381] *CLCA* s 82A(2).

[382] *Infant Life Preservation Act 1929* (UK).

[383] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) 11 [3.15].

[384] *R v Bourne* [1939] 1 KB 687, 691.

within the ambit of both the English and Australian Acts.[385] The offence of child destruction does not appear to have been used to deal with acts performed during childbirth, or for 'late-term' abortion.[386]

3.2.15 The VLRC criticised the offence of child destruction, saying: 'The offence lacks clarity and causes unnecessary complexity.'[387] The VLRC recommended that the offence of child destruction be repealed, regardless of the final model for abortion chosen. The VLRC recommended that this behaviour be covered by an amendment to make it clear that destruction of a fetus (ie, stillbirth) caused by assault of a pregnant woman falls within the definition of 'serious injury' to the woman.[388]

3.2.16 South Australia does not have a specific offence relating to 'child destruction' but it does have a convoluted (some may say now unworkable)[389] provision relating to 'child destruction' in the context of when a late term abortion is unlawful, unless performed to protect the mother's life.[390]

3.2.17 The first of the grounds in South Australia for a lawful abortion, that is a risk to the life or physical or mental health of the woman, does not apply when a woman is pregnant with 'a child capable of being born alive', unless the abortion was performed to save the woman's life.[391]

3.2.18 For the purposes of defining 'capable of being born alive', there is a rebuttable statutory presumption that a pregnancy of 28 weeks or more is prima facie proof that the child is capable of being born alive.[392] This has become increasingly problematic with medical advances as to the stage at which a child can now survive independently of its mother; which is 24 or 22 (or even 20) weeks.[393]

3.2.19 Due to this rebuttable presumption, a clinical decision is required to be made by the medical practitioner which incorporates not only the gestational age of the fetus, but also other factors[394] which can cause difficulties in making an accurate assessment.

3.2.20 In all the circumstances it remains in South Australia a crime punishable by imprisonment for life for any person to perform an abortion unless the procedure is a therapeutic abortion authorised by law. This includes a woman performing her own abortion.[395]

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[385] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) 11 [3.15]. See also *C v S* [1988] 1 QB 135. A provision was added in England to the *Abortion Act 1967* (UK) to clarify that the offence of child destruction could not be committed by a registered medical practitioner performing an abortion in accordance with the provisions of the Act: s 5(1).

[386] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) 11 [3.15]. The VLRC noted from DPP feedback that the offence has been used in cases involving attacks on women in the later stages of pregnancy with intent to harm the fetus.

[387] Ibid. See further at: 96–109.

[388] Ibid. See also at: 109 [95], Rec 2, 109. See further below [21.3.1]–[21.3.8].

[389] SALRI often heard in consultation of the complexity and practical uncertainty of this provision and the effect of legal advice in light of medical advances as to viability. See below Part 11, especially [11.2.5], n 1099.

[390] *CLCA* ss 82A(7), (8). The offence of child destruction was originally in s 10 of the *Crimes Act 1958* (Vic), but this was repealed by the *Abortion Law Reform Act 2008* (Vic) s 9 (Repeal of Subdivision (2) of Division 1 of Part I of the *Crimes Act 1958* (Vic)) following recommendations of the VLRC: see Victorian Law Reform Commission, *The Law of Abortion* (Report, March 2008) [7.92].

[391] *CLCA* s 82A(7).

[392] Ibid ss 82A(7), (8).

[393] See further below Part 11.

[394] This was raised to SALRI by the Department of Health and Wellbeing. Other parties told SALRI in consultation the factors practitioners considered to determine whether a fetus was viable included size, weight and development which can be impacted by genetic factors as well as the lifestyle of the woman and the pre-natal care available to her.

[395] *CLCA* s 82(1).

Conscientious objection

3.2.21 No person is under a duty in South Australia to participate in an abortion procedure when they have a conscientious objection, unless such treatment is necessary to save the life of the woman or prevent grave injury to her physical or mental health.[396]

3.3 The Law in Other Australian Jurisdictions

3.3.1 The law in Australia relating to abortions, and who can perform them, is divided between the Commonwealth, States and Territories. This reflects the federal nature of the Australian system. There is no single consistent law in Australia governing abortion. The State and Territory Parliaments retain the main legal power and responsibility to regulate abortion arrangements in Australia. All States and Territories have various laws and procedures relating to abortion. The Commonwealth has no direct constitutional jurisdiction in the area of abortion. However, it is involved in the regulation and oversight of medical and health practitioners which includes those who perform abortions. It is also involved in national clinical practice (including the regulation of medicine) and as a source of funding in South Australia (though the position differs interstate where private health providers are largely utilised).

3.3.2 The confusion and complexities regarding abortion in Australia are compounded as the relevant laws differ from jurisdiction to jurisdiction. There is no one single uniform, or even consistent, law governing abortion.[397]

3.3.3 The effects of this are marked, as one NSW study notes:

> This lack of uniformity gives rises to a number of concerns, including: the effects of abortion tourism and the extent to which abortions are available where fetal abnormality has been detected … A lack of uniformity gives rise to the potential for 'abortion tourism', which involves women travelling outside their State or Territory to obtain an abortion in a jurisdiction where the procedure is legal. Abortion tourism is not unique to Australia.[398]

3.3.4 One article argued that there is an urgent need for national reform of Australia's abortion laws to provide certainty for the provision of this important health service, and equal access to safe and affordable abortion for all Australian women.[399] While a single national law may be desirable, the

[396] Ibid ss 82A(5)–(6). See also below Part 17.

[397] Natasha Cica, 'Abortion Law in Australia', (Research Paper No 1, Parliament of Australia, 31 August 1998).

[398] Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017) 14. Patrick Ferdinands argues that a lack of uniformity also undermines the abortion laws of jurisdictions such as NSW and Queensland, where the procedure remains criminalised, because it 'allow[s] individuals seeking abortions to "forum shop" across jurisdictions to circumvent the practical effect of existing criminal laws proscribing abortion': Patrick Ferdinands, 'How the Criminal Law in Australia Has Failed to Promote the Right to Life for Unborn Children: A Need for Uniform Criminal Laws on Abortion across Australia' (2012) 17(1) *Deakin Law Review* 77.

[399] Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105.

authors acknowledge this is unlikely given constitutional constraints.[400] They note what is likely to be more achievable is uniform law reform in separate States and Territories.[401]

3.3.5 A summary of the different approaches to abortion regulation in Australian jurisdictions is set out below in **Table 1**.

[400] There are further obstacles to such uniform national laws, especially on a contentious subject such as abortion. SALRI is under no illusions in this context as the slow pace of such national law reform is well established. SALRI notes the colourful remarks of the former South Australian Attorney-General, the Hon John Rau MP, about the slow pace of such uniform national law reform. The comments, though expressed about the National Consumer Affairs Council, have wider application. 'I have something very disturbing to report to the House. You may have seen stuff on television about the way glaciers move. It is reported that some of them move a matter of some centimetres per year and over the millennia they are capable of moving large boulders from point A to point B. This is considered quite good, but you have to work in geological time before you actually witness these marvels. There is a lot in common between a glacier and the National Consumer Affairs Council … What you do is wait for the Commonwealth to extract the digit and make legislative amendments. I can tell you that that can take a great deal of time and, in fact, in my experience, it takes forever': South Australia, *Parliamentary Debates*, House of Assembly, 31 May 2018, 814–815.

[401] Caroline de Costa et al, 'Abortion Law Across Australia — A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 111. SALRI has also heard that interstate travel to access abortion is not uncommon. See also Carolyn Nickson, Julia Shelley and Anthony Smith, 'Use of Interstate Services for the Termination of Pregnancy in Australia' (2002) 26(5) *Australian and New Zealand Journal of Public Health* 421.

Table 1 - Regulatory approaches to abortion in Australian jurisdictions

State	Termination lawful on request	Termination lawful on doctor satisfaction	More than one doctor or committee required	Provision for disability	Criminal offences for unlawful termination	Conscientious Objection / Referral	Counselling requirements	Safe Access Zones
Australia Capital Territory	YES	Not Referred to	NO	NO	YES (doctors excluded)	YES *Not required to refer to another practitioner	Not Referred to	YES
New South Wales (this incorporates the *Abortion Law Reform Act 2019* (NSW))	YES (up to 22 weeks)	YES — after 22 weeks if appropriate in all the circumstances OR in emergency	YES (after 22 weeks but recognising that medical practitioners considering the performance of an abortion after 22 weeks 'may' seek advice from a multi-disciplinary team or hospital advisory committee)	NO New legislation refers to considerations including medical, physical, psychological and social circumstances and professional standards of the practitioner.	YES But only for unqualified persons	YES (either refer to another practitioner or provide prescribed information)	YES Requires a specialist medical practitioner for an abortion after 22 weeks to 'provide all necessary information to the person about access to counselling, including publicly-funded counselling'	YES
Northern Territory	NO	YES -— up to 23 weeks if appropriate in all the circumstances OR in emergency	YES (after 14 weeks up to 23 weeks, 2 suitably qualified doctors, except in emergency)	NO Considerations include medical, physical/ psychological/social circumstances and professional guidelines of the practitioner.	YES (doctors, qualified persons and the woman excluded)	YES (except in emergency) *Must refer to another practitioner	Not Referred to	YES
Queensland	YES (up to 22 weeks)	YES — after 22 weeks if appropriate in all the circumstances OR in emergency	YES (after 22 weeks)	NO New legislation refers to considerations including medical, physical, psychological and social circumstances and professional standards of the practitioner.	YES (doctors, qualified persons and the woman excluded)	YES (except in emergency) *Must refer to another practitioner	Not Referred to	YES
South Australia (current law)	NO	YES If risk to life or health, fetal abnormality, emergency	YES (2 doctors, except in emergency)	YES Fetus must be 'seriously handicapped'.	YES	YES (except in emergency) *Not required to refer to another practitioner	Not Referred to	NO

Tasmania	YES (up to 16 weeks)	YES — after 16 weeks If risk to physical or mental health	YES (after 16 weeks only, 2 doctors required. Including 1 specialist)	NO Considerations include risk to physical/mental health and economic/social circumstances.	YES (doctors and the woman excluded)	YES (except in emergency) *Must refer to another practitioner	Not Referred to	YES
Victoria	YES (up to 24 weeks)	YES — after 24 weeks If appropriate in all the Circumstances.	YES (after 24 weeks only, 2 doctors required)	NO Disability may be grounds for lawful abortion under 'relevant medical circumstances'.	YES (doctors, qualified persons and the woman excluded)	YES (except in emergency) *Must refer to another practitioner	Not Referred to	YES
Western Australia	NO	YES — up to 20 weeks. After 20 weeks, if woman or fetus has severe medical condition.	YES (after 20 weeks only, 2 doctors from a panel)	NO Considerations include informed consent, personal/family/social consequences, danger to physical/mental health. After 22 weeks — whether an unborn child has a 'severe medical condition' is relevant.	YES (doctors excluded)	YES *Not required to refer to another practitioner	Referral Must be Offered	NO (pending changes)

3.3.6 While there are some inconsistencies between the States and Territories, a consistent theme is that it is lawful in every State and Territory for a pregnancy to be terminated under certain conditions (though these conditions vary between the States and Territories) and it is considered to be appropriate for a lawful abortion if there is a risk to the physical and/or mental health of the woman.

3.3.7 The present legislative position within Australia with regard to domestic abortion is summarised as follows:

Australian Capital Territory

3.3.8 The ACT approach considers abortion to be a health issue with the focus being on the women's right to autonomy to make decisions regarding her own health and circumstances.[402]

3.3.9 Based on these underlying policy views, abortion is lawful upon request of the woman at any gestational stage. Decisions regarding whether an abortion can be performed, and the type of abortion available, is dependent on the women's consultation with her treating medical practitioners and those practitioners are regulated by health laws and their governing bodies.

3.3.10 It is permissible for medical practitioners to have a conscientious objection if they do not believe it is appropriate in all the circumstances, whether this is due to their personal beliefs on abortion generally or the circumstances or gestational stage at which the women is seeking to undertake the procedure.[403] However, a health practitioner with a conscientious objection against abortion must assist the women by providing the details of a practitioner or service willing to provide the procedure.

3.3.11 Whether abortion is available in practice will depend on clinical practice and access.[404]

New South Wales

3.3.12 Until 2 October 2019, New South Wales retained abortion as a serious offence in the *Crimes Act 1900* (NSW). The NSW law was based on the common law[405] and the offences drew on the *Offences against the Person Act 1861* (UK).

3.3.13 The previous law in NSW recognised a common law defence to abortion is available at all gestational stages but depended on whether there was a substantial risk to the life or physical or mental health of the woman. The precise definition of a risk to life or health was undefined. The common law in NSW defined a risk to life and health quite broadly.[406]

3.3.14 The Reproductive Health Care Reform Bill 2019 was introduced as a Private Member's Bill to the NSW Legislative Assembly on 1 August 2019 by Alex Greenwich MP.[407] The Bill after lengthy debate and various amendments passed Parliament on 26 September 2019 as the *Abortion Law Reform Act 2019* (NSW).[408] The Act makes major changes to this area and largely removes abortion

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[402] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT).

[403] Various medical and health practitioners told SALRI that a practitioner may be willing to perform an abortion in one situation, but not another. 'Even among medical practitioners who will perform an abortion', as Advocates International told SALRI, 'there is a spectrum with regards to conscientious objection.' See also below [17.7.5].

[404] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 38 [124]–[125].

[405] *R v Davidson* [1969] VR 667; *R v Wald* (1971) 3 DCR 25; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

[406] See *R v Wald* (1971) 3 DCR 25; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

[407] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6.

[408] New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 1–7.

from the criminal law. It is broadly based on the Victorian and Queensland models. The Act received Royal Assent on 2 October 2019 and came into operation on that day.

3.3.15 SALRI considers the 2019 NSW Act and its implications further below.[409]

Queensland

3.3.16 Queensland has a two stage or hybrid model in regard to abortions where up to 22 weeks an abortion is available to a woman on her request, but after that time certain criteria must be satisfied before a lawful abortion can be performed.

3.3.17 The present law in Queensland[410] provides for a two-staged approach with different rules and procedures for early and late term abortions. Abortions before the relevant gestation period of 22 weeks are regulated in the same way as any other medical procedure. The only requirements are the woman's consent and that the procedure be performed, or supervised, by an appropriate health practitioner. Once a pregnancy passes 22 weeks, an abortion is only be lawful if two medical practitioners approve the procedure and determine that it is 'appropriate in all the circumstances'.

3.3.18 Queensland retains criminal sanctions for an unqualified person performing or assisting in performing an abortion, whether surgical or medical. However, the woman concerned, medical practitioners and other qualified health practitioners are exempted from criminal liability.

3.3.19 The Queensland law recognises conscientious objection on the part of health practitioners to decline to be involved in relation to an abortion or potential abortion but the practitioner is required to refer the patient to a practitioner or service willing to provide the procedure.

Tasmania

3.3.20 Tasmania also has a hybrid model, however, abortion on the request of the woman is limited to 16 weeks.[411] After 16 weeks there must be a risk to the woman's physical or mental health before a lawful abortion can be carried out.

3.3.21 Despite any restrictions on the availability of an abortion, the woman and the medical and other health practitioners involved are excluded from criminal liability for performing or assisting in performing an abortion. However, it is still an offence for an unqualified person to perform or assist in the performance of an abortion.

3.3.22 The closure of Tasmania's main abortion provider has forced women to travel to Melbourne, having particular impact on low income women who may well be unable to afford to travel.[412] This increases the risk of women either seeking assistance from unregulated or unqualified individuals or attempting to self-terminate the fetus.[413]

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[409] See below Part 22.

[410] *Termination of Pregnancy Act 2018* (Qld).

[411] *Reproductive Health (Access to Terminations) Act 2013* (Tas).

[412] See Sue Bailey, 'Tasmanian women face big costs if they travel interstate for abortions', *Sydney Morning Herald* (online), 8 March 2018 <https://www.smh.com.au/national/tasmanian-women-face-big-costs-if-they-travel-interstate-for-abortions-20180308-p4z3il.html>: Rhiannon Shine, 'Abortion Rally at Tasmanian Parliament ups pressure on Hodgman Liberal Government', ABC News, 24 May 2018, <https://www.abc.net.au/news/2018-04-28/abortion-rally-at-parliament-ups-pressure-on-state-government/9707190>.

[413] One of the authors of this report draws on previous experience in practice to support this proposition. See also Frances Doran and Julie Hornibrook, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16(1) *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 1, 8.

Victoria

3.3.23 In September 2007, the VLRC was asked to provide legislative advice on the decriminalisation of the termination of pregnancy in Victoria. The VLRC published an Information paper in September 2007.[414] In June 2008, the VLRC after extensive consultation[415] released its Report.[416] The VLRC presented three options for consideration.[417]

3.3.24 In August 2008, a Bill was introduced to the Victorian Parliament that reflected Model B in the VLRC report. All parties allowed MPs a conscience vote. The *Abortion Law Reform Act 2008* (Vic) passed in October 2008. The new Act decriminalised abortion. Under the Act, a woman can access abortion on request up to a gestational limit of 24 weeks. There are no legislative criteria. After 24 weeks, abortion still remains available. However, it requires two medical practitioners to undertake an assessment and determine that the procedure is 'appropriate in all of the circumstances'.

3.3.25 At all stages of gestation, the woman, the medical practitioners involved and other qualified health practitioners are excluded from any criminal liability.

3.3.26 While allowing for conscientious objection, Victoria also requires medical practitioners who object to providing advice, assistance or treatment, to refer the woman for assistance to another suitable and willing medical practitioner who does not hold such an objection. This is to prevent any delay in service delivery and to assist the woman in navigating the medical system.

Western Australia

3.3.27 Western Australia has a relatively restrictive approach. It does not permit abortion upon request of the woman. Rather there is a two stage model. An abortion can occur up to 20 weeks upon the medical practitioner being satisfied that it is appropriate. After 20 weeks an abortion can only be performed in circumstances where the woman or the fetus has a severe medical condition.

3.3.28 The assessment as to whether an abortion can occur after 20 weeks is undertaken by two medical practitioners from a panel. In practice, SALRI was informed that these practitioners are provided with written submissions and access to medical records and make their determination without direct consultation with the woman or her treating practitioner.

3.3.29 The medical practitioners on the panel are anonymous and there is no right of appeal or to provide further clarification once the application is made.

3.3.30 The Western Australian panel or committee approach was the subject of extensive criticism in SALRI's consultation as intrusive, bureaucratic and time consuming and especially undermining the autonomy of the woman.[418]

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[414] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007).

[415] The VLRC held more than 30 meetings with people involved in abortion law reform. These included faith groups, public and private abortion providers, academics, health service providers, women's organisations and peak medical bodies. Meetings were also held with youth and disability service providers to discuss the particular issues abortion law reform raises for these groups. The VLRC received 519 written submissions, 433 from individuals and 86 from organisations. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 72 [5.2].

[416] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008).

[417] Ibid 83–93.

[418] See also Kirsten Black, Heather Douglas and Caroline de Costa, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144. See further below [11.4.1]–[11.4.15], [11.6.16]–[11.6.17].

3.4 Notes on the Law in Other Jurisdictions

New Zealand

3.4.1 On 26 October 2018, the New Zealand Law Commission released a Ministerial Briefing Paper providing advice to the Minister of Justice on alternative approaches that could be taken to New Zealand's abortion laws if the Government decides to treat abortion as a health issue.[419] The New Zealand Law Commission described three alternative legal models:

> Under Model A, there would be no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by the woman in consultation with her health practitioner.
>
> Under Model B, there would be a statutory test. The health practitioner who intends to perform an abortion would need to be satisfied that an abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.
>
> Under Model C, there would be no statutory test until 22 weeks of a pregnancy. After 22 weeks, the health practitioner who intends to perform an abortion would need to be satisfied that the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.

3.4.2 The Abortion Legislation Bill 2019 was introduced to the New Zealand Parliament on 5 August 2019. The Bill provides that a woman can seek an abortion without restrictions within the first 20 weeks. After the 20 week period, a woman seeking an abortion must consult a qualified health practitioner who will assess the patient's physical health, mental health, and well-being. The Bill would require the health practitioner to reasonably believe that an abortion is appropriate with regard to the pregnant woman's physical and mental health, and well-being.

The Bill passed its first reading on 8 August 2019 and has been referred for consideration to the Abortion Legislation Committee.

United States (Alabama)

3.4.3 The laws governing abortion in the United States are contentious and vary from state to state. During SALRI's public consultation phrase, the US state of Alabama introduced controversial new laws in regard to abortion.[420] The Alabama laws impose a near-total prohibition on abortion, making it a crime to perform the procedure at any gestational stage and allows an exception only when the woman's life is at serious risk. It contains no exception for rape and incest.[421] This follows so called 'heartbeat' models recently introduced by several US states which prevent any abortion after a fetal

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[419] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018). The Commission received 3,419 submissions. Of those submissions, 61 were from organisations such as government bodies, professional organisations, academic groups, religious organisations and interest groups. A further four submissions were made by peer groups within professions. The remaining 3,354 submissions were from people speaking in their personal capacity.

[420] 'Alabama State Senate passes near total abortion ban with no exception for rape victims' *ABC News* (online, 15 May 2019) <https://www.abc.net.au/news/2019-05-16/alabama-ban-on-nearly-all-abortions-in-gop-governors-hands/11117568>;Erin Durkin, 'Alabama abortion ban: Republican state senate passes most restrictive law in US', *The Guardian* (online, 16 May 2019) <https://www.theguardian.com/us-news/2019/may/14/abortion-bill-alabama-passes-ban-six-weeks-us-no-exemptions-vote-latest>.

[421] Erin Durkin, 'Alabama Abortion Ban: Republican State Senate passes most Restrictive Law in US', *The Guardian* (online, 16 May 2019) <https://www.theguardian.com/us-news/2019/may/14/abortion-bill-alabama-passes-ban-six-weeks-us-no-exemptions-vote-latest>.

heartbeat is said to be detected, typically at about six weeks.[422] SALRI reiterates that, although several parties raised these recent developments in the United States, any such highly restrictive model is outside SALRI's Terms of Reference. In their operation, any such approach would represent a severe restriction, if not reversal, of the current law in South Australia (and elsewhere in Australia).

3.4.4 After the new Alabama laws were publicised, SALRI received a marked increase in its submissions from the community.

3.5 Case Law: The Common Law Context

3.5.1 Until the late 1960s and early 1970s there was little, if any, Australian judicial or statutory guidance of what circumstances, if any, would render the performance of an abortion lawful. Some guidance, however, was provided by English authorities. The discussion of the common law is instructive in so much as it establishes the position prior to the introduction of the 1969 reforms in South Australia. Moreover, the development of the common law was relevant for the law in New South Wales prior to its 2019 reforms. As will also be outlined, there are some areas where the current statutory requirements in the South Australian law lags behind developments in the common law.

R v Bourne[423]

3.5.2 The 1938 case of *R v Bourne*[424] was a test case involving the prosecution of an eminent London surgeon[425] for performing a surgical abortion on a 14 year old girl who had been gang raped by five Army officers from the Royal Horse Guards.[426] In his address to the jury at the Old Bailey in that case, Macnaghten J (somewhat creatively) held that an abortion would not be unlawful, within the terms of s 58 of the *Offences Against the Person Act 1861*, if the operation were performed for the purpose of preserving the pregnant woman's life. An accused would not be guilty of the crime of unlawful abortion if they had acted in good faith to preserve the life of the woman.[427]

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[422] Associated Press, 'Ohio Governor Severely Restricts Abortion in Move against *Roe v Wade*', *The Guardian* (online, 13 April 2019) <https://www.theguardian.com/us-news/2019/apr/12/ohio-governor-abortion-signs-heartbeat-law >; Jessica Glenza, 'Doctors' Organisation: calling Abortion Bans "Fetal Heartbeat Bills" is Misleading', *The Guardian* (online, 5 June 2019) <https://www.theguardian.com/world/2019/jun/05/abortion-doctors-fetal-heartbeat-bills-language-misleading>.

[423] [1939] 1 KB 687.

[424] Ibid. See also Kerry Petersen, *Abortion Regimes* (Dartmouth Publishing, 1993) 63–65.

[425] Dr Bourne had put himself forward as a test case after at least one other medical practitioner had refused to provide an abortion. See further Caroline de Costa, 'The King versus Aleck Bourne' (2009) 191(4) *Medical Journal of Australia* 230. As early as 1938, a South Australian medical practitioner proposed a local test case similar to *Bourne* to allow for clarification of the law. This suggestion was not supported by the local medical association and never progressed. See Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 45; Clare Parker, 'A Parliament's Right to Choose: Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60, 62–63.

[426] The context is significant. 'It soon became evident that the girl was pregnant, and abortion was requested. The response of the consultant at St Thomas's was that, as the rapists were officers and therefore apparently gentlemen, "she might be carrying a future Prime Minister of England", and anyway, "girls always lead men on". He refused the request': Caroline de Costa, 'The King versus Aleck Bourne' (2009) 191(4) *Medical Journal of Australia* 230.

[427] Glanville Williams subsequently argued that Macnaghten J's interpretation of s 58 relied on the defence of necessity: 'Mcnaghten J's direction is also a striking vindication of the legal view that the defence of necessity applies not only to common law but even to statutory crimes. It is true that the direction proceeded in some slight degree on the analogy of the child destruction statute, which contains an express exemption for the preservation of the life of the mother; but the exception in the one statute was not in itself a ground for reading a similar exception into another. The only legal principle on which the exception could be based was the defence of necessity ... The defence of necessity involves a choice of values and a choice of evils, and the choice made by the judge appears clearly from his statement that "the unborn child in the womb must not be destroyed unless the destruction of

3.5.3 Macnaghten J directed the jury that they could conclude that a medical practitioner had operated for the purpose of preserving the pregnant woman's life if the medical practitioner held 'the opinion, on reasonable grounds and with adequate knowledge that the probable consequence of the pregnancy would be to make the woman a *physical or mental wreck*.'[428] The surgeon was acquitted.

3.5.4 Macnaghten J's interpretation did not confine lawful abortions to those performed to save a woman's life in the strictest sense. His interpretation also allowed abortions performed to save a woman's health from being 'wrecked'.[429] This remained undefined,[430] but there was little doubt that Macnaghten J's test demanded a high level of danger to a woman's health before abortion would be justified.[431] *Bourne* was regarded as the law in both England and Australia.

3.5.5 Cica notes that *Bourne* represented a considerable liberalisation of English abortion law as, until *Bourne,* there was thought to be no common law defence to abortion implied in the *Offences Against the Person Act 1861*. The defence outlined by Macnaghten J nonetheless was restrictive.[432]

3.5.6 The effect of *Bourne* in practice was limited and, apart from failing to resolve the law, in particular, it did not appear to solve the problem of the untrained and negligent abortionist, at least for poorer women.[433] Two subsequent English cases may have further liberalised the test in *Bourne*, by moving the legal emphasis away from a concern solely to preserve the pregnant woman's life, to preserving her physical or mental health as an alternative legal justification for abortion. [434] Notwithstanding these two cases, the statement of the law in *Bourne* was widely assumed to represent the legal position in both the United Kingdom and Australia.[435]

3.5.7 In 1952, Glanville Williams wrote:

> The decision in *Bourne* has ameliorated the law but has not yet taken full practical effect. The medical practitioner is said to be still chary to the act, except in the clearest of cases, partly because he fears that public opinion may not be in favour and partly because he is not certain how far the *Bourne* decision protects him.[436] [T]he attitude of the medical profession in general was hostile, and tragic cases continued to occur … Women who had been raped, women deserted by their husbands, and overburdened mothers living in poverty with large families, also failed to get a medical abortion … in general the mass of woman could only go to a 'back street abortionist',

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that child is for the purpose of preserving the yet more precious life of the mother'": Glanville Williams, *The Sanctity of Life and the Criminal Law*, (Knopf, 1957) 152. Cf *R v Woolnough* [1977] 2 NZLR 508, 516–517.

428 [1939] 1 KB 687, 694 (emphasis added).

429 Glanville Williams, *The Sanctity of Life and the Criminal Law*, (Knopf, 1957) 163.

430 Lord Diplock described this reference to wreckage as 'a vivid phrase borrowed from one of the witnesses, but unfortunately lacking in precision': *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] 2 WLR 279, 298.

431 Macnaughten J himself acknowledged that he was advocating a 'reasonable' rather than a 'wide and liberal' interpretive approach: *R v Bourne* [1939] 1 KB 687, 692.

432 Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998).

433 Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 145 [A.27].

434 *R v Woolnough* [1977] 2 NZLR 508, 515. These two decisions were *R v Bergman* (Central Criminal Court, May 1948) cited in Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998) 5; *R v Newton* [1958] Crim LR 469; see also J Havard, 'Therapeutic Abortion' [1958] *Criminal Law Review* 600.

435 Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998) 5.

436 Glanville Williams 'The Law of Abortion' (1952) 5(1) *Current Legal Problems* 128, 156.

> wielding a knitting needle, syringe or stick of slippery elm … Although illegal abortions ran into thousands each year, convictions were comparatively few.[437]

3.5.8 Williams expressed particular concern about the inequity that enabled affluent women to secure an abortion but poor women to risk the unsafe backyard operators. He argued that, wherever there was a total prohibition, this dilemma remained.[438] A clear distinction emerged in this period between the abortion experiences of the affluent, who could access a network of midwives and doctors, and the experiences of the poor. Both practices operated in the shadow of the criminal law. While the policy aim of the criminal prohibition was to protect women, the effect was actually to drive the practice underground.[439]

1969 South Australian Act

3.5.9 *Bourne* is significant as it informed the formulation and passage of the 1969 South Australian Act.[440] Indeed, the then Attorney-General, Robin Milhouse, in introducing the South Australian Bill, explained it as substantially restating the common law position stated in *Bourne*.[441]

3.5.10 There was a minority view in the South Australian Parliament that *Bourne* stated the law with adequate clarity and legislative intervention was unnecessary.[442] However, there was no authoritative judicial ruling on when abortion would be lawful in South Australia (or indeed elsewhere in Australia) and there was uncertainty as to the scope of the law. The parliamentary debate makes it clear that the South Australian Parliament, unlike other States such as Victoria or New South Wales, sought to clarify the law in this area through the democratic political process rather than leaving it to the courts to resolve if, or when, a case came before it.[443] As one South Australian MP explained: 'The proper way to proceed is to bring before the State Parliament a proposal to establish what the law on abortion should be, rather than to take some doctor, who, according to his own lights, is acting with complete legitimacy, before the courts, and get the courts to determine the law.'[444]

3.5.11 The original South Australian Bill was based on the common law position stated in *Bourne*.[445] South Australian MPs were allowed a conscience vote.[446] The debate was 'complex'[447] and

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[437] Glanville Williams, *Textbook of Criminal Law* (Stevens & Sons, 2nd ed, 1983) 296.

[438] Ibid 296.

[439] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 145 [A.29].

[440] It is significant that the South Australian Bill predated the landmark Victorian case of *R v Davidson* [1969] VR 667.

[441] South Australia, *Parliamentary Debates*, House of Assembly, 19 February 1969, 3710 (Robin Milhouse).

[442] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 47.

[443] Ibid 47–48; Clare Parker, 'A Parliament's Right to Choose: Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60, 73.

[444] South Australia, *Parliamentary Debates*, House of Assembly, 23 October 1969, 2469 (Hugh Hudson).

[445] South Australia, *Parliamentary Debates*, House of Assembly, 19 February 1969, 3710 (Robin Millhouse); South Australia, Parliamentary Debates, Legislative Council, 11 November 1969, 2840 (Charles Hill). See also Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 51; Clare Parker, 'A Parliament's Right to Choose: Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60, 62.

[446] This is likely to remain the case. See Vickie Chapman, 'Law Reform Institute to consider Abortion Law Reform (Press Release, 16 February 2019) <https://www.agd.sa.gov.au/newsroom/law-reform-institute-consider-abortion-law-reform>.

[447] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 49.

every clause was thoroughly tested and debated.[448] The final Bill rejected, on the one hand, those MPs who favoured abortion on demand[449] or at least on request[450] and, on the other hand, those MPs who opposed abortion outright[451] (even in cases of rape and serious fetal abnormality)[452] or would have confined access to lawful abortion based only upon a serious or grave danger to the women's physical health (and removed all reference to mental health from the Bill).[453]

3.5.12 The final 1969 South Australian Act[454] can be seen as a careful intermediate position between these conflicting views. As Heath and Mulligan observe:

> It is clear that this legislation was understood as liberalising and not merely codifying access to abortion at the time it was passed … rather than requiring a serious risk to the physical or mental health of the woman, as *Bourne* had, the Bill established the grounds for lawful termination of pregnancy more widely. Rather than asking whether there was a probability of serious risk to the woman's physical or mental health as *Bourne* did, it compared the risk presented by the continuation of the pregnancy with the risks presented by termination. When it finally emerged as law, s 82A(1)(a)(i) required that two medical practitioners examine the woman and form an opinion in good faith that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated.[455]

3.5.13 However, the 1969 South Australian Act firmly placed the decision about abortion not with the woman, but with the medical practitioner. As Heath and Mulligan state: 'The medicalisation of abortion was central to the 1969 amendments. Parliamentary debate — and the legislation that emerged from it — evince a clear preference for decisions about abortion to be made by medical professionals and not by women seeking an abortion.'[456] The 'medicalisation of a crime' makes medical practitioners the gatekeepers of the criminal law.[457] Thus 'a great social responsibility is firmly placed

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[448] Ibid 50.

[449] The then ALP Leader of the Opposition, Don Dunstan, stated his preference for abortion on demand: 'My own position is that a woman should have a right to determine whether she proceeds with a pregnancy or not and, if required to vote on this, I would vote in favour of abortion on demand': South Australia, *Parliamentary Debates*, House of Assembly, 21 October 1969, 2325–2326 (Donald Dunstan). However, this was a minority view.

[450] An amendment to allow abortion on request was proposed which would have rendered abortion a decision to be made by a woman and her medical practitioner. It was defeated by a 'substantial majority': Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 51. See South Australia, *Parliamentary Debates*, House of Assembly, 28 October 1969, 2530.

[451] One MP even likened abortion to the Nazi concentration camps. South Australia, *Parliamentary Debates*, House of Assembly, 22 October 1969, 2408 (Allan Burdon). However, it is noteworthy that the 1969 debate was largely marked by an absence of religious emphasis or strong rhetoric.

[452] South Australia, *Parliamentary Debates*, House of Assembly, 22 October 1969, 2408 (Thomas Casey).

[453] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 52–53. See also South Australia, *Parliamentary Debates*, House of Assembly, 29 October 1969, 2596; South Australia, *Parliamentary Debates*, Legislative Council, 3 December 1969, 3506, 3511; South Australia, *Parliamentary Debates*, House of Assembly, 4 December 1969, 3676.

[454] *Criminal Law Consolidation Amendment Act 1969* (No 109 of 1969).

[455] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 50–51. The motivation for the 1969 Act is significant. 'The process of abortion law reform in South Australia did not begin because of a campaign for women's reproductive freedom. Rather, it rose on the twin pillars of liberal regard for the principle that law and morality should be distinct domains, and safe abortion as a public health issue': at 51. See also Clare Parker, 'A Parliament's Right to Choose: Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60, 77–78.

[456] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 54.

[457] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 144 [A46].

by the law on the shoulders of the medical profession'.[458] This paternalistic 'medical gatekeeper' role is at odds with the modern focus on client centred care and patient autonomy.[459]

3.5.14 Associate Professor Baird, drawing on the work of Dr Clare Parker,[460] explains the rationale of the 1969 changes as follows:

> [T]he Parliament's intention at the time was to clarify existing law (which was being interpreted restrictively) and to end the practice of unsafe abortions. The Parliament did not seek to instate women's rights, nor to centre the patient in any respect. They aimed to clarify the situation for doctors (referred to in the legislation by male pronouns). In this sense the law was a liberal reform but was and is also paternalistic to patients, and constraining to doctors who wish to afford women and other pregnant people autonomy and self-determination.

3.6 Safety of the Woman as Catalyst for Law Reform

3.6.1 The safety of women and the risks of dangerous unregulated and unsafe procedures by unqualified parties is fundamental to understanding the context and rationale of the present law.[461] Associate Professor Catherine Kevin at Flinders University noted to SALRI that the backdrop of the dangerous abortion performed by an untrained person was effectively used in South Australia in 1969 (as in England two years earlier)[462] to argue for law reform. A retired specialist also emphasised this point to SALRI.

3.6.2 One of the main motivations for the South Australian Parliament to decriminalise abortion in 1969[463] was the compelling evidence of illegal abortions in the state.[464] Eleven of the MPs who gave speeches on the Bill argued that 'the legislation would at least reduce the incidence of

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458 *R v Smith* [1973] 1 WLR 1510, 1512 (Scarman LJ).

459 See also above [1.3.35]–[1.3.39].

460 Clare Parker, 'A Parliament's Right to Choose Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60.

461 See generally Jo Wainer (ed) *Lost: Illegal Abortion Stories* (Melbourne University Press, 2006).

462 The *Abortion Act 1967* (UK) was to ensure that abortions would be carried out 'under the safest conditions attainable': *Royal College of Nursing v Department of Health and Social Services* [1981] 1 All ER 545, 575. Professor Sheldon and her colleagues noted to SALRI that the *Abortion Act 1967* (UK) was also a product of the moral climate and clinical realities of the 1960s: 'Widespread "backstreet" abortions were resulting in significant maternal mortality and morbidity. Abortions performed within formal health settings were done primarily by dilatation and curettage or hysterotomy (a procedure akin to a caesarean section). These were risky, technically demanding procedures that required the skilled hand of a doctor and, on average, a stay of over a week in hospital.' See also *R v Scrimaglia* (1971) 55 Cr App R 280, where the accused pleaded guilty to using an instrument to procure a miscarriage. They carried out a surgical abortion for £35. They received three years imprisonment. The sentence was upheld on appeal. Lord Parker CJ held: 'An offence of this sort, particularly today, does call for a period of imprisonment. The trial judge said: "Now that abortions can be performed legally either under the National Health Service or at a patient's own expense, operations such as yours, carried out at a cut price and in disgraceful, insanitary and even dangerous conditions, are totally unnecessary apart from being against the law." This Court would like to take the opportunity of endorsing what the trial judge there said. It does seem to the Court that the usual argument that prevailed that abortion was done out of pure kindness, there being no legal means of doing it, now does not avail anybody. Indeed, one of the objects, as everyone knows, of the new Act was to try to get rid of the back-street insanitary operations. Accordingly, if anything, there is a case today for increasing what was the norm or what sentence would have been given before the Act came into operation': at 282.

463 These laws came into effect on 8 January 1970. See Farhat Yusuf and Dora Briggs, 'Legalised Abortion in South Australia: the First 7 Years' Experience' (1979) *Journal of Biosocial Science* 11(2) 179, 180.

464 Select Committee of the House of Assembly, Parliament of South Australia, *Report of the Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill, 1968* (Parliamentary Paper No 105, 1968–1969) 17.

"backyard" procedures, if not eliminate them altogether',[465] and the remaining six who argued that illegal procedures would continue regardless of the reform were all 'vehement opponents of abortion'.[466] In the Legislative Council, the Hon D Banfield set out the context of Parliament's fear of backyard abortions with regard to an illegal abortion that resulted in a woman's death:

> One could have seen from *The Advertiser* of September 10 this year[467] that two persons were charged with murder because they assisted in aborting a woman. That woman lost her life because she was forced to go to a backyard abortionist. Had she been able to go to the medical profession or to an approved hospital, there is no doubt that she would still be alive today and those men would not have been charged with murder. Some people say that we do not have the right to abort because an unborn child is being murdered. However, the fact is that an adult human being was murdered because of the laws on our Statute Book and because the medical profession was afraid to go outside the law.[468]

3.6.3 Other MPs disagreed with this position, stating that the laws of a state should set a moral standard rather than reflect the practices of its constituents. The Hon CD Rowe, for example, of the Legislative Council stated:

> I have never accepted the proposition that, if the law is openly flouted and it is known that it will not be obeyed, it will adversely affect the people if it is not amended to suit their circumstances. If I think that the law is right and just in the interests of the community, then I consider that those on whom the responsibility falls of maintaining it must face up to their responsibility. For instance, if we had an epidemic of burglaries which looked like getting out of hand, I do not think we should proceed to legalise burglary. I am not satisfied that the number of breaches of this law are as vast or as extensive as some people would have us believe.[469]

3.6.4 In the *Report of the Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill*, the Inspector of Police Paul Turner, called abortion a 'peculiar' crime in that both the victim and the offender are intent on keeping knowledge of the crime away from everybody, describing it as a 'conspiracy of silence'.[470] This 'conspiracy of silence' indicated why the rate of prosecutions for illegal abortions is disproportionately low to their incidence. Nonetheless, Inspector Turner set out the history of the previous years' investigations and arrests into illegal abortions in the State and stated that 'about every four years [they] have a death from an illegal operation'.[471]

3.6.5 Unregulated abortions, as Parliament understood them in 1969, constituted of Bertram Wainer's description; the 'incompetent, barbarous old lady "round the corner"'.[472] Jill Blewett sets out the number of abortions that Parliament were aware of in 1969:

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[465] Clare Parker, 'A Parliament's Right to Choose: Abortion Law Reform in South Australia' (2014) 11(2) *History Australia* 60, 75.

[466] Ibid 75.

[467] On 10 September 1969, two men were arrested and charged with the murder of a women after performing an illegal 'backyard' abortion. See 'An Illegal Operation', *The Advertiser* (Adelaide, 10 September 1969). The Coroner's Report attributed her death to sepsis, now more commonly referred to as septic shock. This was a regular event in South Australia the decades prior to the 1969 Act.

[468] South Australia, *Parliamentary Debates,* Legislative Council, 25 November 1969, 3213 (Hon DHL Banfield).

[469] South Australia, *Parliamentary Debates*, Legislative Council, 19 November 1969, 3104 (Hon CD Rowe).

[470] Select Committee of the House of Assembly, Parliament of South Australia, *Report of the Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill* (Parliamentary Paper No 105, 1968–1969) 16.

[471] Ibid 17.

[472] Bertram Wainer, *It Isn't Nice* (Alpha Books, 1972).

> But the incidence of illegal abortion was known to be high. With estimates varying from a highly conservative 250 to a liberal 8,900 a year, the minimum estimate of the Abortion Law Reform Association of South Australia (ALRASA) was 5,100 — broken down roughly as 800 backyard abortions, 1,300 abortions performed by doctors in South Australia, and 3,000 done on South Australian women interstate.[473]

3.6.6 An English study of offenders convicted of illegal abortions described the term 'back-street abortionist' as evoking the opinion of 'greed, callousness, ignorance, and the crudest surgical malpractice'.[474] The same article indicates that this image was in many ways false.[475] The literature of the period indicates a divide between medical and non-medical abortionists, divided on class lines between middle and working class women. Whilst middle class women relied upon the medical profession for relatively safe abortions (including illegal ones),[476] working class women preferred 'traditional female abortionists'.[477] With respect to illegal abortions in the UK in the 1960s, Professor Sally Sheldon explains that abortions of 'dubious legality' were already available for women who could pay for them.[478] She states that, although it would only have been possible for the reforms to pass if grounded in medicine,[479] the result is that women were 'decriminalised in order to be pathologised'.[480]

3.6.7 The historical context of the unregulated and untrained abortionist in the 1960s has been presented as indicative of the 'general consolidation of the entire field of treating human ailments' from midwives to doctors.[481] Historians have argued that the decision to make abortion a medical question, particularly the two-doctor requirement, may also have been indicative of society's understanding of the woman as a 'weak creature', incapable of making her own decisions:[482]

> The legal status of abortion places an obligation on doctors (and others) to play a gate-keeping role. The intention of the legislators and judge who established this role was precisely to ensure that the decision rested finally in the hands of the medical practitioner, rather than the woman.[483]

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[473] Jill Blewett, 'The Abortion Law Reform Association of South Australia 1968–1973' in Jan Mercer, *The Other Half: Women in Australian Society* (Penguin Books Australia, 1975) 379. The terms 'backyard' and 'backyarder' were only used with regard to abortion in the 1960s prior to the reform period. See Barbara Baird, '"The Incompetent, Barbarous Old Lady round the Corner": The Image of the Backyard Abortionist in Pro-Abortion Politics' (1996) 22(1) *Hecate* 8. Glanville Williams uses the terms 'professional abortionist' and 'back-street surgeon' to the same end with respect to illegal abortionists in the UK: Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber, 1957) 145.

[474] Editorial, 'Opinions of Women Abortionists' (1963) 282 (7299) *The Lancet* 131.

[475] Ibid.

[476] Lyn Finch and John Stratton, 'The Australian Working Class and the Practice of Abortion 1880–1939' (1988) 12(23) *Journal of Australian Studies* 45, 58.

[477] Ibid 52–53.

[478] Sally Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in Jo Bridgeman and Susan Millns (eds), *Law and Body Politics: Regulating the Female Body* (Aldershot, 1995) 105, 109.

[479] Ibid 111.

[480] Ibid.

[481] Lyn Finch and John Stratton, 'The Australian Working Class and the Practice of Abortion 1880–1939' (1988) 12(23) *Journal of Australian Studies* 45, 62; Barbara Baird, '"The Incompetent, Barbarous Old Lady Round the Corner": The Image of the Backyard Abortionist in Pro-Abortion Politics' (1996) 22(1) *Hecate* 8, 11; Sally Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in Jo Bridgeman and Susan Millns (eds), *Law and Body Politics: Regulating the Female Body* (Aldershot, 1995) 105, 107.

[482] Leslie Cannold, *The Abortion Myth: Feminism, Morality, and the Hard Choices Women Make* (Allen & Unwin, 1998) 9; Sally Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in Jo Bridgeman and Susan Millns (eds), *Law and Body Politics: Regulating the Female Body* (Aldershot, 1995) 105, 112.

[483] Leslie Cannold, *The Abortion Myth: Feminism, Morality, and the Hard Choices Women Make* (Allen & Unwin, 1998) 9.

3.6.8 Historians have documented low rates of arrest, prosecution and conviction of 'doctor abortionists' even prior to liberalisation. Judith Allen, for example, contends (based on NSW data) that selective policing and prosecution meant that from the early 1900s, 'the competent attracted little attention and had little to fear'.[484] She identifies the likelihood of prosecution in that period as being associated with: female non-doctor abortionists; late-term abortion (in the fourth month of pregnancy or later — often occasioned by the time taken to save the necessary fee); high charges; and a critically ill or dead patient.[485] The 1960s prosecutions of abortions reflect a different reality: one centred on the 'professional abortionist'.[486]

3.6.9 Juries have long been reluctant to convict abortionists [487] (especially medical practitioners),[488] and in the 1950s through to the 1970s, abortion was widely available, 'rarely prosecuted',[489] and even less frequently resulted in conviction.[490]

3.6.10 In 1969, the political situation with regard to abortion changed in both England and Australia. Historically, South Australian women often went interstate to Melbourne or Sydney to obtain abortions.[491] This changed slightly in 1969, as evidenced from an anecdote recounted by Associate Professor Barbara Baird in her 1990 study of women who had abortions in the 1960s:

> Jane Holland initially went to a doctor in Melbourne in 1969, but he refused to perform the abortion because she smoked, and had eaten in the previous twelve hours. No-one had told her to do or say otherwise. He judged her to be a bad health risk. She was aware, however, that there were other factors in his refusal to perform the abortion. 'I mean, this is 1969, Bertram Wainer is in the paper every week. He didn't want anybody dying on his abortion table. So I had to go back home again.'[492]

3.6.11 It is therefore crucial to bear in mind the original rationale of the 1969 changes, especially to improve women's health by ending recourse to unsafe and dangerous procedures by unqualified parties.[493]

3.6.12 As one retired specialist with experience back to the 1969 South Australian Act observed:

> The impact of this original ground breaking legislation on Maternal Mortality cannot be overemphasised but may be forgotten with the passage of time. In the six years preceding the original legislation (1963–1969) I recall that there were 15 maternal deaths in South Australia associated with septic criminal abortion however since 1969 there have been only two maternal deaths associated with termination of pregnancy in some 50 years of clinical practice under this law. To put this result into a contemporary perspective the current overall Maternal Mortality rate

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[484] Judith Allen, *Sex & Secrets: Crimes Involving Australian Women Since 1980* (Oxford University Press, 1990) 101.

[485] Ibid 165.

[486] Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber, 1958) 145.

[487] Lyn Finch and Jon Stratton, 'The Australian Working Class and the Practice of Abortion 1880–1939' (1988) 12(23) *Journal of Australian Studies* 45, 47; Barbara Brookes, *Abortion in England 1900–1967* (Routledge 1988) 28; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 144 [A .20].

[488] Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69, 72–73.

[489] Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber, 1958) 145.

[490] Lynda Crowley-Cyr, 'A Century of Remodelling: The Law of Abortion in Review' (2000) 7(3) *Journal of Law and Medicine* 252, 254.

[491] Barbara Baird, '*I Had One Too…' An Oral History of Abortion in South Australia before 1970* (Flinders Press, 1990) 63.

[492] Ibid 63. The reference is to Dr Bertram Wainer, a Victorian medical practitioner, who played a crucial role in uncovering police corruption connected to illegal abortions in Victoria.

[493] See generally Jo Wainer (ed) *Lost: Illegal Abortion Stories* (Melbourne University Press, 2006).

> for Australia now sits at 6–8 maternal deaths per year per 100,000 live births, which for South Australia represents one maternal death from all causes perhaps every two years. As you can appreciate a staggering reduction in Maternal Mortality has been achieved and continues with the provision of safe abortion services for women, which far surpasses the results of the efforts of obstetricians and our multidisciplinary colleagues in trying to reduce maternal mortality and morbidity from other obstetric causes including pulmonary embolism, haemorrhage, infection and pre-eclampsia.

3.6.13 The positive effects of the liberalisation of the abortion laws are significant. A 1964 WHO study had shown Australia to have the highest death rate due to abortion among 12 countries studied. In Victoria, illegal abortion was among the top four causes of death in pregnancy.[494] The Royal Women's Hospital made particular note to the VLRC of the improvement to women's health in Victoria as a result of the legalisation of therapeutic abortion through Menhennitt J's ruling in *Davidson*: 'No longer were women coming to the hospital with sepsis, including clostridial infections and uterine gangrene following a so-called "backyard" abortion at the hands of an unqualified "practitioner".'[495]

3.6.14 SALRI notes that this is a vital consideration and should not be overlooked in consideration of suitable changes to the South Australia's abortion laws, including as to the rationale for any residual offence.

R v Davidson[496] *(the 'Menhennitt ruling')*

3.6.15 The judicial reform of the Australian law regulating abortion began in 1969 in Victoria (but too late to be incorporated in the parliamentary debate on the 1969 South Australian Act). The 1969 landmark ruling of Menhennitt J of the Supreme Court of Victoria in the case of *Davidson* is significant. This case involved the prosecution of a Melbourne medical practitioner with four counts of unlawfully using an instrument to procure a miscarriage, and with one count of conspiring unlawfully to procure a miscarriage. Menhennitt J, drawing (and arguably extending) on *Bourne*, held that, for the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done was

> [n]ecessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and in the circumstances, not out of proportion to the danger to be averted.[497]

3.6.16 Menhennitt J drew on *Bourne* and explicitly invoked the general legal defence of necessity and instructed the jury that acting with intent to procure a miscarriage would only be lawful if the accused held an honest belief on reasonable grounds that the abortion was both 'necessary' and 'proportionate'. The onus lay upon the prosecution to establish unlawfulness by proving the absence of either necessity or proportion.[498] 'Necessary' in this context meant the abortion was necessary to preserve the pregnant woman from a serious danger to her life or to her physical or mental health, beyond the normal dangers of pregnancy and childbirth that would result if the pregnancy continued.

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[494] Robyn Gregory 'Corrupt Cops, Crooked Docs, Prevaricating Pollies and Mad Radicals: A History of Abortion Law Reform in Victoria, 1959–1974' (Unpublished PhD Thesis, Royal Melbourne Institute of Technology, 2004) 126.

[495] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 33 [3.13].

[496] [1969] VR 667.

[497] Ibid 672. This was followed in *R v Heath* (Victorian County Court, Southwell J, February 1972). See also Louis Waller, 'Any Reasonable Creature in Being' (1987) 13(1) *Monash University Law Review* 37, 44.

[498] [1969] VR 667, 672.

'Proportionate' meant the abortion was, in the circumstances, not out of proportion to the danger to be averted.[499] The jury applied Menhennitt J's view and acquitted the accused.

3.6.17 Menhennitt J's ruling in *Davidson* was less restrictive than the test established in the earlier English case of *Bourne*. Menhennitt J's ruling permitting abortion to avert a 'serious danger' to the pregnant women's physical or mental health significantly reduced the level of danger to health required to allow a lawful abortion.[500] However, Menhennitt J's ruling by no means established that the law allowed a medical practitioner to perform an abortion on grounds other than health and certainly does not permit abortion on the basis that a woman simply does not wish to continue with a pregnancy.[501]

3.6.18 There has been some limited critical consideration of *Davidson*, but subsequent cases have largely followed Menhennitt J's ruling.[502]

3.6.19 In *R v Bayliss*[503] the Queensland District Court held in the prosecution of two medical practitioners that *Davidson* applied in Queensland.[504] However, the court did not go so far as *Wald* to refer to the economic or social circumstances of the woman. Judge McGuire emphasised that the defence is 'a humane doctrine devised for humanitarian purposes; but it cannot be made the excuse for every inconvenient conception ... it is only in exceptional cases that the doctrine can lawfully apply.[505] Judge McGuire made it clear that there existed no women's right to abortion, stating that:

> The law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on whim or caprice does not insidiously filter our society. There is no legal justification for abortion on demand.[506]

R v Wald[507] *(the 'Levine ruling')*

3.6.20 *Davidson* was followed by the judgement of Levine DCJ in the NSW District Court in *Wald,* who held that that, when assessing the risk to a woman's health, consideration could be given to her 'economic, social or medical' circumstances.[508] The danger must arise during the woman's pregnancy.

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[499] Ibid.

[500] It has been noted that *Davidson* was 'a convenient judicial response to a political problem': Robyn Gregory, 'Hardly Her Choice: a History of Abortion Law Reform in Victoria' [2007] 19 *Women Against Violence* 62, 66. However, Davidson met with quiet approval. As Young J noted: 'In the end, Cliff [Menhennitt]'s decision satisfied everyone. Had it been against community standards, an appeal would have been certain. But he got it exactly right': Jenny Morgan, 'Abortion Law Reform: The Importance of Democratic Change' (2012) 35(1) *University of New South Wales Law Journal* 142, 146–147.

[501] Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 1998). SALRI has heard in its consultation, not only from parties opposed to the decriminalisation of abortion, that the *Davidson* (or any similar mental health) criteria are a 'sham' or a 'façade' and applied by at least some medical practitioners to generally allow abortion on request. More than one medical practitioner acknowledged to SALRI that it is not their role to 'second guess' a patient and if the woman states that having a child will be disadvantageous for her mental state, this is accepted. See also below Part 5.

[502] *K v Minister for Youth and Community* Services [1982] 1 NSWLR 311; *K v T* [1983] 1 Qd R 396, 398; *Re Bayliss* (Supreme Court of Queensland, McPherson J, 24 May 1985); *Veivers v Connolly* [1995] 2 Qd R 326; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

[503] (1986) 9 Qld Lawyer Reps 8, 45 (McGuire DCJ). In that case, the two accused were both medical practitioners.

[504] Ibid.

[505] Ibid.

[506] Ibid.

[507] (1971) 3 DCR (NSW) 25 (Levine DCJ).

[508] Ibid 29.

3.6.21 This important case[509] involved an unsuccessful prosecution for unlawful abortion of five people, namely a medical practitioner and an anaesthetist who performed abortions at a Bondi clinic, an orderly at the clinic, the owner of the premises, and a medical practitioner who referred patients to the clinic.

3.6.22 In his address to the jury, Levine DCJ adopted, but then expanded the earlier ruling of Menhennitt J. He did this by stating that a medical practitioner could consider the effects of economic and social factors upon the health of the pregnant woman, when assessing whether a proposed abortion would be 'necessary' and 'proportionate' in all the circumstances. Levine DCJ held that an abortion would be lawful if there was 'any economic, social or medical ground or reason' upon which a medical practitioner could base an honest and reasonable belief that an abortion was required to avoid a 'serious danger to the pregnant woman's life or to her physical or mental health'. The accused need not have believed that the woman's health was in 'serious danger' at the time of consultation, merely that her health 'could reasonably be expected to be seriously endangered at some time during the currency of the pregnancy, if uninterrupted'.[510]

3.6.23 *Wald* expanded the grounds on which a medical practitioner was permitted to conclude that a woman faced a risk to her health, and is somewhat more expansive than *Davidson*. *Wald* retained the requirement that a woman has to face a 'serious danger' to her physical or mental health before abortion would be justified. *Wald* did not authorise abortion in any case where a medical practitioner was willing to agree to a woman's request to perform an abortion. This was despite assertions by counsel for the accused in *Wald* that abortion should only be considered unlawful in NSW if performed on a pregnant woman without her proper consent. Levine DCJ did not accept this argument.[511]

3.6.24 *Wald* has been followed in subsequent cases.[512] Of particular note is *CES v Superclinics (Australia) Pty Ltd*.[513] In a civil action, the plaintiff contended the medical practitioner and clinic had been at fault in denying her the opportunity to have an abortion performed at a time when it was medically safe to do so, and that this had resulted in her giving birth to a child she did not want. The trial judge, Newman J, rejected the claim. His Honour, despite citing and purporting to follow *Wald*, had provided a more restrictive definition than that of Levine DCJ as to when an abortion would be lawful. Justice Newman did this by narrowing the circumstances in which it could be shown that an abortion was justified to avert a 'serious danger' to a woman's mental health. His ruling seemed to introduce an new requirement; namely the need for confirmation to the woman's mental health by a psychiatrist who had examined the woman prior to the abortion. Newman J's ruling also left considerable doubt as to when, if ever, social and economic factors could be said to pose a sufficiently serious danger to a pregnant woman's mental health to justify an abortion and render it lawful.[514]

3.6.25 The appeal against the findings of Newman J in the *Superclinics* case was heard in 1995 by the NSW Court of Appeal.[515] The majority, Kirby ACJ and Priestley JA, overturned Newman J's

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[509] This case largely governed abortions in NSW until 2 October 2019 with the commencement of the 2019 NSW Act.

[510] *R v Wald* (1972) 3 DCR (NSW) 25, 29

[511] Ibid 28. See also Catherine Henry, 'Abortion Retried' (1995) 20(5) *Alternative Law Journal* 240.

[512] See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; *R v Sood [No 3]* [2006] NSWSC 762.

[513] (1995) 38 NSWLR 47.

[514] Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 1998).

[515] *CES v Superclinics (Aust) Pty Ltd* (1995) 38 NSWLR 47. See further see Regina Graycar and Jenny Morgan, 'Unnatural Rejection of Womanhood and Motherhood: Pregnancy, Damages and the Law — A Note on *CES v Superclinics (Aust) Pty Ltd*' (1996) 18(3) *Sydney Law Review* 323.

conclusion. The third judge, Meagher JA, supported Newman J's restrictive interpretation. Of these three judges, only Kirby ACJ offered a detailed discussion of *Wald*. Several themes emerged.

3.6.26 First, Kirby ACJ emphasised that a referral to a psychiatrist was not necessary to establish there had been a serious danger to a pregnant woman's mental health for the purposes of *Wald*.[516] Secondly, Kirby ACJ made it clear that, under *Wald*, a medical practitioner is entitled to consider social and economic factors when assessing whether a woman's mental health would be seriously endangered if her pregnancy continued.[517] Indeed, a serious danger to mental health could be based on economic and social grounds.[518] Thirdly, Kirby ACJ clarified *Wald*, stating that the serious danger to a woman's mental health should not be confined to dangers that would arise during the pregnancy. Rather any threat to a woman's mental health after the child was born was also applicable.[519] Fourthly, Kirby ACJ noted that it would be very difficult, in any prosecution of a medical practitioner, to persuade the jury that the practitioner lacked an honest and reasonable belief that there was a serious danger to a woman's mental health.[520] It was impossible to list the criteria against which the honesty and reasonableness of the practitioner's belief could be assessed given the 'wide variety of particularities', including social and economic factors, that will arise for consideration in each case.[521]

3.6.27 Justice Kirby suggested that the meaning of 'unlawful' abortion is determined by a medical practitioner's subjective beliefs about when an abortion is appropriate, based on that practitioner's assessment of the impact of social and economic factors on the woman's health.[522] The test is relatively expansive but Kirby ACJ did not go as far as to state that an abortion will be lawful whenever a woman requests it and a medical practitioner is willing to perform it. Kirby ACJ retained the notion that, in the absence of a significant risk to her life or physical or mental health, a woman cannot obtain a lawful abortion. It is still the medical practitioner and not the woman who ultimately determines whether an abortion will be provided. Justice Kirby's ruling as to whether an abortion is lawful still depends on

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[516] *CES v Superclinics* (1995) 38 NSWLR 47, 64–65.

[517] Ibid 59–60.

[518] Ibid 59.

[519] Ibid 60. 'There seems to be no logical basis for limiting the honest and reasonable expectation of such a danger to the woman's psychological health to the period of the currency of the pregnancy alone. Having acknowledged the relevance of other economic or social grounds which may give rise to such a belief, it is illogical to exclude from consideration, as a relevant factor, the possibility that the patient's psychological state might be threatened *after* the birth of the child, *eg* due to the very economic and social circumstances in which she will then probably find herself. Such considerations, when combined with an unexpected and unwanted pregnancy, would, in fact, be most likely to result in a threat to the woman's psychological health *after* the child was born when those circumstances might be expected to take their toll': at 60, see also 65. See also *Veivers v Connolly* [1995] 2 Qd R 326, 329 (de Jersey J).

[520] *CES v Superclinics* (1995) 38 NSWLR 47, 63.

[521] Ibid 63, 66.

[522] Cica notes that Kirby ACJ's ruling his seems to fulfil a legal prophesy made by Glanville Williams in 1952: 'So far there has been no indication in the American or English cases that abortion would be legally justified on [social or economic grounds *per se*] ... It seems unlikely that the Judges would ever feel themselves able to stretch either the words of statutes or the doctrine of necessity to cover any of those considerations... However — and this cannot be too strongly emphasised — some of these considerations may enter indirectly (at least in those jurisdictions where the mother's health as well as her life can be considered) by giving rise to the practitioner's belief that it would be injurious to the mother to allow her to give birth to the child. In particular, severe worry about the consequences of having the child is one of the factors that may affect the mother's mental health... If the law allows the doctor to take account of the strain that would be imposed on the mother's health by bringing up the child after birth, it will have taken a long step towards allowing abortion on social grounds': Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 31 August 1998), quoting Glanville Williams, 'The Law of Abortion' (1952) 5(1) *Current Legal Problems* 133.

the practitioner's subjective belief that abortion is justified on health grounds, and is not tantamount to abortion on request.[523]

3.6.28 *Davidson*, *Wald* and *Superclinics* are significant. These cases retain the doctor as a gatekeeper and do not go as far as to permit abortion on request. However, these cases postdate the 1969 South Australian Act and seemingly represent a more expansive approach to a lawful abortion than permitted by the 1969 Act. It is unclear to what extent the 1969 Act achieves its apparent objective of superseding and displacing the common law,[524] but the present law in South Australia is arguably more restrictive than the common law position.[525]

3.6.29 The criteria for the availability of a lawful abortion in South Australia remain based on *Bourne,* when *Bourn*e has arguably been overtaken by the more expansive common law approach adopted in *Davidson*, *Wald* and Kirby ACJ in *Superclinics*. The procedural requirements in South Australia of a personal examination by two medical practitioners at a prescribed hospital also result in the South Australian law being more restrictive in procedural terms for determining lawfulness than the common law position.[526]

3.7 Recent Attempts at Reform

3.7.1 There have been considerable efforts at reforming the law of abortion over recent years throughout Australia.

Victoria

3.7.2 In September 2007, the Victorian Government provided Terms of Reference to the VLRC for legislative advice on the decriminalisation of terminations of pregnancy. The Government explained to the VLRC that it was essential that the law be modernised, be clear and be widely understood and reflect current clinical practice and community standards. The Government's aim was that reform should neither expand the extent to which terminations occur, nor restrict current access to services.[527]

3.7.3 The VLRC was asked by the then Attorney-General to provide advice on options to:

> 1. Clarify the existing operation of the law in relation to terminations of pregnancy;
> 2. Remove from the *Crimes Act 1958* offences relating to terminations of pregnancy where performed by a qualified medical practitioner(s).
>
> In providing this advice the Commission should have regard to the following:
>
> A. Existing practices in Victoria concerning termination of pregnancy by medical practitioners;

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[523] Natasha Cica, 'Abortion Law in Australia' (Research Paper No 1, Parliament of Australia, 1998).

[524] It is unclear whether the 1969 Act has displaced the common law. The South Australian Supreme Court has implied that the common law still applies in South Australia; see *R v Anderson* (1973) 5 SASR 256. Indeed, Bray CJ made the point that a jury should always be directed that the defence (as outlined in *R v Davidson* [1969] VR 667) had to be rebutted, whether or not the defence raised it, provided that there was evidential foundation for such a defence: see *R v Anderson* (1973) 5 SASR 256, 270. Cf *R v Smith* [1973] 1 WLR 1510, 1512. See also Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion' (2001) 27(2) *Monash University Law Review* 229, 244, n 99.

[525] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 65–66.

[526] Ibid.

[527] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007) 4.

B. Existing legal principles that govern termination practices in Victoria;

C. The Victorian Government's commitment to modernise and clarify the law, and reflect current community standards, without altering current clinical practice; and

D. Legislative and regulatory arrangements in other Australian jurisdictions.[528]

3.7.4 The VLRC emphasised:

> [we have] been asked to provide options on the decriminalisation of abortion. We have not been asked to address the question of whether decriminalisation is an appropriate policy. Nor have we been asked to make judgments about the ethical and philosophical arguments concerning abortion.[529]

3.7.5 The VLRC published an Information Paper in September 2007.[530] The VLRC held more than 30 meetings with people involved in abortion law reform from the beginning of October until mid-November 2007. These included religious groups, public and private abortion providers, academics, health service providers, community groups, women's organisations and peak medical bodies. Meetings were also held with youth and disability service providers to discuss the particular issues abortion law reform raised for these groups. The VLRC set up a panel of medical experts, with backgrounds in gynaecology, obstetrics, paediatrics, genetic science, midwifery and counselling to provide advice on current clinical practice. Two academic lawyers acted as consultants to the VLRC. The VLRC received 519 submissions. The VLRC final report was tabled in State Parliament on 28 May 2008.[531] The VLRC Report provided three legislative models for the decriminalisation of abortion.

3.7.6 In August 2008, a Bill was introduced to the Victorian Parliament that reflected Model B in the Commission's report. All parties allowed members of Parliament to make a conscience vote. The Bill was passed in October 2008. The *Abortion Law Reform Act 2008* (Vic) decriminalised abortion. Under the Act, a woman can access abortion up to a gestational limit of 24 weeks. Beyond the 24 weeks, a medical practitioner can provide an abortion if another medical practitioner agrees that an abortion 'is appropriate in all the circumstances'. Medical practitioners who object to abortion do not have to provide information to a client, but are required to refer the client to another medical practitioner who can provide the information.

Northern Territory

3.7.7 There has also been recent reform in the Northern Territory. In 2017, the Northern Territory amended its 40-year-old abortion laws, removing abortion from the criminal law and making it largely a health issue.[532]

Queensland

3.7.8 On 10 May 2016, Mr Robert Pyne MP introduced the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 as a Private Member's Bill into the Queensland Parliament. The Bill proposed to remove the crime of abortion from Queensland's law.

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[528] Ibid.

[529] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008).

[530] Victorian Law Reform Commission, *The Law of Abortion* (Information Paper, September 2007).

[531] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008).

[532] The Family Panning Welfare Association of Northern Territory told SALRI: 'The reformed legislation has improved the ability of doctors, nurses and pharmacists to offer abortion in primary health care settings. The reformed law introduced safe access zones which protect health care staff and patients from intrusive behaviours.'

3.7.9 The Bill was referred to the Queensland Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee for detailed consideration. The Parliamentary Committee was also asked to conduct a broader inquiry into options for the reform of Queensland's laws relating to abortion. Its Report was tabled on 26 August 2016 and made one recommendation, simply that the Bill not be passed.[533]

3.7.10 On 17 August 2016, Mr Pyne MP introduced the Health (Abortion Law Reform) Amendment Bill 2016 as a second Private Member's Bill into the Queensland Parliament. The second Bill was also referred to the Parliamentary Committee for examination. The Committee's report on the second Bill was tabled on 17 February 2017.[534] The Committee did not reach agreement on whether to recommend that the Bill be passed.

3.7.11 As part of its consultation process for the first and second Bills and the Inquiry, the Parliamentary Committee held numerous public hearings and received more than 2600 submissions.[535]

3.7.12 On 28 February 2017, both Bills were withdrawn from the Queensland Parliament on the motion of Mr Pyne MP. On the same day, the State Government announced that it would refer the current laws in relation to abortion to the QLRC for its consideration.

3.7.13 On 19 June 2017, the QLRC received its Terms of Reference from the Attorney-General and Minister for Justice to review and investigate Queensland's laws relating to abortion. Specifically, the Terms of Reference asked the QLRC to recommend 'how Queensland should amend its laws relating to the termination of pregnancy to':

A. Remove terminations of pregnancy that are performed by a duly registered medical practitioner(s) from the *Criminal Code* sections 224 (Attempts to procure abortion), 225 (The like by women with child), and 226 (Supplying drugs or instruments to procure abortion).
B. Provide clarity in the law in relation to terminations of pregnancy in Queensland.[536]

3.7.14 In December 2017, the Commission released a Consultation Paper outlining the relevant legal issues in the review, and seeking submissions on a number of specific questions.[537]

3.7.15 On 16 July 2018, the QLRC released its Report and a draft Bill which recommended the repeal of the current offences relating to abortion.[538]

3.7.16 The QLRC favoured a two stage process. A medical practitioner may perform a lawful abortion on request up to the gestational limit of 22 weeks. After 22 weeks, abortion is permissible if the medical practitioner considers that, in all the circumstances, an abortion should be performed, and

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[533] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016).

[534] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017).

[535] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 2 [5].

[536] Ibid 2 [8].

[537] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017).

[538] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018).

has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed; or in emergency circumstances.

South Australia

3.7.17 On 5 December 2018, the Statutes Amendment (Abortion Law Reform) Bill 2019 was introduced in the South Australian Legislative Council by the Hon Tammy Franks MLC as a Private Members Bill.[539] Ms Franks explained the rationale of the Bill as follows:

> I introduce this Bill today because our current abortion law, which was written in 1969 and was once progressive and leading the nation, is no longer fit for purpose. It acts as a barrier to the provision of best health care, a barrier to that care for women living in rural and remote areas, who are particularly disadvantaged, a barrier to women who are new to living in this state and have not been resident for the required two months, and a barrier to the medical profession, who deal with matters of health care every day, none of which, except for abortion, are placed within the criminal code, as this issue is. In South Australia abortion remains in the criminal law. We once led the nation in law reform, in 1969, but that law now causes inequality, especially for those living in rural and remote South Australia, even though there are excellent public abortion services, particularly in Adelaide and the Pregnancy Advisory Centre in Adelaide and those prescribed hospitals that provide that care. Methods have changed, and the law that once was so progressive has now become a barrier to access and availability. Women in our state now face unnecessary restrictions when seeking abortion. Abortion should be treated like any other health service. Women should decide, with their medical professionals aiding their treatment. Abortion should not be in the criminal law.[540]

3.7.18 Ms Franks explained that the Bill would remove abortion (with the exception of safe access zones and associated new offences) from the criminal law and leave it to be governed under health law and practice. [541] 'Abortion should be regulated like other health care.'[542]

3.7.19 The Bill would repeal ss 81, 82 and 82A of the *CLCA*. The Bill also removes the offence of concealing the birth of a child under s 83 of the *CLCA*.[543] The Bill, to avoid any doubt, also abolishes any common law offence relating to abortion. The Bill includes the establishment of safe access zones of 150 metres around premises providing abortion services to protect the 'privacy and dignity' of both patients and staff from anti-abortion protests.[544] The Bill has an associated new offence not to threaten, intimidate, harasses or obstruct anyone within the 150 metre safe access zone approaching such premises.[545] The proposed offence would extend to if a person approaches, communicates or attempts to communicate, with another person about the subject of abortion within the 150 metre safe access

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[539] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2420–2428; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2776–2791.

[540] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2420–2421.

[541] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2779–2782. 'This Bill provides that abortion should be removed from our criminal laws and regulated like any other health service': South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2421.

[542] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2791.

[543] See further below [21.2.1]–[21.2.9].

[544] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2427. See also Health Care (Health Access Zones) Amendment Bill 2019 introduced concurrently to both Houses of State Parliament on 25 September 2019 (by Ms Nat Cooke () and the Hon Tammy Franks (MLC)).

[545] The offence includes recording (by any means whatsoever) images of another person approaching, entering or leaving such premises. See also Health Care (Health Access Zones) Amendment Bill 2019 (SA) introduced concurrently to both Houses of State Parliament on 25 September 2019 (by Ms Nat Cooke (MP) and the Hon Tammy Franks (MLC)).

zone.[546] The Bill includes a power for police to direct persons to leave a safe access zone if the police officer reasonably suspects that a person has engaged, or is about to engage, in prohibited behaviour in a safe access zone.

3.7.20 The Bill does not include any new offence of performing an abortion by an unqualified person.[547] The Bill does not make recognition for conscientious objection by a medical or health practitioner to performing or assisting in performing an abortion or any requirement for a medical or health practitioner with a conscientious objection to refer a patient to a practitioner or service without a conscientious objection. The premise of the Bill is that conscientious objection (and presumably referral) are already covered within health law and practice and professional guidelines and protocols and it is unnecessary and inappropriate to make explicit provision.[548] The Bill also does not include provision for the retention or use of data[549] or clarifying (or 'futureproofing')[550] the health practitioners who can perform or assist in performing an abortion.[551]

3.7.21 The effect of the Bill would be to regulate abortion in the same way as any other medical procedure.[552] Under this approach, abortion would be lawful at all gestational stages with the woman's consent, and if performed by an appropriate health practitioner. This approach places decision-making responsibility with the woman, and service availability with the medical (or health) profession. This is essentially the approach that exists in the ACT.[553] It is often called the 'on request' model.[554]

3.7.22 Ms Franks emphasised that 'decriminalisation does not mean deregulation'[555] and that abortion would still remain subject to comprehensive regulation (as with any other medical procedure) under health law and practice and professional guidelines and protocols. Ms Franks elaborated:

> Once abortion is removed from the criminal law it will be regulated according to the normal standards and practices that govern all other health services. These include specific clinical guidelines for each area of care. All health procedures, practices and services are closely controlled and regulated by government, industry and professional bodies, and breaches are dealt with very seriously. In this way existing health law regulations, codes of practice, clinical protocols and institutional policies and procedures provide a comprehensive regulatory framework that protects patients, promotes good quality and safety in health care and ensures accountability. Under these arrangements women who need abortion care will be afforded the same safe, good quality care as all patients should be able to expect, and healthcare professionals will be able to deliver that care

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[546] SALRI does not support this particular limb as it appears too expansive. However, SALRI, after extensive research and consultation, supports both 150 metre safe access zones and appropriate new offences to protect both patients and staff from obstruction, harassment and intimidation. See further below Part 18.

[547] Ms Franks suggested that health law would adequately cover the situation of unqualified persons and misconduct and unsatisfactory professional performance by health practitioners: at 2781. See further below Part 6.

[548] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2781. See further below Part 17.

[549] Ms Franks explained the Bill was not intended to preclude the continued public reporting of abortion statistics in South Australia: at South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2779. See also below Part 20

[550] See also below [7.7.4]–[7.7.5], [15.5.4], n 1607. Cf below n 1602.

[551] The Hon Tammy Franks MLC appears to have contemplated that specific provision was unnecessary as this could be properly left to health law and practice as well as clinical practice. See South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2779–2782. See further below Part 6.

[552] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2779–2782.

[553] *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT).

[554] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 38 [124]–[125].

[555] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2780.

> within a framework of health laws, standards and regulations, not with the criminal law looming over their practice. I remind members that there are some 20 South Australian and about 70 Commonwealth health statutes. Law and professional practitioner regulatory boards already ensure that only qualified professionals provide health care and that they are held accountable for compliance with standards. Health care is provided in accordance with those specific clinical standards and in appropriate facilities, with hospitals and day surgery centres regulated primarily by SA Health.[556]

3.7.23 Debate on the Bill has been deferred in light of the Attorney-General's reference to SALRI. The Hon Tammy Franks MLC was amongst the many parties who made submissions to SALRI.

New South Wales

3.7.24 The Reproductive Health Care Reform Bill 2019 (passed by Parliament on 26 September 2019 as the *Abortion Law Reform Act 2019* (NSW)) was introduced as a Private Member's Bill into the NSW Legislative Assembly on 1 August 2019 by Alex Greenwich MP.[557] Mr Greenwich explained that the Bill's rationale is 'that the best outcomes in women's reproductive health care are achieved when abortion is treated as a health matter, not a criminal matter, and a woman's right to privacy and autonomy in decisions about their care is protected'.[558] The Bill proposed to largely remove abortion from the criminal law (though retaining an offence for unqualified parties). Mr Greenwich noted that the NSW Bill is closely based on the 2008 Victorian and 2018 Queensland reforms.[559]

3.7.25 The 2019 NSW Act provides that an abortion up to 22 weeks gestation is lawful on a woman's request if performed by a registered medical practitioner. Abortions after 22 weeks gestation[560] are only lawful (except in an emergency) if two specialist medical practitioners consider that the procedure should be performed after considering all the relevant medical circumstances and the woman's current and future physical, psychological and social circumstances.[561]

3.7.26 On 8 August 2019, the Bill passed the Legislative Assembly[562] (though with a number of amendments). The Bill moved to the Legislative Council. The Bill was referred, on 6 August 2019, to the Legislative Council Standing Committee on Social Issues on the recommendation of the Selection of Bills Committee. The Standing Committee released its Report on 27 August 2019[563] noting that there was no consensus amongst interested parties to the inquiry or the Committee 'as to the overall merits of the Reproductive Health Care Reform Bill 2019'.[564] In those circumstances, the Standing Committee decided to refer the Bill back to the Legislative Council for further consideration, 'including consideration of any amendments in the committee stage that address stakeholder concerns raised in this inquiry'.[565]

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[556] Ibid.

[557] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6.

[558] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3.

[559] New South Wales, *Parliamentary Debates,* Legislative Assembly, 1 August 2019, 5.

[560] Mr Greenwich noted that 22 weeks was chosen with the advice of the AMA and RANZCOG and follows the QLRC's recommendations.

[561] New South Wales, *Parliamentary Debates,* Legislative Assembly, 1 August 2019, 4–5.

[562] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 96–97.

[563] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019).

[564] Ibid 56 [3.146].

[565] Ibid 56 [3.147].

3.7.27 After lengthy debate, the Bill passed the NSW Legislative Council (though with a number of further amendments).[566] These amendments were accepted by the Legislative Assembly and the Bill (now renamed the Abortion Law Reform Bill 2019) passed Parliament on 26 September 2019. The Act received Royal Assent on 2 October 2019 and came into operation on that day.

3.7.28 SALRI considers the 2019 NSW Act and its implications further below.[567]

[566] See below Part 22.

[567] See below Part 22.

Part 4 – Incidence of Termination

4.1 Overview

4.1.1 'Abortion is a common procedure.'[568] It is estimated that approximately 1 in 4–5 (20–25%) women in Australia will have an abortion during their lifetime[569] (though the number in Australia has been decreasing over time).[570] There are varying estimates but international estimates generally range between one in three women and one in four women having an abortion in their lifetime.[571]

4.1.2 The concerns that are sometimes expressed that the decriminalisation of abortion encourages or increases abortion rates does not seem to be supported.[572] Indeed, the reverse appears be true.[573]

4.1.3 In 2007, a study by the Guttmacher Institute New York and the WHO of worldwide abortion rates found a decrease over the preceding decade. In 1995, the estimate was 35 abortions per 1000 women aged 15 to 44 years, which had decreased to 29 per 1000 women by 2003.[574] The decrease was particularly evident in developed countries, and found to coincide with substantial increases in the use of contraception.[575]

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[568] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 31 [2.1].

[569] Anthony Smith et al, 'Sex in Australia: Reproductive Experiences and Reproductive Health among a Representative Sample of Women' (2003) 27(2) *Australian and New Zealand Journal of Public Health* 204. Family Planning Alliance Australia noted to SALRI that there is no routine national abortion data collection in Australia and data must be gathered from various sources making it difficult to reliably determine national abortion rates and trends. It noted that a figure of approximately 80,000 induced abortions being performed annually in Australia is often quoted. A 2003 national survey reported that 22.6% of women aged 16 to 69 had received an abortion at some time in their lives. See Anthony Smith et al, 'Sex in Australia: Reproductive Experiences and Reproductive Health among a Representative Sample of Women' (2003) 27(2) *Australian and New Zealand Journal of Public Health* 204, 206.

[570] Allison Branley and Sophie Scott, 'The Rate of Abortion in Australia is lower than you think, *ABC News* (online, 13 December 2017) <https://www.abc.net.au/news/2017-12-13/the-rate-of-abortion-in-australia-is-lower-than-you-think/9250122. Family Planning Alliance Australia noted to SALRI that while a figure of approximately 80,000 induced abortions being performed annually in Australia is frequently quoted, the data from jurisdictions where routine collection occurs, namely South Australia and Western Australia, show a downward trend. Professor Heather Douglas noted to SALRI that this may be connected to the increasing liberalisation of abortion laws.

[571] Annabelle Chan and Rosemary Keane, 'Prevalence of Induced Abortion in a Reproductive Lifetime' (2004) 159(5) *American Journal of Epidemiology* 475.

[572] Rosano Peiro et al, 'Does the Liberalisation of Abortion Laws Increase the Number of Abortions?' (2001) 11(2) European *Journal of Public Health* 190. It has been noted that what increases is unsafe abortions if abortion is criminalised. See Anibal Faundes and Iqbal Shah, 'Evidence Supporting Broader Access to Safe Legal Abortion' (2015) 131(1) *International Journal of Gynecology and Obstetrics* 556. One party in SALRI's consultation noted the example of the Ceausescu regime in Romania. 'Making this [abortions] illegal will not stop abortions, it will just stop safe abortions, and as a result cause endless injury and death in women who no longer have a safe option. We can see by looking at history the statistics of this: in Romania abortion was legal in 1965 and there were approximately 20 abortion-related deaths per 100,000 births. It then became illegal in 1975 and over the next 14 years abortion related maternal deaths rose from 90 to 130 to an extreme 160. It became legal once again in 1990 which lowered those deaths to 50. By making safe abortion an offence you are putting the lives of women all across the state at risk.'

[573] Anibal Faundes and Iqbal Shah, 'Evidence Supporting Broader Access to Safe Legal Abortion' (2015) 131(1) *International Journal of Gynecology and Obstetrics* 556.

[574] Gilda Sedgh et al, 'Induced Abortion: Estimated Rates and Trends Worldwide' (2007) 370(9595) *The Lancet* 1338.

[575] Ibid 1343.

4.1.4 The findings of the study emphasised that lower abortion rates are directly related to lower rates of unplanned pregnancy and improved availability and use of contraception, and are not related to the restrictiveness of legislation governing abortion.[576] The report noted:

> Unrestrictive abortion laws do not predict a high incidence of abortion, and by the same token, highly restrictive abortion laws are not associated with low abortion incidence. Indeed, both the highest and lowest abortion rates (worldwide) were seen in regions where abortion is almost uniformly legal under a wide range of circumstances.[577]

4.1.5 The VLRC similarly noted:

> As contraceptive use and effectiveness of use increase, abortion incidence declines. The factors that do correspond are unsafe and safe abortions with illegal and legal abortions respectively.[578]

4.2 National Statistics

4.2.1 The numbers of abortions in Australia have been decreasing over time with South Australia remaining consistent with this national trend.[579]

4.2.2 While there is no formal national monitoring of the number of abortions in Australia, and few jurisdictions publish official data, estimated national figures show that Australia's abortion rate has been steadily declining. These estimated figures show a fall in the number of abortions from 21.9 per 1000 women aged 15 to 44 in 1995, to 19.7 women in 2003.[580]

4.2.3 The United Nations Department of Economic and Social Affairs has indicated that abortion rates have continued to decline in Australia, reporting rates of 14.2 per 1000 women aged 15 to 44 years in 2010 and 10.6 per 1000 women in 2013.[581]

4.2.4 As noted by the QLRC, 'few jurisdictions in Australia publish official data, making it difficult to identify any changes in the incidence of terminations following law reform'.[582]

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[576] Ibid 1343–1344.

[577] Ibid 1343.

[578] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 33 [3.12].

[579] Allison Branley and Sophie Scott, 'The rate of abortion in Australia is lower than you think', *ABC News* (online, 13 December 2017) <https://www.abc.net.au/news/2017-12-13/the-rate-of-abortion-in-australia-is-lower-than-you-think/9250122>. See also SA Health, *Pregnancy Outcome Statistics* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>. Professor Heather Douglas and others noted to SALRI that decreasing abortion numbers is potentially linked to the liberalisation of the law.

[580] Annabelle Chan and Leonie Sage, 'Estimating Australia's Abortion Rates 1985–2003' (2005) 182(9) *Medical Journal of Australia* 447, 449–450.

[581] United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (Chart, 2013) <https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.asp>; United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health around the World* (Report, 2014) Annex 4, 46 <https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>.

[582] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 34 [2.93].

4.2.5 The introduction of abortion laws in Western Australia in 1998 included a data notification requirement.[583] This data shows that abortion rates in Western Australia declined from 19.7 per 1000 women aged 15 to 44 years in 1999 to 16.4 per 1000 women in 2012.[584]

4.2.6 The QLRC observed:

> A recent qualitative study of the impact of the law reform introduced in Victoria in 2008 found little perceived change in the provision of termination services, with no increase in access to terminations, including terminations at later gestation.[585]

4.2.7 It has been suggested that abortion rates have been stable in the ACT following the decriminalisation of abortion in 2002.[586] Indeed, the ACT has 'the most minimal legal model regulating abortion in Australia'.[587]

4.2.8 SALRI considers late term abortions in more length below,[588] but it is clear that such procedures are (and remain) 'comparatively rare'.[589]

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[583] See *Health (Miscellaneous Provisions) Act 1911* (WA) ss 334, 335(5)(d), inserted by the *Acts Amendment (Abortion) Act 1998* (WA); and *Health (Section 355(5)(D) Abortion Notice) Regulations 1998* (WA).

[584] Western Australian Abortion Notification System, *Induced Abortions in Western Australia 2010–2012* (Report No 4, July 2013) 8 <https://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports and publications/Abortion/PDF/Abortion_Report_2010-12.pdf>.

[585] Queensland Law Reform Commission, Review of Termination of Pregnancy Laws (Report No 76, June 2018) 34 [2.95]: Louise Keogh et al, 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2017) 43(1) Journal of Family Planning and Reproductive Health Care 18, 22. This study found that there was, in fact, concern about reduced access to abortion after 20 weeks gestation. The study involved a qualitative semi-structured interview with experts from a range of health care settings and geographic locations across Victoria. It did not involve analysis of data: 'Due to the lack of routine data collection on abortion provision in Victoria, we are dependent on experts' accounts to describe the impact of law reform': at 20–22.

[586] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 34 [2.96]; Barbara Baird, 'Decriminalisation and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197, 205.

[587] Kerry Petersen, 'Decriminalising Abortion: The Australian Experience,' in Sam Rowlands (ed), *Abortion Care* (Cambridge University Press, 2014) 236, 240.

[588] See below Part 11.

[589] The VLRC and QLRC, for example, noted later terminations are 'comparatively rare'. Almost all (approximately 99%) of terminations in public hospitals and licensed private health facilities are performed before 20 weeks gestation. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 38 [2.10]–[2.11]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 36 [2.110]–[2.111]. There have been suggestions that late term abortions increased in Victoria after the 2008 changes to the law. See, for example, Debbie Garratt, 'NSW is one step closer to abortion on demand — for any reason', *Sydney Morning Herald* (online, 10 August 2019 <https://www.smh.com.au/national/nsw/nsw-is-one-step-closer-to-abortion-on-demand-for-any-reason-20190809-p52fh6.html>; Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 34 [3.57]. However, this view is strongly disputed by parties such as the South Australian Abortion Action Coalition and others. Indeed, it is argued that late term abortions have actually decreased in Victoria by about 20%. See, for example, RMIT ABC Fact Check, 'Have abortions after 20 weeks increased 39 per cent in Victoria post-decriminalisation?', *ABC News* (online, 3 September 2019 <https://www.abc.net.au/news/2019-09-04/fact-check-nsw-abortion-law-victoria/11474570>. See also Louise Keogh et al, 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2017) 43(1) *Journal of Family Planning and Reproductive Health Care* 18; Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 34 [3.58]. Marie Stopes Australia told the NSW Legislative Council Committee that the ACT has no gestational limits and this had not increased the number of abortions at later stages: Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 51 (Dr Philip Goldstone, Marie Stopes Australia).

4.3 South Australian Statistics

4.3.1 In 2016, there were 4,346 terminations of pregnancy notified in South Australia, compared with 4,441 terminations in 2015.[590]

4.3.2 Since 1999, there has been a steady decline in the rate of pregnancy terminations in South Australia from 17.9 per 1,000 women in 1999 to 13.2 per 1,000 women in 2016.[591]

4.3.3 It is significant that 18% of abortions provided in South Australia are for women who reside in rural or remote regions, however, only 2% of all abortions are provided outside metropolitan facilities.[592] In 2016, 797 women who resided in country South Australia underwent an abortion. Only 97 of those (12.2%)[593] were able to have an abortion in their country area, with the rest needing to travel to a metropolitan area for the procedure.[594]

4.3.4 In 2016, 90.2% of abortions were performed in the first trimester (the first 14 weeks of gestation) [595] and 9.8% of abortions were performed in the second trimester (14-27 weeks of gestation).[596]

4.3.5 In 2016, the proportion of abortions performed at 20 weeks gestation or later was 2.8%.[597] Of the 120 abortions performed at 20 weeks gestation or later, 48.3% were for the mental health of the woman, 43.3% were for congenital anomalies, and 8.3% were for specified medical conditions of the woman (8.3%).[598]

4.3.6 Several parties opposed to the decriminalisation of abortion contended to SALRI that abortions are utilised without proper consideration, even irresponsibly or frivolously. More than one health practitioner contended to SALRI that abortions are even utilised as a 'form of contraception'.

4.3.7 Such assertions were often disputed in SALRI's consultation (supported by wider research).[599] The reasons for a woman to undertake an abortion are not simple. There are various reasons for abortion,[600] including the failure of contraception. As the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists observe:

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590 Pregnancy Outcome Unit, SA Health, *Pregnancy Outcome in South Australia 2016* (Report, September 2018) 45.

591 Ibid 45.

592 Pregnancy Outcome Unit, SA Health, *Pregnancy Outcome in South Australia 2015* (Report, August 2017) 54.

593 Pregnancy Outcome Unit, SA Health, *Pregnancy Outcome in South Australia 2016* (Report, September 2018) 47.

594 Ibid. Various parties and health practitioners told SALRI that some (but not the majority) of women from rural areas who travel to Adelaide for an abortion do so for reasons of confidentiality and anonymity. Although this is a choice for some women this should not diminish major problems in terms of access for women from regional, rural and remote and Aboriginal communities.

595 Ibid 48.

596 Ibid 48.

597 Ibid 49.

598 Ibid 49.

599 'This is a very difficult decision for a woman. A woman never, ever chooses to have a termination lightly. It is not a form of contraception. It is a difficult decision; they have made it': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW).

600 Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017) 1–3; Maggie Kirkman et al, 'Reasons Women Give for Abortion: A Review of the Literature' (2009) 12(6) *Archives of Women's Mental Health* 365.

> The accepted facts that no method of contraception is 100% effective,[601] that a number of desired pregnancies will always be found to have fetal malformation or disease that is either not compatible with life or not compatible with adequate quality of life, and that occasionally individual factors of a given pregnancy can represent a threat to the life and/or mental health of the woman, all demonstrate that there will always be a need for TOP in South Australia.

4.3.8 It was emphasised in the literature and in consultation, that recourse to an abortion is a 'complex' and careful decision and is seldom, if ever, lightly undertaken.[602] As one study notes: 'Respondents often acknowledged the complexity of the decision, and described an intense and difficult process of deciding to have an abortion, which took into account the moral weight of their responsibilities to their families, themselves and children they might have in the future.'[603] The NSW Legislative Council Committee also recognised and endorsed the evidence from all parties to its inquiry 'that the decision to have an abortion is often a heart-rending and agonising decision that women and their families take, often in extremely difficult circumstances'.[604]

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[601] The failure of contraception is a significant factor. See, for example, South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2425 (Hon Tammy Franks); Tom Gotsis and Laura Ismay, 'Abortion Law: a National Perspective' (Briefing Paper No 2/2017, Parliamentary Research Service, Parliament of New South Wales, 2017) 2–3; Henry Bodkin, 'Half of Abortions due to Failed Contraception: New Report', *The Telegraph* (online, 7 July 2017) <https://www.telegraph.co.uk/news/2017/07/06/half-abortions-due-failed-contraception-new-report/>. As one specialist nurse explained to SALRI: 'Unplanned pregnancies will always occur because of non-use of contraception, contraceptive failure, sexual coercion and sexual assault. A 2012 study estimated that globally, 40% of all pregnancies were unplanned, and of those, 50% resulted in abortion, 13% ended in miscarriage and 38% ended in an unplanned birth … Abortion services will always be needed and are essential in providing women with autonomy over their bodies and reproductive choices. Abortion services need to be easily accessed, affordable and safe.'

[602] Maggie Kirkman et al, 'Reasons Women give for Abortion: a Review of the Literature' (2009) 12(6) *Archives of Women's Mental Health* 365. See also Akinrinola Bankole, Susheela Singh and Taylor Haas, 'Reasons Why Women Have Induced Abortions: Evidence from 27 Countries' (1998) 24(3) *International Family Planning Perspectives* 117; Maggie Kirkman et al, 'Reasons Women give for Contemplating or Undergoing Abortion: A Qualitative Investigation in Victoria, Australia' (2010) 1(4) *Sexual and Reproductive Health* 149; M Antonia Biggs, Heather Gould and Dianna Foster, 'Understanding Why Women Seek Abortions in the US' (2013) 13(29) *BMC Women's Health* 13.

[603] Lawrence Finer et al, 'Reasons US Women Have Abortions: Quantitative and Qualitative Perspectives' (2005) 37(3) *Perspectives on Sexual and Reproductive Health* 110, 118.

[604] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report 55, 2019) 17 [2.45]. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry Into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 56 [10.1].

Part 5 – Criminal Offences

5.1 Criminality Generally

5.1.1 Abortion is a contentious yet inevitable issue. As one commentator observes: 'Abortion is a subject nobody wants to talk about ... abortion is ignored, marginalised, stigmatised, and yet it is absolutely central to the health of women worldwide.'[605]

5.1.2 The criminal law focus of the present law in South Australia gives rise to differing views about its effect and implications for any change to the law.

5.1.3 One view asserts that the law in practice operates effectively and that the criminal law aspect is exaggerated and any fears of prosecution in relation to abortion are largely unjustified.[606]

5.1.4 Dr Šeman, for example, noted to SALRI that the present law is working in that no woman or health practitioner has been prosecuted and the previous acute problem of unsafe and unregulated abortions has been eradicated. The St Thomas More Society argued to the NSW Legislative Council Committee: 'Abortion today in New South Wales is safe, accessible (without a referral) and lawful as in any other state of Australia.'[607] It is a 'routine procedure'.[608] Gleeson refers to the 'popular myth' that abortion is illegal and the 'tenacious myths about abortion law in Australia, namely that the common law is an "ass" that allows for abortion only by way of a lack of application of the law … [rather] abortion has long been lawful in Australia, and the common law has merit compared with other regulatory regimes.'[609]

5.1.5 There have been very few modern prosecutions in Australia for abortion related offences.[610] There has only ever been one apparent prosecution of a medical practitioner in South Australia for abortion offences since the 1969 changes came into effect[611] (though SALRI is aware of other case(s) where abortion has been charged against other individuals, usually in the context of other offences involving domestic violence and/or sexual abuse).[612]

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[605] Gilda Sedghe et al, 'Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008' (2012) 379(9595) *The Lancet* 625.

[606] Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69.

[607] St Thomas More Society, Submission No 16 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 15 [54], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64850/0016%20St%20Thomas%20More%20Society.pdf>.

[608] Ibid 12 [48].

[609] Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69.

[610] See, for example, *R v Sood* [2006] NSWSC 1141 which is described as an obvious case of patently unsound medical practice where no questions were even asked of the patient: see Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69, 69–71. See further above [3.1.9], below [5.2.13].

[611] *R v Anderson* (1973) 5 SASR 256. The medical practitioner was acquitted of one charge at trial and his conviction on the other quashed on appeal after it was found that the prosecution case asserting the practitioner had failed to comply with the statutory scheme was unable to be proved beyond reasonable doubt. See Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 43, 64–65. Another civil case unsuccessfully asserted the illegality of medical practitioner-provided abortion in South Australia. See *City of Woodville v SA Health Commission* [1991] SASC 2761 (Matheson J).

[612] See, for example, *R v C* [2004] SADC 26 (and on appeal *R v C* [2005] SASC 60). The attempted abortion charge was one of 11 charges and was part of a course of sustained sexual abuse. The victim was his daughter. The defendant was not medically qualified, and the attempted abortion charge related to a violent assault on the victim when she was aged 15. See further above [3.1.19].

5.1.6 Another view is that the criminal law focus is misplaced and is adverse to both patients and health staff. Dr Philip Goldstone told the NSW Legislative Council Committee that the illegality of abortion 'impacts women and patients, and certainly it does add to the shame and stigma of women. But it also causes confusion and uncertainty amongst the medical practitioner profession'.[613] One South Australian MP has noted that the provisions around abortion still exist in s 81 of the *CLCA* 'right between the abduction of children and offences relating to public order, including riot, affray and terrorism. This is inappropriate … We need to start talking about law reform to really serve all South Australians.'[614]

5.1.7 In reviewing the current law, SALRI has identified four main issues as to criminality. These are:

a. The role of the criminal law;

b. The role and actions of the woman;

c. The role and actions of medical practitioners; and

d. Residual offences by unqualified parties.

5.2 Abortion and the Criminal Law

5.2.1 It is often argued that it is inappropriate for abortion to be in the criminal law and it is preferably left to health law and practice. The premise is that abortion in the criminal law results in adverse effects for both the women involved and health care professionals.

5.2.2 As early as 1991, Natasha Cica offered a number of criticisms of Australian abortion law, in particular that they lacked policy coherence. Ms Cica argued:

> The law governing abortion in Australia has been shown to be inadequate in many ways. It is inconsistent, uncertain and unenforced. It does not adequately deal with issues posed by advances in medical technology. It fulfils no coherent guiding policy. Its priorities are not clear concerning the position of the fetus, the father, the pregnant woman and the medical profession in the abortion debate. It does not address the social and ethical dimensions of the problems posed by abortion.[615]

5.2.3 Such criticisms continue. The NSW Council of Social Services recently noted that, whilst the experience of other jurisdictions is that 'decriminalisation of abortion does not result in more terminations',[616] 'it does have the ability to allow for better access and begin to remove the above barriers.'[617]

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[613] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 50 (Dr Philip Goldstone, Marie Stopes Australia).

[614] South Australia, *Parliamentary Debates*, Legislative Council, 30 May 2018, 281–281 (The Hon Tammy Franks MLC).

[615] Natasha Cica, 'The Inadequacies of Australian Abortion Law' (1991) 5(1) *Australian Journal of Family Law* 37, 66.

[616] See Susheela Singh et al, Guttmacher Institute, *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Report, 2018) <https://www.guttmacher.org/report/abortion-worldwide-2017>.

[617] NSW Council of Social Services, Submission No 44 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64880/0044%20NSW%20Council%20of%20Social%20Service.pdf>.

5.2.4 However, one view is that concern over the criminal law focus of the present law is overstated. It is noted that there are very few, if any, prosecutions.

5.2.5 Real Choices Australia, in their submission to the NSW Legislative Council Committee, dismissed assertions that the present law raises major hurdles in access and women's fears of prosecution:

> This is not true. There have been no criminal prosecutions of any woman or doctor acting within the current law and in fact the majority of the general public are unaware that abortion is within the criminal code. Most women have no trouble accessing abortion, and have no awareness that it is not completely legal. Even a short perusal of commentary in social media demonstrates how easy it is to access abortion and how little impact the current legal status has.[618]

5.2.6 Parties opposed to the decriminalisation of abortion argue that the present law, especially the reliance on a woman's mental health as the ground for an abortion, is not working as it should. Archbishop Fischer, for example, supported a stricter enforcement of the present law and told the NSW Legislative Council Committee that:

> I do not for a moment believe that 95% of women who have abortions are having them for mental health reasons … I think the 95 per cent figure in South Australia represents a cover-up or a medicalising of what are mostly other reasons that people are seeking abortions.[619]

5.2.7 However, parties opposed to the decriminalisation of abortion argue that, despite its apparent limited practical effect, the criminal law should not be relaxed. It is argued that the presence of abortion in the criminal law serves wider purposes and recognises fundamental values.[620]

5.2.8 Cherish Life Australia told SALRI that 'abortion is not and never will be just another medical procedure' and to remove abortion from the criminal law 'and /or all legal protection from unborn human beings deprives the unborn child of any legal recognition whatsoever'. Some attendees at SALRI's roundtable with faith groups on 16 May 2019 stated 'that there is a responsibility through legislation to protect the vulnerable. We come from a position where the unborn is a vulnerable person in our community. In a criminal Act, those provisions would reflect that.' It was said that, though there may be very few prosecutions, at the same time, the criminal law plays a valid role in setting out the underlying policy. Professor Margaret Somerville submitted to the NSW Legislative Council Committee that the criminal law is meant to prevent harm, 'but its other important functions are

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[618] Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012 Real Choices Australia.pdf>.

[619] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 7 (Archbishop Anthony Fisher, Catholic Archbishop of Sydney). 'I think that it is probably the case in this State we have got rather too used to abortion and so it is very rare indeed that we have a good look at what is going on, and so I would like the laws applied rather more than they have been. But the reality is these are not laws that are used against women in desperate situations': at 5.

[620] See, for example, Francis Beckwith, *Defending Life: A Moral and Legal Case Against Abortion* (Cambridge University Press, 2008); Australian Christian Lobby, Submission No 33 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64869/0033%20Australian%20Christian%20Lobby.pdf>.

symbolic, an affirmation of the shared values we have, especially regarding respect for human life, and these will be lost if this is taken out of the criminal code'.[621]

5.2.9 There is a strong contrary view is that a criminal law focus and the risk (small as it may be) of prosecution is adverse and is problematic for both women and health practitioners.[622] This theme strongly emerged in both SALRI's consultation and before the NSW Legislative Council Committee.[623]

5.2.10 It is said that as a consequence of the criminal law, medical practitioners are reluctant to be involved and often conceptualise abortion as a service 'others do',[624] whilst women are left confused about the legality of their choices. This reduces the provision of, and access to, safe abortion services.[625]

5.2.11 The stigma around abortion continues to be a factor for women when deciding to continue a pregnancy or not.[626] It was observed that the previous law in Queensland 'created uncertainty among doctors about how the law works in practice' and that the possibility of prosecution 'acts as a deterrent to doctors, impeding the provision of a full range of safe, accessible and timely reproductive services for women'.[627]

5.2.12 One study notes that abortion services in New South Wales and Queensland, in particular, adopted restrictive practices to manage the perceived risk of criminal prosecution even though these practices are not explicitly required by the law. These procedures may take place even where medical practitioners indicate this is 'usually unnecessary, time consuming, emotionally distressing for the woman concerned and often detrimental to her physical and/or mental health'.[628]

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[621] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August, 60 (Professor Margaret Somerville, School of Medicine, University of Notre Dame). 'We protect our most important shared values, the ones on which we found our society, in the Criminal Law. One of those values is respect for human life, which operates at two levels: respect for every individual human life and respect for human life in general, at the societal level. Just the fact of taking abortion out of the *Crimes Act 1900* will affect and harm these values and their protections': Professor Margaret Somerville, Submission No 24 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 9, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64842/0024%20Ms%20Margaret%20Somerville%20AM,%20The%20University%20of%20Notre%20Dame.pdf>.

[622] Caroline de Costa, Heather Douglas and Kirsten Black, 'Making it Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184.

[623] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 21–24 [3.15]–[3.25].

[624] Angela Dawson et al, 'Medical Termination of Pregnancy in General Practice in Australia: A Descriptive-Interpretive Qualitative Study' (2017) 14(39) *Reproductive Health* 13.

[625] Caroline de Moel-Mandel and Julia Shelley, 'The Legal and Non-Legal Barriers to Abortion Access in Australia: a Review of the Evidence' (2017) 22(2) *European Journal of Contraception and Reproductive Health Care* 114, 119.

[626] Alison Norris et al, 'Abortion Stigma: A Reconceptualisation of Constituents, Causes, and Consequences' (2011) 21(3) *Women's Health Issues* S49.

[627] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) [12.1.1].

[628] Caroline de Costa, Heather Douglas and Kirsten Black, 'Making it Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184, 188. See also Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 109; Kirsten Black, Heather Douglas and Caroline de Costa, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144; Heather Douglas, Kirsten Black and

5.2.13 Though prosecutions may be rare, they are not unique.[629] Furthermore a criminal conviction 'is not the only form of harm a medical practitioner can suffer for providing abortion services',[630] especially where the law lacks clarity and certainty. One author notes: 'Most current laws have grey areas that leave doctors vulnerable to accusations, negative publicity and career damage, especially in the case of late abortions.'[631]

5.2.14 These themes in relation to both women and health practitioners were highlighted by Mr Greenwich, the Member for Sydney, in introducing the Bill to decriminalise abortion in NSW on 1 August 2019. Mr Greenwich observed:

> The threat of prosecution of women and healthcare professionals is real. As recently as August 2017, a Blacktown mother of five was prosecuted for self-administrating a drug to cause a miscarriage … The threat of conviction can obviously create fear and stigma for women wanting an abortion and reluctance by healthcare practitioners to provide services or even advice to women about their options. In turn, this prevents many facilities from providing a full range of reproductive healthcare services. This has the biggest impact for women in regional areas, where there are already limited healthcare choices. The law surrounding terminations is no longer fit for purpose and needs to be modernised.[632]

5.2.15 Edwina McDonald of the Human Rights Law Centre in giving evidence before the NSW Legislative Council Committee disagreed with the assertion 'Just leave it [the present law] as is because no women are being prosecuted'.[633] Ms MacDonald explained:

> I think the starting point is that abortion should be treated absolutely as a health matter and not a criminal matter. With the current system it is not just about the prosecutions that are occurring, but also about the context of fear and uncertainty within which both doctors and women are operating and having to make personal decisions. What we are seeing is that it can deter health professionals from being involved in the service delivery for fear of committing a crime and it can also legitimise misinformation. We have heard of cases where doctors with conscientious

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Caroline de Costa, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20(3) *Journal of Law and Medicine* 560.

[629] See, for example, *R v Sood* [2006] NSWSC 1141 (31 October 2006). From 1994 to 2019, 12 people were prosecuted in NSW for abortion related offences. Four of these persons were found guilty. See Michael McGowan, 'NSW Abortion Law: The Decriminalisation Reform Bill Explained', *The Guardian* (online, 19 August 2019) <https://www.theguardian.com/australia-news/2019/aug/19/nsw-abortion-law-the-decriminalisation-reform-bill-explained>. In 1998, two West Australian medical practitioners were charged with abortion. The case led to swift law reform and the case was then dropped 'in the public interest', an outcome that disappointed some medical practitioners who would have welcomed a West Australian precedent. See Adrian McGregor and Matt Price, 'Interstate Show of Solidarity for Doctors', *The Australian* (Sydney, 19 February 1998) 5; Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69, 74, One of the medical practitioners was confident he would have been acquitted as 'this was the prefect case of legal abortion where the patient was under enormous stress at the idea of having another child': at 75. See also above [3.1.9].

[630] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 66.

[631] Lachlan de Crespigny and Julian Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201. A highly publicised Victorian abortion case is instructive. This involved a late term abortion at 31 weeks with severe fetal disability where a medical practitioner was dismissed (though later reinstated), six medical practitioners were suspended and after an eight-year process (including a comprehensive police investigation) all were ultimately exonerated. It is significant that the mother was 'acutely suicidal', the hospital's lawyer commenting that 'rarely, if ever, had a woman in such a desperate state been encountered — she would kill herself or do anything not to have the baby she was carrying': at 61. See also above [3.1.9].

[632] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–4 (Mr Greenwich).

[633] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 4 (Ms Edwina MacDonald, Legal Director, Human Rights Law Centre).

> objections have told women that abortion is illegal, so it can inhibit their access in that way. Ultimately, no other health procedure is treated like this and abortion should be treated like any other health procedure and be removed from the *Crimes Act*.[634]

5.2.16 Mr Cowdery QC, the former NSW Director of Public Prosecutions told the NSW Legislative Council Committee that the abortion offences are 'otiose' and should be repealed.[635] Mr Cowdery elaborated that this law should not depend on the exercise of prosecution discretion:

> The prospect is always there that there can be prosecutions. I am no longer the Director of Public Prosecutions, I do not make decisions any more in these matters. But others may take different views of the interpretation of these guidelines and their application to particular cases. Having the risk of prosecution there in my view creates the harm of causing confusion, the sorts of things that have been mentioned already, confusion in the minds of those who would otherwise be involved, difficulties in accessing appropriate services, particularly in country areas in New South Wales, and the general angst that attaches to anybody who is contemplating doing something that is prima facie criminal and needing to find a way through to avoid that criminal outcome. Those sorts of psychological and practical harms, if a person does not receive service in time, can be done away with by taking the criminality out of it.[636]

5.2.17 It has also been stated that the criminal law focus has a particular and adverse effect on women from rural, remote and Aboriginal communities. The NSW Council of Social Services told the NSW Legislative Council Committee that the criminal law focus of the present law has a particular adverse effect on 'women who experience multiple and intersecting forms of disadvantage — vulnerable women, women living in or at risk of poverty, regional, rural and remote women, women experiencing domestic and family violence, and women from Culturally and Linguistically Diverse and Aboriginal and Torres Strait Islander communities.'[637] They noted that, while abortion remains in the criminal law, women not only face the threat of prosecution and continued stigmatisation, but there are also increased barriers to access such as increased cost and limited accessibility of services. The NSW Council of Social Services commented:

> These barriers are particularly pronounced, and can become insurmountable, for women living in regional areas, women at risk of or experiencing poverty, and women experiencing domestic and family violence. Currently in many regional areas women have to travel unacceptable distances, incur travel costs (which could include overnight accommodation) or even travel across the border to obtain the services they require. For example, in Wagga Wagga and Albury women are forced to travel across the border to access comprehensive reproductive healthcare in Canberra or Victoria. Culturally appropriate services are also not available in many regional areas.[638]

5.2.18 Family Planning NSW similarly outlined to the NSW Legislative Council Committee:

> Criminalisation has a particularly devastating impact on women from disadvantaged or rural and remote communities who lack the financial means to pay for an abortion or who need to travel long distances to access one. Women facing domestic violence or homelessness often need to seek

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[634] Ibid.

[635] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Mr Nicholas Cowdery AC QC, NSW Council for Civil Liberties).

[636] Ibid 50.

[637] NSW Council of Social Services, Submission No 44 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64880/0044%20NSW%20Council%20of%20Social%20Service.pdf>.

[638] Ibid.

> urgent funding, if it is even available, from charities, friends or family to access an abortion in NSW, with costs ranging from hundreds to thousands of dollars.[639]

Submissions

5.2.19 Notwithstanding views to the contrary, there was strong support to SALRI for abortion to be taken out of the criminal law.

5.2.20 This was the firm view expressed by professional medical and health associations such as the AMA(SA) and RANZCOG and nursing bodies and at SALRI's roundtable sessions with the disability sector on 20 May 2019, with the medical and legal sectors on 7 June 2019 and groups in favour of decriminalisation of abortion on 7 June 2019. This was also the strong (though not universal) view to emerge in SALRI's regional visits to Whyalla, Port Augusta, Ceduna, Port Lincoln and Murray Bridge and discussions with medical and other health practitioners and providers.

5.2.21 Many parties favoured the complete removal of abortion (subject to safe access zones) from the criminal law.[640] One submission noted: 'Abortion should be completely removed from the criminal law.' Another representative submission stated: 'Abortion should be completely removed from the criminal law and there should be no new law specific to abortion introduced into health law – with the exception that there should be safe access zones to protect women seeking medical treatment.'

5.2.22 The majority view in SALRI's consultation was that abortion should be wholly or largely (noting any residual offence for abortions by unqualified parties) removed from the criminal law, especially for the woman involved and health practitioners. As one submission commented:

> A pregnant woman or girl shouldn't face the prospect of charges relating to procuring or performing an abortion in any circumstances. A qualified health professional shouldn't face charges when acting in accordance with clinical guidelines. I am concerned that criminalising these procedures creates stigma and barriers to this important healthcare procedure, and that such stigma will lead to real harms.

5.2.23 Over half of all online respondents supported the complete removal of offences relating to abortion from the criminal law. Another noted: 'This is a medical issue, not a criminal one. Abortions should be performed safely and effectively by registered health care professionals with the appropriate medical education and expertise.' Another observed: 'Abortion services should be covered by the health act and by the same laws that apply to all qualified health professionals in their practice.'

5.2.24 The Law Society of South Australia, for example, stated: 'The Society supports the decriminalisation of abortion in South Australia and therefore the repeal of Divisions 17 and 18 of the *CLCA*. The Society considers that abortion is a medical issue and should be regulated under health

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[639] Family Planning NSW, Submission No 15 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64849/0015%20Family%20Planning%20NSW.pdf>.

[640] These parties included a genetic counsellor, Dr Erica Millar, Mark Rankin, Associate Professor Baird, Professor Margaret Davies, Dr Sarah Moulds, Professor Margaret Allen, Australian College of Midwives, the South Australian Abortion Action Coalition, South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists, the Australian Nursing and Midwifery Federation SA Branch Australian, the Women's Health Network, Reproductive Choice Australia, the Castan Centre for Human Rights Law, the Public Health Association of Australia, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), Human Rights Law Centre, the Law Society of South Australia, The Greens (SA), the Hon Tammy Franks MLC, Beth Wilson AM, Children by Choice, Fair Agenda, the Women's Lawyers Association SA, a leading health agency, Marie Stopes Australia, the Royal Australasian College of Physicians, the South Australian Council for Civil Liberties, the Southgate Institute, a genetic counsellor, and the Coalition of Women's Domestic Violence Services SA, Women Lawyers' Association of South Australia Inc and YWCA Australia. See also above [2.1.15]–[2.1.28].

laws and regulations.'[641] Brigid Coombe, drawing on her long involvement in health care, in her personal submission noted: 'Abortion has no place in criminal laws. Legal constraints impact the most vulnerable and perpetuate stigma. If health law is adequate for all other health care, it is adequate for abortion provision.'

5.2.25 The Australian Centre for Health Law Research argued:

> We reiterate our view that decriminalisation of abortion should occur … and that termination of pregnancy should be regulated by the law as fundamentally a women's health matter, rather than a criminal offence. Compelling evidence … as to why decriminalisation should occur, includ[es] that the current law is uncertain, fails to promote women's health, exposes women to harm and inequity, and does not reflect contemporary community standards. Continuing to classify abortion … as a criminal offence warranting condemnation, punishment and penalties is problematic, harmful and counterproductive. Failure to determine this issue once and for all serves only to perpetuate uncertainty, delay and harm for women, their families, medication practitioners and the broader … community.

5.2.26 One person explained:

> I would like to say that it is my belief that it should definitely be decriminalised. There are many reasons as to why this should be the case ranging from giving women rights over their own body to the social and emotional effects on a child that is brought into the world where it cannot be looked after properly. It is crucial … that we do not end up like America where a rapist receives less of a consequence than a rape victim who wants an abortion. While I believe in religious freedom I do not believe this should trump an individual's personal safety and well-being.

5.2.27 Another party noted:

> I fully support the decriminalisation of abortion. Our SA laws around abortion are antiquated and unhealthy. Access to abortion care is access to health care. Abortion needs to be regulated like any other healthcare is and it needs to be provided based on an individual's informed consent. I live in South Australia not Alabama. I want my home to be safe and healthy for women and not have old crusty laws that reek of control and fear.

5.2.28 Another party argued:

> Abortion in South Australia should be legalised and should not in any way be criminalised. Women living in remote South Australia should be able to access the quickest and most effective reproductive healthcare in their own communities without needing to travel thousands of kms from their families to a 'prescribed hospital'. Please reform abortion law in SA.

5.2.29 The Greens (SA) highlighted their support for the unambiguous legal right to bodily autonomy, and for people to be able to 'make their own health choices without the burden of criminality hanging over their heads'. Their submission explained:

> It is clear that the current law is no longer fit for purpose. Abortion has absolutely no place in the criminal law. Not only does this add to the stigma around the procedure, but the threat of criminalisation and potentially life imprisonment is a significant barrier to the provision of best practice health care. Whilst women are not actively prevented from seeking an abortion under our laws, the current law places unnecessary limits on the capacity of doctors and health professionals to provide abortion care.

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[641] Law Society of South Australia, Submission to the South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice,* 'Review of Abortion Laws in South Australia' May 2019, 2 [9] <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

5.2.30 A number of parties such as the Australian College of Midwives favoured the removal of abortion from the criminal law, arguing that this is integral to respect a woman's autonomy. YWCA Australia advocated the complete removal of abortion (bar safe access zones) from the criminal law and this 'affirms that the right for women to control their fertility, which includes the decriminalisation of abortion, is critical to is fundamental to women's empowerment and bodily autonomy'. The South Australian Abortion Coalition supported the decriminalisation of abortion law 'to give women better or greater reproductive control and the right to autonomy over their bodies … abortion should be a woman's decision, affordable to all, and accessible regardless of location.'

5.2.31 It was emphasised by parties in favour of decriminalisation of abortion that the lack of prosecutions is not conclusive as to the problematic effect of the present law. Concerns still exist that abortion providers may be prosecuted, as do arguments which emphasise 'the fundamental criminal status of abortion'.[642] The risk of prosecution cannot be discounted. The Human Rights Law Centre told SALRI: 'The threat is not merely theoretical — only two years ago, a [NSW] mother of five was prosecuted for administering misoprostol to herself in an attempt to end her pregnancy.'[643]

5.2.32 It was also stated, significantly by groups both supporting and favouring the decriminalisation of abortion, that the present law is flawed and simply does not work.

5.2.33 A common complaint of groups opposed to the decriminalisation of abortion in SALRI's consultation is that the present law is a 'charade' or a 'sham' in that it was said abortions are effectively available on request by recourse to the effect on a woman's mental health. This theme was emphasised at both the roundtables on 16 May 2019 with faith groups and on 12 June 2019 with faith groups and NGOs. One rural medical practitioner went so far as to say 'the mental health test of present law is a joke, it has always been a joke' and amounts to 'abortion on demand'.

5.2.34 This theme was also acknowledged (at least in part) by at least some other medical practitioners who consulted with SALRI. More than one medical practitioner acknowledged to SALRI that it is not their role to 'second guess' a patient and if a woman states that having a child will be disadvantageous for her mental state, this is accepted. The Australian Nursing and Midwifery Federation SA Branch (ANMFSA) noted to SALRI that in 2016, 95.5% of abortions in South Australia were for a woman's mental health, 3.7% for foetal abnormality and 0.7% for specific medical conditions. The ANMFSA stated: 'It is our opinion that medical practitioners are forced to use mental health as the access vehicle for women because of the current legislation.'

5.2.35 One article notes that the effect of the present law is that both medical practitioners and women feel obliged to exaggerate or fabricate psychological distress in order to obtain a 'lawful' abortion.[644] The article goes on to observe:

> There is evidence to show that retaining abortion in the criminal law materially affects the practice of doctors and their willingness to take part in abortion provision. This means that abortion is

[642] Mark Rankin, 'The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law?' (2011) 13(2) *Flinders Law Journal* 1. See also above [3.1.9], [5.2.13].

[643] *DPP v Lasuladu* [2017] NSWLC 11.

[644] Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 109. See also Heather Douglas, Kirsten Black and Caroline de Costa, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20(3) *Journal of Law and Medicine* 560; Caroline de Costa, Heather Douglas and Kirsten Black, 'Making it Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184.

> regarded differently from other medical procedures and is not part of mainstream gynecological care.[645]

5.2.36 However, there is a view that, perhaps whilst not ideal, the present law is largely effective in practice and reform is not necessary. More than one party told SALRI that if 'it ain't broke, don't fix it'. Heath and Mulligan have contended that any fear of prosecution in relation to medical procedures carried out in good faith is without foundation[646] and that the 1969 South Australian changes have been effective.[647] They argue:

> … that despite public claims to the contrary, abortion services that comply with the statutory scheme in South Australia are lawful. The demonstrable safety of abortion services in South Australia since 1969, and the absence of prosecutions and convictions in this State, suggest that Parliament achieved its goals. The law in relation to surgical abortion was rendered clear, with immediate, positive impacts on women's health. The deaths and serious injuries that were a persistent feature of abortion provision prior to 1969 have been all but eliminated.[648]

5.2.37 The 'chilling effect' of the criminal law in relation to abortion to both patients and health professionals was highlighted to SALRI by many parties. The Castan Centre for Human Rights Law emphasised that 'when the law treats abortion differently to other medical procedures by imposing gestational limits and grounds, it essentially stigmatises abortion by casting such procedures in a deviant light'. They noted the adverse effects arising from this on both women and health practitioners. One specialist medical practitioner noted that abortion still has a 'whiff of scandal' about it owing to its place in the criminal law. These themes were reiterated by the South Australian Abortion Action Coalition, the Australian Women's Health Network, the Human Rights Law Centre and other parties.

5.2.38 One regional midwife described the present law as 'shocking, it is very bad' and the criminality of abortion was adverse both to patients and health practitioners, especially in a rural, regional or remote context. The issues in relation to Aboriginal communities were also highlighted.

5.2.39 Kate Marchesi emphasised the 'chilling effect' of the criminal law:

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[645] Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 109.

[646] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 67. See also Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6(1) *Bioethical Inquiry* 69 who makes a similar argument in relation to NSW and Western Australia.

[647] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41. 'It appears clear that medicalisation has been similarly successful [as in England] in enabling access to affordable and safe abortion services in South Australia through placing decision-making power in the hands of medical practitioners rather than of women seeking an abortion. In South Australia, in contrast to many other Australian jurisdictions, abortion is primarily provided as a public health service rather than being primarily provided through the private sector': at 55. See also Caroline de Costa et al, 'Abortion Law Across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 109.

[648] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 66–67. However, Heath and Mulligan qualify this argument. 'Nevertheless, the continued presence of abortion-related offences in the criminal law is undesirable. As researchers have demonstrated in relation to other jurisdictions, the presence of abortion offences generates concern in the medical profession and creates potential for the imposition of restrictions on abortion services which the legislative scheme itself does not demand. These circumstances give rise to treatment regimes and restrictions on the availability of abortion that prejudice women's health, rather than protect it … The time is ripe for reconsideration in South Australia. We would argue that South Australia should follow Victoria and the Australian Capital Territory in removing abortion from the criminal law so that abortion provision can be driven by concern for the provision of quality health care services rather than by concern to avoid criminal consequences … or by unfounded beliefs that parliamentary support for safe, medical abortion will be punished by the electorate': at 67–68.

> The fact that abortion remains in the criminal law is damaging to both patients and practitioners. It has a 'chilling effect'. Doctors, particularly in small regional towns, have expressed fear about the prospect of becoming known to perform terminations and the impact this can have on their reputation in the community. They have said 'we don't want to be known as the abortionist'. Others have expressed concerns about the legal ambiguity surrounding terminations and potential consequences stating: 'I can't do it. It is too much of a grey area. I can't take the risk.'

5.2.40 Dr David MacFarlane, drawing on his 'quite horrendous experience' of abortion law and practice in Queensland,[649] highlighted to SALRI the 'chilling effect and stigma' for both patients and health practitioners arising from the placement of abortion in the criminal law. He noted that it is inherently and highly problematic for both patients and staff. 'There is such a negativity around abortion.' Dr MacFarlane highlighted that because of the unwarranted social stigma surrounding abortion it can be bad for a medical practitioner's professional reputation to become known as an 'abortion doctor'. He noted a lack of support from at least some hospital administrators for medical practitioners in this area and emphasised that the negative effects of having abortion in the criminal law cannot be measured by the minimal number of prosecutions. Dr MacFarlane observed that the 'spectre' of the criminal law looms largely over health practitioners and 'is always in the background'.

5.2.41 This theme was repeated by other medical practitioners. A number of medical practitioners, both in and out of Adelaide, told SALRI it is professionally damaging for a medical practitioner to become known as an 'abortion doctor' and it may prevent future career opportunities. They noted the ever present risk of a complaint (including from colleagues opposed to abortion) of misconduct to professional bodies or hospital management or even the police (especially as a public sector health practitioners' work insurance cover does not extend to allegations of criminal conduct), as well as risk adverse and unsupportive hospital administrators

5.2.42 Brigid Coombe, an experienced health provider and former Director of the Pregnancy Advisory Centre, spoke of her experience of the role and the adverse effects of the criminal law and the risk of complaint to hospital management and even the police and how 'as abortion providers we were accustomed to being treated as renegades who needed to be controlled' by often unsupportive hospital management'. Ms Coombe described how the complexity and uncertainty of the present law frustrates effective health care:

> My experience there ultimately led me to conclude that abortion needed to be removed from criminal law and legislated like all other health care. The work was layered with hurdles; the practical everyday hurdles of providing human services, the hurdles resulting from judgment and criticism of aborting women and abortion providers and the hurdles constantly arising from having to navigate two pages of legislation, and more of regulation, fashioned by a Parliament decades earlier. I was derailed to learn that no-one could tell me for sure what the words or sentences definitely meant when a new circumstance or legislative question or medical technology appeared. I also learned that uncertainty and misunderstandings about the legal status of a procedure,

[649] See *Central Queensland Hospital and Health Service v Q* [2016] QSC 89. McMeekin J authorised a medical abortion to be carried out on a 12 year old girl. His Honour noted that both the medical practitioners and the girl involved (see also *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112) and her parent/guardian agreed that such a procedure was appropriate. McMeekin J agreed with the medical and expert opinion (at [13]–[17]) and was satisfied that such a procedure was necessary and lawful as 'there are strong grounds to believe that Q is at risk of suffering psychological harm, and serious harm, if the pregnancy is not terminated there is good reason to think that she is at considerable risk of physical harm as well': at [6]. Dr MacFarlane was subjected to a professional complaint from Queensland Health arising from his role as one of the medical practitioners in this case. As a result of the complaint, Dr MacFarlane pointed out that he suffered serious adverse professional, financial and employment consequences until the case was dismissed, almost a year later, as unfounded and he was cleared.

particularly one which is contested and where women's rights are subordinate to the decisions of others, can lead to women not receiving the care they need.

5.2.43 The Castan Centre for Human Rights Law stated that the 'maintenance of unclear and uncertain criminal provisions criminalises and stigmatises women and doctors and compromises access to health services'.[650] A specialist medical practitioner spoke to SALRI of their frustration of working under the 'shadow of the criminal law' and the regular threat of complaint to often unsupportive hospital management and even the police by colleagues who opposed abortion. Associate Professor Catherine Kevin submitted that without decriminalisation, 'abortion will continue to bear the stigma that prevents knowledge sharing and generates ignorance and shame'. This impacts not only on patients, would-be patients and their friends and families but 'also contributes to the workforce issues facing services by preventing training from being a normalised part of medical degrees, and is a disincentive for doctors and other health professionals who might otherwise consider assisting in the delivery of this crucial reproductive health care service.'

5.2.44 A former workplace advocate noted:

> While ever terminations, as an appropriate medical procedure, with informed consent procedures in place are still overshadowed by possible criminal law repercussions, women will continue to experience fear and shame when faced with a pregnancy they choose to terminate. Pregnancy termination is widely practised but still taboo, not able to be spoken of, especially in many workplaces where the attitudes of employers may be informed by ignorance or rigidly held views … Decriminalising abortion will improve safety for women and practitioners but also go a long way to breaking down stigma and stereotypes amongst our community. To take away the fear of judgement for what should be an accepted medical procedure will be a huge gift to women in our continued efforts to secure up to date human rights for women in all spheres of their lives, including at work.

5.2.45 One party, drawing on his wife's involvement with the Woodville Clinic, observed:

> The first thing I became aware of when she commenced … was the lack of support for her work within the Department of Health. Her superiors were clearly wishing to keep her at a distance, as if they did not wish to be connected to the service at all. She would often talk about the unwillingness of other health practitioners to assist and her immediate superiors who would take very restrictive view of the law, and then demand that she do the same, simply to keep then well clear of any controversy or the criminal law … Another issue she had was the almost constant stream of ministerial requests that emanated from individuals with a particular religious view of the issue. It appeared to me that the main reason for such requests was the hope of finding some breach of the law that would enable prosecution of someone who worked to provide essential service to women. And of course, as there were significant criminal sanction attached to any breach of the law, there were always risks. For a simple example, was the woman seeking the abortion a resident of South Australia. What if she had given a false address, or other details that may lead to a breach of the law. What were the consequences for the service, or the woman if she was not … My belief is that removing regulation of abortion from the criminal law is not a major moral issue, nor a legal issue. It is an issue for women seeking an abortions, and the responsibility of the state to provide the best possible care, without the unnecessary stigma, and harm that comes from regulating a medical procedure in the common law. I would urge you to make a strong recommendation to completely decriminalise abortion.

[650] Castan Centre for Human Rights Law quoting Gilda Sedgh et al, 'Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008' (2012) 379(9595) *The Lancet* 625.

5.2.46 There were differing views in SALRI's consultation as to the effects and implications of the criminal law in relation to abortion.

5.2.47 One view asserted that the criminal law largely works, and the negative effects are overstated. The contrary view asserted that the criminal law aspect of the present situation is flawed and raises major adverse implications.

5.2.48 Anna Walsh, for example, argued that abortion should remain in the criminal law. She elaborated:

> The criminal law prevents unscrupulous doctors from taking advantage of women who are vulnerable and disgracing their profession which is committed to not doing harm. The fact that the law is infrequently applied is evidence indeed that the criminal system is indeed working as a general and specific deterrent.[651]

5.2.49 However, the effectiveness of the present law was widely doubted, even by parties opposed to any relaxation of the present law. Anna Walsh noted that the 'mental harm' ground in the present law is applied in such a way as to effectively allow abortion 'on demand'. Genesis Pregnancy Support Inc, drawing on its role,[652] noted that the present law is 'flouted' and 'not enforced' and abortion in South Australia 'is effectively already available on demand up to the late term of 28 weeks … No woman or medical practitioner is being charged or criminally treated' due to abortion being in the criminal law. Some attendees at the 12 June 2019 roundtable with faith groups and NGOs also expressed concern at the low level of prosecution under the current law and perceived this as a lack of its enforcement and effectiveness.

5.2.50 Another party complained that the present law does not work:

> … it is way too easy to have this done in Adelaide. The doctor signs off without hardly looking up. There's no discussion. No suggestion of adoption, which should be encouraged. Staff treat you like a number and whisk you through. Once you're on their merry-go-round you can't get off.

5.2.51 Parties in favour of the decriminalisation of abortion also said the present law does not work.

5.2.52 One view highlighted the problems of the criminal law. Professors White and Willmott emphasised the complexity and uncertainty of the present law.

> Doctors should not be in fear of prosecution for carrying out women's health procedures. Legalising abortion would remove current uncertainty about its legality, and provide greater confidence and protection for doctors who perform these procedures.

5.2.53 Professors White and Willmott further discussed the fact that the lack of any enforcement or prosecutions brings the administration of the law into disrepute.[653] The two central premises of any

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[651] Ms Walsh though added that the present law allowing abortion if necessary for the woman's 'mental health' is 'in practice, it seems … a very low threshold that is a mask for what is essentially "abortion on demand".'

[652] 'Genesis works at the coalface of this topic. We deal everyday with the issues and difficulties that affect women's choices regarding whether to continue with a pregnancy or not. Unlike clinics and hospitals providing terminations, we engage with and assist women who have chosen to proceed with their pregnancies despite their difficulties and see how they closely reflect the reasons why other women have often chosen to terminate … Women come to Genesis for counselling after their abortions. They are experiencing typical symptoms of grief and trauma, even PTSD.'

[653] ACHLR stated to the 2016 Queensland Parliamentary Committee that enforcement of a criminal law is an important component of the principle of the rule of law, as if 'laws are flouted and not enforced, our legal system

Office of Director of Public Prosecutions in Australia is that a prosecution should only be bought if there is 'a reasonable prospect of conviction' and it must be in the public interest to prosecute.[654] Professors White and Willmott highlight that abortion offences are problematic in relation to both these central premises. They note abortion offences 'are inherently difficulty to enforce' and from a law enforcement perspective, it is very difficult to obtain sufficient evidence that an abortion has occurred, particularly given the existence of physician-patient privilege, which protects the privacy, confidentiality and dignity of a patient with respect to their health matters. They further note that 'there is no public interest in pursuing abortions' and from the very limited prosecutions which had occurred in Queensland (which also applies in South Australia), it appears (in addition to the difficulties in obtaining sufficient evidence to provide a reasonable prospect of conviction to prosecute) 'there is very little interest' from the authorities in prosecuting women or health practitioners for these offences, even if it is known that an abortion has occurred. They commented:

> We also consider there is minimal public interest in the Crown pursuing such matters. There is no evidence that the small number of prosecutions to date have had deterrent effect on women obtaining and receiving terminations, and doctors performing these procedures. Such prosecutions serve only to exacerbate the distress, harm and humiliation of the women concerned and their families, and have the potential to cause stress, anxiety and damage to the reputation of their doctors.

5.2.54 Mr Cowdery QC, the former NSW Director of Public Prosecutions, was also critical to the NSW Legislative Council Committee of the role of abortion in the criminal law.[655] Mr Cowdery questioned any public interest in the prosecution of abortion offences and noted that the NSW police have a policy to not enforce the law relating to abortion.[656] Mr Cowdery contended that,

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is at risk of being brought into disrepute': Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry Into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 80 [14.2.2].

[654] See, for example, Commonwealth DPP, *Prosecution Policy of the Commonwealth* (Guidelines) 4–7 [2.1]–[2.18]; Director of Public Prosecutions South Australia, *Statement of Prosecution Policy and Guidelines* (Policy, October 2014) 5–8.

[655] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 48–50 (Mr Nicholas Cowdery AC QC, NSW Council for Civil Liberties); NSW Council for Civil Liberties, Submission No 42 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64878/0042%20New%20South%20Wales%20Council%20for%20Civil%20Liberties.pdf>.

[656] NSW Council for Civil Liberties, Submission No 42 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 3 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64878/0042%20New%20South%20Wales%20Council%20for%20Civil%20Liberties.pdf>. 'It is almost impossible to conceive of the case of self-termination, or termination by a qualified medical practitioner, that could properly be prosecuted. Police, I am told, have a policy of not charging abortion offences. A prosecutor is bound to apply the New South Wales Director of Public Prosecutions' prosecution guideline No 4, the decision to prosecute. I can identify at least nine public interest factors in that guideline… that individually or in some combinations depending on the circumstances of the case, would require a prosecutor not to proceed. The offences are otiose and should be removed. I see no problem with enacting a provision such as the one proposed to criminalise termination by an unqualified person. That would be a reasonable provision to seek to prevent foreseeable harm which should be the prime purpose of the criminal law. The present state of this law, in my view, does not prevent harm it causes harm': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Mr Nicholas Cowdery AC QC, NSW Council for Civil Liberties).

notwithstanding the relative lack of any prosecutions, the present law is 'no longer fit for purpose and should be repealed'[657] and:

> Having to rely on this limited [*R v Wald*] defence is a deeply flawed and unsatisfactory legal position for both women and medical practitioners. Some doctors are reluctant to perform terminations because of this legal uncertainty. Women with limited means and women living outside cities in regions who want a termination are disadvantaged in that access to qualified and willing medical practitioners is often not easily available. While the current provisions in the *Crimes Act* cause uncertainty for doctors and women, they provide little practical legal substance.[658]

5.2.55 However, parties opposed to the decriminalisation of abortion, whilst often accepting problems in its enforcement, were clear that abortion should remain in the criminal law. The South Australian Right to Life Association asserted that abortion should remain in the criminal law as 'the intentional taking of human life in the womb was considered (and still is by many) to be of sufficient gravity to warrant such legal protection' and it is an 'over-simplistic dichotomy to assert that abortion should be a health issue and not a criminal one'. 40 Days for Life argued that 'removal of all abortion related sanctions from the Criminal Code is tantamount to saying that the baby has no value and can be discarded by the woman like a useless chattel. It would deny the humanity, personhood and citizenship of the baby.' One survey response submitted: 'The current legislation protects both the mother and child from any criminal activity surrounding abortion. Deregulating will put vulnerable girls who want the pregnancy kept secret at greater risk of backyard abortions.'

5.2.56 Mr Doecke submitted that abortion should continue to be regulated under the criminal law 'as any deviation from the law is a criminal act' and changing it to a medical procedure under the health laws 'makes it appear like any other health procedure when clearly it is not; the fact still remains that it is the ending of human life and should be taken very seriously'.

5.2.57 The Australian Christian Lobby argued that 'the current law should be preserved'.[659] Its argument was that the criminal law exists to provide sanctions for the breach of society's ethical standards and to uphold social cohesion and removing the issue of the abortion from the criminal law 'answers this question by asserting that the life of the child in the womb has no value that should be protected by law. Given the current state of medical knowledge that is an incorrect response.' The Australian Christian Lobby explained:

> ACL's position therefore is that as a putative human being, the unborn child (and especially from 24 weeks or thereabouts) has value and so it is important to retain criminal sanctions for the unlawful termination of the child's life. It may be that those sanctions are moved from the *Criminal Law Consolidation Act 1935* to the *Public Health Act 2011*, but sanctions for breach of the provisions of the law, particularly as to gestation periods must be preserved.

5.2.58 One party similarly saw the continued role of the criminal law as necessary:

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[657] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Mr Nicholas Cowdery AC QC, NSW Council for Civil Liberties).

[658] NSW Council for Civil Liberties, Submission No 42 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 3 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64878/0042%20New%20South%20Wales%20Council%20for%20Civil%20Liberties.pdf>.

[659] This party also suggested that there should be a provision that gender selective abortion is not allowed 'and there should be sanctions for any person involved in sex selective abortion'. See further below Part 14.

> This legislation addresses the taking of human life. There will be grounds under which the ending of the child's life is clearly not warranted. The gravity is such that the condemnation implied by a defining it as a matter of criminal offence is appropriate.

5.2.59 Anna Walsh opposed any change to the present law and submitted: 'The purpose of the provisions in the *CLCA* is to maintain a standard for the community and is based on the belief that terminating human life is morally wrong and a criminal act unless there is a proper medical exception.' Cherish Life Australia argued that to remove abortion from the *CLCA* 'altogether would deprive the unborn child of any legal recognition whatsoever. Abortion is not and never will be just another medical procedure.'

5.3 SALRI's Observations and Conclusions

5.3.1 SALRI acknowledges that opinion is divided but it is of the view that the criminal law focus of the present law as to abortion is now misplaced and produces adverse effects on both patients and health professionals. SALRI notes the particular criticism of the role of abortion in the criminal law expressed to the NSW Legislative Council Committee by Mr Cowdery QC, the former NSW Director of Public Prosecutions. The fact that the present law appears to be effectively unenforced and there is little risk of prosecution, as well as the fact (as SALRI has heard from submissions across a range of perspectives) that abortion remains generally available on request in South Australia through the expansive use of the mental health ground, raises a real question as to the rationale for retention of the present law.

5.3.2 SALRI accepts, as contended by various parties opposed to the decriminalisation of abortion (and also conveyed to the NSW Legislative Council Committee), that the criminal law has a vital role in declaring society's views and values as to the boundaries of acceptable conduct. However, this is not a conclusive consideration. SALRI notes the analogous comment of a South Australian Parliamentary committee. 'It is the view of the Committee that it is not the role of Parliament to enact laws of no meaningful effect, aimed solely at conveying a message to the community. There are other mechanisms at the disposal of Parliament to achieve that end.'[660]

5.3.3 SALRI is unable to support the retention of the present law. It reiterates its views that abortion should be treated as a health issue rather than as a criminal law matter and a woman's autonomy, and best health care, should be respected and promoted. SALRI is of the view that abortion should be largely (though not totally in relation to procedures by unqualified parties)[661] removed from the criminal law, especially the *Criminal Law Consolidation Act 1935* (SA), and placed in health law and practice. SALRI suggests that ss 81, 82 and 82A of the *CLCA* should be repealed and replaced with the appropriate provisions recommended below, either in a standalone Act or the most suitable Act (though not the *Criminal Law Consolidation Act 1936* (SA)).[662]

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[660] Legislative Review Committee, Parliament of South Australia, *Report of the Legislative Review Committee into the Partial Defence of Provocation* (Report, 2 December 2014) 40. See also Legislative Review Committee, Parliament of South Australia, *Review of the Report of the Legislative Review Committee into the Partial Defence of Provocation* (Parliamentary Paper No 346, 31 October 2017) 16, 21, 30.

[661] See further below Part 6.

[662] SALRI understands the *Health Care Act 2008* (SA) may be unsuitable.

5.3.4 Recommendations

Recommendation 3

SALRI recommends that abortion should be largely (though not totally) removed from the criminal law, especially the *Criminal Law Consolidation Act 1935* (SA), and placed in health law and practice.

Recommendation 4

SALRI recommends that sections 81, 82 and 82A of the *Criminal Law Consolidation Act 1936* (SA) should be repealed and replaced with the appropriate provisions recommended below in a standalone Act or the most suitable Act (though not the *Criminal Law Consolidation Act 1936* (SA)).

5.4 The Role and Actions of the Woman

5.4.1 Section 81(1) of the *CLCA* provides for attempts to procure an abortion, such that 'any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, shall be guilty of an offence and liable to be imprisoned for life'.

5.4.2 The relevant laws in the Northern Territory, Tasmania and Victoria (and recently included in New South Wales) expressly remove criminal responsibility from a woman who consents to, or assists in, the termination of her own pregnancy.[663]

5.4.3 The potential criminal liability of a woman in relation to an abortion performed on herself is a contentious proposition.

5.4.4 The VLRC was of the view that it 'seems appropriate to render it quite clear' that a woman cannot be charged with performing an abortion upon herself, charged as an accessory to an unlawful abortion performed by an unqualified person or if she knowingly or permits a medical practitioner to perform an unauthorised abortion upon her.[664] The VLRC considered that any new abortion law should make it clear that a woman also commits no legal wrong if a non-qualified person performs her abortion.[665]

5.4.5 The 2016 and 2017 Queensland Parliamentary Committees reported that views diverged on whether a woman should be criminally responsible for the termination of her own pregnancy.[666] Some parties suggested to both the QLRC and the 2017 Queensland Parliamentary Committee that there should be an express legislative provision that a woman is not criminally responsible for the termination of her own pregnancy, to clarify the law and provide certainty, particularly in relation to

[663] *Criminal Code Act 1983* (NT) s 208A(4); *Criminal Code Act 1924* (Tas) s 178D(1)(b) and *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 8; *Crimes Act 1958* (Vic) s 65(2); *Abortion Law Reform Act 2019* (NSW) s 12. The provision in Tasmania extends to the woman administering or performing her own abortion.

[664] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 131 [8.189].

[665] Ibid 131 [8.190].

[666] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 21–22 [4.4.2].

medical termination.[667] It was suggested this would support the dignity and privacy of the woman when she has made the very personal decision to have an abortion.

5.4.6 Others considered that the offence should remain as a deterrent to procedures involving unqualified parties, or to women 'self-administering' terminations without medical supervision.[668]

5.4.7 The QLRC was clear that a woman should be specifically exempted from the scope of any offence relating to an abortion (whether medical or surgical) performed upon herself:

> International human rights bodies have recognised that criminalisation of termination stigmatises women.[669] The fact that it is a criminal offence, punishable by seven years imprisonment, for a woman to procure her own miscarriage in Queensland not only has the effect of increasing the uncertainty about the circumstances in which women have a right to lawfully access termination of pregnancy services, but also of increasing their anxiety and preserving the stigma surrounding terminations … generally, termination should be treated as a health issue, not a criminal matter. As a matter of principle, the draft legislation should not only protect a medical practitioner who performs a termination (and a health practitioner who assists in that performance) under the legislation from criminal responsibility for the termination of a woman's pregnancy, but also the woman. This protection, together with the clarification under the draft legislation as to the circumstances in which a woman's pregnancy may be terminated, are intended to increase women's access to safe and lawful termination. Accordingly, the draft legislation should provide that, despite any other Act, a woman who consents to, assists in, or performs a termination on herself does not commit an offence.[670]

5.4.8 This recommendation was accepted by the Queensland Parliament. The *Termination of Pregnancy Act 2018* (Qld) expressly provides protection from criminal responsibility for women. Section 10 provides that 'despite any other Act, a woman who consents to, assists in, or performs a termination on herself does not commit an offence.' This reflects the law in Victoria.[671]

5.4.9 The New Zealand Law Reform Commission also did not favour the retention of potential criminality attaching to a woman and their three potential models all exempted both the woman and any medical practitioner from the operation of the criminal law in relation to the performance of an abortion.[672]

5.4.10 The 2019 NSW Act also provides that a woman is expressly protected from criminal liability in relation to performing or assisting in the performance of an abortion upon herself.

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[667] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) [118]. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 21–22 [4.4.2].

[668] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 21–22 [4.4.2].

[669] See, for example, *A v Ireland* [2010] VI Eur Court HR 185, 230 [126], 240 [162].

[670] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 109 [3.62]–[3.64].

[671] *Abortion Law Reform Act 2008* (Vic) s 11.

[672] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 13, vii.

Submissions

5.4.11 There were differing views as to removing the criminal law in relation to a woman for an abortion performed on herself. However, there was extensive support to SALRI for the suggestion that the woman involved should be specifically exempted from criminal liability in relation to abortion.

5.4.12 Many parties favoured removing the application of the criminal law towards the woman.[673] RANZCOG declared its 'view that the criminal law has no place in the regulation of abortion services'.

5.4.13 This was also the adamant view expressed by professional medical and health associations[674] and at SALRI's roundtable sessions with the disability sector on 20 May 2019, with the medical and legal sectors on 7 June 2019 and groups supportive of the decriminalisation of abortion on 7 June 2019.[675] This was also the position expressed in SALRI's regional visits to Whyalla, Port Augusta, Ceduna, Port Lincoln and Murray Bridge and discussions with medical and other health practitioners and providers, including three rural GPs whom SALRI met separately. A number of lead clinicians also expressed this view: 'Punishing a women for deciding to terminate an abnormal baby or to prevent her death or exacerbation of illness or controlling her fertility when contraception has failed violates a women's basic rights of autonomy and self-determination.'

5.4.14 The vast majority of survey responses agreed that a woman should never be criminally responsible for the termination of her own pregnancy. As one response stated: 'A woman should never be held criminally responsible for the termination of her pregnancy regardless of means of termination or gestation.' Another survey response noted that abortion should never be a criminal act 'unless performed by an inappropriate person (ie without relevant training/qualifications), it should be regulated as any other voluntary medical procedure is with no risk of criminal prosecution for [the] doctor or patient.'

5.4.15 Professor Emerita Margaret Allen of the University of Adelaide, drawing on the significant historical context,[676] commented:

> My life spans from the period of girls 'getting into trouble', 'shot-gun' marriages, backyard abortions, and maternal deaths from botched illegal abortions through to the changed situation effected by the 1969 legislation. Now more change is needed with regard to legislation around abortion. The situation in South Australia sadly lags behind most other states and behind public opinion. Women must be given back the responsibility for their own lives and their own decisions. Abortion should be treated as a health issue and removed from the *Criminal Law Consolidation Act*.

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[673] These included Associate Professor Barbara Baird, Brigid Coombe, Professor Caroline De Costa, Professor Margaret Allen, Professor Heather Douglas, Dr Erica Millar, Australian Women's Health Network, Australian Lawyers for Human Rights, Children by Choice, the Coalition of Women's Domestic Violence Services SA, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Human Rights Law Centre, South Australian Council for Civil Liberties, the Southgate Institute, the Hon Tammy Franks MLC, The Greens (SA), Marie Stopes Australia, a leading health agency, Professor Margaret Davies, Professor Sally Sheldon and her colleagues, Beth Wilson AM, Associate Professor Baird, Dr Sarah Moulds, the Equal Opportunity Commissioner, the Law Society, Public Health Association of Australia, Fair Agenda, Women Lawyers' Association of South Australia Inc, Women's International League for Peace and Freedom and YWCA Australia.

[674] These parties included the Australian College of Midwives, AMA(SA), Australian Nursing and Midwifery Federation SA Branch, the Public Health Association of Australia, RANZCOG, South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists.

[675] It was noted that the risk of prosecution of the woman involved cannot be discounted. See, for example, *R v Brennan* [2010] QDC 329. See Kerry Petersen, 'Abortion Laws and Medical Developments: A Medico-Legal Anomaly in Queensland' (2010) 18(3) *Journal of Law and Medicine* 594. See also *DPP v Lasuladu* [2017] NSWLC 11.

[676] See above [3.6.1]–[3.6.14].

5.4.16 The Family Violence Legal Service Aboriginal Corporation works with Aboriginal victims of family violence and sexual abuse. The Corporation noted its client group is almost exclusively Aboriginal women living in regional and remote areas and many of its clients have lived in relationships marked by sustained and significant family violence. The Corporation made it clear that it did not support the use of criminal sanctions for women who access, or seek to access, abortion services.

5.4.17 The South Australian Abortion Action Coalition was opposed to any suggestion of a woman being criminally liable for an abortion carried out on her. They explained:

> No woman should ever be criminally responsible for the termination of her own pregnancy. Criminalisation of abortion reinforces stigma and is directly linked to medical practitioners being reticent to provide abortion services for fear of prosecution and imprisonment. In addition, criminalisation of abortion procedures increases the risk of reluctance to seek medical assistance. [We] respect women's rights to make decisions about their own health care and their own bodies. Criminalising health procedures that are accessed only by women and those with female sexual organs discriminates against them on the basis of sex or gender, and infringes their human rights.

5.4.18 The South Australian Council for Civil Liberties argued that a pregnant woman has an inalienable right (supported by international human rights law)[677] to bodily integrity and it is she alone who should make any decision concerning an abortion. 'If a woman therefore decides to have an abortion; there should be no law that prevents that from occurring … this is a fundamental right possessed by every woman and it should not be criminalised.'

5.4.19 Women's Electoral Lobby Australia argued:

> It should not be possible for a woman or pregnant person to be charged for accessing a termination of pregnancy, or consenting to someone else providing them with a termination of pregnancy. This is clearly one of the most pernicious aspects of the criminalisation of abortion. Recent cases in Queensland and NSW demonstrate the punitive cruelty that underpins the provision, where extremely vulnerable and even desperate women can be charged when they most need to access support and advice without fear.

5.4.20 Parties supportive of the decriminalisation of abortion generally opposed the retention of offences to apply to procedures carried out by health practitioners. It was generally considered that misconduct by a health practitioner in relation to the performance of an abortion should be an issue for disciplinary or professional avenues as opposed to the criminal law.

5.4.21 A South Australian medical specialist agreed that both women and qualified health practitioners should be excluded from the criminal law. She commented: 'Health regulations can regulate people who are in the health system.' The Southgate Research Institute stated that 'necessary regulation for abortion care is adequately provided under health law and regulations'.

5.4.22 A number of parties such as Advocates International, the Australian Christian Lobby, Cherish Life Australia, the Canberra Declaration, 40 Days for Life, the Lutheran Church, the Right to Life Association and Anna Walsh maintained that the criminal law should remain capable of applying to the woman in question.[678] As one party asserted: 'I believe anyone involved in providing, procuring or referring a mother for an abortion, including the mother, has to be held accountable and responsible within the law. The structure of the law is a boundary we all hold high.'

[677] See further above [2.1.53]–[2.1.71].

[678] Some attendees expressed this view at the roundtables with faith groups and NGOs but there was no consensus.

5.4.23 The Australian Christian Lobby opposed removing a woman from the scope of the criminal law:

> The answer to this question depends on the answer to the ethical question. The question cannot be answered simply on the basis of a woman's autonomy. If the life of the unborn child has value, which ACL submits it does … (at least from 24 weeks the child is a viable human person) then just as there remain sanctions for a woman terminating the life of her born child, there must be sanctions for a woman who terminates the life of her viable but unborn child.

5.4.24 The Catholic Archdiocese of Adelaide and Port Pirie stated that though it would be 'extremely rare', there may be circumstances where a woman unlawfully terminates her own pregnancy and there should be provisions under the criminal law that would make her criminally responsible.[679]

5.4.25 Birthline Pregnancy Support Inc similarly argued:

> Notwithstanding the absence of any (apparent) prosecution for an offence under Div 17 of Pt 3 of the *CLCA*, Birthline submits that it would be inappropriate to remove the criminal aspect of an offence committed by a woman with child, or a third party who contributes to the process under s 82. The fact that Parliament has seen fit to include an unlawful offence against a child by a woman or a third party — with commensurate sentences of imprisonment — represents the seriousness which attends the practice of abortion (subject to the permissible course outlined in s 82A).[680]

5.4.26 A similar view was expressed by the Lutheran Church who indicated that 'we should not rule out the possibility of cases occurring in which criminal prosecution of the woman is warranted … One such scenario could be the seeking of abortion for the purpose of sex selection.'[681] The Lutheran Church accepted that any prosecution of a woman for an unlawful abortion will be very rare, but the criminality of a woman should be retained:

> It is reasonable to retain offences in the *Criminal Code* relating to women procuring abortions even if they are hardly ever used. Criminal sanctions can deter malevolent actions. However, to remove the ability of the law to even consider the possibility of holding a woman responsible for ending the life of her unborn child is to hold the lives of the unborn in contempt. Decriminalisation leads to the normalisation of abortion.

5.4.27 There was some support for the retention of the present criminal law and including the woman, medical and health practitioners and other parties.

5.4.28 One survey response stated that the current law 'protects both the mother and child from any criminal activity surrounding abortion' and deregulation 'will put vulnerable girls who want the pregnancy kept secret at greater risk of backyard abortions'.

5.4.29 However, some parties otherwise opposed to the decriminalisation of abortion argued to the NSW Legislative Council Committee that the criminal law should not apply to the woman involved.

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[679] The Catholic Archdiocese highlighted to SALRI: 'We do not advocate for penalties against women who feel their only option is to have an abortion, rather we would wish to ensure there are sufficient support mechanisms in place to enable her to find an alternative solution.'

[680] A similar view was expressed by the Canberra Declaration: 'Since the *Criminal Law Consolidation Act* (*CLCA*) amendments were made, no woman has been denied their choice regarding termination and no doctor or woman has been prosecuted that we are aware of in South Australia. Concerned about the return of "backyard abortions" and with patient safety in mind, we would recommend retaining clauses 81(1), 81(2), 82, 82(A)(1) in the *CLCA* or ensure that they are transferred to another act such as the *Health Care Act*.'

[681] See further below Part 14.

Women's Forum Australia expressed its 'in principle' position against the criminalisation of women who have had an abortion. 'We consider that there are systemic issues which mean that women are not provided with all the necessary support or information to make a real choice, and due to various pressures, often feel like abortion is their only choice.'[682] A similar view was expressed by the Women's Bioethics Alliance.[683]

5.5 The Role and Actions of Medical Practitioners

Overview and Submissions

5.5.1 The QLRC considered that unprofessional conduct or misconduct by a health practitioner in relation to an abortion should not be an issue for the criminal law or specific offences, but rather an issue for disciplinary or professional action. The QLRC explained:

> The Commission does not recommend a specific penalty for a medical practitioner's failure to comply with the requirements for a termination under the draft legislation. The Commission considers that, in this respect, medical and other health practitioners should be subject to the same professional and legal consequences as those that apply in relation to other medical procedures. There is a strong regulatory framework governing registered health practitioners, with potentially serious consequences for unprofessional conduct or professional misconduct, including restriction, suspension or loss of a practitioner's registration. The Commission recommends that the draft legislation should provide that in deciding an issue under another Act about a registered health practitioner's professional conduct, regard may be had to whether the practitioner performs a termination, or assists another practitioner to perform a termination, other than as authorised. This approach is likely to deter non-compliance with the draft legislation…[684]

5.5.2 This recommendation was accepted by the Queensland Parliament, and health practitioners in Queensland are exempted from criminal liability in relation to the performance of an abortion.[685] Any misconduct in this context is an issue for professional or disciplinary action. This is also the position in Victoria[686] and in the 2019 NSW Act.[687]

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[682] Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 31–32 [146] <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046 Womens Forum Australia.pdf>.

[683] Women's Bioethics Alliance, Submission No 49 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (19 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64931/0049%20Women%27s%20Bioethics%20Alliance%20ORIGINAL.pdf>.

[684] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.236]–[3.240].

[685] See *Termination of Pregnancy Act 2018* (Qld) s 25: 'Insertion of new s 319A'. Section 319A of the *Criminal Code Act 1899* (Qld) creates an offence for the performance of a termination of pregnancy by unqualified persons only. See also *Criminal Code Act 1899* (Qld) s 282.

[686] See *Abortion Law Reform Act 2008* (Vic) s 11 'New sections 65 and 66 substituted'. Section 66 of the *Crimes Act 1958* (Vic) abolishes any rule of the common law that creates an offence in relation to procuring a woman's miscarriage. Section 65 creates an offence for the performance of abortions by unqualified persons only. For the purposes of this section, a registered medical practitioner is a qualified person; and a registered pharmacist or registered nurse is a qualified person only for the purpose of performing an abortion by administering or supplying a drug or drugs in accordance with the *Abortion Law Reform Act 2008*.

[687] See *Abortion Law Reform Act 2019* (NSW) s 10. An amendment to extend the unqualified person offence to errant health practitioners was not accepted. See New South Wales, *Parliamentary Debates*, Legislative Council, 19 September 2019, 41–47.

5.5.3 SALRI's consultation found differing views as to retaining any abortion related offences relating to health practitioners.

5.5.4 Parties supportive of the decriminalisation of abortion generally favoured the removal of any offence relating to the performance of an abortion by a heath practitioner.

5.5.5 There was wide support[688] for the proposition that medical and other health practitioners should not be criminally liable in respect to an abortion offence and inappropriate conduct should be treated as a professional or disciplinary issue. This was the prevailing view at SALRI's roundtables with the legal and medical sectors, the disability sector and parties favouring decriminalisation.[689] It was noted this is the position in Victoria and Queensland (and is also within the 2019 NSW Act).

5.5.6 A number of professional associations opposed the application of the criminal law to health practitioners in relation to abortion. The Public Health Association of Australia argued:

> The regulation of abortion should be removed from criminal laws and codes of the States and Territories and regulated under existing health care legislation. Health professional practice should be regulated according to the *Health Practitioner Regulation National Law Act 2009* and the *Health Practitioner Regulation National Law (South Australia) Act 2010*. Qualified Health Practitioners should not be placed at risk of criminal sanctions for delivering health care. Laws which criminalise and/or restrict abortion are not associated with lower abortion rates, but with higher maternal mortality and unsafe abortion rates. The provision of termination services should be regulated the same as any other medical procedure of similar complexity.

5.5.7 The Coalition of Women's Domestic Violence Services SA stated registered qualified health and medical practitioners with appropriate qualifications and training should not be subject to abortion offences. 'In cases where a health practitioner performs an abortion that is not authorised by law, it is the view of this submission that they should face professional sanctions and be deemed to have engaged in professional misconduct, however, criminal offences should not be applicable.'

5.5.8 One survey response said medical practitioners must be able to perform abortions without fear of criminal prosecution and 'access to safe abortion is a human right and a matter of health care, not criminality'.

5.5.9 The South Australian Council of Civil Liberties argued:

> Qualified health practitioners are regulated by numerous laws relating to standards and obligations for performing medical procedures. Abortions are simply a medical procedure and there should not be offences relating to qualified health practitioners performing abortions. Abortion is not a criminal act and does not warrant criminal sanctions.

5.5.10 The AMA(SA) opposed the application of the criminal law to either the woman or health practitioners:

> The AMA(SA) believes abortion should be a regulated medical procedure rather than a criminal law issue. As such, it should be removed from the criminal code, so that neither qualified health

[688] This included a number of lead clinicians, various medical practitioners and specialists, Professor Heather Douglas, Professor Caroline De Costa, the Australian Nursing and Midwifery Federation SA Branch, the Public Health Association of Australia, Women Lawyers' Association of South Australia Inc, the South Australian Abortion Action Coalition, Children by Choice, the Marie Stopes Association, Dr Erica Millar, the Australian Women's Health Network, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Australian College of Midwives, Beth Wilson AM, Fair Agenda, the Women's Electoral Lobby, the Southgate Research Institute, Women's Electoral Lobby, Marie Stopes Australia, the Human Rights Law Centre and RANZCOG.

[689] Some attendees at SALRI's roundtables with faith groups and NGOs disagreed with this approach. But there was no consensus.

> practitioners who perform abortions, nor individuals who seek abortions, can be prosecuted for these actions. An individual should never be regarded as having performed a criminal act in seeking or undergoing an abortion.

5.5.11 This also emerged from the survey responses, the common view being that only unqualified people should be caught by the criminal law, and never the woman or a health practitioner.

5.5.12 The health practitioners in Whyalla expressed different views. One view was that 'rogue' health practitioners should remain subject to the possible application of the criminal law for procedures performed in extreme situations. It was noted the criminal law might deter such egregious misconduct. The opposing view was that such 'rogue' practitioners were unlikely to be deterred by the criminal law, and misconduct by a health practitioner in relation to performing or assisting in performing an abortion was better dealt with by professional and disciplinary avenues.

5.5.13 Parties opposed to the decriminalisation of abortion such as the Australian Christian Lobby, Cherish Life Australia, Advocates International and Dr Šeman argued that the criminal law should also remain capable of applying to health practitioners. A number of attendees at SALRI's roundtables with NGO and faith groups shared this view. It was considered that it is inadequate to treat unprofessional conduct by a health practitioner relating to an abortion as merely a disciplinary or professional issue. One survey response observed: 'There should be criminal offences for medical professionals preforming pregnancy termination outside of the current abortion guidelines.' Another survey response said:

> I believe that doctors should be under certain circumstances be made [criminally] accountable by the law for carrying out abortions in some cases. Some examples might be mid to late term abortions done without a clear medical reason (for example to save a woman's life), carrying out gender selective abortions, carrying out abortions that cause harm to women.

5.5.14 One party submitted: 'Please amend your abortion Laws to prohibit abortion in SA, amend your laws to read abortion is a criminal offence. The killing of innocent children by abortion is criminal. Those participating in abortion, Drs, Nurses, Administrators, Participants, should be held responsible and dealt according to the Law.' Another party submitted: 'Even qualified medical practitioners could act so improperly in this area that they should be charged with a criminal offence.'

5.5.15 The Lutheran Church argued the criminal law should remain capable of applying to errant health practitioners:

> Yes, it should be a criminal offence if a health practitioner performs an abortion outside the prescribed gestational limits or where the grounds for lawful abortion are not met, or where a practitioner fails to provide a woman with comprehensive information about non-lethal alternatives. Criminal sanctions protect women from unsafe abortion practices and prevent babies being aborted for relatively minor reasons.

5.5.16 A survey response outlined:

> I believe the current laws surrounding abortion in South Australia are sufficient to guarantee a woman is able to access services she requires in a safe environment which provides good health care. There should be offences relating to qualified health practitioners performing abortions in the *CLCA 1935* (SA) to ensure the integrity and high standards of health services. South Australia should have criminal offences for abortions not performed by an appropriate health practitioner — and by appropriate health practitioner, I mean a registered practising medical doctor in an authorised facility (hospital or clinic). There should be offences relating to the woman procuring an abortion in the *CLCA 1935* (SA) but each case should be judged on merit and the mercy of the court should prevail. I think there are circumstances where a woman should be criminally

> responsible for the termination of her own pregnancy based on the parameters of gestation period, reasons for and circumstances surrounding the termination.

5.5.17 These concerns were also raised to the NSW Legislative Council Committee. Women and Babies Support, for example, argued:

> … the law should also afford women the best protection against unsafe terminations and unscrupulous abortion providers. We know that women have and will be harmed by serious medical malpractice in the provision of terminations. Disciplinary action over providers by peak medical bodies is insufficient as a deterrent and in ensuring women receive justice in the law for grievous bodily harm they may experience at the hands of abortion providers.[690]

5.5.18 Women's Forum Australia accepted that a woman should not be criminally liable for an abortion performed upon herself but this reasoning should not extend to errant medical practitioners:

> … we are of the firm belief that criminal penalties must remain for any other person [beyond the woman] who performs an unlawful abortion in order to maintain some level of protection for both women and unborn children … the Bill does not protect women against doctors who perform abortions unlawfully. Cases such as *R v Smart* (1981) and *R v Sood* (2006), which involved unlawful late term abortions and the dangerous mistreatment of patients, affirm the need to retain the offences for unlawful abortions in the Crimes Act as a matter of justice, deterrence and protection for women. Without such protections, doctors like Dr Smart and Dr Sood may not face adequate penalties, will likely face less scrutiny, and will be less deterred from performing unsafe abortions that benefit them financially.[691]

5.6 SALRI's Observations and Conclusions

5.6.1 SALRI notes the differences in opinion that emerged in its consultation but reiterates that, as far as possible, abortion be regulated through health law and professional practice as opposed to through specific offences (especially with such severe penalties) in the criminal law. The adverse effect of abortion's place in the criminal law to both patients and staff is clear. These adverse effects cannot be assessed in terms of the fact that the risk of criminal prosecution may be more superficial than real. This is only part of the picture. SALRI has heard many compelling accounts in consultation of the 'chilling effect' that abortion's continued retention in the criminal law has on both patients and health practitioners. SALRI also agrees with the observation of a Report for the Queensland Parliament:

> The legal position of abortion and its practice appear to be at odds … Few prosecutions have been successful against practitioners or women for 'unlawful' abortion. However, it cannot be said that

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[690] Women and Babies Support, Submission No 36 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) 13 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64873/0036%20Women%20and%20Babies%20Support%20(WOMBS).pdf>. See also Women's Bioethics Alliance, Submission No 49 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (19 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64931/0049%20Women%27s%20Bioethics%20Alliance%20ORIGINAL.pdf>.

[691] Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 32 [147]–[148] <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

a State or Territory government would never use the technical abortion offence provisions to sanction doctors and women.[692]

5.6.2 SALRI agrees with the view and reasoning of the QLRC and the VLRC and the strong view expressed in consultation and research and international human rights, that the law in South Australia should make it clear that a woman should not be criminally liable for an unlawful abortion performed on her. It is incongruous with modern attitudes and at odds with the position adopted interstate for a woman to remain at risk (even if largely theoretical) of prosecution for performing or assisting in performing an abortion on herself. It is significant that the woman involved is excluded from criminal liability in Victoria and Queensland and under the 2019 NSW Act.

5.6.3 SALRI is of the view that any new law should make it clear that a woman who consents to, assists in, or performs an abortion on herself does not commit an offence (either in the *CLCA* or any relevant health law). SALRI is also of the view that a woman should not be liable to any legal sanction if she knowingly permits a medical practitioner to perform an abortion upon her. Further, any new law in South Australia should provide that it should not be possible for a woman to be charged as an accessory to an unlawful abortion performed upon her by an unqualified person.

5.6.4 SALRI agrees with the view and reasoning of the QLRC and the view expressed in consultation and research that the law in South Australia should be clear that a health practitioner should not be criminally liable in relation to the performance or assisting in the performance of an abortion. This is the position in Victoria and Queensland and under the 2019 NSW Act. SALRI suggests that, to avoid any doubt, any new offence in South Australia should not extend to the performance of an abortion or assisting in the performance of an abortion by a medical or health practitioner acting within the scope of their practice. Rather, any acting outside of the scope of practice by a health practitioner should be subject to professional standards and regulation and, in an extreme case, any criminal sanctions that may arise under general heath law. In regard to such criminal sanctions it should be noted that this is currently possible for any medical procedure where the treating practitioner acts wholly outside of their authority and scope of practice and no new offence is necessary in regard to abortion services involving a health practitioner (unlike the situation for unqualified parties as discussed in the next Chapter).

5.6.5 SALRI also concurs with the QLRC that any misconduct by a health practitioner should be ordinarily dealt with as a potential professional or disciplinary issue. This is the position in Victoria and Queensland and under the 2019 NSW Act. SALRI recommends that, to avoid any doubt, any new law in South Australia should provide that, in deciding any issue about a health practitioner's professional conduct in relation to the performance of an abortion or assisting in the performance of an abortion, regard may be had to all of the circumstances surrounding the procedure, including any issue as to authorisation and scope of practice.

5.6.6 Recommendations

Recommendation 5

SALRI recommends that any new law should provide that a woman who consents to, assists in, or performs an abortion on herself does not commit an offence (either in the criminal law or relevant health law).

[692] Nicolee Dixon, *Abortion Law Reform: An Overview of Current Issues* (Research Brief No 2003/9, Parliamentary Library, Parliament of Queensland, 2003) 17.

Recommendation 6

SALRI recommends that any new law in South Australia should provide that it should not be possible for a woman to be charged as an accessory to an unlawful abortion performed upon her by an unqualified person.

Recommendation 7

SALRI recommends that a woman should not be liable to any legal sanction if she knowingly permits a health practitioner to perform an abortion upon her.

Recommendation 8

SALRI recommends that, to avoid any doubt, any new offence in South Australia should not extend to the performance of an abortion or assisting in the performance of an abortion by a medical or health practitioner within the scope of their practice.

Recommendation 9

SALRI recommends that, to avoid any doubt, any new law in South Australia should provide that, in deciding any issue about a health practitioner's professional conduct in relation to the performance of an abortion or assisting in the performance of an abortion, regard may be had to all of the circumstances surrounding the procedure, including any issue as to authorisation and scope of practice.

Part 6 – The Role and Rationale of a Residual Offence

6.1 Residual Offences Generally

6.1.1 Most Australian jurisdictions provide that an abortion is unlawful unless performed by a registered medical practitioner.[693] In the Northern Territory, Tasmania and Victoria, it is unlawful for a person other than a medical practitioner to perform an abortion.[694] The ACT (which has the most liberal approach), has such an offence.[695] An offence also appears in the 2019 NSW Act (though with the qualification any proceedings can only be brought by or with the consent of the DPP). These offences generally extend to performing or assisting in performing either a surgical or medical abortion.

6.1.2 The 2018 South Australian Bill does not contain a residual offence relating to the performance of an abortion by an unqualified party.

6.1.3 One question that arises is whether or not there is a need for a new residual offence in South Australia to apply to an abortion carried out by an unqualified party, in the event that any new law does not provide for criminal liability on the part of a health practitioner or the woman involved.

6.1.4 The VLRC noted it had not received any information which suggests that unqualified people, or unregulated abortionists, were presently offering abortion services in Victoria, but had little doubt, however, that such abortionists had operated in Victoria in the past.[696] The VLRC believed that it should be a specific offence 'for an unqualified person to perform an abortion in any circumstances'.[697]

6.1.5 The QLRC also considered whether specific residual offences were necessary. Some parties such as the former Victorian Health Services Commissioner, a group of health law academics and RANZCOG, submitted to the QLRC that it should continue to be a criminal offence for an unqualified person to perform an abortion. The former Victorian Health Services Commissioner favoured this approach for consistency with 'women's human rights, health and safety'.[698]

6.1.6 The QLRC (admittedly without detailed discussion)[699] supported such an offence to 'provide that a person who performs or assists in the performance of a termination, when not qualified

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[693] *Health Act 1993* (ACT) s 81; *Criminal Code* (NT) s 208A and *Termination of Pregnancy Law Reform Act 2017* (NT) ss 4–10; *Criminal Law Consolidation Act 1995* (SA) s 82A; *Criminal Code* (Tas) ss 51(1A), 178D and *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; *Crimes Act 1958* (Vic) ss 65–66 and *Abortion Law Reform Act 2008* (Vic) ss 4–5; *Criminal Code Act 1913* (WA) s 199.

[694] *Criminal Code* (NT) s 208A; *Criminal Code* (Tas) s 178D; *Crimes Act 1958* (Vic) s 65.

[695] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT) s 55B

[696] Victorian Law Reform Commission, *Law of Abortion*, Report No 15 (2008) 130 [8.182].

[697] Ibid [8.183]. The VLRC favoured the retention of a residual offence for abortions by unqualified persons in all of its three proposed models.

[698] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws*, Report 76 (June 2018) 110 [3.269].

[699] It was discussed at the 7 June 2019 roundtable session with groups in favour of decriminalisation of abortion that the QLRC had supported specific residual criminal offences for unauthorised procedures by persons who were not medical practitioners. One attendee noted that the QLRC, reflecting the Queensland context, was anxious 'to still protect vulnerable people who might be at risk of seeking procedures from people who were not qualified'. The worry in Queensland of 'backyard abortions' was that something should be specifically retained in the criminal law should the issue ever arise. The attendee explained that the QLRC Report should not be read in a vacuum and 'there is a broader political context to why that Report landed the way it did' in relation to this and other aspects.

to do so … commits a crime'.[700] The offence should cover both surgical and medical abortions carried out or assisted by an unqualified party. The QLRC explained:

> The main purpose of the new offence is to protect the health, safety and well-being of women by deterring the practice of unregulated or 'backyard' terminations. The offence will apply to a termination performed by an unregistered medical practitioner and to a termination in which a person who is not medically qualified assists in the performance of a termination (for example, by unlawfully administering or supplying a termination drug) … the draft legislation removes the criminal responsibility of a medical practitioner for performing a termination. A person who is 'qualified' to assist in a termination under the new legislation should also ordinarily be protected from criminal responsibility. However, if a qualified person assists an unqualified person to perform a termination, the general provisions of the *Criminal Code* which extend criminal responsibility to a person who is a party to an offence will still operate.[701]

6.1.7 It is significant that such an offence also appears in the 2019 NSW Act. Mr Greenwich, the Member for Sydney, in introducing the Bill explained that 'a new safeguard' for women is to be introduced through the insertion of a clause in the *Crimes Act 1900* (NSW) that will make it an offence for a person who is not a medical practitioner to perform an abortion or for a person to assist in an abortion not performed by a medical practitioner.[702] The proposed offence has penalties of up to seven years' imprisonment. Mr Greenwich explained:

> This will protect the community from any potential emergence of backyard abortion clinics. The offence is aimed at capturing people who are exploiting, profiting from or harming women in vulnerable situations. A safeguard has been included in the bill to require the Director of Public Prosecutions to institute or approve any proceedings in court for this offence to ensure that it does not criminalise anyone who is genuinely trying to help a pregnant woman.[703]

6.1.8 The New Zealand Law Reform Commission expressed, or at least contemplated, a different approach.[704] However, the Abortion Legislation Bill 2019 (NZ) replaces the existing offences relating to the woman concerned and health practitioners and introduces a new offence for a person who is not a health practitioner to procure or perform an abortion for a woman.

A Recent Case: R v Kaur[705]

6.1.9 In 2012 and 2013, Ealing Hospital in West London reported to police that a number of women had presented with major complications resulting from unauthorised medical abortions. As a result of this, the police and health authorities launched an investigation into the supply of abortifacients, drugs used to cause miscarriage, in the surrounding areas. In response, police developed an undercover operation targeting shops of a naturopathic nature in the area. Gurpreet Kaur worked part time as a receptionist at a naturopathic centre called the Rana Herbal Ayuveridic Centre in Southal for a man called Khurana. Neither she nor Khurana were medical or even health practitioners. An undercover police officer presented at the shop and asked Khurana for 'medication for his girlfriend

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[700] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 110 [3.270].

[701] Ibid 111 [3.275]–[3.276].

[702] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

[703] Ibid.

[704] New Zealand Law *Reform Commission, Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018).

[705] [2015] EWCA Crim 2202 (29 October 2015); See also Medicines and Healthcare Products Regulatory Agency, *Woman Sentenced to 27 Months for Selling Abortion Pills Illegally* (Press Release, UK Government, 26 June 2015) <https://www.gov.uk/government/news/woman-sentenced-to-27-months-for-selling-abortion-pills-illegally>. SALRI is grateful to Jon Polnay of 5 Kings Bench Walk, London, prosecution counsel in this case, for kindly providing SALRI with a detailed account of this case.

who was pregnant but did not want the child'. He provided the drug RU486 ('mifepristone') for a fee. Khurana claimed to be 'a doctor'. Several days later, the officer returned and asked Kaur for the same. She provided mifepristone, again for a fee. She wore white medical overalls. Kaur did not take a medical history, ask about rhesus status or provide any instructions about what to do if any complications arose. On a subsequent occasion, Kaur again provided what she claimed was mifepristone to the undercover police officer. She said she was 'a doctor' and gave detailed instructions as to the use of the drugs. Again Kaur did not take a medical history, ask about rhesus status or provide any instructions about what to do if any complications arose. Kaur and Khurana did not ensure the drugs were taken under any form of supervision, let alone qualified medical supervision.

6.1.10 Kaur accepted in interview that she was not a registered health practitioner.[706] She appeared at Southwark Crown Court and pleaded guilty. The prosecution submitted that, even if Kaur was unaware of the dangers involved, 'it is extraordinarily reckless to supply abortion medication. Even to an untrained and unqualified person, it is submitted abortions carry an obvious, real and serious risk to the health of a mother and her fetus.' Kaur was sentenced to 27 months' imprisonment for 'conspiracy to supply a poison with intent to procure a miscarriage, contrary to s 1(1) of the *Criminal Law Act 1977* and s 59 of the *Offences Against the Person Act 1861*'. She was given a 'discount' of 25% for her plea of guilty.

6.1.11 Judge Gledhill took a dim view of the offence and highlighted the risks to public health:

> This is an extremely serious case. Members of the public can be forgiven for thinking backstreet abortions ended decades go. That is exactly what was happening through this clinic. I appreciate you were an employee of Khurana who has absconded and does not fall to be sentenced today. But you knew exactly what you were doing. As you didn't want to lose your job you were prepared to do exactly what was expected of you. To supply these drugs, to procure an abortion … I now have to sentence you for your role. An important, though I accept not as important as Khruana in this very serious offence. It is quite clear on the evidence I have heard that this clinic was targeting people from those you describe as 'your community': Punjabi speakers in the Southall and Ealing area of West London. And women were going to this clinic, not only for the sort of medicine that it is perfectly proper to supply, but also to obtain abortion drugs … This case can only be dealt with by an immediate custodial sentence. A strong message must go out from these courts that it is not legal nor is it acceptable in 2015 for clinics such as this to illegal supply abortion drugs to women who go there for difference reasons, because they feel they are not able to go their GP or the NHS. The dangers that are entailed to the women are too obvious for me to point out.[707]

6.1.12 On 29 October 2015, Kaur's sentence was upheld on appeal. The Court of Appeal[708] held that Judge Gledhill had been entitled to conclude that the Rana Ayurvedic centre was the common denominator between the three women admitted to hospital and 'the unauthorised supply of Mifepristone represents a major and concerning public health risk and the harm was considerable'.[709] The court agreed with the judge's comments that a strong message had to go out from the court that

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[706] Kaur stated: 'I have diplomas in Ayurvedic medicine, reflexology and face rejuvenation. I do not tell people I am a Western style Doctor. I have been working part time for Mr Khurana for about six months. I work as receptionist. Mr Khurana gives out the medicine. I believe him to be a qualified Ayurvedic practitioner. He said he has a GMS. I have let people know I am qualified as an Ayurvedic doctor but not as an allopatric or Western Doctor. But I don't work as a Doctor, only as a receptionist.'

[707] This account was provided by Mr Polnay.

[708] Sharpe LJ, Cooke J and Judge Cutts QC.

[709] [2015] EWCA Crim 2202 (29 October 2015) [24].

it is not legal or acceptable in 2015 for clinics such as this to illegally supply the drugs for a medical abortion. 'In our view, this was very serious offending … this sentence was not manifestly excessive.'[710]

6.1.13 The risk to public health raised by unqualified individuals providing the drugs for use in medical abortion is not confined to West London. A similar case occurred in New South Wales in 2007. In the case of *Dix v Lin,*[711] Lin worked at a shop identified with a sign reading 'Chinese Medicine'.[712] Two 'private enquiry agents', posing as a pregnant woman and her partner, told Lin that they were pregnant and needed an abortion. Lin was asked whether he could operate to get rid of the baby and he responded that he could. After taking a pulse and blood pressure and checking the length of the pregnancy (to which he was told seven weeks), he provided tablets. Lin stated that after three days 'the baby [would] come out'.[713] The tablets were mifepristone. For the mifepristone-related offences and additional holding out offences, Lin was sentenced by Matthews AJ to 13 months imprisonment (with a non-parole period of four months), suspended for 13 months.[714] Matthews AJ noted: 'General deterrence is a major consideration in this case. The public is exposed to enormous risks if unqualified persons assume the role of medical experts, whether for gain or not.'[715]

6.2 Would There Be a Gap to Rely on Health Law?

The distinction between medical and surgical abortions

6.2.1 There is a fundamental distinction between surgical and medical abortions.[716] The 1969 Act was premised on the basis of surgical abortions and predated the now widespread availability of medical abortion. The background to the 1969 Act was motivated by concerns of the real risk to public health posed by unsafe surgical procedures carried out by unqualified parties. The question must be asked what other offences would remain if s 81, 82 and 82A of the *CLCA* are repealed and whether these offences would prove adequate to cover any risk to public health arising from surgical or medical abortions carried out or assisted by unqualified parties.

6.2.2 Cases such as *Kaur* and *Yao Guo Lin* indicate that at least the supply of drugs for medical abortion by unqualified parties is not unknown. In its consultation, SALRI heard anecdotal accounts indicating unauthorised procedures by unqualified persons may remain in South Australia, particularly in rural and regional areas. It was stated that unauthorised procedures were largely (though not totally) medical abortions. This was described to SALRI as not a usual practice, but not unique. Some parties doubted that abortions by unqualified parties remain a real problem in South Australia.

[710] Ibid [26].

[711] [2007] NSWSC 846.

[712] Ibid [5].

[713] Ibid.

[714] Ibid [30].

[715] Ibid [25].

[716] See further below Part 8.

6.3 Offences if a Medical Practitioner Procures an Illegal Abortion

Assault and Registration-Based Offences

6.3.1 It was suggested to SALRI by a number of parties such as the Public Health Association of Australia, the Southgate Research Institute and the South Australian Abortion Action Coalition that a specific offence relating to an abortion by an unqualified party is unnecessary as this situation is adequately (and preferably) covered by either the criminal law of assault or health law. This was also outlined at SALRI's roundtable on 7 June 2019 with parties supportive of decriminalisation.

6.3.2 There are various assault type offences in the *CLCA* that might apply to an abortion involving an unqualified party. These offences include assault,[717] assault causing harm,[718] intentionally or recklessly causing harm[719] or intentionally or recklessly causing serious harm.[720] However, SALRI notes that there are real doubts about whether a surgical or medical abortion in South Australia by an unqualified party would fall within any of these offences. An 'assault' in this context requires the intentional application of 'force'. This requirement would be satisfied for a surgical abortion but would be unlikely to be satisfied for a medical abortion.[721] However, more fundamental is the fact that the woman's consent is available as an actual (for assault or assault causing harm) or potential defence (for intentionally or recklessly causing harm or intentionally or recklessly causing serious harm). For the offences of assault or assault causing harm, an absence of consent is an essential ingredient of any alleged offence. For the offences of intentionally or recklessly causing harm or intentionally or recklessly causing serious harm, consent is available as a potential defence.

6.3.3 The precise circumstances of when consent is available as a defence to intentionally or recklessly causing harm or intentionally or recklessly causing serious harm is not simple. The common law position to the recognition of consent as a defence to an alleged criminal act causing harm is complex and contentious.[722] The offences of intentionally or recklessly causing harm or intentionally or recklessly causing serious harm 'do not apply to the conduct of a person who causes harm to another if the victim lawfully consented to the act causing the harm'.[723] Section 22(3) of the *CLCA* provides that a person may validly consent to 'harm (including serious harm) if the nature of the harm and the purpose for which it is inflicted fall within limits that are generally accepted in the community'. The intention of this far from simple provision is 'a person may [lawfully] consent to harm, if the nature of the harm and the purpose for which it is inflicted fall within the limits that are generally accepted in the

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[717] *CLCA* s 20(1).

[718] Ibid s 20(4).

[719] Ibid s 24.

[720] Ibid s 23.

[721] See *R v Walken* (1845) 1 Cox CC 282 where it was held that causing the victim to take a deleterious drug was not an assault.

[722] See further *R v Donovan* [1934] 2 All ER 207, 210; *R v Brown* [1994] 1 AC 212; *R v Emmett* [1999] EWCA Crim 1710; *R v Stein* (2007) 179 A Crim R 360. Cf *R v Lee* [2006] 3 NZLR 42. The law remains that, established exceptions of public interest or utility such as surgery or tattooing or sports asides, the victim's consent is immaterial if the act of the defendant is intended or is likely to cause bodily harm to the 'victim'. Bodily harm in context simply means the harm is more than transient or trivial. It is a very low threshold. See further David Plater et al, 'Non-Fatal Offences against the Person' in David Caruso et al, *South Australian Criminal Law and Procedure* (2nd ed) (LexisNexisButterworths, 2016) 203, 249–255 [6.86]–[6.90]; Marianne Giles, '*R v Brown*: Consensual Harm and the Public Interest' (1994) 57 *Modern Law Review* 101.

[723] *CLCA* s 22(1).

community. It is up to the jury to decide this.'[724] Section 22 avoids either a comprehensive list of activities deemed to be in the public interest where consent is available as a defence or a single overriding test such as actual or serious harm. Rather, the effect of s 22 is that any case will have to be considered on its own facts to assess if it 'falls within limits that are generally accepted by the community.[725]

6.3.4 Any surgical or medical abortion (even by an unqualified person) is likely to be undertaken with the consent of the woman involved. Any South Australian court considering an allegation of intentionally or recklessly causing harm or intentionally or recklessly causing serious harm would have to resolve whether the woman's consent is available as a defence and assess 'if the nature of the harm and the purpose for which it is inflicted fall within limits that are generally accepted in the community'. Surgery by a qualified medical practitioner is treated at common law as an activity of public interest in which the patient's consent is legally recognised and is valid as a defence.[726] It is unclear if a South Australian court would regard a surgical or medical abortion by an unqualified person on a willing patient to fall within limits that are generally accepted in the community.

6.3.5 SALRI considers that it is would be imprudent to rely on the offences of assault, assault causing harm, intentionally or recklessly causing harm or intentionally or recklessly causing serious harm. There is real doubt that the administration of an abortion (whether surgical or medical) by an unqualified person would fall within these offences, notably as the woman's consent is available as an actual (for assault or assault causing harm) or potential defence (for intentionally or recklessly causing harm or intentionally or recklessly causing serious harm).

6.3.6 It was alternatively argued that a specific residual offence relating to an abortion carried out by an unqualified person is unnecessary, even unhelpful, as this conduct would be adequately captured by health law. 'Holding out' offences were often cited.

6.3.7 The *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) (*'HPR Act')* sets out the national health regulations as they apply in South Australia. In brief, if health practitioners do not comply with certain requirements, they can face professional sanctions including censure, loss of registration, financial penalties and, in some circumstances, even imprisonment. These can be regarded as 'registration-based offences'. Registration-based offences are regulated by the Australian Health Practitioner Regulation Agency ('AHPRA').

6.3.8 Health practitioners may be reported for malpractice and other conduct-based offences. This reporting can result in a disciplinary action; practice can be restricted and licenses can be refused renewal. A National Board determines whether or not a practitioner can hold general registration, having regard to factors including the person's relevant criminal history[727] and their suitability to competently and safely practice the relevant profession.[728] Registration for medical and health practitioners is annually renewed and accompanied by an annual statement declaring 'details of any complaint made about the application to a registration authority or another entity having functions

[724] South Australia, *Parliamentary Debates*, House of Assembly 22 October 2003, 586 (Michael Atkinson, Attorney-General).

[725] David Plater et al, 'Non-Fatal Offences against the Person' in David Caruso et al (eds) *South Australian Criminal Law and Procedure* (LexisNexis Butterworths, 2nd ed, 2016) 203, 254–255 [6.89]–[6.90].

[726] *R v Brown* [1994] 1 AC 212, 266.

[727] *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) sch 2 pt 7 div 1 cl 55(1)(c).

[728] Ibid cls 55(1)(g) and 55(1)(h)(ii).

relating to professional services provided by health practitioners or the regulation of health practitioners'.[729]

6.3.9 The *HPR Act* defines notifiable conduct as including conduct that has 'placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards'.[730] The most recent directive for professional standards with respect to abortion in South Australia was published in 2014. It should be noted that this directive includes principles from the *CLCA* including the definition of terms such as 'capable of being born alive'.[731]

'Holding Out' Provisions

6.3.10 AHPRA also regulates and enforces offences relating to health practice under the *HPR Act*. The most likely offence that would apply to performing or assisting in performing an unlawful surgical or medical abortion is the offence of 'holding out' as it applies to both medical and surgical abortions. Clause 116 of the HPR Act protects against what is known colloquially as 'holding out': that is, if they claim to be a registered health practitioner or use language, inter alia, that indicates that the person is a registered health practitioner or qualified person.[732] The maximum penalty for an individual is $60,000 or three years imprisonment or both.

6.3.11 In *Dix v Lin*, for example, Lin identified himself on a business card as 'Dr Yao Guo Lin, Director of Chinese Medical Centre, Specialist in Orthopaedic Surgery, Prof of Fujian Chinese Medical Uni, Vice President of ASA'.[733] As he used the letters 'Dr' and identified himself as a specialist, he was in breach of s 105(1) of the *Medical Practice Act 1992* (NSW).[734] Lin received visits from mostly international students during which he would provide medical certificates and sign as 'Dr'.[735] Lin not only held himself out as a medical practitioner, he also unlawfully supplied Mifepristone. In sentencing Lin, Mathews AJ pointed out the potential for harm in handing out Mifepristone; after noting that the drug must be used under medical supervision and has potentially adverse side effects. Matthews AJ stated: 'It is clear therefore that the provision of RU486 on demand, without appropriate medical assessment or supervision, is a very serious matter carrying significant potential hazards.'[736]

6.3.12 One fact that may be overlooked is that, although the holding out provisions may apply to, and cause, issues for any individual claiming to be a medical or health practitioner, they do not apply to individuals who *do not* hold themselves out to be a medical or other health practitioner. If Kaur or Lin, for example, had not held themselves out as medical practitioners, they would not be covered by the holding out offence. In other words, if a layperson without representing themselves to be a health practitioner performs, or assists in performing, a medical or surgical abortion (or any other medical procedure) there is seemingly no offence under health law that would apply to their activities. If someone performs the act without claiming to be a health practitioner, there is no holding out offence.

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[729] Ibid sch 2 part 7 div 9 cl 109(1)(e).

[730] Ibid sch 2 part 8 div 2 cl 140(d).

[731] SA Health, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 4.

[732] See Appendix C.

[733] *Dix v Lin* [2007] NSWSC 846, [10].

[734] The South Australian equivalent is cl 116 of the *HPR Act*. It should be noted that, potentially, Lin would not have been convicted of this same offence in South Australia as the *HPR Act* allows for the registration of an individual practising Chinese Medicine.

[735] *Dix v Lin* [2007] NSWSC 846, [11].

[736] Ibid [9].

6.4 Offences if a layperson procures mifepristone

6.4.1 If a layperson contravened proper medical practices to acquire or administer mifepristone, they may be in breach of the *Therapeutic Goods Act 1989* (Cth) (*TGA*). Under the relevant laws, in order to administer mifepristone a medical practitioner must gain approval as an Authorised Prescriber under s 19(5) of the *TGA*.[737] Since 2006, only the regular TGA approvals and not the approval from the Minister for Health is required to import mifepristone.[738] Currently, although it has been sponsored in Australia by MS Health, mifepristone is categorised by the Therapeutic Goods Administration as a 'special drug'.[739] This means that medical practitioners who prescribe it need to register with MS Health and complete an education program.[740] Registered medical practitioners with a Fellowship or an Advanced Diploma from the Royal Australian New Zealand College Obstetricians Gynaecologists do not have to complete the training, but are still required to register with Marie Stopes.[741] Mifepristone may 'only be dispensed by registered pharmacies'.[742] Further, accessing the drug outside of registered pharmacies or medical practitioners is illegal.[743] To obtain prescribed medication outside of the TGA is a criminal offence.[744] SALRI has heard from many medical and health practitioners in consultation that the present operational and/or training requirements are onerous and unduly and unnecessarily bureaucratic.[745]

6.4.2 It should be noted that access to mifepristone remains vastly disproportionate to the number of eligible pharmacies and GPs.[746]

6.5 Submissions

6.5.1 SALRI heard some anecdotal accounts from a number of parties in its consultation that unauthorised procedures by unqualified persons may remain in South Australia, particularly in rural and regional areas. It was stated that unauthorised procedures were largely (though not totally) medical abortions. This was described to SALRI as not a usual practice, but not unique. These procedures were discussed in the contexts of domestic violence/sexual assault or international students. It was also

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[737] Caroline de Costa and Naomi de Costa, 'Medical Abortion and the Law' (2006) 29(2) *University of New South Wales Law Journal* 218.

[738] Caroline de Costa et al, 'Early medical abortion in Cairns, Queensland: July 2006–April 2007' (2007) 187(3) *Medicine and the Community* 171.

[739] Cate Swannell, 'RU486: Time to Lift Restrictions on Medical Abortion' (Media Release, Medical Journal of Australia, 24 Mar 2019) <https://www.mja.com.au/journal/2019/ru486-time-lift-restrictions-medical-abortion>.

[740] Cate Swannell, 'Lifting the Lid on Mifepristone and Medical Abortion' [2019] 12 *Insight* (online) <https://insightplus.mja.com.au/2019/12/lifting-the-lid-on-mifepristone-and-medical-abortion/>.

[741] Department of Health, Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>; SA Health, Government of South Australia, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 10.

[742] Cate Swannell, 'Lifting the Lid on Mifepristone and Medical Abortion' [2019] 12 *Insight* (online) <https://insightplus.mja.com.au/2019/12/lifting-the-lid-on-mifepristone-and-medical-abortion/>.

[743] *Controlled Substances Act 1984* (SA) s 18.

[744] *Therapeutic Goods Act 1989* (Cth) s 19B. See further below Part 8.

[745] A number of parties who highlighted what they said were the risks associated with early medical abortion, stated such requirements are necessary and prudent. See below Part 8.

[746] Caroline De Costa and Naomi de Costa, 'Medical Abortion and the Law' (2006) 29(2) *University of New South Wales Law Journal* 218.

however noted that they were undertaken due to availability of alternatives particularly caused by cost, conscientious objections restricting service or concerns regarding privacy of the woman.

6.5.2 Opinions were divided on the need for a new residual offence to apply to an abortion carried out by an unqualified party in the event that any new law does not provide for criminal liability on the part of a health practitioner or the woman involved.

6.5.3 The support for residual offences came from both parties opposed and supportive to decriminalisation of abortion (though there was a contrasting view that such laws are unnecessary and inappropriate and can be left to general health law).

6.5.4 A lead clinician who was of the view that both women and qualified health practitioners should be excluded from the criminal law stated that 'backyard abortions' and coercion[747] should still be offences commenting: 'Health regulations can regulate people who are in the health system, but are not designed to think about others.'

6.5.5 The Catholic Archdiocese of Adelaide and Port Pirie supported the retention of offences for procedures not carried out by an appropriate health practitioner: 'Otherwise we would see ourselves back in the situation of backyard abortions. Even medical abortions require a high level of medical supervision and ongoing care.' Other groups such as Cherish Life Australia, the Australian Christian Lobby, Advocates International and Pregnancy Help Australia expressed a similar view. The Women's Electoral Lobby similarly stated it is 'appropriate that it should be a criminal offence for an unqualified person to perform a termination, given the potential serious cost to a woman's health that can occur from an unsafe abortion'.[748]

6.5.6 The Lutheran Church outlined:

> Although we do not consider the deliberate termination of viable pregnancies to be consistent with the ethics of health practitioners, we believe that whoever performs this regrettable task should be trained, certified and licensed to perform it in a way that is as safe as possible for the mother. The law should state that anyone without such qualifications who performs an abortion commits an offence, and specify what penalties can be applied.

6.5.7 Many parties[749] questioned the need and/or rationale of any new residual specific offence. One experienced health provider noted to SALRI that abortion should be totally removed from the criminal law and there is no need for any specific residual offences: 'Abortion has no place in criminal laws. Legal constraints impact the most vulnerable and perpetuate stigma. If health law is adequate for all other health care, it is adequate for abortion provision.'[750] The Northern Territory Family Planning

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[747] See further below [19.3.1]–[19.3.34].

[748] Any offence for an unqualified person performing an abortion must ensure precise wording so as not to inhibit the role of health practitioners.

[749] These included Professor Sally Sheldon, the Australian Women's Health Network, the South Australian Abortion Action Coalition, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), Children by Choice, Professor Margaret Davies, the Human Rights Law Centre, Marie Stopes Australia, the Public Health Association of Australia, the South Australian Council for Civil Liberties, the Southgate Research Institute, Women Lawyers' Association of South Australia Inc, a leading health agency and Dr Erica Millar.

[750] This approach was elaborated by the Human Rights Law Centre. 'This ["unqualified person"] offence provision arose from a recommendation of the VLRC in 2008, and it was the history of "backyard abortionists" that led the Commission to make this recommendation. It is important to realise however, that it is the criminalisation of abortion and a lack of affordable abortion services that create a market for unqualified operators: if abortion services are affordable, confidential and accessible across South Australia, women will not need to turn to unqualified people to access the healthcare they need. There does not appear to be an issue of unqualified people holding themselves out as qualified abortion providers in South Australia based on our inquiries. In any event,

Welfare Association in light of health laws and practice saw no need for specific residual offences and 'this type of thinking originates from a time when only 'backyard' abortions were possible'. More than one health practitioner saw particular problems and concerns relating to the unauthorised use of MS-2 Step if it fell within a specific residual offence.[751] This concern was also raised at SALRI roundtables with groups in favour of decriminalisation of abortion and the medical and legal sectors on 7 June 2019 (though several attendees supported such offences).

6.5.8 One survey response noted: 'Once safe and legal abortions are made available, people won't have to resort to "home-remedies".' Another survey response also doubted the rationale for any specific residual offence, noting that criminal sanctions can deter people from seeking help when they need it and deter providers from making services available. 'Assault law can be strengthened as Victoria has done to ensure appropriate sanctions can be imposed where a pregnancy is harmed by any form of malintent [sic] or negligence.' Another survey response elaborated that a residual offence is unnecessary and removing all reference to abortion within the criminal law will not remove or reduce the comprehensive protections afford by health law. 'While I acknowledge the desire to prevent "backyard abortions", if we provide adequate access to safe abortion services in the first place, we will have achieved this goal.'

6.5.9 The Southgate Institute argued a residual offence for unqualified persons is unnecessary:

> Since shortly after reform of the abortion law in 1969, there has been no demand for abortions provided by unqualified people. Prosecution has been extremely rare and mostly in cases of abortion charges related to other crimes. It is completely unnecessary to have a special offence, just as it is unnecessary to have a special offence for unqualified providers of any other specific medical or surgical procedure (for example, appendectomy). Decriminalisation of normal abortion care will further ensure that there is no demand for such abortions. There are existing penalties under the *Health Practitioner Registration* laws that prevent health professionals from providing care outside the limits of their professional registration or accredited scope of practice that provide effective protection for patients.

6.5.10 The South Australian Abortion Action Coalition similarly did not support any new offences for abortions not performed by an appropriate health practitioner. It observed:

> … sufficient safeguards against medical procedures being performed by unqualified persons exist under the law currently. All health procedures, practices and services are closely controlled and regulated by government, industry and professional bodies, and breaches are dealt with seriously. In this way, existing health law, regulations, codes of practice, clinical protocols and institutional policies and procedures provide a comprehensive regulatory framework that protects patients, promotes good quality and safety in health care and ensures accountability. There are more than 20 health statutes in South Australia, and nearly 70 Commonwealth statutes, covering virtually every aspect of health, aged and disability care and public health.

6.5.11 Mark Rankin at Flinders University also doubted the need for residual offences:

existing offence provisions in health laws such as the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA), as well as laws criminalising assault, would adequately address a situation in which an unqualified person holds themselves out as qualified to perform a medical procedure, including abortion. Further, the *Therapeutic Goods Act 1989* (Cth) restricts who can supply mifepristone and misoprostol. If an "unqualified person" offence is created, it is critical that the law is clear that a person does not commit an offence by consenting to or assisting in an abortion on themselves.'

[751] It was raised to SALRI that the Queensland and Victorian law reform reviews had not adequately considered this problem. The VLRC review took place before medical abortion was routinely provided in Australia.

> Once removed from the criminal law abortion will be regulated, like any other medical procedure and/or health service, through applicable health law, regulations, policy, clinical guidelines, and relevant professional standards and codes of ethics.[752] All of which promote appropriate 21st century health care. There is no need for abortion specific legislation any more than there is a need for colonoscopy specific legislation. Indeed, any such abortion specific legislation, no matter how well intentioned, will only serve to dilute women's rights, and may well also serve to create adverse health impacts on women seeking abortion.

6.5.12 Associate Professor Bernadette Richards at the University of Adelaide also questioned any need for residual offences:

> The need to shift abortion out of the criminal law framework and into the appropriate category of 'healthcare' means that there should not be any residual criminality. It is healthcare, and if it is defined as such then there should be no exceptions. There are other legal frameworks that cover inappropriate care and personal injury, these apply equally to all forms of healthcare and abortion should not be an exception.

6.5.13 Brigid Coombe, a former director of the Pregnancy Advisory Centre, drawing on the 2010 Queensland case of *R v Brennan* [2010] QDC 329, expressed concern to SALRI at the 'shocking' implications of a residual offence carrying a maximum of seven years imprisonment (as in Queensland) applying to the providing or administering drugs for medical abortion by a partner or relative of the woman. Ms Coombe saw no benefit in this:

> To me, it is shocking that under the Queensland law passed in 2018 (*Termination of Pregnancy Bill 2008*) Sergie Brennan (*R v Leach & Brennan 2010*) would have had to have been found guilty of a crime with a maximum penalty of 7 years imprisonment. In Victoria, under the *Abortion Law Reform Act 2008* the penalty is five years. I can see no benefit in this. This young man was assisting his partner … Mifepristone and misoprostol are not dangerous drugs; but like all drugs they can be used incorrectly, so it is far preferable that use is guided and managed by trained providers. None the less, sanctions should at most be the same as any other the *Therapeutic Goods Act* imposes.[753]

6.5.14 It will be recalled that SALRI heard some anecdotal accounts that procedures by unqualified persons may remain in South Australia.[754] One attendee at the 7 June 2019 roundtable with parties favouring decriminalisation was unconvinced that such procedures remained and opposed any residual offence covering unqualified persons. One health agency also questioned the need for new specific residual offences:

> The discussion … that 'backyard' procedures still exist in South Australia appeared to be (in part) in the context of domestic violence to induce an abortion, with or without consent to assault. While acknowledging the very really problem of reproductive coercion in all its forms, [we] don't support weight being given to anecdotal reports of abortions being induced by physical or sexual violence that might seek to retain aspects of abortion law in the criminal law, beyond any already existing assault provisions. The expansion of abortion care by way of who, where, and how

[752] In South Australia, Mr Rankin noted the relevant laws in this respect includes the *Health Care Act 2008* (SA); *Health Care Regulations 2008* (SA); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health and Community Services Complaints Act 2004* (SA). Some of the above provide for the Registration of Health Practitioners, and establishe bodies such as the Health Performance Council, various Health Advisory Councils, the South Australian Health Practitioners Tribunal, the Pharmacy Regulation Authority SA and the Australian Health Practitioner Regulation Agency.

[753] This concern was also raised at the roundtable with parties in favour of decriminalisation on 7 June 2019.

[754] The recent English case of *R v Kaur* is also relevant in this respect.

> abortion services are provided will go a significant way to eliminating the very rare instances of a person consenting to physical violence to induce an abortion.[755]

6.5.15 However, other parties supported the retention of residual specific offences involving unqualified persons. This support was significantly expressed by parties both opposed to,[756] and supportive of, the decriminalisation of abortion. This view was shared by attendees at both of SALRI's roundtables with faith groups and faith groups and NGOs. Some health practitioners also saw value in the retention of a residual offence to cover the unqualified person. The Ceduna health practitioners, for example, supported a residual offence to cover the 'backyard abortionist'. The Port Lincoln health practitioners also favoured a residual offence, as did the AMA(SA).

6.5.16 One survey response noted that there should be offences for abortions that are not performed by an appropriate health practitioner 'as this would be dangerous and potentially life-threatening to the woman involved'. Another noted that the penalty for a provider (in cases where they are not an appropriate health practitioner) should always be more severe than the penalty for the person accessing the abortion as 'this reflects the fact that the person performing the abortion is potentially taking advantage of another person in a vulnerable situation'.

6.5.17 Australian Lawyers for Human Rights observed that the laws adopted in other Australian jurisdictions (even those that have allowed or relaxed access)[757] still provides that an unqualified person who performs or assists in an abortion commits a crime. Australian Lawyers for Human Rights noted 'the importance of such provisions in protecting people, particularly vulnerable people, from unsafe medical procedures … ALHR would support the inclusion of such legislative provisions in South Australia to uphold the right of all pregnant persons to obtain safe and credible medical services.'

6.5.18 A number of lead clinicians also supported a residual offence for abortions not performed by an appropriate health practitioner:

> Performance of any operative or medical procedure by a person not trained to do the procedure properly or not trained and experienced to recognise and deal with complications, both physical, psychological and emotional would be of detriment to women in need of expert care. As in any operative or medical procedure, an abortion provided by anyone other than an appropriately qualified and registered medical practitioner should be a criminal offence.

6.5.19 The Women's Electoral Lobby similarly believed it is appropriate that it should be an offence for an unqualified person to perform an abortion, 'given the potential serious cost to a woman's health that can occur from an unsafe abortion'. The Women's Electoral Lobby said any offence for an unqualified person performing an abortion 'must ensure precise wording so as not to inhibit the role of health practitioners'.

6.5.20 The AMA(SA) also supported a specific offence for unqualified persons:

> The AMA(SA) also recommends criminal consequences for an individual who performs abortions who is not a qualified medical practitioner or a nurse working under the direct supervision of a qualified medical practitioner. This advice is based on our belief that abortion must be performed

[755] The Women Lawyers' Association of South Australia Inc also submitted: 'Legislation should respond to perceived problems in the community. There is no evidence of which WLASA is aware, that suggests abortion is being performed in circumstances that raise problems for consumers or providers.' The Human Rights Law Centre also made this point to SALRI.

[756] Advocates International, 40 Days for Life and the Australian Christian Lobby,

[757] This is especially applicable to the ACT.

by people qualified to do so, to ensure a termination is performed correctly and for the safety, health and wellbeing of the patient during and after the procedure.

6.5.21 Jonathan Polnay, a London barrister, drawing on his role as prosecution counsel in *Kaur*[758] (though speaking in a personal capacity), urged caution before discarding offences relating to abortions by unqualified persons. Mr Polnay noted that significant harm, as in *Kaur*, can result from the involvement of unqualified persons in medical abortion and such drugs should only be administered by, or under the supervision of, qualified health practitioners.

6.5.22 One suggestion was that a residual offence should only be able to be brought by or at least with the consent of the Attorney-General and/or the DPP. This is the model in the 2019 NSW Act. This approach could address the concern of vexatious or at least inappropriate private prosecutions or any public prosecution without the proper oversight of the DPP.[759]

6.6 SALRI's Observations and Conclusions

6.6.1 SALRI has carefully considered whether a specific residual offence is necessary to deal with procedures carried out by (or with the assistance of) unqualified parties or this is something that can be left to either the criminal law of assault or provisions in health law.

6.6.2 A number of medical practitioners and others told SALRI that the 1960s concerns of unsafe practices that promoted the 1969 South Australian Act may now have been overlooked by parties both supportive and opposed to the decriminalisation of abortion and this should be kept in mind. SALRI agrees that this vital consideration should not be discounted.

6.6.3 When the South Australian Parliament decriminalised abortion in 1969, they contemplated the disturbing situation where women were dying as the result of sepsis and blood poisoning as a result of unsafe surgical abortions by unqualified individuals. In 2019, both surgical and medical abortion are safe procedures, but they still require medical oversight. SALRI in particular accepts that medical abortion is an established and approved procedure that is 'medically straightforward and very safe',[760] but only if under the supervision of qualified health practitioners.[761]

6.6.4 SALRI has heard anecdotal accounts (though questioned by some parties) that abortions involving unqualified parties remain in South Australia. The risk remains to a woman's health of an abortion (whether surgical or medical) by an unqualified individual without the proper involvement or oversight of a qualified health practitioner. The recent UK case of *Kaur* is also illustrative. SALRI accepts that both surgical and medical abortions are overwhelmingly safe,[762] but this is in the context of the proper involvement or oversight of a qualified health practitioner.

6.6.5 SALRI considers that it would be imprudent to rely on the offences of assault, assault causing harm, intentionally or recklessly causing harm or intentionally or recklessly causing serious harm. There is real doubt that the administration of an abortion (whether surgical or medical) would fall within these offences, notably as the woman's consent is available as an actual (for assault or assault

[758] *R v Kaur* [2015] EWCA Crim 2202 (29 October 2015). See further above [6.1.9]–[6.1.12].

[759] *R (Hubert) v Director of Public Prosecutions* [2015] EWHC 3733 (Admin). See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich). See above [6.1.7].

[760] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* 41, 65.

[761] *R v Kaur* [2015] EWCA Crim 2202 (29 October 2015).

[762] See below Part 8.

causing harm) or potential defence (for intentionally or recklessly causing harm or intentionally or recklessly causing serious harm).

6.6.6 There is an apparent gap in health law. Crucially, Australia's health laws apply *only to health practitioners* and *those holding themselves out to be health practitioners*. Additional pharmaceutical laws do not allow laypeople to import or prescribe medications. These laws do not cover laypeople carrying out surgical procedures. Even if no illegal abortions are currently occurring in South Australia, this does not mean that none will ever occur. If they do occur and are not carried out by health practitioners or people who hold themselves out as health professionals, the health law provides inadequate public protection and punishment for any unqualified party who perform or procure abortions.

6.6.7 SALRI agrees with the view of Professor Sally Sheldon and her colleagues that 'there is a clear state interest in protecting the public from dangerous and unsafe practice in any area of medicine'. The question, as Professor Sheldon raises, is whether the imposition of a specific residual offence 'offers a necessary and proportionate means to achieving this important objective'.

6.6.8 The public health rationale for the 1969 South Australian Act to protect women from unsafe abortion procedures by unqualified parties should not be overlooked. This remains an enduring consideration. SALRI accepts that the accounts it has heard are anecdotal but the risk of unsafe procedures (whether surgical or medical) should not be easily discounted. Both surgical and medical abortions are safe and accepted procedures but this is only if carried out by or under the supervision of qualified health practitioner. The graphic history of unsafe and unregulated procedures by unqualified parties highlights the concerns of medical abortions carried out by unqualified individuals. The recent UK case of *Kaur* indicates that such concerns are also not fanciful in relation to medical abortions.

6.6.9 SALRI has carefully considered the issue of residual offences and considers that such offences are necessary and justified. It respectfully disagrees with the contention that this issue can be left to either the law of assault or general health law. Rather there is an apparent gap in the law. Neither the law of assault nor health law adequately covers such conduct. It is also significant that all other Australian jurisdictions, including the ACT, retain residual offences for either medical or surgical abortions performed by unqualified persons. SALRI notes that Nick Cowdery QC, the former NSW Director of Public Prosecutions, supports the retention of such an offence.[763]

6.6.10 In light of the apparent inadequacy of the law in this area, SALRI considers that a new offence should be added to the *Health Care Act 2008* (SA) to provide that either an unqualified person who performs an abortion, or an unqualified person who assists in the performance of an abortion, commits a crime. SALRI considers that, for the purposes of the new proposed offence, an 'unqualified person' should be defined to mean, in relation to performing an abortion or assisting in the performance of an abortion, a person who is not a health practitioner.[764] The question of a health

[763] 'I see no problem with enacting a provision such as the one proposed to criminalise termination by an unqualified person. That would be a reasonable provision to seek to prevent foreseeable harm which should be the prime purpose of the criminal law': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Mr Nicholas Cowdery AC QC, NSW Council for Civil Liberties).

[764] For the purposes of the new offence, SALRI suggests an 'unqualified person' means: in relation to performing an abortion — a person who is not a medical practitioner; and in relation to assisting in the performance of an abortion — a person who is not a medical practitioner or health practitioner (including a nurse, midwife or pharmacist) providing the assistance in the practice of their respective occupation. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) ii, n 10.

practitioner who is acting outside the scope of their health practice should be left to disciplinary and professional avenues as opposed to the criminal law.[765]

6.6.11 The QLRC recommended that the unqualified person offence should be a major indictable offence with a maximum penalty of seven years imprisonment. The QLRC considered this 'to be an appropriate penalty, given that the mischief to which this offence is addressed is risk to the health of the woman posed by an unqualified person performing or assisting in the performance of a termination'.[766] SALRI agrees with the QLRC and suggests that the new offence should be a major indictable offence with a maximum penalty of seven years imprisonment.

6.6.12 The 2019 NSW Act provides that proceedings for the unqualified offence should only be able to be instituted by, or with the consent of, the Attorney-General or the Director of Public Prosecutions. SALRI agrees that a residual offence should only be able to be brought by or at least with the consent of the Attorney-General and/or the DPP. This approach addresses the concern of vexatious, or at least inappropriate, private prosecutions and ensures any 'public' prosecution will be carefully considered by the DPP and only brought if genuinely in the public interest.[767]

6.6.13 Recommendations

Recommendation 10

SALRI recommends that a new offence should be added to the *Health Care Act 2008* (SA) or the most appropriate Act (though preferably not the *Criminal Law Consolidation Act 1936* (SA)) to provide that an unqualified person who either performs, or who assists in the performance of, an abortion, commits a crime.

Recommendation 11

SALRI recommends that, for the purposes of the new proposed offence in Recommendation 10 above, an 'unqualified person' should be defined to mean, in relation to performing an abortion or assisting in the performance of an abortion, a person who is not a health practitioner.

Recommendation 12

SALRI recommends that the new offence proposed in Recommendation 10 should be a major indictable offence with a maximum penalty of seven years imprisonment. Proceedings for any such offence should only be able to be instituted by, or with the consent of, the Attorney-General or the Director of Public Prosecutions.

[765] See above Part 5, Rec 8.

[766] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) x, Rec 3.10; 11–112 [3.278].

[767] See above [6.1.7]. See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

Part 7 - Clinical Practice in South Australia

7.1 Regulation of Health Professionals

7.1.1 The provision of lawful abortion services in South Australia is governed by a comprehensive legal, regulatory and clinical framework.

7.1.2 Currently, the provision of abortion services, while assisted by health practitioners, limits the specific performance of the procedure to the defined class of 'medical practitioner'. Included in the term 'medical practitioner' are different types of registration to reflect different levels of training and expertise and to recognise specialists.[768]

7.1.3 Under the *Health Practitioner Regulation National Law (South Australia)* a person practising in a health profession must be a 'registered health practitioner'.[769]

7.1.4 In the same way that medical practitioners must comply with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards), policies and guidelines, so too do registered health practitioners.[770] Non-compliance may result in a finding that a health practitioner's conduct is in some way unsatisfactory or unprofessional.[771] This finding may result in disciplinary action, for example cautioning or reprimanding a practitioner, or the suspension or cancellation of, or imposition of conditions on, a practitioner's registration.[772] Australian health practitioners are also required to undergo a formal

[768] Queensland Law Reform Commission, Review of Termination of Pregnancy Laws (Report No 76, June 2018) 22 [2.50]. For example, a medical practitioner may be registered as a specialist in obstetrics and gynaecology: Health Practitioner Regulation National Law pt 7 div 2; Medical Board of Australia, *List of Specialties, Fields of Specialty Practice and Related Specialist Titles* (MBA Doc, 1 June 2018) <https://www.medicalboard.gov.au/registration/types/specialist-registration/medical-specialties-and-specialty-fields.aspx>; Medical Board of Australia, *Registration Standard: Specialist Registration* (MBA Doc, 15 February 2018) <https://www.medicalboard.gov.au/Registration-Standards.aspx>. Specialist registration is available to medical practitioners who have been assessed, by an Australian Medical Council accredited specialist college, as being eligible for fellowship: see Medical Board of Australia, *Specialist Registration* (Web Page, 26 February 2018) <www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>. RANZCOG trains and accredits medical practitioners in the specialties of obstetrics and gynaecology, and Fellowship of the College ('FRANZCOG') is the qualification awarded to a medical practitioner who has completed the FRANZCOG training program to become a specialist obstetrician/gynaecologist: see Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Specialist Training* (Web Page, 2018) <www.ranzcog.edu.au/Training/Specialist-Training>.

[769] A person must register with the National Board relevant to their profession. For example, medical practitioners must be registered with the Medical Board of Australia, nurses and midwives with the Nursing and Midwifery Board of Australia, and pharmacists with the Pharmacy Board of Australia.

[770] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 22 [2.51].

[771] Ibid 24 [2.51]. Specifically, it may be decided that the way a registered health practitioner practices the profession, or the practitioner's professional conduct, is or may be unsatisfactory; or that a practitioner has behaved in a way that constitutes 'unsatisfactory professional performance', 'unprofessional conduct' or 'professional misconduct': *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) pt 8, divs 10–12.

[772] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 22 [2.51].

process of 'credentialing'[773] as well as defining their 'scope of clinical practice[774] as part of a wider organisational quality and risk management system.[775]

7.1.5 Relevantly, for the provision of abortion services, registered health practitioners include medical practitioners, nurses, midwives and pharmacists. A number of submissions to SALRI noted the capacity of some non-medical health practitioners (for example, nurse practitioners and midwives as well as other health practitioners) to perform an abortion, despite being currently unable to do so, due to legislative barriers.

7.1.6 Marie Stopes Australia noted to the QLRC that the authority to prescribe the drugs used for medical terminations is currently limited to general practitioners and specialist obstetricians and gynaecologists who meet the legal certification requirements, and raised the possibility of this prescribing authority being extended to experienced nurse practitioners.[776]

7.1.7 There are different views as to the safety and consequences of abortion.[777] However, the prevailing medical view is that such procedures, if properly administered by a qualified health practitioner, are safe.[778] As the New Zealand Law Reform Commission recently observed: 'When performed in appropriate conditions by a trained health practitioner, abortion is a safe and usually straightforward procedure. It is significantly safer than carrying a pregnancy to term.'[779]

7.1.8 The Hon Tammy Franks MLC has suggested that suitably qualified health practitioners beyond medical practitioners should be able to administer at least some forms of abortion procedures.[780] This is contemplated in the 2018 South Australian Bill.

7.1.9 Most parties who addressed this issue to the QLRC submitted that appropriately qualified and trained medical practitioners and other health practitioners (such as registered nurses, midwives and pharmacists) should be authorised to perform or assist in the performance of an abortion.[781] It was noted that health practitioners are required to satisfy the legal requirements and professional standards

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[773] 'Credentialing' means 'the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments': Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework* (Publication, November 2017) 31 (definition of 'credentialing').

[774] 'Scope of clinical practice' means 'the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation': Ibid 33 (definition of 'scope of clinical practice').

[775] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 23 [2.52].

[776] Ibid 55 [3.23].

[777] See further above [2.1.42]–[2.1.52].

[778] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Abortion' (RANZCOG Statements and Guidelines, March 2019) 4: 'Women should be provided with accurate information including that abortion is a safe procedure for which major complications and mortality are rare.' See also World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012); SA Health, *Abortions* (Web Page, 25 July 2019, <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions>.

[779] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 32 [2.6].

[780] South Australia, *Parliamentary Debates,* Legislative Council, 5 December 2018, 2424.

[781] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 53 [3.15]. In contrast, some respondents to the QLRC considered that any new law should not permit anyone to perform terminations: at 53, n 25.

that apply to the practice of their respective professions and it was considered that this health care framework should govern the eligibility of health practitioners to carry out abortions.[782]

7.1.10 SALRI's consultation supported this position. However significant reservations were expressed by most parties (including medical and other health practitioners) as to the involvement of pharmacists beyond the role of dispensing medication for an abortion procedure.[783] One pharmacist in Port Lincoln noted that they (being pharmacists) would not be equipped to prescribe RU486 even if they were permitted to as they would not have the training or equipment to undertake the necessary test to ensure the medication was safe for the patient.

7.1.11 AMA Queensland noted that, as a matter of clinical practice, other health practitioners, such as nurses, midwives, ATSI health practitioners and pharmacists, may also assist in performing an abortion, as long as this occurs under a medical practitioner's direction.[784]

7.1.12 However, there was a view that abortions should be performed only by, or under the direction of, suitably qualified medical practitioners. It was also noted that surgical and medical abortions may require different qualifications, skills and training.[785]

7.2 Guidelines for Practice

7.2.1 SA Health has published mandatory standards and clinical guidelines for the management of termination of pregnancy in South Australia.[786]

7.2.2 The *Standards for the Management of Termination of Pregnancy in South Australia* assists health care staff employed in the public health service in their management of patients requiring a termination of pregnancy. The standards determine the minimum requirements for the safe management of the woman requiring a termination of pregnancy, in consideration of current legislation, research and professional standards of clinical practice.[787] This includes an outline of mandatory standards of care, the level of service that should be provided, and requirements to offer unbiased and comprehensive information and professional counselling.[788]

7.2.3 SA Health outlines:

> Services for termination of pregnancy offered in publicly funded health services in South Australia are undertaken within a service delineation framework that determines the minimum standards of care and the level of service that should be provided to a woman given the complexity of care she requires. In consideration of the quality and safety of care required and the legislative requirements,

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[782] Ibid 53 [3.16].

[783] SALRI contacted pharmacist associations but they did not make any comments in relation to this reference. Professor Heather Douglas noted to SALRI that research has shown that early medical abortions can be provided safely by pharmacists. See further Sarah Raifman et al, 'Medication Abortion: Potential for Improved Patient Access through Pharmacies' (2018) 58(40) *Journal of American Pharmacy Association* 377.

[784] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 55 [3.25].

[785] Ibid 54 [3.20].

[786] SA Health, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014); SA Health, *South Australian Perinatal Practice Guidelines: First Trimester Medical and Surgical Termination of Pregnancy* (Clinical Guidelines, June 2014); SA Health, *South Australian Perinatal Practice Guidelines: Medical Induction for 2nd Trimester Terminations of Pregnancy and Miscarriages* (Clinical Guidelines, June 2014).

[787] SA Health, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 8.

[788] SA Health, Standards for the Management of Termination of Pregnancy in South Australia (Policy, 2014); SA Health, *South Australian Perinatal Practice Guidelines: First Trimester Medical and Surgical Termination of Pregnancy* (Clinical Guidelines, June 2014), 7–8.

> the framework defines the relevant workforce, equipment, facilities, protocols and service arrangements that need to be formally in place to ensure the continuity of a particular level of service.[789]

7.2.4 The *South Australian Perinatal Practice Guidelines: First Trimester Medical and Surgical Termination of Pregnancy* set out requirements for undertaking pre-termination assessment and obtaining consent, considerations relating to the different methods of termination, and recommendations concerning follow-up care, management of complications, and the provision of contraceptive advice.[790]

7.2.5 Included in clinical guidelines and standards are requirements to obtain informed consent under the *Consent to Medical Treatment and Palliative Care Act 1995* (SA).[791] As with any other medical procedure or treatment, all patients must give fully informed consent for abortion services. Medical practitioners are required to explain the nature, consequences and risks of treatment and any alternatives.[792] This ensures that patients decide freely and on an informed basis whether or not to undergo medical treatment of any kind. These provisions are also designed to operate to protect patients from coercion by partners, parents or any other person by requiring health practitioners to rule out coercion and be satisfied of a patient's free will in order to meet their obligations.[793]

7.2.6 Specific guidelines, standards and regulatory requirements may vary depending on the method for abortion undertaken. An abortion may be performed as either an early medication abortion, surgical abortion, or medical abortion (late term). The method chosen will depend on the gestation of the pregnancy and clinical indications including the preferences of the woman, the risk of complications and any other relevant circumstances.

7.2.7 It is also important to note that there are protocols regarding the care of a fetus which is born with signs of life after an abortion procedure. While it is was noted to SALRI by several parties such as the South Australian Abortion Action Coalition that such an occurrence is so rare as to not occur at all, it is important to acknowledge that, if such an event did occur, the child would not 'be left to die'.[794] This issue was comprehensively canvassed in the recent debate around the 2019 NSW Act, notably the amendment which was ultimately passed to clarify 'that a person born after a termination who shows signs of life has the full protection of the law and must receive appropriate treatment'.[795] Dr Roach of RANZCOG explained to SALRI that a child 'born alive' during a late term abortion procedure is extremely rare, if not non-existent, and this situation is already fully covered by existing clinical practice. Dr Roach emphasised to SALRI that the claim of children 'left to die' is unfounded and offensive to the health practitioners involved and the parents. Any legislative provision (as in the 2019 NSW Act) seeking to regulate what happens is simply unnecessary and unhelpful as this situation,

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[789] SA Health, Government of South Australia, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 6.

[790] SA Health, *South Australian Perinatal Practice Guidelines: First Trimester Medical and Surgical Termination of Pregnancy* (Clinical Guidelines, June 2014).

[791] Ibid 3–6.

[792] Ibid.

[793] Ibid. See also below [19.1.1]–[19.1.23].

[794] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 4 (Hon Niall Blair). See also at 4–10, 26–31; New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 68–80.

[795] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 4 (Hon Niall Blair). See also at 4–10, 26–31; New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 68–80; Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 69. See further below n 2238.

if it ever arises, is preferably left to clinical practice as to what is appropriate in the circumstances and to reflect the choice of the parties involved in careful consultation with their medical practitioners. SALRI concurs with the views and reasoning of Dr Roach on this point.[796]

7.3 Who Can Provide Abortion Medication and Services?

7.3.1 Since the introduction of the present law in relation to abortion in 1969, there has been considerable progress to clinical practice, including medical termination methods and modern health service provision. There have been particular changes concerning the responsibilities of nurses and midwives, who now perform a wider range of tasks in various fields in order to meet the changing demands of the healthcare system.[797]

7.3.2 A strong theme in SALRI's consultation was that South Australia's current legislative framework (and associated practices) has not been updated to reflect these developments and changes to the scope of practice of health practitioners. The present law restricts the provision of abortion medications and services to medical practitioners and also restricts the now widely recognised potential for nurse practitioners and midwives (as well as other health practitioners) to have a more active role.

7.3.3 A consistent view in consultation was that the present restrictions on who can perform an abortion, especially the two doctor rule, are outdated and do not accord with current clinical practice and serve to impede or restrict equitable and effective regional, rural and remote access. As the Hon Tammy Franks MLC submitted to SALRI:

> Barrier number two is the requirement for an examination and certification by two doctors. In SA, abortion is the only health procedure that requires examination and certification by not one but two legally qualified medical practitioners in order to make the procedure 'lawful'. One doctor is not lawful. This is unnecessary and archaic and underscores and reminds all involved, especially those doctors, that in our healthcare system abortion is still firmly placed within a criminal context. By delegating this authority to not one but two medical practitioners, the current law compromises women's right to self-determination … The third barrier is that the provision of abortion is limited to 'medical practitioners'. International research demonstrates that abortion can be safely and effectively provided by appropriately trained healthcare providers, not only by 'medical practitioners'. That is of course not to say, as has been mischievously suggested, that no appropriate training or processes apply to ensure quality health care but rather that with advances in technology a range of options should be facilitated. The World Health Organisation advises that early medication abortion is the responsibility of women with the support of trained healthcare providers. These providers not only include doctors, of course, but also nurses, midwives and pharmacists. By precluding these providers from supporting women in this way, the current law yet again constrains the possibilities for best health care.[798]

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[796] See generally New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 4 (Hon Niall Blair).

[797] See SA Health, *Advanced and Extended Scope of Practice* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/department+of+health/system+performance+division/nursing+and+midwifery+office/nursing+and+midwifery+professional+practice/nursing+and+midwifery+advanced+and+extended+scope+of+practice>. SA Health, *Prescribing by Non-Medical Healthcare Professionals* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/prescribing+medicines+regulations+and+requirements/prescribing+of+medicines+by+non-medical+professionals/prescribing+by+non-medical+healthcare+professionals>.

[798] See also South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2424.

7.3.4 This issue has been addressed elsewhere in Australia. The law in a number of other Australian jurisdictions allows health practitioners, including nurses, midwives, Aboriginal and Torres Strait Islander health practitioners and pharmacists to perform, or assist with the performance of, abortion procedures under the direction of a medical practitioner.[799]

7.3.5 Following the introduction of the *Termination of Pregnancy Act 2018* in Queensland, a nurse, midwife, pharmacist, Aboriginal health practitioner or other registered health practitioner prescribed by Regulation may, in the practice of his or her health practice, assist in the performance of an abortion.[800]

7.3.6 In Victoria, a registered pharmacist or registered nurse who is authorised under the *Drugs, Poisons and Controlled Substances Act 1981* may administer or supply a drug to cause an abortion in a woman who is not more than 24 weeks pregnant.[801] After 24 weeks gestation, a registered medical practitioner may, in writing, direct a registered pharmacist or registered nurse to administer or supply a drug to cause an abortion.[802]

7.3.7 In the Northern Territory, a suitably qualified medical practitioner may direct an authorised Aboriginal health worker, authorised midwife, authorised nurse or authorised pharmacist to assist in the performance of an abortion on a woman of not more than 14 weeks gestation, if the medical practitioner considers that procedure is appropriate.[803] While authorised pharmacists may only supply an abortion drug,[804] authorised Aboriginal health workers, midwives or nurses may also administer an abortion drug.[805]

7.3.8 The WHO has recommended that first trimester abortion care can be safely provided at a primary care level by a range of appropriately trained health practitioners, including nurses and midwives, with referral systems in place for higher level care where required.[806] The WHO emphasises that enhancing the role of non-medical practitioners may facilitate access to safe and timely healthcare where there are shortages of specialist medical practitioners.[807]

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[799] See *Termination of Pregnancy Law Reform Act 2017* (NT) s 8; *Termination of Pregnancy Act 2018* (Qld) s 7; *Criminal Code Act 1924* (Tas) sch 1, cl 1 (definition of 'terminate'); *Abortion Law Reform Act 2008* (Vic) ss 6–7.

[800] *Termination of Pregnancy Act 2018* (Qld) s 7; Under subsection 7(4), a reference in this section to assisting in the performance of a termination by a medical practitioner includes dispensing, supplying or administering a termination drug on the medical practitioner's instruction.

[801] *Abortion Law Reform Act 2008* (Vic) s 6.

[802] *Abortion Law Reform Act 2008* (Vic) s 7.

[803] *Termination of Pregnancy Law Reform Act 2017* (NT) s 8(1).

[804] Ibid s 8(4).

[805] Ibid s 8(3).

[806] World Health Organization, *Expanding Health Worker Roles for Safe Abortion in the First Trimester of Pregnancy,* WHO Doc WHO/RHR/16.02 (May 2016). A number of parties opposed to the decriminalisation of abortion queried relying on the WHO view in this regard, suggesting the WHO is not talking of a country such as Australia with an advanced heath service. See also Sharmani Barnard et al, 'Doctors or Mid-Level Providers for Abortion' [2015] 7 *Cochrane Database of Systematic Reviews* (1–37): The results from analysis of three medical abortion studies showed that there does not seem to be an advantage when these are provided by medical practitioners as opposed to mid-level health care providers such as midwives, nurses and other non-physician providers. Additionally, there was no statistically significant difference in the risk of failure for medical abortions performed by mid-level providers compared with medical practitioners.

[807] World Health Organization, *Expanding Health Worker Roles for Safe Abortion in the First Trimester of Pregnancy,* WHO Doc WHO/RHR/16.02 (May 2016).

7.3.9 Most parties who addressed this issue to the QLRC submitted that appropriately qualified and trained medical practitioners and other health practitioners should be authorised to perform or assist in the performance of an abortion.[808] It was noted that health practitioners are required to satisfy the legal requirements and professional standards that apply to the practice of their respective professions and it was considered that this health care framework is sufficient to govern the eligibility of health practitioners to carry out abortions.[809] SALRI notes that this theme was consistently expressed in South Australia also.

7.3.10 AMA Queensland noted that, as a matter of clinical practice, other health practitioners, such as nurses, midwives, ATSI health practitioners and pharmacists, may also assist in performing an abortion, as long as this occurs under a medical practitioner's direction.[810]

7.4 Extended Scope of Practice for Health Practitioners

7.4.1 The relevant laws in the Northern Territory, Queensland, Tasmania and Victoria specifically recognise other health practitioners who may assist in the performance of an abortion.

7.4.2 General prescribing rights in South Australia have already been extended to non-medical healthcare professionals 'as a way to improve the quality of services to clients, whilst maintaining client safety, increasing client choice and improving access to healthcare'.[811] Prescribing rights and responsibilities by non-medical practitioners are governed by the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) and the *Controlled Substances Act 1984* (SA).[812]

7.4.3 Authorised non-medical prescribers who are working within the South Australian Public Sector are also required to abide by policies and guidelines established or endorsed by SA Health.[813]

7.4.4 Under current practice, nurse practitioners endorsed by the Nursing and Midwifery Board of Australia are authorised to prescribe certain medications, within the limits of the nurse practitioner's scope of practice, as well as any relevant Medicare Benefits Schedule (MBS) or Pharmaceutical Benefits

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[808] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 53 [3.15]. In contrast, some respondents to the QLRC considered that any law should not permit anyone to perform abortions: at 53, n 25.

[809] Ibid 53 [3.16].

[810] Ibid 55 [3.25].

[811] SA Health, *Prescribing by Non-Medical Healthcare Professionals* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/prescribing+medicines+regulations+and+requirements/prescribing+of+medicines+by+non-medical+professionals/prescribing+by+non-medical+healthcare+professionals>.

[812] 'The provisions of the National Law have been designed to support nationally consistent scopes of prescribing practice for the non-medical professions to meet the changing demands of the health system. This includes the registration of health professionals under the National Registration and Accreditation Scheme (NRAS). A registration may be endorsed in relation to specific specialities and registrations of individual practitioners can also be endorsed, where applicable, in relation to certain uses of scheduled medicines and in relation to approved areas of practice': SA Health, *Prescribing by Non-Medical Healthcare Professionals* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/prescribing+medicines+regulations+and+requirements/prescribing+of+medicines+by+non-medical+professionals/prescribing+by+non-medical+healthcare+professionals>.

[813] See SA Health, *Medicines and Prescribing: Policies and Guidelines* (Web Page, 24 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/medicines+and+prescribing+policies+and+guidelines/medicines+and+prescribing+policies+and+guidelines>.

Scheme (PBS) requirements or additional prescribing arrangements.[814] Prescribing rights may also extend to midwives who are endorsed by the Nursing and Midwifery Board of Australia for scheduled medicines.[815]

7.4.5 Relevant policy directives also incorporate requirements to ensure robust governance of prescribing requirements, restrictions, monitoring and evaluation.[816]

7.4.6 Noting that the authority to prescribe the drugs used for early medical abortion is currently limited to general practitioners and specialist obstetricians and gynaecologists who complete the additional training and registration requirements, Marie Stopes Australia raised the possibility to the QLRC of this prescribing authority being extended to experienced nurse practitioners.[817]

7.5 Education and Training

7.5.1 It was bought to the attention of SALRI by a number of medical (and other health practitioners) that during their tertiary studies information about abortion procedures, medical or surgical, was not included in the curriculum. SALRI understands that this is now covered by university education and professional training, but a number of perhaps older practitioners raised this theme.

7.5.2 The lack of basic guidance in this area led the medical practitioners who raised this issue to SALRI to note that it made them less likely to incorporate abortion provision into their general practice. This was especially relevant for those practicing as GPs as they were not equipped, through their tertiary studies, to assist patients who presented with an unwanted pregnancy. Even before the stage of considering dispensing MS-2 Step or making a referral for a surgical abortion.

7.5.3 SALRI was also informed that procedures related to abortion were also not previously canvassed in the further studies required for an obstetrics specialisation.

7.5.4 The exclusion of general training in relation to abortion as part of a medical practitioners' studies, particularly as it relates specifically to reproductive health, further stigmatises the procedure and is likely to result in restricting the number of practitioners appropriately trained to assist.

7.5.5 A number of health practitioners who spoke with SALRI, who both supported effective decriminalisation of abortion in South Australia and those who did not support significant change, submitted to SALRI that information relating to abortion services should be incorporated into a medical practitioner's initial training so that they are fully equipped to assist patients, even if this is only by having sufficient knowledge to make an accurate and timely referral.

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[814] SA Health, *Prescribing by Non-Medical Healthcare Professionals* (Web Page, 25 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/prescribing+medicines+regulations+and+requirements/prescribing+of+medicines+by+non-medical+professionals/prescribing+by+non-medical+healthcare+professionals>.

[815] Ibid.

[816] See SA Health, *Governance Framework for Advanced Scope of Practice Roles and Extended Scope of Practice Roles in SA Health* (Policy Directive, 7 March 2013) <https://www.sahealth.sa.gov.au/wps/wcm/connect/26da83804fe0732e9831faf2d1e85ff8/Directive_Advanced+and+Extended+Scope+of+Practice_21102016.pdf?MOD=AJPERES&CACHEID=26da83804fe0732e9831faf2d1e85ff8>; SA Health, *Nurse Practitioner Policy Directive* (Policy Directive, 6 February 2017) <https://www.sahealth.sa.gov.au/wps/wcm/connect/4230538042d3d05d849ba5693c255719/Directive_Nurse+Practitioner_v5.0_27032017.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4230538042d3d05d849ba5693c255719-mMH60pe>.

[817] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 55 [3.23].

7.5.6 It was specifically noted to SALRI that appropriate training should be provided to all health practitioners seeking to obtain qualifications in reproductive health, including obstetrics and gynaecology, as abortion procedures form part of this scope of practice.

7.5.7 It was believed by the health practitioners who spoke to SALRI, particularly from rural and remote areas, that, by having this training as a mandatory component to a degree would assist in removing the stigma from the procedure but, more importantly, work toward reducing the skills shortage in this area.

7.5.8 The University of Sydney Policy Reform Project went further and recommended to SALRI that 'the South Australian government should actively encourage high schools to incorporate unintended pregnancy education within their health and physical education courses'. It was the view of the University of Sydney Policy Reform Project that the current Australian School Curriculum[818] focuses on contraception, consent and preventing sexually transmitted diseases, but fails to appropriately cover issues related to pregnancy, including, but not limited to, an unwanted pregnancy.

7.5.9 Several health practitioners identified what they saw as significant gaps in the provision of guidelines, education and training, and professional development for abortion health care providers.[819]

7.5.10 SALRI positively notes, however, that the training currently provided to those undertaking both specialist and General Practitioner programs does include abortion services.[820]

7.6 Submissions

The role of only medical practitioners in medical abortions

7.6.1 The view of parties opposed to the decriminalisation of abortion was generally that only suitable medical practitioners should perform or administer any form of abortion. A number of parties to SALRI's consultation, particularly attendees at the roundtable with faith groups and NGOs on 12 June 2019, expressed unease over an enhanced role for other health practitioners. The risks said to be associated with early medical abortion were highlighted.[821]

7.6.2 Women's Forum Australia, for example, stated 'an abortion is a serious procedure with significant consequences and risks for woman and child. It should not be delegated to health practitioners who are not medical practitioners'.

7.6.3 A number of parties in SALRI's consultation held the view that any abortion should only be performed by, or under the direction of, suitably qualified medical practitioners. Pregnancy Help Australia and the Australian Christian Lobby contended that only medical practitioners should be allowed to carry out an abortion in order to protect the woman.

7.6.4 Advocates International suggested that best medical care requires a qualified medical practitioner with the appropriate skills and facilities because only such a person will be able to address

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[818] See Australian Curriculum, Assessment and Reporting Authority, *Health and Physical Education* (Web Page) <https://www.australiancurriculum.edu.au/f-10-curriculum/health-and-physical-education>.

[819] See also Ea Mulligan, 'Striving for Excellence in Abortion Services' (2006) 30(4) *Australian Health Review* 468.

[820] Confirmation of current training provided was supplied by RANZCOG and Professor Ian Symonds, Dean of Medicine, Head of School, Adelaide Medical School, University of Adelaide.

[821] See further below Part 8.

any complications arising from an abortion. 'Allowing any lower standard in South Australia will necessarily mean offering something less than the best medical care, which should be rejected.'

7.6.5 40 Days for Life argued that, although South Australia has remote communities 'far from doctors, the high risk of complications with medical terminations (9.8% on the 2016 figures)[822] with consequent risk to the mother's health and potentially her life, means a doctor should always be involved.' 40 Days for Life elaborated: 'A doctor is required to remove something as simple as an appendix, where no one dies. A doctor should always be involved in an abortion, where the very purpose of the procedure is to kill an innocent human being.'

7.6.6 One party to SALRI's online consultation stated:

> I do not believe non-medical practitioners could perform this safely, as they would be unable to examine a patient with respect to the safety of medical or surgical terminations, or associated health issues such as sexually transmitted infections, contraception and fertility. Furthermore, like any health intervention, there are risks involved such as post-operative infections which a medical practitioner can safely recognise and treat.

7.6.7 One survey response noted:

> Medical practitioners should be the person to perform the termination as they can examine the patient in a holistic manner and are more equipped to deal with any complications that may arise. In very rural/remote areas perhaps nurse practitioners could also be given qualification/training to reduce barriers to access for remote women.

7.6.8 Other submissions considering if a person, other than a medical practitioner, should be able to facilitate medical abortions noted:

> No, it is not always a straight-forward manner. Feedback from the abortion drug legalised in the NT shows as many as 17% having complications such as an incomplete 'evacuation' and so required a follow up medical procedure.
>
> Medical abortions should also be performed by medical practitioners given the risk of failure and need for surgical intervention.
>
> [G]iven the amount of physical and psychological risk that is attributed to such a procedure only medical practitioners should be permitted to authorise and perform an abortion. Outsourcing this health care procedure would result in — unregulated care of women around Australia. Further, this would lead to inclines in emergent incidences and a decline in the proper education and psychological screening of women attending an abortion clinic.

The role of nurses and midwives in medical abortions

7.6.9 The Hon Tammy Franks MLC[823] and many others such as Professor Margaret Davies and a rural midwife, in SALRI's consultation have suggested that suitably qualified health practitioners beyond medical practitioners should be able to administer at least some forms of abortion procedures in South Australia.

7.6.10 At SALRI's roundtable session with the medical and legal sectors on 7 June 2019, there was strong support for nurse practitioners[824] and midwives to have an enhanced role in relation to

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[822] See further below Part 8.

[823] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2424.

[824] A nurse practitioner is 'a Registered Nurse (RN) experienced in their clinical specialty, educated at Masters Level, and who is endorsed by the Nurses and Midwives Board of Australia (NMBA) to provide patient care in an

medical abortions in particular, in line with training and accreditation processes that are already in place, noting that any such role would also be subject to developments in wider health law and practice.

7.6.11 This view was almost universally expressed by the medical and health practitioners that SALRI spoke to in Port Augusta, Whyalla, Ceduna[825] and Port Lincoln. In Ceduna it was noted that there are a number of medications, some with more serious risks of complications, which are available by way of a 'standing order' meaning that an appropriately trained nurse or midwife can administer the medication without prior direct consultation with a medical practitioner. It was considered that those staff who were specifically trained to do so would be able to assess the suitability of RU486 for a patient and facilitate a medical abortion to prevent delays caused by a lack of medical practitioners in a rural area or the impact of conscientious objections by the medical practitioners in a rural area.

7.6.12 This position was also shared by most professional associations at SALRI's roundtable session with the medical and legal sectors on 7 June 2019.

7.6.13 There was strong support in both the online survey and consultation for nurses and midwives to carry out or assist in early medical abortions. One party noted: 'If they have been trained in performing abortions, they should be allowed to perform abortions, no matter what title they hold.' One survey response said: 'The roles of nurse practitioner and clinical nurse may play an integral part in this service. This overlap of roles and upskilling of nursing staff already happens in many other fields and is a highly effective use of resources.' Another survey response commented: 'In rural or remote areas, it maybe more feasible for a nurse practitioner to perform the procedure but this would have to be done under close supervision of a medical practitioner.'

7.6.14 Indeed, there was support for other categories of health practitioners. One survey response said: 'Health practitioners ie nurses, Aboriginal health workers are invaluable in provision of abortion services, particularly in rural and remote areas.' Another party said, 'Research shows that early medication abortion can be safely and effectively provided by appropriately trained health care providers and it need not be confined to only medical practitioners'. Another responses noted that women across all parts of the country should be able to have safe access to health practitioners performing abortions. 'This includes rural and remote communities, and therefore training for lawful terminations should be made available to those health practitioners living in those communities who may not be medical practitioners.'

7.6.15 The Department of Health and Wellbeing stated that specified classifications of nurses and midwives should be able to conduct medical abortions if there are no other legal impediments. Nurse-led early medical abortion is currently available in the ACT and Victoria. The Department of Health and Wellbeing noted that 'this would not only increase access to safe, early medical abortion but would reduce costs'.[826]

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advanced and extended clinical role': NSW Government, 'Becoming a Nurse Practitioner', *Health* (Web Page, 26 July 2017) <https://www.health.nsw.gov.au/nursing/employment/Pages/nurse-practitioner.aspx>.

[825] It was noted that there are so few nurse practitioners that at present the inclusion of them as prescribers would have little practical effect. However, this may change in the future.

[826] The Department of Health and Wellbeing noted that current legal or operational barriers that would need to be first addressed include:

1. The majority of Registered Nurses and Midwives cannot order ultrasounds or other blood tests which will be necessary to undertake independent early medical abortions.
2. Non-Medicare women who have private cover might only be covered if they see a medical practitioner.
3. Registered Nurses and Midwives are currently unable to complete or sign off on consents.
4. Prescribing medications: The majority of Registered Nurses and Midwives are unable to prescribe.

7.6.16 Australian Lawyers for Human Rights supported extending the classes of health practitioners able to be involved:

> All abortion services must be accessible … geographic accessibility is one component of this. ALHR recommends that any new legislative framework and guidelines must specifically consider the impact of the guidelines on all women who live in remote areas, and how to eliminate any barriers to them accessing abortion services. The definition of a suitably qualified medical practitioner should require the practitioner to have appropriate knowledge of abortion services without being overly prescriptive. We recommend that a definition similar to that used in the Northern Territory be adopted. Section 4 of the *Termination of Pregnancy Law Reform Act 2017* (NT) defines a 'health practitioner' as 'a person registered under one of the following health professions within the meaning of the Health Practitioner Regulation National Law (other than as a student): (a) Aboriginal and Torres Strait Islander health practice; (b) medical (c) midwifery (d) nursing (e) pharmacy'.

7.6.17 Dr Erica Millar of LaTrobe University argued in favour of extending the role of health practitioners and its role to address rural access issues:

> All health practitioners (not just medical practitioners) should be authorised to perform and assist in performing lawful terminations. This would bring SA law into line with global guidelines. The World Health Organisation stipulates that 'abortion care can be safely provided by any properly trained health-care provider, including midlevel (ie non-physician) providers' and that such a regime for provision is 'safe, and minimizes costs while maximizing the convenience and timeliness of care for the woman'. Expanding the provision of abortion to all suitably trained and accredited health practitioners would help address the shortage of abortion providers in South Australia, particularly in rural and regional areas. The careful regulation of healthcare provision in South Australia … would ensure that abortions remain safe.

7.6.18 Supporting an enhanced role for nurses in the delivery of early medical abortion services, Dr Caroline De Moel raised the importance of early medical abortion provision by primary health care nurses to improve abortion access in under-served areas. She observed:

> Primary health care nurses (PHCNs) can be used for the delivery of EMA[827] services. This evidence-based practice is already extensively implemented in a range of developed countries, including the US, France, Great Britain and Sweden, but not yet integrated in Australian practice. PHCNs in Australia, however, have proven to be capable of making autonomous decisions, and to deliver safe, effective and equitable PHC services. Moving beyond specialist physicians and allowing other health workers, such as PHCNs, to be involved with abortion provision can be an essential public health strategy that ensures an optimisation of the health workforce, improve health outcomes, is cost effective, and increases access to services, especially in service-poor areas. A nurse-led EMA model approach not only addresses the shortage of physicians but also the time-intensive aspect of the EMA process. Furthermore, it provides women with choice and flexibility, which is indispensable to their reproductive autonomy and, thus, to their overall welfare.

7.6.19 In its submission to SALRI, the Pregnancy Advisory Centre stated:

> Best practice evidence arising from early medication abortion models of care, as practiced in many parts of the world, indicate that 'nurse led' practice is appropriate and that 'non-physician' providers have been shown to provide medical abortion as effectively and safely as physicians in different settings.

7.6.20 Children by Choice argued that legislating for health practitioners to authorise or perform, or assist in performing lawful abortions aligns with modern clinical practice and the law in other

[827] EMA means early medication abortion, commonly referred to as MS-2 Step. See further below Part 8.

Australian jurisdictions (now also under the 2019 NSW Act). Children by Choice noted that evidence exists to support the safety and efficacy of medical abortion services provided by suitably trained health practitioners, including Nurse Practitioners or pharmacists, without direct supervision by a medical practitioner, and the willingness of these practitioners to provide medical abortion in this way.[828]

7.6.21 The Castan Centre for Human Rights Law supported the removal of the two doctor and the prescribed hospital requirements and advocated for the greater use of health practitioners beyond medical practitioners in light of changes in clinical practice (such as early medical abortion):

> we submit that when considering who should be permitted to perform or assist in performing terminations, reference be made to appropriately qualified practitioners with a view that different qualifications will be required for the administration of early medication abortion as against a surgical abortion.

7.6.22 In particular, the value of enhancing the role of health practitioners to facilitate rural and remote access was highlighted. The Pregnancy Advisory Centre advocated nurse led models of care or GP/nurse partnerships reduce barriers to access, stating 'shortage of physicians as well as physicians' unwillingness to provide abortion is common in rural areas, but is also becoming an increasing problem in high resource environments and in settings where abortion is legal'.[829] The Northern Territory Family Planning Welfare Association favoured skilled nurses or midwives to be able to assist in the provision of abortions, noting: 'specially trained nurses/midwives working in a supported team environment should also be able to perform medical abortions.'

7.6.23 The Human Rights Law Centre submitted that the two doctor rule should be repealed and the roles of other health practitioners recognised:

> The law currently requires two doctors to approve access to an abortion … this treats women as incapable of making decisions about their bodies and should be excluded from South Australia's reformed abortion laws. Recently reformed abortion laws, such as those in Queensland, allow nurses, midwives, Aboriginal and Torres Strait Islander health workers, pharmacists and other registered health practitioners to assist with an abortion, for example by dispensing medication authorised by a doctor. In the future, medical practice may evolve to allow a greater role for specially trained health practitioners who are not doctors, which may improve access to quality and affordable services. It is important that the law facilitate advancements in clinical practice, rather than restrict them through overly prescriptive rules.

7.6.24 Throughout SALRI's consultation, it was emphasised that surgical and medical abortions may require different qualifications, skills and training. The Castan Centre for Human Rights Law, for example, observed:

> We submit that when considering who should be permitted to perform or assist in performing terminations, reference be made to appropriately qualified practitioners with a view that different qualifications will be required for the administration of early medication abortion as against a surgical abortion.

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[828] See also Meera Kishen and Yvonne Stedman, 'The Role of Advanced Nurse Practitioners in the Availability of Abortion Services' (2010) 24(5) *Best Practice and Research: Clinical Obstetrics and Gynaecology* 569. Children by Choice added that present clinical guidelines on the provision of medication abortion require the drugs to be prescribed by a registered medical practitioner. But if this were 'to change to reflect the international landscape of medical abortion provision, the legislation would also have to be updated to reflect this. Future-proofing termination of pregnancy legislation is important and recommended.' See also below [7.7.5]–[7.7.6], [15.5.4].

[829] See further below Part 15.

7.6.25 Medical abortion is widely considered a safe and effective procedure when 'performed by appropriately trained personnel under modern medical conditions'.[830]

7.6.26 Differing views have been expressed concerning whether the role of health practitioners should be limited to administering the relevant medications, or extend to prescribing.

7.6.27 It was noted that, in other often major aspects of health care, it is routine for health practitioners (other than medical practitioners) to hold an enhanced role, particularly in relation to prescribing rights.

7.6.28 Dr Carole De Moel of La Trobe University noted:

> Currently, the extent of the primary health care nurses' involvement in the delivery of EMA services is limited by federal legal restrictions that do not allow PHCNs to prescribe abortion medication. Should the TGA change this regulation, then it needs to be assured that there are no legal impediments in the new South Australian abortion law.

7.6.29 A number of medical and health practitioners who practice in this area, observed that surgical abortion procedures are inevitably carried out by qualified medical practitioners with the routine assistance of nurses or midwives (as with any other significant medical procedure).

7.6.30 Generally, views held by professional medical and health associations and practitioners, while supporting an enhanced role of health practitioners, supported a multidisciplinary approach and a level of oversight by an experienced medical practitioner.

7.6.31 It was noted by a number of parties that, in practice, health care always involves a multi-disciplinary approach. One party stated, 'any nurse running a clinic in a rural setting will ultimately be able to access a doctor if concerned about the situation. There will be oversight.'

7.6.32 A few medical practitioners, although supportive of allowing nurses and midwives to administer MS-2 Step, expressed concern over enabling nurses and midwives to prescribe. It was noted that prescribing medication 'requires an in-depth understanding of the details of the procedure with the whole of the person's health'. The need to examine the patient in a holistic manner in the context of any other health conditions was highlighted.

7.6.33 While recommending that nurses and midwives with appropriate credentialing should be able to provide medical abortions, SA Health outlined operational barriers that need to be considered. It was explained that currently, the majority of registered nurses and midwives in South Australian cannot order ultrasounds or other blood tests, which will be necessary to undertake independent medical abortion procedures. The majority of registered nurses and midwives are also unable to prescribe. In addition, nurses and midwives are not authorised to complete or sign off on consents.

7.6.34 Indeed, a key issue highlighted in SALRI's roundtable session with the medical and legal sectors on 7 June 2019 was that an assessment needs to be made of the circumstances of the pregnancy before a medical abortion can occur. This includes gestational age, informed consent, and access to follow-up services where necessary.

7.6.35 However, several attendees suggested that this is simply a question of training and nurses are likely to be just as able to make those assessments, as long as they have access to ultrasound

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[830] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6]; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 2– 4, 10, 17–18 (although this item appears to be no longer available on the RANZCOG website). See also above Part 8.

technology. It was stated that under South Australia's health system, even in remote locations women can be brought to a suitable site for follow up services where necessary.

The roles of pharmacists in medical abortions

7.6.36 Several parties to SALRI's consultation suggested that pharmacists should be trained and empowered to deliver medical abortions, including pre-procedure screening and assessment as well as dispensing the medications. One respondent to SALRI's online survey stated 'consideration must be given to the skills of pharmacists and the role they can play given their widespread distribution in regional communities'.

7.6.37 However, overall there was little support in SALRI's consultation for pharmacists to have a role with respect to medical abortion. A clinical pharmacist supported changing the law to make it a health and not a criminal law issue but did not want the role of providing medical abortion: 'Not without doctor prescribing the medication and no to nurses. I am a pharmacist and do not feel I have the mental health qualifications and do not want the responsibility of this.'

7.6.38 The general view held by health practitioners, including pharmacists themselves, is that pharmacists should be able to dispense the prescribed medication, but should have no role in screening or prescribing themselves.

7.7 SALRI's Observations and Conclusions

7.7.1 The present requirement in South Australia for an abortion to be approved by two medical practitioners after personally examining a woman is outdated and unnecessary.

7.7.2 SALRI notes that the present requirement for two medical practitioners to personally examine the patient does not account for current clinical practice, including telehealth,[831] and other remote forms of consultation, and recommends that this requirement should be removed.

7.7.3 The prevailing view which SALRI heard from professional health bodies and medical and health practitioners is that current health regulations, policies, clinical guidelines and practice are sufficient to ensure that health practitioners are only involved in abortion procedures to the extent that it is appropriate, and in consideration of their qualifications, experience and scope of practice.

7.7.4 SALRI agrees with this approach and notes that the clinical landscape continues to evolve and, as such, legislation should not preclude changes to health regulations, policies and clinical guidelines over time, which would impact on who could perform medical abortions in the future. It is prudent for this area to be 'futureproofed'.[832]

7.7.5 The current law in South Australia provides for abortion to be dealt with solely by a medical practitioner. However, SALRI wishes to ensure that the law can evolve with clinical practice and procedure without the need for further legislative reform. In this way, the reference to 'health practitioners' throughout SALRI's Recommendations acknowledges the evolving clinical landscape (which includes potential changes to the nature of the health work force). This particularly relates to prescribing rights, which may impact who can perform and assist in an abortion in the future, including the provision of MS-2 Step.

7.7.6 SALRI is therefore of the view that any new law in South Australia should clarify that the performance of an abortion should not necessarily be confined to a medical practitioner, but should

[831] See further below [15.3.1]–[15.3.8].

[832] See also below [15.5.4], n 1607. Cf below n 1602.

(subject to national health law and practice) refer to a 'health practitioner'. In addition, a health practitioner may assist another health practitioner to perform an abortion, within the scope of their health practice. A reference to assisting in the performance of an abortion by a health practitioner includes dispensing, supplying or administering a medical abortion drug.

7.7.7 SALRI acknowledges that there was little support in consultation for pharmacists to have a role with respect to screening or providing for medical abortion and concludes that pharmacists should continue to dispense, but should have no role in screening or prescribing abortion medication. Pharmacists should not, however, be required to complete additional registration in order to dispense medication for a medical abortion.

7.7.8 SALRI considers that, consistent with Victoria and Queensland and the 2019 NSW Act, the relevant law should clarify these issues. It should not be left purely to clinical practice.

7.7.9 Recommendations

Recommendation 13

SALRI recommends that the present requirement for two medical practitioners to personally examine the patient does not account for current clinical practice, including telehealth and other remote forms of consultation, and should be removed.

Recommendation 14

SALRI recommends that any new law in South Australia should clarify that the performance of an abortion should not necessarily be confined to a medical practitioner but should (subject to national health law and practice) refer to a health practitioner.

Recommendation 15

SALRI recommends that any new law in South Australia should provide that a health practitioner may assist another health practitioner to perform an abortion, in the scope of their health practice. A reference to assisting in the performance of an abortion by a health practitioner includes dispensing, supplying or administering a medical abortion drug.

Recommendation 16

SALRI recommends that Recommendation 15 should not apply to an abortion that the assisting medical or health practitioner knows, or ought reasonably to know, is being performed outside the scope of a health practice.

Part 8 - Medical Abortions

8.1 Overview

8.1.1 Medical abortions refer to the use of pharmaceutical drugs to induce the termination of pregnancy.[833] Two medications, Mifepristone (RU486) and Misoprostol, are used in combination and taken orally to cause the woman to miscarry.[834] In Australia, Mifepristone and Misoprostol are registered for use as two mono products. A composite pack, containing both Mifepristone and Misoprostol tablets, is also available and is known as 'MS-2 Step'.[835] The medications are administered over approximately a 48-hour period and, together, these medications cause the uterus to contract and the expulsion of pregnancy tissue.[836] This expulsion usually occurs between one and six hours after taking the second medication.[837] Medical abortion can be performed up to 63 days into gestation.[838]

8.1.2 The introduction of Mifepristone and Misoprostol in Australia followed a lengthy process.[839] They have been available in Australia since 2006 through the federally administered Therapeutic Goods Administration Authorised Prescriber Scheme.[840] Both medications were

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[833] SA Health, *Early Medication Abortions* (Web Page, 28 May 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>. See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Mifepristone for Medical Termination of Pregnancy* (RANZCOG Statements and Guidelines, March 2019); Michael Permezel, Susan Walker and Kypros Kyprianou, *Beischer & Mackay's Obstetrics, Gynaecology and the Newborn* (Elsevier Australia, 4th ed, 2015) 463–4.

[834] SA Health, *Early Medication Abortions* (Web Page, 28 May 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>.

[835] Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Public Summary,* ARTG ID 210574 (Public Summary, 20 October 2016); Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Product Information,* ARTG ID 210574 (Product Information, 28 March 2017) 7. MS-2 Step is also included in the Pharmaceutical Benefits Scheme (the 'PBS'). The PBS listing requires treatment 'by a prescriber who is registered with the MS-2 Step Prescribing Program': Australian Government, Department of Health, *The Pharmaceutical Benefits Scheme* 'Mifepristone & Misoprostol' (Web Page) <http://www.pbs.gov.au/medicine/item/10211K>.

[836] SA Health, *Early Medication Abortions* (Web Page, 28 May 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>. See also Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Product Information,* ARTG ID 210574 (Product Information, 28 March 2017) 3–19; Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Consumer Medicine Information* (Consumer Medicine Information, 28 March 2017) 2; World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) 43.

[837] SA Health, Early Medication Abortions, 28 May 2019, <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>.

[838] SA Health, Abortions, 21 June 2019, <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions>. See also Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Public Summary,* ARTG ID 210574 (Public Summary, 20 October 2016); Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Product Information,* ARTG ID 210574 (Product Information, 28 March 2017) 7.

[839] The availability of Mifepristone in Australia has been described as 'convoluted and controversial': Ronli Sifris, 'The Legal and Factual Status of Abortion in Australia' (2013) 38(2) *Alternative Law Journal* 108. Caroline de Costa describes Mifepristone as 'the object of great controversy in Australia, probably greater than in any other country': Caroline De Costa, 'Medical Abortion: The Australian Experience' (2012) 7(1) *Expert Review of Obstetrics and Gynaecology* 25.

[840] Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

registered on the Australian Register of Therapeutic Goods for early termination of pregnancies as of 29 August 2012, following evaluation of their quality, safety and efficacy.[841] Mifepristone is separately registered and indicated for use in an abortion beyond the first trimester.[842] These medications are also used for other purposes in obstetrics and gynaecology.[843]

8.1.3 In August 2012, the Therapeutic Goods Administration granted approval to Marie Stopes International Australia (as sponsor) to import Mifepristone and Misoprostol into Australia through its subsidiary, MS Health Pty Ltd (MS Health), for use in both metropolitan and country areas.[844]

8.2 Professional Standards and Clinical Guidelines

8.2.1 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has issued Statements and Guidelines setting out professional standards and clinical guidelines for medical practitioners who undertake medical abortion procedures using Mifepristone and Misoprostol. RANZCOG Statements and Guidelines are regularly updated to reflect contemporary evidence-based practice. In particular, the RANZCOG Statements and Guidelines outline the expectations of the prescribing medical practitioner's role in supervising the entire process of a medical abortion, from prescribing the medications to ensuring access to after-care.[845]

8.2.2 RANZCOG, in its Statement *The Use of Mifepristone for Termination of Pregnancy*, states:

> The prescribing practitioner must supervise and take responsibility for arrangements for the entire process of termination of pregnancy from administration of mifepristone through to confirmation of termination of pregnancy and completion of follow-up including implementation of a contraceptive plan.
>
> These arrangements must include 24 hour access to specific telephone advice and support and to provision of surgical uterine evacuation or other interventions required for the management of complications, for example through on call arrangements or in an emergency department resourced to respond to women's health needs (such as required for miscarriage care).

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[841] Ibid.

[842] Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Public Summary,* ARTG ID 210574 (Public Summary, 20 October 2016); Australian Register of Therapeutic Goods, *MS-2 Step Composite Pack: Product Information,* ARTG ID 210574 (Product Information, 28 March 2017) 4–5.

[843] Misoprostol is used as part of the treatment for miscarriage. There is considerable evidence in published studies about the use of misoprostol in obstetrics. There are in excess of 200 randomised controlled trials included in the Cochrane Systematic Reviews, involving more than 35,000 women where misoprostol has been administered for obstetric or gynaecological indications: Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Misoprostol in Obstetrics and Gynaecology* (RANZCOG Statements and Guidelines, March 2016). Misoprostol is also approved in Australia for the treatment of acute duodenal and gastric ulcers: Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

[844] Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

[845] See Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Misoprostol in Obstetrics and Gynaecology* (RANZCOG Statements and Guidelines, March 2016). This Statement was reviewed in March 2019 and continues to represent the College's considered position on these issues: RANZCOG, Submission to the South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice,* 'South Australian Law Reform Institute: A Suitable Legislative Framework for Termination of Pregnancy in South Australia' (June 2019).

> Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care (in a service accepting this responsibility) from administration of mifepristone until termination of pregnancy is complete.[846]

8.2.3 In Australia, clinical guidelines provide that Mifepristone should not be used in an ectopic pregnancy.[847] It is standard practice to ensure an ultrasound is conducted prior to administering the drug both to determine the gestation and also to determine the pregnancy is intra-uterine.[848] Medical experts who have participated in SALRI's consultation have noted:

> Whilst Early Medication Abortion does not require a hospital setting for commencement, it does require pre-treatment assessment relying on pathology testing (swabs, cervical screening test, blood tests) and ultrasound, and for the patient to be within ready reach of a hospital to manage potential complications which may require emergency surgical evacuation of the uterus.

8.3 Certification Requirements

8.3.1 All medical practitioners in Australia must presently have completed the tailored educational package and be certified by MS Health in order to prescribe RU486.[849] In addition, pharmacists must also be registered with MS Health in order to possess and dispense the medications.[850]

8.3.2 While it is a Commonwealth issue, it was widely agreed amongst parties in SALRI's consultation that the present requirement of additional training, registration and/or certification for medical practitioners and pharmacists who prescribe or dispense RU486 is unnecessary. The Ceduna health practitioners that SALRI spoke to noted that the prescribing of RU486 is no different to any other medication and the additional training required seems to do no more than reflect 'an implied moral burden to be put on it'.

8.3.3 Many medical practitioners noted the level of training and certification requirements exceed that for other medications, including medications with higher rates of adverse health effects. One Australian medical specialist commented that medical abortion presents less risks for the woman at any gestation than during pregnancy or delivery, but the stigma attached to the procedure has resulted in pressure on the Therapeutic Goods Administration to establish a risk management infrastructure including additional training standards.

8.3.4 Many metropolitan, regional and rural medical practitioners who contributed to SALRI's consultation emphasised that the current training requirements create an additional barrier to access. The training and certification requirements mean that some medical practitioners, who may otherwise be willing to assist a patient to access a medical abortion, are unable to do so.

8.3.5 The Women Lawyers' Association of South Australia Inc submitted:

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[846] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Mifepristone for Medical Termination of Pregnancy* (RANZCOG Statements and Guidelines, March 2019) 5 [3.3].

[847] An ectopic pregnancy is where a fertilised egg implants itself outside the womb, usually in one of the fallopian tubes.

[848] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Mifepristone for Medical Termination of Pregnancy* (RANZCOG Statements and Guidelines, March 2019) 5 [3.5].

[849] Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

[850] Ibid. See also Anne O'Rourke, Suzanne Belton and Ea Mulligan. 'Medical Abortion in Australia: What are the Clinical and Legal Risks? Is Medical Abortion Over-regulated?" (2016) *24 Journal of Law and Medicine* 221, 228.

> In 2012 the TGA gave mifepristone, the key pharmaceutical drug in EMA, a full license but only on stringent conditions that are not applied to any other drug. This singling out of mifepristone stigmatises the women for whom it is prescribed and dissuades doctors from registering to use the drug. Removing the unnecessary restrictions that currently apply to mifepristone will give it the status of any other drug and will enable it to be made available in ways that are most suitable in providing care in diverse locations. This could include prescription by nurse practitioners … This is a matter outside the purview of South Australian law that nevertheless needs urgent attention.

8.3.6 Attendees at the 7 June 2019 roundtable with the medical and legal sectors also highlighted the issue that the requirement for pharmacies to be registered in order to provide the medications further restricts access in communities where negative attitudes towards abortion are prevalent. It was noted that pharmacists may not be willing to register with MS Health so that they can possess and dispense MS-2 Step, due to a perception that it is not commercially worthwhile to do so. All attendees to this consultation session agreed that there is no need for a second check to be carried out by a pharmacist (to confirm that the prescribing medical practitioner is registered to do so with MS Health) once a responsible medical practitioner has prescribed the medication.

8.3.7 It was revealed to SALRI that some pharmacists are reluctant to register with MS Health due to the conservative attitudes towards abortion held within the community where they operate.

8.3.8 In response to the suggestion that barriers to access for medical abortion be decreased, by no longer requiring a medical professional to be present at the time the drugs are administered, one respondent commented:

> The idea of letting women taking 'abortion tablets' (please excuse my lack of the exact terminology) without the current level of medical professional present is also very concerning. With nearly 1 in 10 women currently experiencing complications, it would seem that we are actually endangering women's lives. I find this proposal seriously flawed.

8.3.9 Conversely, Gold and Chong contend that 'eliminating the requirement to take mifepristone at the clinic disabuses the notion that there is something dangerous [about] the drug that requires it to be taken in the presence of the provider'.[851]

8.4 Risks and Complications

8.4.1 The safety and reliability of medical abortions was a prominent theme raised in consultation by parties both supportive and opposed to the decriminalisation of abortion. Parties supportive of the decriminalisation of abortion typically argued the safety and reliability of the procedure whilst parties opposed to decriminalisation typically argued the lack of safety and reliability.

8.4.2 One view widely presented to SALRI, in particular, by professional health agencies and associations (notably RANZCOG) and most health practitioners, is that medical abortions, at least when properly administered, are a safe, effective and reliable procedure.[852] This point was emphasised to SALRI by Dr Heather McNamee, a medical practitioner who runs a Queensland telehealth service (generally conducted by Skype as opposed to phone) that includes medical abortion, utilising MS-2 Step for rural, remote and Aboriginal communities. The Port Lincoln health practitioners that SALRI spoke to also highlighted their position that the drugs used for a medical abortion are generally safe

[851] Marji Gold and Erica Chong, 'If we can do it for Mifepristol, Why not for Mifepristone? The Case for Taking Mifepristone out of the Office in Medical Abortion' (2015) 92(3) *Contraception* 195.

[852] See also above [2.1.42]–[2.1.52].

and are also regularly used in obstetrics. As one author notes: 'Used in combination with a second drug, misoprostol, mifepristone has been shown to be safe, very effective, highly acceptable to women, and requiring little by way of specialist skills or facilities to administer.'[853]

8.4.3 It is significant to note that medical abortion is widely considered safe and effective when 'performed by appropriately trained personnel under modern medical conditions', and no further medical treatment is required.[854] The WHO has observed that '[t]he vast majority of women who have a properly performed induced abortion will not suffer any long-term effects on their general or reproductive health'.[855] Research has shown that there is no increased risk of adverse outcomes in subsequent pregnancies following safely performed medical abortion procedures.[856]

8.4.4 Indeed, the reputable world literature concerning known complications of MS-2 Step was reviewed by the Therapeutic Goods Administration prior to registration of Mifepristone on the Australian Register of Therapeutic Goods. The conclusion was that it was 'no more harmful than the currently available alternate treatment, which is early surgical abortion'.[857] Mifepristone has been said to provide 'increased safety for women', and is a cheaper and easier alternative to surgical abortion.[858]

8.4.5 This position is reiterated elsewhere. Dr Darren Russell, a Queensland-based medical practitioner who performs early medical abortions, told the 2016 Queensland parliamentary Committee that: 'Of the more than 3000 medical abortions we have performed over the last 10 years there have been no fatalities and very few significant complications.'[859] The Committee also cited a study which assessed the reported complications of 13,345 early medical abortions across Australia for the two years from 1 September 2009.[860] Complications arose in 519 (3.89%) of the 13,345 terminations conducted, including one death from sepsis (under 0.01% of cases). The complication in 465 cases

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[853] Sally Sheldon 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283, 284–285. See also Allan Templeton and David Grimes, 'A Request for Abortion' (2011) 365(23) *New England Journal of Medicine* 2198.

[854] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6]. See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 2– 4, 10, 17–18 (although this document appears to be no longer available on the RANZCOG website).

[855] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6.8]. The findings are inconsistent, but the evidence suggests that abortion does not increase the risk of subsequent ectopic pregnancy, placenta praevia or infertility, although there is a possible increased risk of subsequent preterm birth or miscarriage in some cases; there does not appear to be a causal relationship between abortion and breast cancer; and lawful and voluntary abortion rarely causes negative psychological consequences in healthy women: Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 25–27 (although this document appears to be no longer available on the RANZCOG website.

[856] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6.8].

[857] See Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone/Misoprostol* (Report, 13 October 2014) <https://www.tga.gov.au/sites/default/files/auspar-mifepristone-misoprostol-141013.pdf>, cited in Anne O'Rourke, Suzanne Belton and Ea Mulligan, 'Medical Abortion in Australia: What are the Clinical and Legal Risks? Is Medical Abortion Over-Regulated?' (2016) 24(1) *Journal of Law and Medicine* 221.

[858] Caroline De Costa and Naomi de Costa, 'Medical Abortion and the Law' (2006) 29(2) *University of New South Wales Law Journal* 218.

[859] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 39 [7.2.4.1].

[860] Philip Goldstone, Jill Michelson and Eve Williamson, 'Early Medical Abortion Using Low-Dose Mifepristone Followed by Buccal Misoprostol: A Large Australian Observational Study' (2012) 197(5) *Medical Journal of Australia* 282.

(3.48%) was that the attempted abortion was unsuccessful. The other main complications were 21 (0.16%) suspected infections and 11 (0.08%) haemorrhages that required blood transfusions.[861]

8.4.6 The view that medical abortions are inherently unsafe was also widely challenged in SALRI's consultation. Medical and health practitioners, professional associations and agencies, experts and others, presented SALRI with much research that contradicts claims that the potential complications associated with medical abortions are likely to result in significant adverse effects.[862] It is highly significant that Mifepristone and Misoprostol have been approved by the Therapeutic Goods Administration[863] and are also subsidised by the Pharmaceutical Benefits Scheme.[864]

8.4.7 However, a number of parties including the Australian Christian Lobby, Advocates International, Adelaide Centre for Bioethics and Culture, 40 Days for Life, Cherish Life Australia, Concerned Women's Collective, Genesis Pregnancy Support Inc, the Canberra Declaration, the UK-based Christian Legal Centre, the Right to Life Association of South Australia and Dr Šeman and Dr Turnbull, raised concerns about the safety of medical abortions, and advocated for any legislative and/or practical changes to take the risks and potential complications said to be associated with the procedure into account.[865]

8.4.8 Advocates International submitted:

> If 'safety' is defined in terms of maternal mortality (death rate) and morbidity (the complication rate), then medical abortion is less safe than early surgical abortion. For this reason, retired Canberra academic and prochoice activist, Renate Klein, was a staunch opponent of medical abortion, describing it as 'a return to backyard abortion'.

8.4.9 The Adelaide Centre for Bioethics and Culture contended:

> Medical abortion is increasingly being promoted as an option for women in rural and remote settings. However, medical abortion carries an increased risk of some very serious adverse effects that require immediate access to emergency care that does not exist in such settings. It is therefore entirely unsuitable for promotion in that setting. Moreover, women in rural and remote areas do

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[861] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 39 [7.2.4.1]. See also Philip Goldstone, Jill Michelson and Eve Williamson, 'Early Medical Abortion Using Low-Dose Mifepristone Followed by Buccal Misoprostol: A Large Australian Observational Study' (2012) 197(5) *Medical Journal of Australia* 282.

[862] See, for example, Felicity Goodyear-Smith, Alison Knowles and Jonathan Masters, 'First Trimester Medical Termination of Pregnancy: An Alternative for New Zealand Women' (2006) 46(3) *Australian and New Zealand Journal Of Obstetrics and Gynaecology* 193; Caroline de Costa et al, 'Introducing Early Medical Abortion in Australia: There is a Need to Update Abortion Laws' (2007) 4(4) *Sex Health* 223; Caroline de Costa, 'Use of Mifepristone for Medical Abortion in Australia, 2006–2009 (2011) 194(94) *Medical Journal of Australia* 206; Philip Goldstone, Jill Michelson and Eve Williamson, 'Early Medical Abortion Using Low-Dose Mifepristone followed by Buccal Misoprostol: A Large Australian Observational Study' (2012) 197(5) *Medical Journal of Australia* 282; Caroline de Costa and Michael Carrette, 'Early Medical Abortion: Available and Safe' (2012) 197(5) *Medical Journal of Australia* 257; Philip Goldstone, C Walker and K Hawtin, 'Efficacy and Safety of Mifepristone-Buccal Misoprostol for Early Medical Abortion in an Australian Clinical Setting' (2017) 57(3) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 366.

[863] Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone/Misoprostol* (Report, 13 October 2014) <https://www.tga.gov.au/sites/default/files/auspar-mifepristone-misoprostol-141013.pdf>.

[864] Department of Health, *Pharmaceutical Benefits Scheme*, 'Mifepristone, tablet 200mg, Mifepristone LinepharmaTM, and GyMiso®' (Public Summary Document, March 2013) <http://www.pbs.gov.au/info/industry/listing/elements/pbac-meetings/psd/2013-03/mifepristone>.

[865] This was highlighted in such areas as the role of telehealth and the use of other health practitioners. See also below [15.3.1]–[15.3.8].

> not have easy access to treatment for a raft of health needs. Abortion should not be singled out as the one procedure that is preferenced above all others for special treatment (at public expense).

8.4.10 SALRI notes that the 1969 South Australian Act was designed to address the serious issues which were caused by 'backyard abortions', most significantly, the prevalence of sepsis and mortality rates. These complications are no longer seen in the use of medical abortions as occurred in 1969.

8.4.11 Submissions to SALRI by parties who disputed the safety of medical abortion often made reference to the most recent *Pregnancy Outcome in South Australia* report published by SA Health.[866] The report notes that, in 2016, abortions using Mifepristone and Misoprostol resulted in 142 complications, representing 9.8% of all abortions using this method, compared to a 0.8% complication rate for abortions using vacuum aspiration.[867] This complication rate was emphasised to demonstrate what were said to be the unsafe implications of Mifepristone and Misoprostol. The Right to Life Association of South Australia, for example, stated:

> It is a fairly standard claim that medical abortion is highly effective, extremely safe and acceptable (whatever 'acceptable' can be taken to mean for a woman who may feel her options are limited). The rate of effectiveness of medical abortion in the first trimester using Mifepristone/Misoprostol in controlled research environments is around the 90–95% mark, but in a real-world setting is likely to be lower. Moreover, most of the studies were for less than nine weeks gestation, later gestations entailing lower effectiveness, and medical abortion in the second trimester having lower rates of effectiveness still.
>
> Furthermore, taking a regime of Mifepristone/Misoprostol outside of a clinic setting will likely lead to poorer effectiveness because dose, timing and stage of gestation are all critical determinants. It would not be unrealistic to expect that around 1 in 10 women who have a medical abortion would return for follow up surgery. This does not translate to medical abortion being 'highly effective'.

8.4.12 However, the 'complication rate' requires closer scrutiny. SALRI notes that 1455 patients out of a total of 4346 undertook an abortion using MS-2 Step over the more intrusive surgical option. This represents just under 33.5% of all abortions in South Australia in 2016.[868] Of the 142 women with complications reported using MS-2 Step, 111 of these were due to retained products of conception.[869] Of the 173 complications recorded as resulting from a termination of pregnancy in 2016 (medical and surgical), retained products of conception was the most common (123 women), representing 71.1% of all complications and occurring in 2.8% of all abortions in 2016.[870]

8.4.13 Figures from the Therapeutic Goods Administration in 2012 recorded that the rate for failed abortions requiring intervention and surgical evacuation of the uterus nationally was at rates of up to 7%.[871]

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[866] Pregnancy Outcome Unit, SA Health, *Pregnancy Outcome in South Australia 2016* (Report, September 2018).

[867] Ibid 51 [6.8].

[868] Ibid 50 [6.7], Table 79.

[869] Ibid 51 [6.8]; See also Table 83, 52.

[870] Ibid 50 [6.8], Table 81.

[871] Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone* (Report, 13 October 2014) 52.

8.4.14 South Australian data from the period between 2013 and 2017 has shown an overall 6.6% complication rate for medical abortion procedures using MS-2 Step.[872] The majority of the adverse effects (5.5% of procedures) were attributed to retained products of conception, and required a subsequent surgical procedure.[873] It should be noted that retained products of conception requiring a subsequent surgical procedure can also occur after a spontaneous miscarriage,[874] which is the same biological process caused by MS-2 Step.[875] Dr Heather McNamee noted to SALRI that the likely complication rates of MS-2 Step and a spontaneous miscarriage are largely the same.

8.4.15 Dr McNamee stated to SALRI that the use of MS-2 Step is a safe and effective procedure for remote and rural patients. She explained that the '9% complication rate' of MS-2 Step includes all possible complications such as pain and bleeding, and most do not require further intervention. Dr McNamee elaborated that 3% of procedures resulted in retained products of conception that required further action. This could include either communication with health staff, a further dosage of mifepristone and, for a minimal proportion of women, surgical intervention.

8.4.16 Mulligan and Messenger also confirm: 'Both surgical and medical abortion are safe and effective, however, retained products of conception treated with [dilation and curettage] are more likely after early medical abortion.'[876]

8.4.17 Importantly, SA Health emphasised, in its consultation with SALRI, the need to distinguish between side effects that are intrinsic to the process of an abortion and the potential adverse effects of the medications.

8.4.18 The Therapeutic Goods Administration states that 'side effects related to the abortion itself include prolonged post-abortion bleeding, spotting, severe haemorrhage, endometriosis, breast tenderness, heavy bleeding and fainting'.[877]

8.4.19 Side effects of the medication commonly include nausea, vomiting, diarrhoea, dizziness, abdominal pain, headache, fatigue, uterine spasm and vaginal bleeding.

8.4.20 Vaginal bleeding is inherent in the process of an abortion and is not considered an adverse effect of the drug.[878] Most studies report a duration of bleeding of around 12 days, but in some cases,

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[872] Pregnancy Outcome Unit, Prevention and Population Health Branch, SA Health, Government of South Australia, Submission to the South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice,* 'Early Medication Abortion', 7 June 2019.

[873] Ibid.

[874] If a miscarriage is incomplete and the remaining pregnancy tissue does not pass naturally, a medical practitioner may recommend a dilation and curettage: The Royal Women's Hospital, *Treating Miscarriage* (Web Page) <https://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-problems/early-pregnancy-problems/treating-miscarriage/>.

[875] National Women's Health Network, *Health Facts: Abortion With Pills and Spontaneous Miscarriage* (Web Page, August 2019) <https://nwhn.org/abortion-pills-vs-miscarriage-demystifying-experience/>.

[876] Ea Mulligan and Hayley Messenger, 'Mifepristone in South Australia: The first 1343 Tablets' (2011) 40(5) *Australian Family Physician* 345, cited in Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

[877] Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

[878] Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone* (Report, 13 October 2014) 50. See also SA Health, *Early Medication Abortions* Web Page, 28 May 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>.

prolonged bleeding can last up to a period of 60 days.[879] It is usual for two to three days of bleeding to be considered heavier than regular menstrual bleeding.[880] Significant bleeding that leads to a transfusion occurs at a rate of around 0.12% or less.[881]

8.4.21 The known complications resulting from medical abortion include failed or incomplete termination (retained products of conception), infection, cervical injury, haemorrhage, and uterine perforation or rupture.

8.4.22 Submissions to SALRI made reference to complications such as pain, bleeding, low-grade fevers resulting from retained products of conception, haemorrhage, uterine perforation, bowel or bladder injury and failed abortions.

8.4.23 It is significant that serious complications arising from medical abortion are rare.[882] Out of a total of 6621 medical abortion procedures performed in South Australia between 2013 and 2017, there was one case of a perforated uterus, one case of sepsis, and 14 cases of uterine infection.[883]

8.4.24 Serious infection has been found to occur in less than 1% of cases.[884] Uterine rupture is very rare, particularly prior to 18-weeks' gestation, except in the presence of a uterine scar following a previous caesarean section procedure.[885] The risk of maternal death is estimated at less than 1 in 100,000.[886]

8.4.25 It has been repeatedly stated in SALRI's consultation that, while abortion by any method carries a degree of risk, reputable research confirms that continuing a pregnancy and going through childbirth holds a greater risk to a woman's health.[887]

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[879] Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone* (Report, 13 October 2014) 50.

[880] Ibid.

[881] Ibid 54.

[882] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6]; RANZCOG, 'Termination of Pregnancy: A resource for health professionals' (November 2005) 2–3, 11–12. See also SA Health, *Early medication abortions*, 28 May 2019, <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions> ; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 2– 4, 10, 17–18 (although this item appears to be no longer available online). In a large scale study of 233,805 medical abortions in the United States, 'significant adverse events and outcomes' were reported in only 0.65% of cases. The majority of complications were incomplete abortions. See Kelly Cleland et al, 'Significant Adverse Events and Outcomes after Medical Abortion' (2013) 121(1) *Obstetrics and Gynecology* 166.

[883] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 2– 4, 10, 17–18 (although this item appears to be no longer available online).

[884] Kelly Cleland et al, 'Significant Adverse Events and Outcomes after Medical Abortion' (2013) 121(1) *Obstetrics and Gynecology* 166.

[885] Therapeutic Goods Administration, *Australian Public Assessment Report for Mifepristone*. (Report, 2012)54.

[886] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (RANZCOG Statements and Guidelines, November 2005) 2, 10–11, 13 (although this item appears to be no longer available online). See also World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [2.2.6]. This compares with the estimated rate of maternal death from unsafe terminations of 30 per 100 000 terminations. Unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both: World Health Organization, *Preventing Unsafe Abortion* (Web Page, 19 February 2018) <http://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion>.

[887] See SA Health, *Myths and Facts About Abortion* (Web Page, 24 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/healt

8.4.26 Removing access to medical abortions would lead to the need for all abortions to be performed surgically, resulting in an additional 6257 surgical procedures. The risks associated with undertaking a surgical procedure are significantly higher than those associated with a medical abortion. Additionally, such a significant increase in surgical procedures would add an additional burden to South Australia's health system, and impact on health service provision generally.

8.5 Medicare Item Number

8.5.1 Both medical practitioners and pharmacists and parties such as the Women Lawyers' Association of South Australia Inc have raised to SALRI that MS-2 Step does not have a specific Medicare item number. A number of rural medical practitioners submitted that this makes the administration and recording of appointments and the dispensing of the drugs considerably more onerous than the vast majority of other medications.

8.5.2 One rural medical practitioner commented: 'This adds to the stigma that this is a thing we shouldn't be doing. It differentiates early medication abortion from every other medical procedure.'

8.5.3 The TGA notes that it is not usual practice for a separate Medicare item to be introduced for the prescribing of medication and that the prescribing of medications for abortions would usually be covered by Medical Benefits Scheme (MBS) items covering GP attendances (covered by a combination of standard long and short consultations),[888] non-referred specialist attendances[889] or referred specialist consultations.[890]

8.5.4 Any surgical procedures required as follow-up treatment to medical terminations would be claimed under the appropriate Medicare item.[891]

8.5.5 While use of a Medicare item may assist in administrating appointments and dispensing medication for medical abortion, data collection for such services would be incomplete as the identification of MS-2 Step using Medicare item numbers would not include those patients who do not hold, or are not entitled to hold, a Medicare card and therefore pay full fees for appointments and medication.[892]

h+conditions+prevention+and+treatment/abortions/myths+and+facts+about+abortion>. Many more women die from childbirth than those undergoing any form of abortion. See Anne O'Rourke, Suzanne Belton and Ea Mulligan, 'Medical Abortion in Australia: what are the Clinical and Legal Risks? Is Medical Abortion Over-Regulated?' (2016) 24(1) *Journal of Law and Medicine* 221.

888 MBS items 3, 23, 36 or 44. See Therapeutic Goods Administration, *Registration of Medicines for the Medical Termination of Early Pregnancy* (Web Page, 30 August 2012) <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

889 MBS items 52, 53, 54 or 57. See ibid.

890 MBS items 104 and 105. See ibid.

891 MBS item 35643 (for the evacuation of the contents of the gravid uterus by curettage or suction curettage (including for incomplete miscarriage)); MBS item 16530 (management of second trimester labour – 14 weeks to 15 weeks and 6 days); or MBS item 169531 (management of second trimester labour – 16 weeks to 22 weeks and 6 days). See Department of Health, *MBS Online* (Web Page) <http://www9.health.gov.au/mbs/search.cfm>.

892 SALRI notes the interrelation between this issue and the two month residency requirement in that both may affect similar groups of women, such as international students.

8.6 SALRI's Observations and Conclusions

8.6.1 SALRI notes that both Mifepristone and Misoprostol have been registered on the Australian Register of Therapeutic Goods for early termination of pregnancies since 2012, following the evaluation of their quality, safety and efficacy. In addition, Mifepristone is separately registered and indicated for use in an abortion beyond the first trimester.

8.6.2 SALRI notes the concerns raised in consultation by parties opposed to the decriminalisation of abortion as to the safety and reliability of medical abortion, especially in a rural and remote context. SALRI does not the doubt the sincerity of these concerns. However, SALRI has no reason to doubt the safety and reliability of these drugs if administered by and/or under the supervision of a suitable qualified health practitioner.[893] Medical abortion appears an established and safe procedure. The '9.8% complication rate' does not bear the interpretation placed on it by some parties, and largely reflects complications relating to retained products of conception. These complications require a relatively simple surgical procedure to complete the abortion.

8.6.3 Professional health associations, the Department of Health and Wellbeing, most health practitioners and parties at SALRI's roundtables with the medical and legal sectors and the disability sector supported the use of MS-2 Step. There was also overwhelming support in SALRI's trips to Whyalla, Port Augusta, Ceduna and Port Lincoln for medical abortion.

8.6.4 It is significant that the relevant drugs are approved by the TGA and are subject to strict (many health practitioners would say too strict) controls as to their prescription and use. It is also significant that the use of these drugs for medical abortion was widely, though not universally, supported in SALRI's consultation.

8.6.5 SALRI agrees with the prevailing view that medical abortion is of benefit in addressing some of the problems in rural, regional and remote access identified in SALRI's research and consultation.

8.6.6 SALRI acknowledges that while it is a Commonwealth issue, the present requirements of additional training, registration and/or certification for medical and other health practitioners who prescribe or dispense MS-2 Step are unnecessary. Noting the barriers to access they create, SALRI recommends these additional requirements be removed.

8.6.7 SALRI suggests that the Commonwealth should add a Medicare identification number for appointments related to both abortion consultations and abortion procedures, as well as the dispensing of MS-2 Step for pharmacists, to reflect the work involved in these appointments and better collect appropriate data sets.

[893] *R v Kaur* [2015] EWCA Crim 2202 (29 October 2015) illustrates the risks that may arise from medical abortions involving unqualified parties.

8.6.8 Recommendations

Recommendation 17

SALRI recommends that the present additional Commonwealth administrative requirements[894] relating to the authorisation and/or registration of medical and other health practitioners to prescribe or dispense MS-2 Step should be removed.[895]

Recommendation 18

SALRI recommends that the Commonwealth should add a Medicare identification number for appointments related to both abortion consultations and abortion procedures, as well as the dispensing of MS-2 Step for pharmacists, to reflect the work involved in these appointments and better collect appropriate data sets.

[894] SALRI acknowledges the overwhelming agreement received from health practitioners in this area who noted that the additional requirements for proscribing and dispensing MS-2 Step are more onerous than for other medications which have more severe side effects for the patient and are more likely to cause harm if incorrectly proscribed.

[895] SALRI further notes the comments of regional, rural and remote service providers who noted to SALRI that the time required to satisfy these requirements, when the procedure may only be sought by a small number of women in any year, is sometimes considered to be not worthwhile and therefore the service is not available in the area despite health practitioners being present who would otherwise be willing and able to assist.

Part 9 - Facilities

9.1 The Current Position

9.1.1 The current law in South Australia requires any abortion to be carried out at a 'prescribed hospital'.[896] The list of prescribed hospitals in which abortion procedures can be undertaken is set out in Schedule 3 of the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA).[897] However, many of the prescribed hospitals listed in the Regulations are no longer in operation, or no longer have the clinical staff or facilities to undertake abortion procedures in accordance with SA Health guidelines, either medical, surgical or both.

9.1.2 The SA Health website provides a current list of public health services, by area, for women with an unplanned pregnancy.[898]

9.1.3 Consistent with the understanding of clinical practice in 1969, there is no current legislative distinction between the facilities required for a medical abortion or a surgical abortion although, in practicality, the needs of these procedures are substantially different. 'It is important,' as the VLRC observed, 'that the law does not restrict the development of best clinical practice for either surgical or medical termination.'[899]

9.1.4 There was particular concern in SALRI's consultation that present law and practice in South Australia, including the prescribed hospital rule, undermines rural, remote and regional access.[900] The general view raised to SALRI is that the 1969 requirement for prescribed hospitals reflects the position from when abortion was limited to surgical procedures, and no longer reflects contemporary clinical practice or medical advances, particularly the availability and widespread use of early medical abortion ('EMA').[901] Indeed, the current requirement limits the availability of services.[902] It was emphasised that the prescribed hospital requirement undermines the provision of early medical abortion.

9.1.5 This was also the position expressed by various medical and other health practitioners as well as by professional medical and health associations and at SALRI's consultation sessions with medical and legal sectors and groups in favour of decriminalisation on 7 June 2019. There was wide agreement that the requirement that any abortion should only take place at a 'prescribed hospital'

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[896] *CLCA* s 82A (1)(a).

[897] See Appendix D.

[898] According to the SA Health website, metropolitan services for women with an unplanned pregnancy are available at four locations: Pregnancy Advisory Centre, Flinders Medical Centre, Noarlunga Hospital and Lyell McEwin Hospital. Regional services are available at Berri Hospital, Clare and Burra Hospital, Gawler Health Service, Murray Bridge, Port Lincoln, Tanunda Hospital and Wallaroo Community Hospital. Two hospitals in Victoria are also listed for women in the South-East of South Australia (Geelong Hospital and Warrnambool Public Hospital) SA Health, *Unplanned Pregnancy Services* (Web Page, 26 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/womens+health+services/unplanned+pregnancy+services>.

[899] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 130 [8.79].

[900] See also below Part 15.

[901] Misgivings were expressed by a number of parties opposed to the decriminalisation of abortion who either did not support allowing an abortion to be carried out at other than at a prescribed hospital or that medical abortion should only be carried out within a certain distance of a prescribed hospital. These parties raised the complications and risks said to be inevitably associated with such procedures, especially in a rural or remote context.

[902] These findings are consistent with those of the QLRC and VLRC. See Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 104–5 [3.231]–[3.235]; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 128–30 [8.162]–[8.180].

should be removed as it is seen as outdated, misplaced and does not reflect current clinical practice or medical technology. This theme was emphasised to SALRI by rural medical and health practitioners.

9.1.6 SALRI notes, for example, the suggestion of RANZCOG:

> RANZCOG does not see any need for a specific provision in the law requiring abortions to be performed in prescribed hospitals. The regulatory framework that applies to all health services provides adequate protection for women undergoing abortion, and there is no reason to differentiate abortion from other medical services. Moreover, requiring abortions to be performed in prescribed hospitals limits access to early medical abortion which can safely be provided outside a hospital setting, subject to appropriate arrangements being in place for back-up or emergency care in the event of complications.

9.1.7 This position also overwhelmingly emerged during SALRI's trips to Port Augusta, Whyalla, Ceduna and Port Lincoln and in discussion with other medical and health practitioners (although there was a view expressed by a handful of practitioners that abortions should only take place in Adelaide). It was highlighted that the present 'prescribed' hospital requirement is not only unnecessary, but now also acts to impede effective and equitable access, especially for regional, rural and remote communities. Rural practitioners highlighted that the requirement undermines the use of EMA.

9.1.8 The Human Rights Law Centre and other parties noted that the prescribed hospital rule does not reflect modern medical practice and should be repealed. The Human Rights Law Centre said:

> The law restricts abortion to prescribed hospitals. But for the law, early medication abortion could be prescribed by a local GP, as is the case elsewhere around Australia. The hospital requirement has also precluded the use of telehealth services. Telehealth services are used in all other states and territories (except the ACT) to provide women with access to early medication abortions. This severely disadvantages women in regional and remote South Australia, who have to travel long distances to hospitals at considerable financial, social and emotional cost. Law reform should ensure that all South Australians can take advantage of developments in medicine as they happen. This means not limiting in law access to abortion services to prescribed hospitals or facilities. Recent reforms in Victoria, Queensland and the Northern Territory have all excluded such a requirement.

9.1.9 Associate Professor Baird noted that, notwithstanding the high quality of services at the Woodville clinic and other city hospitals, the current law in South Australia now stands in the way of the effective provision of contemporary services. Associate Professor Baird continued:

> This is acutely so in relation to the requirement that all abortions are provided in prescribed hospitals and that two doctors must approve an abortion. These requirements weigh heavily on women in rural and remote locations (88% of whom must travel to Adelaide to access a service) and obstruct the provision of Early Medication Abortion (EMA) by GPs in primary health care settings. Mifepristone, one of the two pharmaceutical drugs that induce EMA, has been available in Australia since 2006 and subsidised by the PBS since 2013.

9.1.10 The impact of the current legal requirement for all abortions to be performed at a prescribed hospital is most significant in the context of regional, rural and remote (as well as Aboriginal)[903] access. There are a very limited number of prescribed hospitals in these rural, remote or regional areas, many of which are unable, due to staffing expertise and availability and/or issues of

[903] See further below Part 16.

conscientious objection,[904] to provide medical and/or surgical abortion procedures.[905] The majority of women living in regional South Australia have to travel to Adelaide to access abortion services. This involves delays, stress and an undue financial burden.[906] This theme was especially expressed by medical and other health practitioners in SALRI's trips to Port Augusta, Whyalla and Ceduna.[907]

9.1.11 One party, reflecting a widely expressed theme, noted to SALRI that women living in remote and rural areas 'should be able to access the quickest and most effective reproductive healthcare in their own communities without needing to travel thousands of kilometres from their families to a "prescribed hospital".'

9.1.12 Parties opposed to the decriminalisation of abortion favoured the retention of the two doctor rule. Parties such as Dr Šeman and Dr Turnbull, Advocates International, 40 Days for Life, the Australian Christian Lobby and Cherish Life Australia did not support allowing anyone other than medical practitioners to carry out surgical or medical abortions. They raised the complications and risks said to be inevitably associated with such procedures, especially in a rural or remote context. They raised particular concern over the risks said to be associated with early medical abortion.

9.2 Appropriate Facilities

9.2.1 Several parties raised concerns to SALRI that the removal of the 'prescribed hospital' requirement would create the risk that surgical or medical abortions (after nine weeks) would not be provided at appropriate facilities. The particular risks said to be associated with early medical abortion were outlined.[908] Dr Šeman and Dr Turnbull, for example, said it would compromise patient safety to permit surgical and medication abortions to be performed outside of a hospital 'of prescribed class' or a purpose-built medical facility like the Pregnancy Advisory Centre at Woodville.

9.2.2 However, the general view to SALRI from professional bodies and medical and other health practitioners is that current clinical guidelines and practice are sufficient to regulate the safe and effective provision of both surgical and medical abortion procedures, and ensure they are carried out at suitable facilities. It was emphasised that the prescribed hospital requirement is not only restrictive, but unnecessary and costly.

9.2.3 As the VLRC observed: 'Historically, the policy aim of limiting abortions to prescribed facilities was to ensure proper medical standards and hygiene. Laws of general application now deal with these important issues in most places.'[909]

9.2.4 The laws and guidelines that regulate facilities that provide abortion services are discussed above in Part 7.

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[904] See further below Part 17.

[905] Some of the listed hospitals also no longer exist. Seven regional facilities at which abortion services are provided are listed on the SA Health website: SA Health, *Unplanned Pregnancy Services* (Web Page, 26 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/womens+health+services/unplanned+pregnancy+services>.

[906] See below Part 15.

[907] It should be noted that SALRI was told that at least some women in rural and remote areas choose to travel to Adelaide out of a wish to for anonymity.

[908] See further above Part 8.

[909] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 128 [8.164].

9.3 Medical Abortion and the Prescribed Hospital Requirement

9.3.1 In 2016, pharmaceutical termination of pregnancy using MS-2 Step was used in 33.5% of all abortions performed in South Australia, increasing in use over the past 5 years (27.2% of all terminations in 2012).[910] However, while medical abortion is commonly selected as a method of termination, the 1969 legal requirements prevent women from taking MS-2 Step at home, or at an alternative health facility other than a 'prescribed hospital'.

9.3.2 The effect of the current law is that women are required to take both doses of the MS-2 Step at a prescribed facility. In most cases, this means that women must attend a prescribed hospital on two separate occasions over a 24 to 48 hour period.[911]

9.3.3 It was noted by a number of parties to SALRI's consultation that, as a result of being required to attend to a prescribed hospital on two separate occasions, many women elect to have a surgical rather than a medical procedure. This is especially so in the case of women travelling from regional, rural or remote areas of South Australia.

9.3.4 Several attendees at SALRI's roundtable with faith groups and NGOs noted their support for the present prescribed hospital rule. The risks said to be present were highlighted, particularly those associated with medical abortion. Many attendees were opposed to telemedicine as well as RU486 being made available for at-home use, due to the possibility of complications and the lack of access to hospitals in some regional and rural areas. One attendee expressed a view that 'ease and access shouldn't supersede safety'.

9.3.5 However, there is no evidence relating to safety or effectiveness of medical abortion that should prevent women from taking the drugs at home.[912] Indeed, as the expulsion of pregnancy tissue occurs between one and six hours after taking the second medication,[913] it is currently common practice for women to complete the abortion at home.

9.3.6 Medical and health practitioners and professional bodies SALRI consulted widely agreed there is no need for women to take the medication at a prescribed facility, and in fact it could be safer to allow women to take the medication at home. It has been raised by a number of parties that many women travelling to a prescribed hospital from rural or remote regions may not have reached home before expulsion occurs, and as such many women complete the abortion while travelling.

9.3.7 Enabling women to take MS-2 Step at home is consistent with the approach taken in other Australian jurisdictions, in accordance with best practice guidelines of leading health authorities. These guidelines enable women to take the prescribed medication at home with support and follow-up care if required.[914]

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[910] Pregnancy Outcome Unit, SA Health, *Pregnancy Outcome in South Australia 2016* (Report, September 2018) 49.

[911] Generally, the woman is administered Mifespristone (RU486) at the initial appointment, and 24–48 hours later the woman returns and Misoprostol is administered.

[912] Medical abortion is widely considered safe and effective when 'performed by appropriately trained personnel under modern medical conditions', and no further medical treatment is required. See further Part 8.

[913] SA Health, *Early Medication Abortions* (Web Page, 28 May 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions>.

[914] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.224]–[3.225]; See also South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2423–2428 (Hon Tammy Franks).

9.3.8 This was also the view held by professional medical and health associations at SALRI's consultation session with medical and legal sectors on 7 June 2019. There was wide agreement that the requirement that any procedure could only take place at a 'prescribed hospital' is outdated, misplaced and does not reflect current clinical practice or medical technology. These parties emphasised that, with proper instruction, phone support and access to follow-up care if required, MS-2 Step could safely be taken at home. A number of medical and health practitioners have explained that the medical abortion process is comparable to a spontaneous miscarriage, which many women experience at home without medical supervision.[915]

9.4 SALRI's Observations and Conclusions

9.4.1 The QLRC did not favour any formal requirement for an abortion to be carried out at only a 'prescribed facility'. The QLRC said 'a requirement of this kind could operate as a barrier to the provision of medical terminations, particularly in rural, remote and regional areas of Queensland'.[916] SALRI concurs with the QLRC. The safety of facilities and procedures carried out there should be governed under general health law, as is the case for all other health services. This approach would treat abortion consistently with other procedures carrying a similar level of risk.

9.4.2 SALRI is of the view that the current requirements in South Australia that an abortion can only be carried out or administered at a 'prescribed hospital' should not be retained. There is no sound reason for the retention of the prescribed hospital rule. This requirement is at odds with current clinical practice and undermines equitable and effective access, especially for regional, rural, remote and Aboriginal communities. It restricts the use of telehealth in relation to abortion.

9.4.3 Recommendation

Recommendation 19

SALRI recommends that the present requirement in South Australia that an abortion can only be carried out or administered at a 'prescribed hospital' does not account for current clinical practice and should be removed.

[915] For discussion of early medication abortion and the general view that it is safe and effective, see above Part 8.

[916] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.235].

Part 10 – Criteria for Lawful Terminations

10.1 The Current Position

10.1.1 An abortion can only be lawfully performed in South Australia where the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated. It is also currently permissible where there is a substantial risk that the child would suffer from such physical or mental abnormalities as to be seriously handicapped.[917]

10.1.2 The present law also requires any abortion to be carried out in a prescribed hospital by two medical practitioners who have personally examined the woman.

10.2 Grounds for Termination

10.2.1 One of the difficulties in framing a list of specific grounds for an abortion is that the specific circumstances are not necessarily decisive grounds, but represent one or more of several possible factors that may inform a decision about whether to undertake an abortion.

The Victorian experience

10.2.2 The option of different criteria was opposed in the VLRC's consultation.[918] It was noted as undermining patient autonomy and clinical practice. It was described as 'particularly harsh',[919] 'arbitrary'[920] and 'extremely problematic'.[921]

10.2.3 The VLRC considered the role and value of criteria and came up with three models for consideration.

10.2.4 Model A was a statutory confirmation of the *Davidson* criteria. This approach restricts the ground upon which a woman may have an abortion at any gestational stage to the risk of physical or mental harm to her if she does not have an abortion. 'Final decision-making responsibility rests with the medical practitioner who performs or supervises the abortion.'[922]

10.2.5 Model B would allow a woman to have final decision-making responsibility about an abortion until 24 weeks gestation. After this point, the decision-making responsibility would shift to her medical practitioner, who must determine if there is a risk of physical or mental harm to her for an abortion to be lawful.[923]

10.2.6 Models A and B contain a professional sanction if a medical practitioner performs an unauthorised abortion.

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[917] *CLCA* s 82A.

[918] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 78–80 [5.63]–[5.81]

[919] Ibid 78 [5.66].

[920] Ibid 79 [5.77].

[921] Ibid.

[922] Ibid 86 [6.8]. See also at: 87–89.

[923] Ibid 86 [6.9]. See also at: 90–92.

10.2.7 Model C allows a woman to have final decision-making responsibility about an abortion at all gestational stages.[924]

10.2.8 Model C adopts the ACT approach. The VLRC noted that this approach does not involve criteria or any formal distinctions based on gestational stages. The VLRC observed that the policies upon which this model is based may be described as follows:

> A woman retains the right to determine what medical procedures she will undergo and what relationships she will enter throughout pregnancy [and] abortion should be regulated in the same way as any other medical procedure.[925]

10.2.9 The VLRC noted that (as with the QLRC) it received divergent views about the role and value of criteria such as threat to a woman's life (and rape),[926] risk to a woman's physical and/or mental health,[927] social and economic factors[928] and fetal disability[929] in determining access to abortion. The VLRC observed that 'a significant majority' of parties favouring decriminalisation argued that a woman's consent should be the only requirement of lawful abortion performed by a qualified practitioner, as with any other medical procedure.[930] Opponents of decriminalisation wanted further requirements that the woman must meet before an abortion could be lawful,[931] typically that her life was at immediate risk.[932]

10.2.10 The VLRC proposed as one of its three models an approach based on the ACT. The VLRC discussed this model as follows:

> Under this model abortion would be governed by the same legal rules which regulate all other medical procedures. An abortion performed by a medical practitioner would be lawful at any stage of a pregnancy if the woman gives her consent and if the medical practitioner considered it ethically appropriate to perform that procedure. Abortion, like any other medical procedure, would be a private decision for a woman in consultation with her doctor. The consent of a woman would provide the legal authority for an abortion when it was performed, or supervised by, a medical practitioner. Medical practitioners would make their own individual decisions about whether they considered it ethically appropriate to provide abortions in particular cases. This model does not involve abortion on demand because a woman must engage the services of a medical practitioner who is under a general legal obligation to provide services which are clinically appropriate.[933]

The Queensland experience

10.2.11 The QLRC also considered these issues at some length and found no agreement.

10.2.12 Many parties expressed their opposition to the QLRC to the inclusion of a list of specific grounds that would need to be satisfied to perform a lawful abortion.[934] It was noted that this would

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[924] Ibid 86 [6.11]. See also: at 93.

[925] Ibid 93 [4.4].

[926] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 77 [5.50]–[5.52].

[927] Ibid 77 [5.53]–[5.56].

[928] Ibid 77–78 [5.57]–[5.58]

[929] Ibid 78 [5.59]–[5.61].

[930] Ibid 76 [5.43].

[931] Ibid 76 [5.44].

[932] Ibid 77 [5.50].

[933] Ibid 93 [1.1]–[1.3].

[934] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 79 [3.116].

usurp the woman's decision-making capacity and remove her autonomy.[935] Sustainable Population Australia Inc (Queensland Branch) opposed a list of specific grounds:

> There should be no specified grounds, at least up to a gestational limit if one applies. Freedom of choice means freedom to choose on what grounds … it is for her to decide what weight they [any grounds] carry. We consider particularly obnoxious the notion that the State could stipulate which abortion requests are worthy or unworthy.[936]

10.2.13 It was also noted to the QLRC that no criteria can ever cover all the infinite and individual circumstances that may arise.[937] The QLRC quoted RANZCOG's comments to the 2016 Queensland Parliamentary Committee:

> No specific clinical circumstance should qualify or not qualify a woman for termination of pregnancy. The impact of any particular condition is highly individual and often complex. No list can be complete and becomes highly restrictive in the most complex of circumstances. A list may also be seen as offensive to those affected with specific disabilities.[938]

10.2.14 The contrary view to the QLRC from parties opposed to the decriminalisation of abortion was that abortion should only be permitted (if at all) in restrictive circumstances, typically a significant threat to the woman's life (or least physical health).[939] As one party explained: 'Abortion itself is not without medical risk — so any lawful abortion needs to be only on rigorous medical grounds … In short, not simply a woman's right under any circumstances by virtue of the fact that we are considering another human life.'[940]

10.2.15 There was support to the QLRC for the ACT on request approach without criteria.[941] The Australian Psychological Society Limited, for example, preferred an approach that 'recognises women as competent and conscientious decision-makers' and treats abortion like other medical services that are provided in compliance 'with professional, ethical, legal and best practice Australian standards.'[942]

10.2.16 The QLRC noted that the ACT approach 'most closely aligns with the principles of reproductive autonomy and privacy'.[943] The QLRC outlined various arguments in favour of an on request approach without criteria:

> It removes legal barriers to access.
>
> It accords maximum respect for women's autonomy and choice.
>
> It allows medical practitioners to focus on their primary role of determining their patients' clinical interests, rather than interpreting and applying additional legal tests.[944]

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[935] Ibid 79–80 [3.120]–[3.123].

[936] Ibid 88 [3.153].

[937] Ibid 79 [3.117]–[3.119].

[938] Quoted by Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 98 [3.201].

[939] Ibid 81 [3.127].

[940] Ibid 80–81 [3.124]. See also at 81 [3.125].

[941] Ibid 67–70 [3.70]–[3.80]

[942] Ibid 68 [3.73].

[943] Ibid 61 [3.46].

[944] Ibid 61 [3.46]–[3.47].

> Abortion is and should be treated as a health matter, rather than a criminal matter, for decision by the woman in consultation with her medical practitioner.
>
> Women should be protected from forced pregnancy.
>
> The on request approach is consistent with Australia's international human rights obligations.
>
> Legislative restrictions impede access, create barriers and unfair burdens, especially in relation to the most vulnerable or disadvantaged women.
>
> Gestational limits are arbitrary.[945]

10.2.17 The QLRC received various submissions opposing the ACT approach and favouring a restrictive approach to the availability of abortion. However, there was disagreement as to how restrictive any model should be. Some parties considered there should be a total prohibition on abortion at any gestational stage of gestation and for any reason. Some parties considered that abortion should be available only on very narrow grounds, whatever the gestational stage, such as where the woman's life is in danger. Some parties considered there should be no change to the current law. Others — including many who were opposed to abortion but expressed a view about what the law should provide if abortion is to be permitted — considered that there should be an early upper gestational limit, for example, of 12 weeks, beyond which abortion should never be permitted or be permitted only in exceptional circumstances.[946]

10.2.18 Respondents expressed a range of views to the QLRC in support of the restrictive approaches outlined above, including the views that:

> Life begins at conception and the right to life of the unborn should be protected.
>
> The fetus is able to feel pain and should be protected from harm.
>
> Abortion procedures are 'brutal', particularly in later stages of pregnancy.
>
> Gestational limits are arbitrary. Abortion, especially in later gestational stages, involves risk to the woman's physical and mental health.
>
> Women should be protected from being coerced or forced into having an abortion.
>
> Even if the mother's life is in danger, other measures can be taken to try to save both the mother and child. Other options should be considered, such as premature delivery and care of the infant, the provision of support, or adoption.
>
> Abortion 'on demand' will increase the number of terminations.[947]

10.2.19 The QLRC also considered a number of specific potential criteria to govern access to lawful abortion.

10.2.20 The ground of rape or incest was considered by the QLRC. Many parties told the QLRC that abortion may be warranted in such cases. However, concern was expressed that this should not be singled out as a specific ground for abortion, including many who favoured an ACT on request approach or a combined Victorian approach.[948]

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945 Ibid 74 [3.93].

946 Ibid 63 [3.56].

947 Ibid 66–67 [3.68].

948 Ibid 85 [3.141].

10.2.21 The Centre Against Sexual Violence Inc submitted to the QLRC that access to lawful abortion should not be denied in the case of sexual assault:

> In the context of sexual assault, a rape that results in an unplanned pregnancy for a woman takes away a survivor's right to make decisions about her body. Denying the survivor a right to access a termination of pregnancy by holding her criminally responsible, further prevents the survivor from making decisions about her own body and health. Trauma-informed research demonstrates that empowering survivors to make decisions about their own lives and bodies is key to trauma recovery.[949]

10.2.22 It was also noted to the QLRC that a specific ground would impose a difficult evidentiary burden on women, particularly given the low rates of the reporting of sexual offences.[950] The WHO has cautioned against requirements for evidence to support such a ground, noting that this can delay and restrict access.[951] As Women's Legal Service Queensland explained:

> [Women's Legal Service Queensland] support women who have experienced rape and reproductive coercion within the context of their relationship and have made the decision not to report the crime to police, receive medical treatment or professional support for a variety of valid reasons ... The choice to report, and thereby create evidence, should have no impact on whether a woman or pregnant person is able to access a termination of pregnancy. [Women's Legal Service Queensland] also acknowledges that it should not be the rape victim and/or domestic violence victim's responsibility to prove that rape or reproductive coercion has occurred in order to access any health service.[952]

10.2.23 This concern should not be understated.[953] There was acknowledgement to the 2016 Queensland Parliamentary Committee that unplanned pregnancies can result from sexual assault and can occur in violent relationships but there were differing views to the Committee as to the implications of this. 'Many submitters considered that abortion in these circumstances was justified and sought decriminalisation of abortion. Other witnesses argued that abortion was never justifiable, including when a pregnancy resulted from sexual assault.'[954]

10.2.24 The QLRC also heard from parties that abortion is inappropriate in the case of sexual assault. One party submitted that:

> If the pregnancy is the result of a rape or another coerced or unlawful act, then adding the trauma of an abortion on top of that will not improve the woman's recovery from the initial trauma. The

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[949] Ibid 85 [3.142].

[950] Ibid 86 [3.145].

[951] See World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2012) [4.2.1.3].

[952] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 86–87 [3.146].

[953] 'An audit conducted in 2006–2007 of clients using the Pregnancy Advisory Service in the Melbourne Royal Women's Hospital found that one per cent of women using the service cited pregnancy as a result of rape as their primary reason seeking an abortion. While sexual assault, including rape and incest, is not a common reason for women seeking abortion, it should not be considered insignificant. The number of submissions that drew attention to this issue attests to this': Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 70 [12.4].

[954] Ibid.

> woman should be given all the support she needs to deliver the baby and supported through her options re adoption etc.[955]

10.2.25 Other parties argued to the QLRC that the 'unborn child should not suffer because of a wrong done to the woman'.[956] There were similar arguments to the 2016 Queensland Parliamentary Committee that, based on the premise that the welfare of the fetus should be considered as well as the mother, 'one violent act should not absolve another violent act, namely terminating the pregnancy'.[957] The Committee also heard that, following a sexual assault, 'two wrongs don't make a right', and that abortion will not necessarily improve a woman's situation.[958]

10.2.26 The QLRC received divergent views on the role and value of restricting availability to abortion to a serious threat to the woman's life of physical or mental health.

10.2.27 Parties in favour of the decriminalisation of abortion opposed such criteria as overly restrictive and uncertain.[959] It was also noted that such criteria intrude on the woman's autonomy. One party noted to the QLRC that such a 'requirement is draconian and removes autonomy of decision-making from the woman' and both medical practitioners and patients 'are put into difficult ethical positions to satisfy this requirement'.[960]

10.2.28 On the other hand, many parties considered that a risk to the woman's mental health should be excluded, with some suggesting that this was too broad.[961] Parties opposed to the decriminalisation of abortion tended to support confining the threat to a threat to the woman's life.[962] As one party explained:

> In order to protect all human life, especially those unborn humans that do not yet have a voice of their own, termination of any pregnancy should only be allowed in extreme circumstances where the life of the respective mother is in significant danger should the pregnancy be continued to full term.[963]

10.2.29 The 2016 Queensland Parliamentary Committee heard that the present law encourages medical practitioners to legally justify an abortion by focussing on mental health concerns rather than physical health concerns of their patient in the diagnosis. The Committee referred to a study 'where doctors manufacture mental illness to justify a lawful abortion'.[964] Professor Caroline de Costa noted to the 2016 Queensland Parliamentary Committee:

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[955] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 86 [3.144].

[956] Ibid 87 [3.147]–[3.148]

[957] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 71 [12.4].

[958] Ibid 71 [12.4].

[959] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 82–83 [3.130]–[3.132].

[960] Ibid 82 [3.131]

[961] Ibid 81 [3.128].

[962] Ibid 81 [3.125], 82 [3.129].

[963] Ibid 82 [3.129].

[964] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 64 [12.1], citing Heather Douglas, Kirsten Black and Caroline de Costa, 'Manufacturing Mental Illness (and Lawful Abortion): Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20(3) Journal of Law and Medicine 560, 574.

> Consequently, pregnant women and their doctors must claim psychiatric sequelae as a result of the diagnosis, in women who really wish simply to make an intelligent and private decision for themselves based on the implications for the infant and for their family as a whole.[965]

10.2.30 Concerns were raised by a number of parties to the QLRC about the inclusion of a specific ground to the effect that abortion is 'necessary or appropriate having regard to the woman's social or economic circumstances'.[966] It was felt to be too broad.[967] One party argued that having a baby 'will have significant social and economic impacts and consequently this would in effect allow termination on demand'.[968]

10.2.31 Others considered that a specific ground (even such as abortion is 'necessary or appropriate having regard to the woman's social or economic circumstances') would remove decision-making autonomy from the woman and still require a value judgement by a medical practitioner. Children by Choice and others expressed concern to the QLRC that such a ground still 'relies on someone other than the pregnant person to deem a procedure "necessary or appropriate"'.[969]

10.2.32 The QLRC did not support (for either early or late term abortions) criteria based on sexual assault. It noted that different people may respond in different ways and the decision whether to seek an abortion is likely to encompass both medical and personal considerations and to be highly dependent on the individual's own circumstances. 'Further, there is a concern about the possible difficulty and distress of requiring a woman to 'prove' such a ground in order to access a termination.'[970]

10.2.33 The QLRC was unconvinced of the benefit of criteria based on a woman's life or health:

> If it is necessary to preserve the woman's life or health — This is a longstanding exception in the criminal law to the offence of procuring a miscarriage, and was supported by many respondents, including a number of those who otherwise considered that termination should be prohibited. Yet, there is a concern that the scope and application of such a ground is unclear and uncertain in practice. In particular, it has been noted that an accepted medical definition of 'serious risk' is lacking for this purpose, leaving the matter to the interpretation of individual medical practitioners. There was also considerable divergence in respondents' views about the proper scope of such a ground.[971]

10.2.34 The QLRC ultimately favoured a combined model, accepting that different considerations and complexities apply for late term procedures.[972] After 22 weeks, the approval of two medical

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[965] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 65 [12.1].

[966] Ibid 87 [3.149].

[967] Ibid 87 [3.150].

[968] Ibid 87 [3.151]. This theme was also raised to both SALRI and the NSW Legislative Council Committee. Cherish Life Australia told SALRI that the woman's social or economic circumstances should not be sufficient grounds for an abortion as 'this opened the floodgates to sex-selective abortion'. Real Choices Australia was also unimpressed with the expression: 'Reference to "future physical, psychological and social circumstances" is euphemism for any reason at all that could be anticipated, even if unlikely and/or unpredictable': Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) 3 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012 Real Choices Australia.pdf>.

[969] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 88 [3.152].

[970] Ibid 99 [3.202].

[971] Ibid 98 [3.202].

[972] Ibid 94–95 [3.181]–[3.185].

practitioners that an abortion was 'appropriate in all the circumstances' was necessary.[973] The QLRC suggested 22 weeks as the dividing point, acknowledging that any limit is, 'to some extent, arbitrary but considers there is a need to define a point of demarcation between terminations on request and later terminations where further oversight is justified.'[974]

10.2.35 The QLRC favoured the ACT 'on request' approach up to 22 weeks without criteria. It explained:

> Generally, termination should be treated as a health matter, not a criminal matter. The law should take into account Australia's international human rights obligations in recognising women's decision-making autonomy and should ensure that women are not denied access to sexual and reproductive health services, including termination.[975]

10.2.36 Additionally, the QLRC concluded:

> On balance, therefore, the Commission recommends that a single, more broadly expressed ground be adopted to ensure greater discretion to meet the range of individual circumstances that may arise in practice.
>
> It is also preferable to provide one ground for all terminations after 22 weeks, rather than having different grounds at different stages of pregnancy. This approach leaves assessment of the individual circumstances to the medical practitioner and the woman; the stage of the pregnancy may be only one of several relevant factors.
>
> Consistently with the approach in Victoria and the Northern Territory,[272] the ground should be that the medical practitioner considers that the termination should, in all the circumstances, be performed, having regard to:
>
> - 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 the performance of terminations.
>
> This is generally consistent with current clinical practice.[273]
>
> The formulation of the test in terms of whether the medical practitioner considers the termination 'should, in all the circumstances, be performed' avoids the use of the word 'appropriate', which might be considered unclear or uncertain. It also adopts the standard of 'consider', as used in the Northern Territory legislation, rather than the standard of 'reasonable belief', which is used in the Victorian legislation.[274]
>
> The reference to all relevant medical circumstances ensures that consideration is given to the woman's physical and mental health, the medical circumstances of and relating to the fetus and the pregnancy, and the range of medical options and their respective medical risks.
>
> The reference to the woman's physical, psychological and social circumstances is wide enough to capture the range of relevant considerations that might inform the woman's request, including, for example, the impact of a pregnancy that is the result of rape, safety concerns arising in the context

[973] Ibid.

[974] Ibid 95 [3.185].

[975] Ibid 94 [3.181].

of domestic or family violence, or the combined impact of the woman's age, economic disadvantage and social isolation.[976]

10.3 Submissions

10.3.1 SALRI received divergent views on the role and value of criteria and the preferable approach to govern access to abortion in South Australia.

10.3.2 There was strong (though not universal) support in SALRI's consultation for the importance of a woman's autonomy, and to remove any criteria governing access to an abortion and to treat it purely as a health issue. It was emphasised that this did not mean unrestricted access, as abortion would be still subject to health law and practice, and professional practice and protocol.

10.3.3 There was a consistent view that criteria are inevitably restrictive and unhelpful and undermine a woman's autonomy and are also 'doomed to failure'.

10.3.4 In Ceduna, the prevailing view from health practitioners was that the present criteria are 'irrelevant and not used' and, further that any future criteria should represent only 'good practice' and 'do we need to legislate this, probably not'. The Port Lincoln health practitioners also opposed criteria, saying the only emphasis should be on the patient's safety.

10.3.5 The South Australian Abortion Action Coalition opposed mandated criteria and note that requiring certain preconditions to be satisfied in order to have a lawful abortion 'unreasonably and unnecessarily limits individuals' access to health care'. The Southgate Institute said that criteria are neither required nor helpful as 'these difficult decisions are best made by women and their health care teams, as for all other health care.' Reproductive Choice Australia stated the unique circumstances for their individual patients should be addressed, 'rather than deciding whether each patient fits a narrow set of criteria as is currently the case'. The Women Lawyers' Association of South Australia Inc expressed a similar view.

10.3.6 Professor De Costa observed that the decision for an abortion should be made by the woman concerned in consultation with her medical practitioners (and whoever else she may wishes to seek advice from) and 'specified grounds can never cover all the reasons a woman may request an abortion, all of which are important to her, and this kind of restriction is anyway unnecessary'. Marie Stopes Australia noted that any criteria are 'artificial and arbitrary' and act to 'disempower a person from making a decision about their healthcare'. The Women's Electoral Lobby warned against including any specific grounds in any law. 'The fact is, terminations of pregnancy are necessary for a myriad of reasons.' They noted that restricting laws so only women who meet set criteria can access abortion 'will create too many serious issues'. Professor Margaret Davies also opposed both gestational limits and criteria as 'the general law is a blunt instrument and any specific requirements it contains regarding both gestational limits and grounds are likely to lead to uncertainty and therefore additional obstacles to service provision'. The Australian Nursing and Midwifery Federation (SA Branch), the Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Law Society and Reproductive Choice Australia also supported the removal of specific grounds and gestational limits.

10.3.7 The Castan Centre for Human Rights Law expressed its opposition to gestational limits and grounds for an abortion, observing:

> Such an approach would enable abortion to be managed in the same way as any other medical procedure — with informed consent and professional willingness rather than period of gestation

[976] Ibid 100 [3.205]–[3.211].

being the primary consideration … Further, when the law treats abortion differently to other medical procedures by imposing gestational limits and grounds, it essentially stigmatises abortion by casting such procedures in a deviant light.

10.3.8 Australian Lawyers for Human Rights submitted that there should be no specific ground or grounds for a lawful abortion at any gestational stage and supported the approach adopted in the ACT, explaining:

> … the decision as to whether to terminate a pregnancy should be a private matter of consultation between a patient and their doctor, assessed in each case according to its circumstances, best practice and clinical guidelines. Specified grounds for the lawful termination of pregnancy are unnecessary where access to abortion is approached in this manner.

10.3.9 The Southgate Institute opposed any specific ground or grounds for a lawful abortion:

> … Any medical treatment provided in the health system must be based on clinical indications, need and informed consent. Health law, standards and policies provide a suitable framework to protect both women and health professionals from receiving or providing inappropriate treatment. The attempt to develop a comprehensive categorisation of valid reasons is forlorn, and inadequate categorisation merely distresses patients and distorts the processes of care … These difficult decisions are best made by women and their health care teams, as for all other health care.

10.3.10 Associate Professor Baird argued that a woman should be allowed to access abortion at any stage of pregnancy and there should not be any gestational limits in law nor any specification of grounds on which women can be given access to abortion, except her informed consent.[977] Various other parties shared this view.[978]

10.3.11 The Greens (SA) stated that there should not be specifications of the grounds for an abortion:

> When the law starts getting prescriptive on these issues, it creates scenarios where a situation does not fit neatly within such rules and means a woman is either subjected to further stress and uncertainty during a difficult time, or that she is prevented from making a choice about her own body. Women need — and deserve — to be trusted to know what is best for them, to be recognised as the experts in their own personal lives and situations. They deserve reproductive rights, and these rights should not be curtailed.

10.3.12 Fair Agenda, for example, argued:

> Women should not be required to comply with narrow criteria … We strongly believe that a woman or pregnant person is best placed to make decisions about their health, body and future. We believe a requirement that a termination is necessary to preserve the physical or mental health of the woman is too restrictive, and doesn't factor in the many complex reasons a woman may need to access this treatment at relevant stages of the pregnancy (including, but not limited to those [raised by SALRI] … We strongly oppose any requirement linked to a criterion of rape or another coerced or unlawful act, on the basis that it is too restrictive. We further note that such

[977] See further below [19.1.1]–[19.1.23].

[978] The parties that shared this position included the South Australian Council for Civil Liberties, Reproductive Choice Australia, Children by Choice, the Law Society, Australian College of Midwives, a leading health agency, the Southgate Institute, Women Lawyers' Association of South Australia Inc, Marie Stopes Australia, the Public Health Association of Australia, a genetic counsellor, Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Australian Women's Health Network, the Human Rights Law Centre, the Castan Centre for Human Rights Law, Dr Erica Millar and Beth Wilson AM.

criteria would create a requirement of disclosure, which would be distressing and likely re-traumatising to the person involved.

10.3.13 Many parties in opposing any criteria highlighted the fact that criteria inevitably undermine the autonomy of the woman, which should be the paramount feature of any system.[979]

10.3.14 YWCA Australia opposed criteria and supported women of all backgrounds to access 'non-judgemental information and affordable services relating to … reproductive health and rights' and advocated for the maintenance of reproductive autonomy. Australian Lawyers Alliance also agreed that a pregnant woman 'should be empowered to make [her] own decisions regarding whether or not to terminate a pregnancy'. Marie Stopes Australia also opposed criteria, noting specific grounds 'disempower a person from making [a] decision about their healthcare'.

10.3.15 The importance of protecting a woman's autonomy and the adverse effects of criteria were highlighted by many other parties.[980] This theme also strongly emerged in SALRI's survey responses and at SALRI's roundtables with the disability sector, the medical and legal sectors and parties favouring the decriminalisation of abortion. Children by Choice, for example, stated that the only requirement for a lawful abortion should be the woman's 'informed consent' and they noted their 'strong opposition' to the introduction of specific legislated grounds to be met for an abortion to be considered lawful, as the 'autonomy of decision making is removed from the pregnant person and placed in the hands of others'. The Ceduna health practitioners that SALRI spoke to were clear they did not want to make the decision about whether an abortion should take place; 'the views of the health practitioner are not relevant and it is the view of the patient and proving a safe environment that is the only consideration.' A specialist medical practitioner told SALRI that a woman should not have to go to a medical practitioner and prove that she has a good enough reason to be allowed an abortion. This puts the medical practitioner in a difficult position as they are the ones deciding and the patient is deemed not competent to make her own decision.

10.3.16 The Human Rights Law Centre submitted to SALRI that any new law must respect a woman's autonomy and a woman's rights to non-discrimination, bodily autonomy, health and privacy, which are undermined by South Australia's present abortion laws. The Human Rights Law Centre argued that the current law places medical practitioners in the now outdated role of a 'gatekeeper' over a woman's exercise of reproductive freedom and any new law should respect a woman's autonomy, in order to maintain their 'right to control what happens to their body'.

10.3.17 Australian Lawyers for Human Rights expressed the need for laws that safeguard reproductive health rights and allow women to exercise autonomy over their own body. They emphasised that 'bodily autonomy is an essential human right and women must have the power to decide whether and when they will have children and the manner of their birth and upbringing.' This position applies to all women, including women with disabilities.[981]

10.3.18 Parties opposed to the decriminalisation of abortion qualified a woman's autonomy in the context of abortion, arguing that the 'rights' of an unborn child should take priority. One submission noted that the right to privacy or health of the pregnant mother must be balanced against the

[979] See also above [1.3.35]–[1.3.39].

[980] These included health and medical associations, the South Australian Abortion Action Coalition, Children by Choice, the Coalition of Women's Domestic Violence Services SA, The Greens SA, the Women's Lawyers' Alliance, Dr Erica Millar and the Hon Tammy Franks MLC.

[981] See further below [13.3.4], [13.4.10]–[13.4.15].

competing right to life of the unborn baby. Another party said law should proceed 'on the basis that the value of life of the child takes on equal weight to that of the mother at conception'.

10.3.19 Right to Life South Australia argued against this proposition:

> [T]he right of the mother to be free of her pregnancy trumps the right of the unborn child to live. This is a really difficult position to sustain, and few do it. That is because it demands the intentional killing of an innocent human being because that human being is not wanted, for a host of possible reasons. How can one innocent human life be justifiably ended at the request of another? Setting such a principle in place is deadly and unsustainable …

10.3.20 Some parties opposed to the decriminalisation of abortion supported the retention of criteria and saw no reason to change the present law. A retired GP supported retention of the present criteria, with 'clinical proof' that an abortion is necessary to protect the physical or mental health of the woman. One party submitted: 'I advocate for no changes to increase the extent abortion is currently practiced in this state.' Cherish Life Australia argued that legal criteria are necessary because abortion 'is a serious procedure, often with long-lasting effects on the mother, and to avoid abuses like coercion of the woman into abortion, legislation has to provide a legal framework to protect both mother and child as far as possible.'[982]

10.3.21 Several attendees at the 16 May 2019 roundtable described the ACT approach of allowing abortion without criteria or gestational limits as 'abhorrent'.

10.3.22 One view that was raised with SALRI was that abortion should only be allowed in a life threatening situation and confined to a direct threat to the mother's life. Anna Walsh stated that 'as abortion is the termination of human life, it should only occur in the context of a narrow definition of emergency that favours the significant risk of the imminent loss of the woman's life' and this should be incorporated into Australian health law. One couple argued that abortion should only be permitted in cases of 'conditions that directly threaten the mother's life for medical reasons'.

10.3.23 The Lutheran Church favoured a very narrow approach: 'Our Church's position is that the only acceptable grounds for abortion is when the continuation of the pregnancy directly endangers the mother's life, and saving the baby as well as the mother is impossible.'

10.3.24 Another party expressed a similar view and questioned if such a situation would ever arise:

> Improvements in medical treatment and care over the past four decades enable doctors to handle almost every adverse medical condition that pregnant women face, without resorting to the deliberate ending of the child's life in order to save the life or health of the mother. Apart from a life-saving operation performed to save a mother with an ectopic pregnancy, a situation in which the child will certainly die, it is difficult to imagine any situation in which the procurement of the death of the child was actually necessary to save the life of the mother. In fact, doctors are on the public record stating this as in their experience they have never had to kill the unborn child to save a mother's life.

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[982] A concern that was raised to SALRI by some groups such as Cherish Life Australia was that liberal abortion laws allowed gender selective abortion. See also *R (Hubert) v Director of Public Prosecutions* [2015] EWHC 3733 (Admin). *Hubert* involved an attempted private prosecution of two UK medical practitioners who had been allegedly willing to perform gender selective abortions. The private prosecution was taken over and discontinued by the DPP. The court commented: 'It is important to make clear from the outset that this case is not about whether it is possible to prosecute a doctor who has carried out an abortion on the ground of the gender of the fetus. It is possible to prosecute on such a basis, where there is good evidence to show that termination was authorised solely on gender-specific grounds and provided there is no legitimate reason for such a termination, such as a risk of sex-linked abnormalities or other clear legal and ethical justification': at [2] (Irwin J).

10.3.25 A number of parties such as 40 Days for Life, Advocates International, Pregnancy Help Australia, the Australian Christian Lobby and the Lutheran Church were not supportive of allowing abortion in the situation of sexual assault.[983]

10.3.26 As Cherish Life Australia noted: 'Abortion is often a traumatic experience in itself; research has found that abortion is more likely to create mental health issues than other traumas including rape. Moreover, being conceived by rape or incest is not grounds for being killed.'

10.3.27 Another party similarly argued:

> I am writing to say that I do not agree with abortion for any reason other than the absolute safety of the mother's physical health, and that more than one specialist should be consulted where possible. I had thought in the case of rape or incest it could be acceptable leaving it to the conscience of the woman, but after hearing testimonies of people conceived in these ways, I cannot condone abortion in these situations, and think much counselling should be given.

10.3.28 Other views were not as rigid. One party submitted that abortion should be allowed in 'exceptional circumstances' to be assessed by two medical practitioners, explaining: 'Exceptional circumstances should include situations where the pregnancy has a significant impact on the life of the mother, there is an ectopic pregnancy, the pregnancy is the result of severe trauma, eg rape or abuse of an individual with severe mental disability.'

10.3.29 The availability of a lawful abortion on the grounds of fetal or abnormality disability proved especially problematic in consultation.[984] A number of parties such as Professor Sally Sheldon, Dr Niki Vincent and a senior specialist obstetrician told SALRI that they found this an especially difficult area.[985] This was also stated at SALRI's various roundtables. There was virtually no support, whether from parties supportive of or opposed to the decriminalisation of abortion, for the retention of this specific criteria. Strong objections were raised, especially from the disability sector.[986]

10.3.30 The present criteria of an abortion as necessary for the woman's physical or mental health received relatively limited support from parties both supportive of and opposed to the

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[983] Pregnancy Support Australia, for example, stated: 'the woman has already been violently assaulted and abortion would be another trauma. Abortion does not erase memory/trauma of the rape. Support and encouragement to be removed from an abusive relationship is a far better option. The rights of the child also need to be considered. Conception following rape is a very rare occurrence.' SALRI disagrees with such reasoning. As one recent article notes: 'A woman who says she was conceived through child rape ... describe[es] herself as 'a walking crime scene'': Frances Perraudin, 'Woman Conceived after Rape of 13-year-old wants Birth Father Prosecuted', *The Guardian* (online, 6 August 2019) <https://www.theguardian.com/law/2019/aug/05/woman-conceived-after-of-13-year-old-wants-birth-father-prosecuted>.

[984] One medical scientist, for example, cautioned against allowing abortions on the ground of fetal disability. 'We are quick to defend and provide for the disabled in our society and that should be commended. This should extend to the unborn. This provision for abortion is applied widely to include those with Down syndrome and other conditions … A paper that looked at the emotional outcomes of hundreds of parents who continued with pregnancies where a life-limiting foetal condition was identified found that, "Absence of regret was articulated in 97.5% of participants. Parents valued the baby as a part of their family and had opportunities to love, hold, meet, and cherish their child. Participants treasured the time together before and after the birth. Although emotionally difficult, parents articulated an empowering, transformative experience that lingers over time." Instead of providing abortion of these children, as a society we should provide them care and dignity. Palliative neonatal care keeps the baby comfortable and supports the family in caring for their baby. This service is already being provided in Australia for families in this situation.' See also Charlotte Wool et al, '"I Would Do It All Over Again": Cherishing Time and the Absence of Regret in Continuing a Pregnancy after a Life-Limiting Diagnosis' (2018) 29(3) *Journal of Clinical Ethics* 22.

[985] See below Part 13

[986] See below Part 13.

decriminalisation of abortion.[987] Parties in favour of decriminalisation considered that they are arbitrary, too strict and at odds with the fundamental need for patient autonomy, and that the woman's consent is the only factor that should determine legality. Parties opposed to decriminalisation largely thought that the present criteria, especially the mental health ground, are not strict enough and tighter criteria should be imposed (though some of these parties such as Advocates International, Dr Šeman and the Australian Christian Lobby also argued that the present law and criteria in South Australia should not be changed as this is preferable to diluting the present law).

10.3.31 A number of parties complained that the present mental health ground has been unduly extended. SALRI's roundtables with faith groups and NGOs found dissatisfaction with the use of the mental health test. One attendee outlined:

> Post-24 weeks is the elasticity that's been given to mental health of the mother because it now includes social, environmental factors so that the reality is that a woman who wants an abortion under 24 weeks gets it. That is the lived reality. That question is difficult because the terms have elasticised so that they practically have no useful application.[988]

10.3.32 There was some support at the roundtable with faith groups on 16 May 2019 for the *Bourne* test of a mental 'wreck' as the relevant criteria. One party said: 'As exemplified in the case of *Bourne*, it sets the bar of the degree of mental or social threat that there is. But I don't know how to codify it.' Others disagreed and would not permit recourse to the effect on a woman's mental health.

10.3.33 There was very little support for the inclusion of a specific ground to the effect that abortion is necessary or appropriate having regard to the woman's 'social or economic circumstances'. On the one hand it was felt to be too broad and subjective and would effectively allow abortion on request. On the other hand, it was considered that such a specific ground removes decision-making autonomy from the woman, retaining the gatekeeper model and still requiring a value judgement by a medical practitioner as to the performance of an abortion.[989]

10.3.34 The criteria in Queensland and Victoria (and now included in the 2019 NSW Act) of 'appropriate in all the circumstances' also received very little support in SALRI's consultation from parties both supportive of and opposed to the decriminalisation of abortion. Parties opposed to the decriminalisation of abortion contended that the criteria are not stringent or specific enough and are so vague as to be effectively meaningless and to allow abortion on request.[990] Parties supportive of the

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[987] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 77 [5.53]–[5.56]. See further above [1.3.35]–[1.3.39].

[988] Another attendee noted: 'Aside from the faith issue, the reality is that if you're going to make it legal but only based on mental health, social etc, then a bit of a waste of time because people are going to do it anyway. I think that's problematic, you can say that your mental health might improve if you have the baby. How can you determine when the baby is 12 weeks whether the mother is going to be better or worse off. To me it's a bit of a waste of time.'

[989] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 77–78 [5.57]–[5.58].

[990] This is consistent with submissions to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019*. Right to Life (NSW), for example argued: 'The range of circumstances to be considered is so broad that it is hard to imagine a scenario where a doctor who personally believed in abortion for any reason or none up to full term could be faulted if he or she claims to have considered "that, in all the circumstances, the termination should" have been performed': Right to Life NSW, Submission No 13 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64847/0013%20Right%20to%20Life.pdf>. 'The clause is stated so broadly that it effectively allows abortion at any stage, for any reason': Women's Forum, Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 29 [130]

decriminalisation of abortion opposed such criteria as still undermining the autonomy of the woman as well as 'been so vague as to be next to useless'. Ms Marchesi told SALRI that such criteria offer 'some political comfort … but probably don't change much in terms of what happens in practice' and are ultimately 'essentially meaningless'.

10.3.35 There was strong emphasis, by many parties supportive of the decriminalisation of abortion, on the need to avoid criteria and respect the fundamental principle of the woman's autonomy. SALRI notes this also reflects modern health care, which has shifted from the 'doctor knows best' gatekeeper model, to a model that emphasises patient centred care and patient autonomy.[991]

10.3.36 Australian Lawyers for Human Rights commented that 'bodily autonomy is an essential human right and women must have the power to decide whether and when they will have children and the manner of their birth and upbringing'. They elaborated:

> [Any model which] empowers a practitioner to effectively override a woman's wishes, it is not supported by ALHR. Any such proposed decision making process by a practitioner usurps a woman's decision-making capacity. Allowing practitioners to have a right of veto in respect of a woman's choice to terminate undermines a woman's right to make a decision about her own body.

10.4 SALRI's Observations and Conclusions

10.4.1 The present criteria governing access to abortion in South Australia received little support in consultation. Parties in favour of decriminalisation consider they are too strict and at odds with the need for patient autonomy, and parties opposed to decriminalisation largely thought that they were not strict enough and tighter criteria should be imposed (though some of these parties also argued that the present law should not be changed).

10.4.2 The various criteria that exist are inherently problematic.

10.4.3 SALRI does not support the retention of the present criteria (necessary to protect the woman's life or her physical or mental welfare) for a lawful abortion. These are highly material considerations as to why an abortion may be sought by a woman, but it is inappropriate to include them as specific legislative grounds. Such an approach is said to be either too restrictive, or ineffectual. Such criteria also serve to undermine the woman's autonomy and transfer the decision-making process from the patient to the medical practitioner. This medical gatekeeper approach is at odds, as Professor Sheldon and others have told SALRI, with the modern focus on patient centred care. It is also significant that all other Australian jurisdictions, notably Victoria, Queensland and NSW with the 2019 NSW Act, have moved away from these criteria.

10.4.4 The present ground of allowing access to abortion if there is a 'substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer

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<https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[991] The Nursing and Midwifery Board of Australia, for example, provides the following description of patient or person-centred practice. 'Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice': Nursing and Midwifery Board of Australia, Registered Nurse Standards for Practice (Professional Codes and Guidelines, 2018) <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx>.

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from such *physical or mental abnormalities* as to be *seriously handicapped*.'[992] received virtually no support in SALRI's consultation. Strong objections to this ground were identified by parties both supportive and opposed to the decriminalisation of abortion. This issue is discussed further in Chapter 13. SALRI does not support the retention of this criteria under whatever approach is adopted.

10.4.5 The suggestion of specifying that abortion is permissible where the pregnancy is the result of rape or incest or some other coerced or unlawful act also received very little support in SALRI's consultation. These are highly material considerations as to why an abortion may be sought by a woman but it is inappropriate to include them as specific legislative grounds and SALRI does not support such specific legislative criteria. Such criteria would serve to undermine the woman's autonomy.[993] This suggestion is also impracticable and intrusive and requires a medical practitioner to act as a quasi-judicial officer as well as the gatekeeper. As identified by Children by Choice:

> [This ground] presumably requires evidentiary criteria to be met in order to satisfy the grounds of rape, coercion or unlawful acts, which places the burden on the survivor of these acts to prove their case and carries a significant risk of re-traumatising survivors. In international jurisdictions, criteria for satisfying these grounds can be onerous and may include the necessity of the survivor reporting to the police; evidence on sexual assault reporting in Australia suggests that fewer than 15% of offences are reported to the police.

10.4.6 The inclusion of a specific ground to the effect that abortion is 'necessary or appropriate having regard to the woman's social or economic circumstances' also received little support.

10.4.7 Parties opposed to the decriminalisation of abortion viewed this formulation as too broad[994] and effectively allowing abortion on 'demand'.[995] Parties opposed to the decriminalisation of abortion considered such a specific ground still removes decision-making autonomy from the woman and requires a value judgement by a medical practitioner.[996]

10.4.8 After careful consideration, SALRI sees no merit in criteria as to when an abortion should be permitted. Any such criteria will undermine the crucial autonomy of the woman. It has the inevitable effect of transferring the decision making from the patient to the medical practitioner — a role that many medical practitioners told SALRI, in consultation, that they neither welcomed nor felt equipped to undertake. SALRI also agrees that any such criteria are ultimately unworkable.

10.4.9 SALRI agrees with the view of Professor De Costa that any criteria 'are doomed to failure'[997] as no criteria can ever cover the many situations that will arise. SALRI also notes the view of

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[992] The construction of *CLCA* s 82A(8) and its application to late term abortion is another factor to be considered. Western Australia includes similar language, with reference to a 'severe medical condition' in the *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3). New Zealand's current abortion law allows abortion up to 20 weeks gestation if there is a substantial risk that the child, if born, would be 'so physically or mentally abnormal as to be seriously handicapped': *Crimes Act 1961* (NZ) s 187A(1)(aa).

[993] SALRI also notes that any such criteria would undermine a woman's right to choose whether or not to disclose or report any incidence of rape or other sexual violence.

[994] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 87 [3.150].

[995] Ibid 87 [3.151].

[996] Ibid 88 [3.152].

[997] Professor De Costa explained to SALRI: 'The woman herself must be able to make an informed, non-coerced decision about her own health, and have this decision respected and approved by her treating doctor/s. "Specified grounds" can never cover all the reasons a woman may request an abortion, all of which are important to her, and this kind of restriction is anyway unnecessary.'

RANZCOG that '[n]o specific clinical circumstance should qualify or not qualify a woman for termination' as the 'impact of any particular condition is highly individual and often complex'.[998]

10.4.10 Even something as open as 'necessary' or 'appropriate in all the circumstances' is problematic. It is either so vague as to be meaningless or is open to criticism, as from Children by Choice that it still 'relies on someone other than the pregnant person to deem a procedure "necessary or appropriate"'.

10.4.11 In Queensland and Victoria (and included in the 2019 NSW Act), a late term abortion is permissible if two medical practitioners consider that the abortion 'should, in all the circumstances be performed'. This approach, whether for early or late term abortions, received very little support in SALRI's consultation from parties either supportive or opposed to the decriminalisation of abortion. Medical practitioners in regional, rural and remote locations particularly raised that this version still made them feel like the decision maker for the procedure; a role they were neither equipped nor keen to undertake. It is also questionable what this approach actually achieves in practice. The criteria are so vague and subjective as to be open to interpretation and next to meaningless. SALRI does not support this approach for early or late term procedures.

10.4.12 SALRI considers that the ACT approach[999] is to be preferred, namely where an abortion is lawful at all gestational stages with the woman's consent, and if performed by an appropriate health practitioner. Under this approach, abortion should be a health decision made between a woman and her medical practitioner which should be governed by the same legal principles that apply to all other health care. There is no reason to single out abortion for special mention. The reasons women may have for seeking an abortion are varied and personal and should not be subject to public scrutiny.[1000]

10.4.13 The QLRC noted that an 'on request' approach may be considered appropriate for a number of reasons such as removing legal barriers to access, according maximum respect for women's autonomy and providing greater clarity for health practitioners because they are not required to interpret and apply additional, often difficult, legal tests and can focus on their primary role of determining their patient's best clinical interests.[1001] SALRI agrees with the QLRC's reasoning in this context.

10.4.14 This approach respects a woman's autonomy, placing decision-making responsibility with the woman and service availability with the medical (or health) profession. This approach does not leave the subject of abortion unregulated as a comprehensive framework of health law and practice and professional guidelines and protocols still apply. Any health practitioner would still have to consider, as for any other medical procedure or treatment, whether an abortion is medically appropriate.

10.4.15 SALRI acknowledges that late term abortions, though 'comparatively rare' in practice, are contentious and linked with the question of fetal viability. SALRI's preferred approach is that no

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[998] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy* (RANZCOG Statements and Guidelines, July 2016), cited in Queensland Law Reform Commission, *Review into Termination of Pregnancy Laws: Consultation Paper Queensland Law Reform Commission* (Consultation paper, WP No 76, December 2017) 48.

[999] *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT). This is also the model proposed in the Statutes Amendment (Abortion Law Reform) Bill 2018 (SA).

[1000] Queensland Law Reform Commission, *Review into Termination of Pregnancy Laws: Consultation Paper Queensland Law Reform Commission* (Consultation paper, WP No 76, December 2017) 38 [128].

[1001] Ibid 38–39 [129].

distinction should be drawn based on gestational stage, and an abortion is lawful at all gestational stages with the woman's consent, and if performed by an appropriate health practitioner. It should be noted that as a matter of clinical practice and professional protocol, a late term abortion will be more carefully considered than an early term abortion.[1002]

10.4.16 SALRI is of the view that, whatever option is adopted, any new law in South Australia should not provide any specified criteria for access to lawful abortion.[1003]

10.4.17 Recommendations

Recommendation 20

SALRI recommends that, whatever option is adopted, any new law in South Australia should not provide any specified criteria for access to lawful abortion.

Recommendation 21

SALRI recommends that, consistent with Recommendation 2, the relevant law in South Australia should be amended, consistent with general health law and practice, to provide that an abortion can be undertaken at any gestational age with the involvement of one health practitioner.

[1002] See further below Part 11.

[1003] See also Recommendations 22 and 23.

Part 11 - Late Term Abortion

11.1 Preliminary Consideration

11.1.1 When considering late term abortions, it must first be considered what constitutes 'late term'. This question is aligned to the concept of fetal viability; in other words at what gestational stage a child might have a realistic prospect of life if born premature. An abortion after this stage is a particularly sensitive issue.

11.1.2 The 1969 South Australian Act, reflecting medical standards of the time, adopted 28 weeks as a rebuttable presumption of fetal viability and provides that, after this point, an abortion is only lawful if necessary to save the woman's life. However, there was wide agreement in SALRI's consultation from health practitioners and parties both supportive of and opposed to decriminalisation, that 28 weeks is now outdated and that fetal viability is earlier, due to medical advances. However, there is no consensus as to when exactly this is; Queensland and NSW adopt a 22 week approach, and Victoria 24 weeks.

11.2 Current Developments

11.2.1 A prominent issue in SALRI's consultation (as also arose in relation to the 2019 NSW Act) concerned late term abortions. It is clear that late term abortions are contentious[1004] (though public opinion may be more nuanced and supportive than is sometimes supposed).[1005]

11.2.2 In South Australia, the current law contains a specific 'child destruction'[1006] provision which deals with abortions involving a 'child capable of being born alive', which is relevant to some late term procedures.[1007]

11.2.3 The effect of the current provision is that there is a prohibition on the performance of an abortion in South Australia after 28 weeks (unless necessary to save the woman's life).[1008] This is a complex provision.[1009] As 28 weeks is a rebuttable presumption, there is a widespread view and practice in South Australia that an abortion cannot be performed after either 22 or 24 weeks gestation. Medical

[1004] "'We consider ourselves to be potential targets for domestic terrorism." That's the reason one abortion provider gave for not wishing to be named when asked for comment about the situation facing later-term abortion providers in Australia': Amelia Paxman, 'Later-Term Abortions: Stigma Versus Reality', *Sydney Morning Herald* (online, 20 July 2017) <https://www.smh.com.au/lifestyle/laterterm-abortions-stigma-versus-reality-20170720-gxf4ym.html>.

[1005] Lachlan de Crespigny et al, 'Australian Attitudes to Early and Late Term Abortions' (2010) 193(1) *Medical Journal of Australia* 8.

[1006] This is the terminology used in the legislation and is therefore adopted by SALRI for this discussion however the language is considered to be less than ideal and not a reflection of the actual offence.

[1007] It is noted by SALRI that not all late term abortions relate to a fetus capable of being born alive despite the gestation exceeding 28 weeks as some of these abortions are of fetuses with abnormalities inconsistent with life. Additionally it was noted in consultation, including by those who did not support changes to the current abortion legislation, that some fetuses capable of being born alive were not capable of remaining alive due to severe genetic abnormalities, and despite any medical technology available, would not survive long after birth.

[1008] See generally Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 95–109.

[1009] *CLCA* ss 82A(7), (8). See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 22 [2.42].

advances since 1969 mean a child is now generally capable of being born alive from 24 or even 22 weeks.[1010]

11.2.4 SALRI will return later in this Part to the issues and implications arising from both the present 28 weeks upper limit rule and the suggestion it is effectively now somewhere from 22 to 24 weeks.

11.2.5 The difficulty in determining a dividing line for any different requirements based on viability was noted by the VLRC as 'a task of considerable complexity'.[1011] The VLRC found there was 'no general agreement about where a line based on viability should be drawn'.[1012] The VLRC, after much consideration, eventually settled on 24 weeks.[1013] The QLRC, whilst accepting it is 'arbitrary', settled on 22 weeks. The 2019 NSW Act settled on 22 weeks.[1014]

11.2.6 The medical profession recognised to the VLRC that 22–26 weeks gestation is a 'grey zone', where some fetuses have survived, most with ongoing disability, through major medical intervention.[1015]

11.2.7 In 2007, the UK House of Commons Science and Technology Committee released an influential report into various scientific issues around abortion.[1016] The Terms of Reference asked the Committee to gather scientific and medical evidence from witnesses about the general 24-week upper limit on abortions in the UK. The Committee considered developments in medical interventions and examined evidence concerning fetal viability. It focused on neonatal survival rates and fetal viability, fetal consciousness and pain, and the reasons why women present for late abortions. The Committee recommended no change to the general upper gestation limit of 24 weeks in the UK.[1017]

11.2.8 A 2008 UK study[1018] by a team of neonatal specialists reviewed hospital records for the periods 1994–2005 to determine whether the survival of premature infants had improved due to medical and technological advances in neonatal intensive care. The study found that neonates less than 23 weeks gestation were unable to survive regardless of how much medical intervention they received. This was consistent over time despite advances in neonatal intensive care. Those born at 24 and 25 weeks gestation had slight improvement in survival rates (to discharge) with improvements in medical care, however these were still in the minority and invariably suffered high rates of morbidity and disability. This is consistent with the views of some medical practitioners to SALRI who stated that,

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[1010] Though there have been occurrences of survival of a fetus at earlier gestation this is not a common occurrence and generally requires significant medical intervention. There was no consensus in SALRI's consultation as to the exact gestation period for viability as it is significantly impacted by individual fetal development but generally the period between 22 to 24 weeks was identified by health practitioners.

[1011] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 90 [1.4].

[1012] Ibid 80 [5.79].

[1013] Ibid 90 [1.4]. See also at 40–41 [3.56]–[3.63], 79–80 [5.75]–[5.81].

[1014] See below Part 22.

[1015] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 40 [3.60]; John Keogh et al, 'Delivery in the "Grey Zone": Collaborative Approach to Extremely Preterm Birth' (2007) 47(4) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 273.

[1016] Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report* (House of Commons Paper No 1045-1, Session 2006–07) vol 1.

[1017] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 26 [2.71].

[1018] David Field et al, 'Survival of Extremely Premature Babies in a Geographically Defined Population: Prospective Cohort Study of 1994–9 compared with 2000–5' (2008) 336(7655) *British Medical Journal* 1221.

notwithstanding medical advances, viability would not decrease any further. Other medical practitioners took a different view.

11.2.9 If there is a late term limit for abortion and/or a gestational stage at which extra considerations (such as the approval of a second medical practitioner) apply, the vital question is what is such a stage? There was no consensus to SALRI on this difficult question. It may, though not necessarily, be linked to viability. Suggestions ranged from 'conception',[1019] six weeks (the purported detection of a heartbeat),[1020] 12 weeks, 16 weeks (as in Tasmania), 20 weeks (as in Western Australia and from where some claim a child is (or may soon be) able to survive independently),[1021] 22 weeks or 24 weeks. Some parties both supportive of and opposed to the decriminalisation of abortion opposed any distinction based on gestational stage and were clear that the same procedure (whether unrestricted or restrictive) should apply regardless.

11.2.10 There was no consensus in the SALRI consultation on the present gestational stage of viability though the general view (especially amongst medical and other practitioners) was that it is between 22 weeks and 24 weeks with more leaning toward 24 as opposed to 22 weeks.

11.2.11 Those raising 22 weeks as the appropriate assessment of viability noted to SALRI the latest as well as possible future medical advances[1022] and that 22 weeks also reflects local clinical practice as to when lifesaving treatment may be implemented. Those raising 24 weeks as the appropriate assessment of viability noted that 22 weeks remains unrealistic for consistent viability and 24 weeks more accurately reflects current clinical practice and medical knowledge. It was also noted by a genetic counsellor and a clinical geneticist that results from genetics testing, even with possible future medical advances, take time and that further time is required for confirmation of results and consideration by the woman (and her partner). This may hamper a woman's ability to make an informed decision prior to 24 weeks.[1023]

11.2.12 The issue of determining a dividing line based on viability (or otherwise) for any different requirements between early and late term abortions was noted by the Australian Lawyers' Alliance as one where it is impossible to identify a 'gestational age limit that will be acceptable to all Australians'.[1024]

11.2.13 Many of the parties opposed to the decriminalisation of abortion described to SALRI (sometimes in graphic terms)[1025] the nature of late term abortions. Parties opposed to decriminalisation highlighted their particular objection at the suggestion of late term abortions, highlighting the fact that such procedures involve a viable fetus (or child) capable of being born alive and surviving.

[1019] One party opposed to decriminalisation asserted 'the great change of state which occurs at conception renders this point a logical place to put such a threshold'.

[1020] See above [1.3.22].

[1021] See New South Wales, *Parliamentary Debates*, 17 September 2019, Legislative Council, 42–43 (Hon Scott Farlow).

[1022] 'In November 2017 a case report was published in the journal, *Pediatrics*, on a female infant resuscitated after delivery at 21 weeks four days gestation with a birth weight of 410 grams — possibly the most premature known survivor to date. As of November 2018, Lyla Stensrud was four years old and happily attending preschool. She had a slight delay in speech but no other known medical issues or disabilities': New South Wales, *Parliamentary Debates*, 17 September 2019, Legislative Council, 43 (Hon Scott Farlow). See also Kaashif Ahmad et al, 'Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation' (2017) 140(6) *Pediatrics* 1.

[1023] See below [13.9.1]–[13.9.12].

[1024] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 90 [1.4].

[1025] SALRI is under no illusions as to the nature of late term abortions. These were made clear by parties both supportive and opposed to the decriminalisation of abortion and medical practitioners. As one woman, drawing on her personal experience, said: 'This is a graphic subject to write about but it must be discussed … I would not wish this experience on any woman under any circumstance.'

11.2.14 A lead clinician expressed to SALRI that differences exist between the capability of a child to be born alive and viability:

> Fetal viability needs to clearly be differentiated from 'capable of being born alive'. In this sense, 'signs of life' does not equate to viability. Furthermore, gestational age is but one factor contributing to an assessment of viability. The degree of medical intervention required to sustain that life is also a factor.

11.2.15 Parties supportive of the decriminalisation of abortion emphasised that late term abortions are very rare in practice and only occur in the most compelling of circumstances. As Dr Richard Goldstone of Marie Stopes Australia submitted to the NSW Legislative Council Committee:

> You have to remember that the majority of terminations, by far, occur in the first trimester — somewhere between 90 and 95%. The majority of the small percentage above that occur in the early to mid-second trimester … the circumstances in which a woman seeks a termination at a later stage of pregnancy are very complex, very compelling, horrible fetal anomalies, horrible social circumstances, substance abuse, mental health issues. I think we are talking about an extremely small proportion of terminations and we should not allow that to derail decriminalising abortion in this State.[1026]

11.2.16 It is therefore argued by many parties in favour of the decriminalisation of abortion that late term abortions should be allowed in accordance with clinical practice and a woman's views. These parties opposed either separate criteria and/or a formal requirement for the involvement or approval of a second health practitioner. This is the approach in the ACT and in the 2018 South Australian Bill.

11.2.17 However, some parties in favour of decriminalisation such as Professor De Costa and Dr Carol Portmann accepted that a different procedure should be in place for late term abortions to reflect the additional complications and sensitivities of such procedures. This approach accords with that adopted in Victoria and Queensland. The 2019 NSW Act also has additional measures for late term abortions and 'recognises that terminations at this later stage often involve disadvantage, distress, complexities and higher risks to the pregnant woman'.[1027]

11.2.18 Submissions to the VLRC noted that late term abortions are 'very rare'[1028] and 'very difficult to obtain'.[1029] The VLRC observed:

> Abortions at later gestation account for a very small percentage of overall abortions. The AIHW study found that throughout Australia 94.6% of abortions occurred before 13 weeks gestation,[1030] 4.7% occurred after 13 weeks but before 20 weeks and 0.7% occurred after 20 weeks. In 2005 there were 309 abortions post 20 weeks gestation, out of a total number of abortions of approximately 18,000.[1031]

[1026] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 56 (Dr Philip Goldstone, Marie Stopes Australia).

[1027] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

[1028] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 39 [3.52] quoting submissions from Reproductive Choice Australia, Gippsland Women's Health Service, Key Centre for Women's Health in Society, Association for the Legal Right to Abortion and Liberty Victoria — Victorian Council for Civil Liberties.

[1029] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 39 [3.52].

[1030] Narelle Grayson, Jenny Hargreaves and Elizabeth A Sullivan, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia* (Perinatal Statistics Series No 17, Australian Institute of Health and Welfare, 2005) xvi, 42.

[1031] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 36 [3.36]. See also at: 37, n 44.

11.2.19 Late term procedures are confronting for both the women and the health practitioners involved. Very few abortions occur after 20 weeks, but when they do, the circumstances are more likely to be very distressing, especially for the woman involved. Such abortions after 20 weeks of gestation often occur as a result of factors such as fetal abnormalities or rape.[1032] Dr Philip Goldstone stated to the NSW Legislative Council Committee that the idea that women would 'frivolously decide' to end their pregnancy at 30 weeks is 'offensive to women'. Dr Goldstone added that 'as gestation increases the reasons why women seek termination of pregnancy become more complex and more compelling and nobody seeks terminations at late gestations for insignificant reasons'.[1033]

11.2.20 These themes have been reiterated by the QLRC[1034] and elsewhere.[1035] As one report notes:

> In reality, abortions after 20 weeks are costly, difficult to access and sometimes subject to individual doctor's personal ethics about upper term limits, which can be earlier than the law stipulates. Later-term procedures also tend to be more complex procedures, and require different training.[1036]

11.2.21 There were occasional suggestions in SALRI's consultation from parties opposed to the decriminalisation of abortion that late term abortions, especially psychosocial abortions, may be undertaken lightly.[1037] All the evidence that SALRI has seen, overwhelmingly supported in its consultation, rebuts any such suggestion.

11.2.22 Abortions occurring later in gestation are especially likely to involve complex medical circumstances, including serious or fatal fetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the fetus is one of a multiple pregnancy; or complex personal circumstances, including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, socio-economic disadvantage, or mental health issues.[1038]

11.2.23 A particular example of a late term abortion for psychosocial reasons, provided in consultation, is illustrative. The case involved a minor with an intellectual disability who became pregnant as a result of sexual abuse by a family member. Given her intellectual disability, she was unable to appreciate or understand her pregnancy until she was at a late gestational stage. When her

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[1032] Katherine Kerr 'Queensland Abortion Laws: Criminalising One in Three Women' (2014) 14(2) *Queensland University of Technology Law Review* 1, 17.

[1033] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 51 (Dr Philip Goldstone, Marie Stopes Australia).

[1034] 'Later terminations are comparatively rare. Almost all (approximately 99%) of the terminations in public hospitals and licensed private health facilities are performed before 20 weeks gestation': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws,* Report 76 (June 2018) 36 [2.110]–[2.111]. See further at: 70–71 [3.81]–[3.85], 71–74 [3.87]–[3.92], 99 [3.203].

[1035] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 46 [7.52], 65–66 [12.2.1]–[12.2.2]; Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions): Report 55* (2019) 34–35 [3.58]–[3.60].

[1036] Amelia Paxman, 'Later-Term Abortions: Stigma Versus Reality', *Sydney Morning Herald* (online, 20 July 2017) <https://www.smh.com.au/lifestyle/laterterm-abortions-stigma-versus-reality-20170720-gxf4ym.html>.

[1037] See also Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 30–31 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[1038] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 99 [3.203].

situation became known, the girl was clear that she did not wish to wish to proceed with her pregnancy and a late-term abortion was carried out. The severe and adverse effect on her, had she continued with the pregnancy, were noted. This type of case was presented to SALRI as far from unknown by Dr Carol Portmann and others.[1039]

11.2.24 Dr David MacFarlane (reflecting a theme he also told SALRI) told the 2016 Queensland Parliamentary Committee that he opposed late term limits and precluding abortion in such rare circumstances:

> … no gestational age restrictions [should] be placed on abortion, because the very uncommon later term abortions involve peculiar and rare circumstances that legislation could only complicate and make more traumatic for the families involved in making terribly difficult decisions about these pregnancies.[1040]

11.2.25 The VLRC noted that in its consultation it heard of many psychosocial reasons for late term abortions. The VLRC explained:

> These included: young women not recognising or being in denial of pregnancy, out of fear or because the pregnancy resulted from rape or incest; women whose partner has left them or died who do not want to raise a child on their own; and women who have not recognised or not taken action about a pregnancy due to mental illness or drug addiction.[1041]

11.2.26 The VLRC had 'heard that forcing a woman to proceed with an unwanted pregnancy has a greater negative impact than abortion, even at later gestation'.[1042] The VLRC elaborated:

> The truly heart-rending circumstances that confront women considering termination at this stage and the expensive, time consuming and arduous experience of doing so, it is imperative that the law should impose no great difficulty or distress for these women … Arguably, the trauma related to terminations at this stage demand even more respect from the law for the woman's autonomy, privacy and dignity, while the codification of justifications after particular gestations undermines the values, compelling women and couples to explain themselves and seek to measure up to standards of behaviour set by those who have no knowledge of their particular circumstance, and in most instances, the traumatic experience of considering termination at this stage of pregnancy.[1043]

11.2.27 It is significant that all Australian jurisdictions (other than the ACT) have differing requirements for late term abortions than for procedures undertaken at early gestation. Queensland and Victoria, for example, require an abortion after 22 or 24 weeks respectively, to be approved by two

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[1039] One of the authors of this report, drawing on 16 years as a prosecution lawyer in the UK and Australia, can confirm that such cases, whilst not common, are far from unknown.

[1040] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 26 [5.4.1].

[1041] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 38 [3.50]

[1042] Ibid 39 [3.53]. See also 'A US examination of late abortions noted that non-recognition or denial of pregnancy by young women is "not particularly unusual, especially among teenagers" and that 'women who seek late abortions typically are poor, young, and poorly educated': Nancy Rhoden, 'The New Neonatal Dilemma: Live Births from Late Abortions' (1984) 72(5) *Georgetown Law Journal* 1451, 1451, n 2. UK studies have also found that in most cases of late presentation for abortion the woman has not recognised or not realised she was pregnant for various reasons, including: continuation of menstruation; menstruation was usually irregular so missing periods were not noticed; no physical symptoms of pregnancy; and use of contraception masking any signs of pregnancy. See Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report* (House of Commons Paper No 1045-1, Session 2006–07) vol 1, 27.

[1043] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 39 [3.52] citing Submission No 227 (Reproductive Choice Australia).

medical practitioners as appropriate in the circumstances. The 2019 NSW Act also requires an abortion after 22 weeks to be approved by two specialist medical practitioners as appropriate in the circumstances. The additional presence and approval of two medical practitioners after 22 weeks was said in the NSW parliamentary debate to 'recognise that terminations at this later stage often involve disadvantage, distress, complexities and higher risks to the pregnant woman'.[1044]

11.2.28 The QLRC explained that community concern about abortions on request without any limits, particularly in later gestational stages, are sought to be addressed by ensuring that later abortions are subject to additional oversight. It also recognises concerns that, without legislative provision, a medical practitioner may be left in uncertainty as to whether a late term abortion is lawful.[1045]

Professor De Costa's approach

11.2.29 Professor De Costa explained to SALRI she does not support criteria, but favours an approach broadly drawn from Queensland, which requires the involvement and approval of two medical practitioners after 22 or 24 weeks. She explained:

> At the same time, it is important that women who are making the decision to terminate a later pregnancy for the reasons already mentioned have appropriate information and support around the decision making and during and after the procedure. We also found in Queensland, in the numerous consultative processes that were conducted in the lead-up to our law change, considerable public concern that later abortion only be performed for very clear reasons and with appropriate safeguards for the woman. For these reasons in Queensland 22 weeks gestation was chosen as the point, up to which a woman can request and receive an abortion with the approval and involvement of one doctor; after 22 weeks another doctor must also be involved and that doctor must be in possession of all the relevant information about the case. Currently 22 weeks is just before the earliest gestational age at which a fetus has a reasonable chance of survival if born alive. In Victoria 24 weeks was chosen as the point from which two doctors are required to approve the abortion, for similar reasons to ours in Queensland.

11.2.30 This approach does not include formal criteria, but rather the approval of the two medical practitioners as to whether the proposed procedure is medically appropriate.

11.2.31 There was significant support in SALRI's consultation for this approach.[1046]

11.3 Gestational Limits and Criteria for Late Term Abortions

11.3.1 One sensitive issue is whether different considerations should apply to late term abortions. There is debate as to whether there should be different criteria and/or especially a need for the involvement or approval of more than one medical practitioner for late term procedures.

11.3.2 The 2018 South Australian Bill removes the current general upper limit of 28 weeks at which an abortion can be performed and provides that an abortion can be performed at any gestational stage with the woman's consent.[1047] Ms Franks, noting that late term procedures are rare, explained:

> Domestic violence, mental and physical health problems, injury, trauma and addiction often frame the personal circumstances of a woman's decision to have an abortion beyond that 14 weeks. In the case of fetal anomaly, the complexities of making that decision to have an abortion is bound

[1044] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

[1045] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 95 [3.183].

[1046] See further below [11.5.38]–[11.5.48]. There were also views against this approach.

[1047] It should be emphasised that a medical practitioner still has to be satisfied that, as with any medical procedure, it is clinically appropriate.

> up, of course, with the timing of tests. The timing restrictions that we currently have set out in our current law prescribe an upper limit of 28 weeks. Interpretation of that law, however, means that in practice abortion is provided in South Australia mostly only up to 24 weeks, yet certain relevant tests may only be available at that 20-week mark, leaving a very narrow and possibly very pressured window of time for that woman's decision, a pressure that woman should not have to face. If an anomaly is identified, further tests may be ordered to give women as much information as possible for their decision-making. While medical and healthcare practitioners can provide this woman with that important information, the current law actually restricts them from giving that woman as much time as she needs with the appropriate information to make the decision she must. Best care practices for health require that a woman be able to make those decisions about their reproductive health, as the experts of their situation, with the support of their health practitioner, not rushing her into time frames that were set by parliament and not by the professional advising her.[1048]

11.3.3 The Anglican Bishop of Newcastle, Rev Dr Peter Stuart, in supporting the 2019 NSW Act, also supported the need for the law to allow late term abortions in suitable cases:

> Anglicans have often learnt through pastoral conversation about the experience of women who, late in pregnancy, received news that devastates them: news about what is occurring within their body around a child for which they have longed. The understanding that in these circumstances a termination of that pregnancy may be the best available moral outcome means that any law regulating termination must provide a framework for those decisions. Again, such framework should be outside the criminal code.[1049]

11.3.4 The VLRC in its consultation found no consensus on the question of late term abortions.

11.3.5 Most parties in favour of decriminalisation did not support gestational limits or fetal viability to the VLRC as a sound policy basis.[1050] Some parties opposed any dividing line or limit based on gestational stage and felt that the same criteria, typically the availability of an abortion on request (as under the ACT approach), should apply at any gestational stage. Many parties did not suggest an appropriate gestational limit to the VLRC as they felt the woman's consent should be the only consideration. Gestational limits were seen to undermine the woman's right to choose; make women navigate hurdles; and interfere with best-practice standards of care, which involves the decision being made by a woman in consultation with her medical practitioner.[1051] Many criticisms of using viability as a basis for a gestational limit were raised to the VLRC. Many parties felt that imposing a gestational limit was arbitrary, problematic, difficult to implement and lacked adequate medical justification.[1052]

11.3.6 Other parties took a different approach to the VLRC, noting that 'viability was the important indicator for any gestational limit. They argued that the fact a child could be born alive was significant.'[1053] Other parties submitted to the VLRC that no point in time is acceptable for an abortion to be performed or that gestational limits are too difficult to set and that the fetus should be protected from conception.[1054] The VLRC observed:

[1048] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2424–25.

[1049] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 61 (Rev Dr Peter Stuart, Anglican Bishop of Newcastle). See also at 69.

[1050] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 40 [3.58]–[3.59]

[1051] Ibid 79 [5.75]

[1052] Ibid 79 [5.77].

[1053] Ibid 79 [5.76].

[1054] Ibid 80 [5.79].

> Viability was a very important concept for decriminalisation opponents. Some argued that it was unacceptable that women with fetuses of the same gestational age were treated differently by hospitals. Some were given significant paediatric intervention following very premature birth, while others sought abortions at the same stage of pregnancy.[1055]

11.3.7 The difficulty in determining a dividing line for any different requirements between early and late term abortions was noted by the VLRC as 'a task of considerable complexity'.[1056] The VLRC found there was 'no general agreement about where a line based on viability should be drawn'.[1057] Concern was raised to the VLRC that any line lower than 24 weeks would not allow appropriate time to make decisions after routine prenatal testing,[1058] which typically occurs around 20 weeks. The range of proposals for where a line based on viability should be placed was generally between 20 and 24 weeks, though one party believed it should be 12 weeks, and Reproductive Choice Australia thought it should be 26 weeks.[1059]

11.3.8 The VLRC also found no agreement as to the role of the medical practitioner in relation to late term abortions:

> Throughout the review we heard differing views from medical practitioners and staff about the role of the doctor in the decision to provide abortion after 24 weeks. Some believed that patient autonomy and informed consent were the only relevant considerations. Most found the support of colleagues in a consultative decision-making process useful. Decisions to undertake an abortion after 24 weeks are seen by medical staff involved as 'controversial and difficult ethical decisions' and 'onerous'.[1060]

11.3.9 The VLRC (with an apparent lack of enthusiasm)[1061] ultimately opted for 24 weeks as reflecting viability and as according with current clinical practice in Victoria.[1062]

11.3.10 The VLRC, drawing on this 24 week stage, in its two stage model (recalling there were three potential models presented in its Report)[1063] proposed that, whilst abortion would be available on request up to 24 weeks, after 24 weeks a lawful abortion could only be performed if it was appropriate to prevent the risk of harm to the woman and was approved by two medical practitioners.[1064]

11.3.11 The VLRC discussed this option as follows:

[1055] Ibid 40 [3.57].

[1056] Ibid 90 [1.4].

[1057] Ibid 80 [5.79].

[1058] Ibid 41 [3.63].

[1059] The VLRC heard from some medical practitioners and others, that 24 weeks may be an appropriate line to draw at a clinical practice level, but not in law: ibid 40 [3.62].

[1060] Ibid 37 [3.43].

[1061] 'Determining where to place the gestational line that divides the two stages of this model is a task of considerable complexity': ibid 90 [1.4]. See also at 79–80 [5.75]–[5.81].

[1062] Ibid 90 [1.4].

[1063] Ibid 6–7, 83–93.

[1064] The VLRC noted there were two reasons why it may be beneficial to require a determination by two medical practitioners. First, it is common clinical practice to rely upon more than one medical practitioner's opinion whenever a decision involves complex considerations. 'Such an approach may promote community confidence in the quality of decision making; generate an increased sense of confidence in the correctness of the decision among the treatment team that will perform the abortion; and it may relieve some of the pressure that individual doctors may experience when making decisions of this nature. Secondly, this requirement would largely reflect current clinical practice': ibid 91 [2.1].

> This model constitutes a partial legislative affirmation and restatement of the existing judge made law and reflects current clinical practice. The two-staged approach to regulation means that a woman is the final decision maker for early abortion. In the later stages of pregnancy medical opinion about the risk of harm to the woman determines whether abortion is lawful. This model is broadly similar to British abortion laws. It occupies a middle ground when considered in the context of the Australian jurisdictions that have recently amended their abortion laws.[1065]
>
> The policies upon which this model is based may be described as follows: Different laws should govern early and late abortions.
>
> During the early stages of pregnancy, abortion should be regulated in the same way as any other medical procedure. During the early stages of pregnancy a woman retains the right to determine what medical procedures she will undergo and what relationships she will enter.
>
> During the later stages of a pregnancy, abortion is an exception to a woman's general right to determine what medical procedures she will undergo and what relationships she will enter.
>
> - the exception exists because there are other matters which must be taken into consideration when the medical procedure is abortion during the later stages of a woman's pregnancy, such as the potential life of the fetus and the role of the state in safeguarding that potential life
> - the exception does not operate when there is a risk of harm to a woman in continuing with the pregnancy.
>
> A medical determination is the best means of deciding whether an abortion is necessary because of risk of harm to a woman. The positioning of the dividing line between the two stages of a pregnancy involves a difficult exercise in judgment because of the range of factors that must be taken into consideration. The placement of the dividing line at the end of the 24th week of a pregnancy reflects current clinical practice and the experience of other jurisdictions. A medical practitioner who performs an abortion when not authorised by law should be liable to professional sanction.[1066]

11.3.12 The QLRC considered a range of different approaches and models, gestational limits and grounds and ultimately favoured a two stage model with different stages based on viability. The QLRC observed:

> However, the Commission recognises that, as the fetus develops, its interests are entitled to greater recognition and protection … It is also consistent with the view of the majority of Australians who support a woman's right to choose, but not all of whom consider that this right should be absolute.[1067]

11.3.13 The QLRC settled upon a combined approach of a gestational limit of 22 weeks and a single broad additional ground to be satisfied after that time.[1068] The QLRC reasoned that a gestational limit of 22 weeks represents the stage immediately before the 'threshold of viability' under current clinical practice; aligns with current clinical practice in Queensland in which terminations from 22

[1065] Those jurisdictions were then Western Australia, Tasmania, the ACT and the Northern Territory.

[1066] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 91–92.

[1067] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 94 [3.181]

[1068] Ibid v [13].

weeks gestation are required to be performed at particular hospitals and 'reflects that terminations after 22 weeks involve greater complexity and higher risk to the woman'.[1069]

11.3.14 The QLRC recorded the strong view relayed to it (as also expressed to SALRI) that abortion should be a health decision made between a woman and her medical practitioner which should be governed by the same legal principles that apply to all other health care. There should be no reason to single out abortion for special mention. The reasons women may have for seeking an abortion are varied and personal and should not be subject to public scrutiny.[1070]

11.3.15 The QLRC noted that an 'on request' approach might be considered appropriate for a number of reasons such as removing legal barriers to access, according maximum respect for women's autonomy and providing greater clarity for health practitioners because they are not required to interpret and apply additional, often difficult, legal tests and can focus on their primary role of determining their patient's best clinical interests.[1071]

11.3.16 The QLRC noted that there are also arguments against an 'on request' approach. There is some concern that an 'on request' approach would not regulate, and could therefore allow, termination of late term pregnancies up to birth, giving inadequate recognition to the interests of the fetus.[1072] The QLRC asserted: 'It has long been recognised that, as the fetus develops, its interests are entitled to greater recognition and protection.'[1073] There might also be concern about laws that could allow 'abortion on demand' where it is considered that there is an inadequate justification or reason for abortion (for example, abortion used for gender selection,[1074] as a primary form of contraception or for convenience).[1075]

11.3.17 The QLRC in light of these concerns ultimately favoured a two stage model, namely for an abortion to be available on a woman's request up to 22 weeks but, for after 22 weeks, to require the approval of two medical practitioners that the procedure is appropriate in the circumstances.

11.3.18 The QLRC (as with the VLRC) did not support late term limits.[1076] The view of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to the QLRC was clear:

> Gestational limits discriminate against the most vulnerable of women and women in the most difficult of clinical circumstances. Often disadvantaged women may not access diagnosis of lethal or serious anomalies until later gestations. Gestational limits discriminate against women who may

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[1069] Ibid v–vi [15].

[1070] Ibid 38 [128].

[1071] Ibid 38–39 [129].

[1072] See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 31–32 [6.5.2.3].

[1073] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 39 [130]. See, for example, *R v Woolnough* [1977] 2 NZLR 508, 516–517 (Richmond P), quoted in *R v Bayliss* (1986) 9 Qld Lawyer Reps 8, 39: 'it would, I think, be in accordance with the thinking of a great majority of people that the further a pregnancy progresses, the more stringent should be the requirements which will justify its termination'. See also L Syd M Johnson, 'Abortion: Contemporary Ethical and Legal Aspects' in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 8. However, this view is at odds with the fundamental rule that a child has no legal rights until born. See above [1.3.18]-[1.3.19].

[1074] See Rachel Wong and Grant Gillett, 'Think of the Children: Sex Selection and Child Welfare' (2015) 22(4) *Journal of Law and Medicine* 751. See also *R (Hubert) v Director of Public Prosecutions* [2015] EWHC 3733 (Admin).

[1075] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws,* (Consultation Paper, WP No 76, December 2017) 39 [130].

[1076] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) iii.

have severe congenital infections such as cytomegalovirus which may not be apparent until later gestations or may only be diagnosed beyond 20 weeks.[1077]

11.3.19 It has been noted that leading health bodies, such as the RANZCOG, the Royal Australasian College of Physicians and the Public Health Association of Australia, do not support legislative gestational limits that set out different criteria for different stages of pregnancy.[1078]

11.3.20 The position of RANZCOG is that 'there should not be a specified gestation range and that late termination of pregnancy must be an option available to women'. As Beth Wilson noted to SALRI, 'their position was arrived at after much consultation and carries weight because they of their expertise in this area.'

11.3.21 There are suggestions that late term abortions, owing to their potential complications, should be the subject of approval of a second specialist practitioner or even a panel or committee.

11.4 Second Medical Practitioner (or Specialist) or Ethics Panel or Committee

11.4.1 The VLRC noted that parties opposed to the decriminalisation of abortion 'strongly welcomed' a requirement for the approval of more than one medical practitioner and/or panels, and a range of options was put forward about the number of medical practitioners, the size and function of panels, and who might be involved (medical practitioners, gynaecologists, obstetricians, and psychiatrists).[1079]

11.4.2 However, the VLRC found strong opposition by parties supporting the decriminalisation of abortion and some health practitioners to any suggestion of a Panel or Committee to approve late term abortions, including its adverse effect on patient autonomy.[1080]

11.4.3 The QLRC opposed the need for a specialist to approve an abortion: 'The [legislative] requirement should not be unduly onerous or burdensome. It should reflect the minimum that is required, whilst leaving flexibility for service providers to adopt further measures in practice if deemed appropriate.'[1081] The QLRC further viewed it as unnecessary for the law to impose additional requirements about the qualifications, expertise or experience of a second medical practitioner. 'These are matters properly to be determined on a case-by-case basis in accordance with good medical practice.'[1082]

11.4.4 A number of parties suggested to SALRI the need for the approval of a second medical practitioner, ideally a specialist or even a specialist committee for early and especially late term abortions. It was argued that a specialist or even a committee would provide greater oversight and guidance. Cherish Life Australia, for example, submitted:

> As abortion is a risky procedure, consulting with another practitioner increases the physician's accountability and enables the mother to have better informed consent with a second medical opinion. Second medical opinions are lifesaving in many medical procedures … If a consultation is required, should it include: another medical practitioner … to minimise risk to the mother or a

[1077] Ibid 56.

[1078] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2783 (Hon Tammy Franks).

[1079] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 81 [5.86].

[1080] Ibid 47–48 [3.44]–[3.48], 80 [5.84].

[1081] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 81 [3.127].

[1082] Ibid [3.129]

> specialist obstetrician or gynaecologist … as they are best qualified to give a medical opinion on a pregnancy or a referral to a specialist committee … [as] this provides more complete professional support for the woman.

11.4.5 However, there was limited support to SALRI for the option of a second specialist for either early or late term abortions. A recurrent concern was the effects of such a requirement for rural or remote access. Children by Choice noted that requirements for specialist consultation can impact heavily on rural and remote women and their medical practitioners, 'potentially further delaying access to patients already facing restrictive barriers to access'. The particular implications in terms of regional, rural and remote access were highlighted to SALRI by various regional, rural and remote health practitioners. In Port Augusta, for example, the current requirements for an abortion procedure already make it impossible for the procedure to be carried out and, in the event that the current requirements were altered, but required a specialist, this issue would remain. Professor Heather Douglas urged SALRI in any requirements for consultation to avoid 'inequities and delays of access'. She suggested that if consultation with a second person is determined to be necessary, it should be able to occur online or by video link 'so that inequities (and delays) are not created'. Professor Douglas argued that any requirement to consult with a specialist practitioner or a Western Australia style ethics panel is misplaced, especially for rural communities:

> Any requirement for specialist consultation should be avoided. Such requirements create particular inequities for regional, remote (especially ATSI women) and poor women. They may also lead to significant extensions of time (and gestation) endangering women's health. While it may be possible to identify the relevant 'specialist' in urban areas it may be very difficult to do this in more remote and regional areas leading to inequity in access and delay. Any requirement for a committee to make the decision should be avoided. Such a requirement creates particular inequities for regional, remote (especially ATSI women) and poor women. They may also lead to significant extensions of time (and gestation) endangering women's health. It also adds to costs. There is no evidence that a committee is necessary to promote the women's health and well-being.

11.4.6 The ethics panel process in Western Australia was the subject of extensive criticism during SALRI's consultation as being unnecessarily bureaucratic, stressful and protracted both for women and medical practitioners. Professors Willmott and White, for example, said such 'an approach is unnecessarily onerous and burdensome, and would constitute unwarranted intrusion and delay.'[1083] It was noted such a Panel may not even be headed by a medical practitioner.[1084]

11.4.7 Fair Agenda noted the bureaucratic burden of an ethics panel. They strongly opposed any requirement for a panel, highlighting such 'a requirement for specialist consultation could be expected to impact heavily on pregnant people and medical practitioners in rural and remote areas; and impact their ability to access timely healthcare'. Professor De Costa noted that the Western Australian cut-off point of 20 weeks, after which approval is required from two members of a committee appointed by the Minister for Health, has made access to later abortion 'very difficult' for many women in Western Australia who have then travelled interstate or overseas to access abortion. She was clear that South Australia should not adopt this approach. Beth Wilson, the former Victorian Health Services Commissioner, also opposed the committee approach. Marie Stopes Australia shared this view, referring to the unnecessary delays and additional costs of the Western Australian committee model.

[1083] It was also noted that the Ethics Panel, based on their decisions, appears to have interpreted severe medical condition as to mean will cause death.

[1084] Reproductive Choice Australia noted the Termination Review Panel at the Royal Women's Hospital in Victoria (until decriminalisation in 2008) was chaired not by a clinician but by a hospital administrator.

11.4.8 The extent of the problems with the panel or committee approach were made clear by the Southgate Research Institute:

> [This option] is likely to give rise to particularly serious problems in practice. The woman is likely to be subjected to requirements for clinically unnecessary or counterproductive examinations. Such committees cause harmful and unnecessary delays in what are always difficult circumstances. They create additional distress for women who have struggled to make difficult decisions only to find their decisions suspended pending a committee meeting, or overruled. Typically, over time such committees come to be partly populated by individual health professionals who are compromised in their capacity to exercise good judgement in individual cases because of strongly-held moral positions regarding abortion per se.

11.4.9 A retired specialist also urged against the adoption of a formal committee or ethics panel approach and described the delays that already occur in practice in South Australia.[1085]

11.4.10 The suggestion of a West Australian panel or committee to approve an abortion has been criticised elsewhere,[1086] notably for its effects in even further restricting regional, rural, remote or Aboriginal access. The Australian Association of Social Workers told the QLRC:

> The imposition of panels or committees … would create further barriers to a woman's agency; position the health practitioners in the position of power over a woman's body and decision making; and create even further barriers for women who live in rural, regional or remote locations, women who have experienced sexual assault or domestic and family violence, Aboriginal and/or Torres Strait Islander women and women from [culturally and linguistically diverse] backgrounds.[1087]

11.4.11 The suggestion of a legal requirement for a second specialist or a committee to approve a late term abortion is problematic, especially in terms of rural and remote access. SALRI does not support any formal requirement in late term abortions for either a committee[1088] or a specialist.

11.4.12 SALRI notes the 2019 NSW Act provides that a specialist considering a potential abortion after 22 weeks may 'ask from advice from a hospital advisory committee or disciplinary team'.[1089] It

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[1085] The retired specialist explained to SALRI that in some institutions already 'there is a complicated process of attempting to obtain permission for a late termination of pregnancy to be carried out past 23 weeks gestation which entails the calling together of a specially constituted committee of medical and non-medical personnel at the respective hospital … to consider each case on its merits but as part of the discussion is the requirement that the fetal abnormality is not compatible with life, which, depending on the definition used, cannot be guaranteed as neonatal resuscitation is very skilled nowadays. Inherent in the delay before a firm diagnosis can be made and a likely prognosis given, along with the further delay after 23 weeks gestation for a committee to be brought together to make a decision as to whether the patient / couple can proceed with a requested termination of pregnancy, is the overwhelming anxiety and emotional trauma experienced by the patient / couple, their families and their medical, midwifery and paramedical attendants particularly if permission is not given which happens not infrequently.' See also below [13.11.5].

[1086] See, for example, Kirsten Black, Heather Douglas and Caroline de Costa, 'Women's Access to Abortion after 20 weeks' gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 144.

[1087] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 92 [3.170].

[1088] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Queensland Abortion Law Reform* (Media Statement, 15 February 2017) <https://www.ranzcog.edu.au/news/Queensland-abortion-law-reform>.

[1088] SALRI understands from consultation that hospitals, both in South Australia and interstate, may choose to utilise multidisciplinary committees to determine later term abortions. SALRI does not wish to preclude such practices but such questions are better left for clinical and operational determination than legislative requirement.

[1089] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 59–65

was explained that this amendment sought to merely codify existing clinical practice and provide additional advice in complex situations.[1090]

11.4.13 This amendment was criticised by some MPs. The Hon Abigail Boyd argued:

> However, these amendments still go beyond a reflection of the status quo and would potentially cause delays or obstruct access to late term terminations … This amendment would impact disproportionately on those in regional and rural areas and those in domestic and family violence situations. It would also lead to additional pressure on pregnant people to have terminations earlier than they would otherwise or in circumstances when they would otherwise choose not to have a termination, in light of further information or consideration only becoming available at a later time and because of concerns over later access to abortion being governed by a regime, which includes these amendments. We know from the Western Australian experience that hospital committees lead to unacceptable delays.[1091]

11.4.14 The Hon Rose Jackson was also critical:

> The arrangement, as presently outlined in the legislation, for terminations post-22 weeks is for the woman herself, her doctor and a second medical specialist, which is an adequate oversight provision for the occurrence of that termination. I think the inclusion of multidisciplinary teams and hospital advisory committees complicates and overburdens a matter in an unnecessary way. It is already an extremely complicated, challenging and complex decision, and these amendments only exacerbate that complicated situation. In fact, the uncertainty around the word 'may' and other words, to me, creates more uncertainty and complication in a situation and a circumstance that is deeply tragic and already very challenging.[1092]

11.4.15 SALRI notes these cogent criticisms of the NSW amendment and SALRI would not support the adoption of a similar provision in South Australia. There is the risk that cautious medical practitioners or hospital administrators will read 'may' as 'shall', requiring reference of any late term abortion to a committee. Such an amendment risks producing the unsatisfactory Western Australia committee approach, especially compounding issues for rural and remote access.

11.5 Submissions

11.5.1 SALRI received many submissions on late term abortions and whether there should be such procedures and, if so, what the criteria should be. There was a wide diversity in views.

11.5.2 The issue of late term abortions (especially on the grounds of fetal abnormality) proved especially contentious and parties opposed to the decriminalisation of abortion raised particular concern in relation to late term abortions.[1093]

11.5.3 The difficulties in asking if there should be a late term limit was outlined by a number of lead clinicians. One explained:

[1090] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 59–60 (Hon Damian Tudehope).

[1091] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 60.

[1092] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 64.

[1093] There were also calls for SALRI to urge that certain procedures should be precluded such as 'partial birth' procedures. SALRI acknowledges this is a contentious area but it is beyond SALRI's remit to enter into this area. SALRI concurs with the comments of Reproductive Choice Australia: "'Partial birth" is terminology used by anti-choice groups in the USA, however this type of technique is not used in Australia. In any case, it is not the role of the Parliament to dictate in law what procedural techniques doctors can and can't use. Medical technology will always outpace law and to outlaw any particular surgical technique would set a dangerous precedent. Determining appropriate medical procedures is the role of medical colleges and health professionals, not Parliamentarians.'

> This is a highly complex question. While many would advocate for women being able to access termination of pregnancy at later gestational ages than currently exist within the law, facilitating termination of pregnancy beyond currently accepted gestational ages is potentially associated with fetal viability, and provides an ethical dilemma for many practitioners. Providing no upper limit for gestational age at which termination can be procured would require a practitioner to cause fetal death prior to initiating labour, or would need to allow infanticide if a child was born alive at a viable gestation. There are considerable practical ethical barriers to these processes. The question relating to gestational age limits for performing termination of pregnancy is an extremely superficial distinction in addressing the more relevant underlying question relating to viability.

11.5.4 It was emphasised to SALRI by many parties (including RANZCOG) and health practitioners that there are many, and powerful, reasons why, in rare cases, a woman may need to resort to late term abortion, and it is undesirable that any law should seek to prevent or unduly restrict the availability of such a procedure.[1094] There was support from many parties for the removal of late term limits, highlighting such procedures are rare and only undertaken in the most compelling of circumstances. The AMA(SA) expressed this view. This was the prevailing view at SALRI's roundtables with the disability sector, the legal and medical sectors, and parties favouring decriminalisation.

11.5.5 Fair Agenda opposed late term limits, highlighting the importance of allowing lawful abortions after 24 weeks in light of 'the very rare situations in which terminations are sought after 24 weeks … often in relation to very unique and difficult circumstances that often involve fetal abnormality'.

11.5.6 One submission noted that less than 2% of abortions are late term and 'this very small percentage of abortions largely consists of wanted pregnancies with devastating complications'.

11.5.7 Dr Susie Allanson explained:

> Women have abortions for good reasons. Their decision-making capacity and bodily autonomy throughout pregnancy should be respected in legislation and as a health issue … We do not yet have 100% reliable contraception, sexual assertiveness can be difficult, people are imperfect, forgetful and passionate, and women are disproportionately afflicted by physical and sexual violence. Women do not become pregnant so that they can continue to be pregnant until late gestation and then, on a whim, terminate. Approximately 96% of abortions are early (prior to 12 weeks). Women accessing abortion at much later gestation face sad and complex circumstance often involving serious fetal abnormalities or risks to the pregnant woman.

11.5.8 Dr Margie Ripper, a South Australian academic, stated a gestational limit is not required. She highlighted that the small proportion of women who seek abortion at later gestation are predominantly women with wanted pregnancies where a fetal abnormality has been discovered[1095] or where the woman has a life-threatening illness or injury which requires medical treatment that is incompatible with pregnancy. Dr Ripper explained that the rare presentation for abortion at later gestation by women outside these categories inevitably involves a complexity of circumstances such as

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[1094] The assertion that late term abortions, including on account of fetal disability, are especially harmful to women's mental health is disputed. See Julia Steinberg, 'Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions: A Critical Review of the Research' 21 (3S) *Women's Health Issues* S44. 'The existing literature suggests that women who have later abortions for reasons of fetal anomaly have no worse mental health than women who give birth to infants with lethal or severe mental or physical conditions or experience other types of later perinatal loss (eg, stillbirth or later miscarriage). Consequently, policies based on the notion that abortion — and particularly later abortions for reasons of fetal anomaly — harms women's mental health are not warranted. Further research on the psychological experiences of women having later abortions is needed to inform clinical practice': at S47.

[1095] See also below Part 13.

violence and reproductive coercion, incest and rape, misdiagnosed pregnancy, or a life which is compromised by addiction or mental illness. In none of these 'rare and extreme circumstances', she noted, would a gestational limit improve the situation. 'In these cases, a team of health professionals would be working with the woman about her options.'

11.5.9 This view was expressed elsewhere. Professor Heather Douglas noted the 'extremely complex reasons' for late term abortions and opposed any gestational limits. The Greens (SA) similarly maintained that there should not be a gestational limit placed on access to abortion. 'Abortion, at any stage of a pregnancy, should remain at the discretion and judgement of the woman involved and her health care team.' It was said that Parliament should not place 'arbitrary limits' on such a health care procedure, particularly as such limits 'regularly and demonstrably impede the provision of best practice health care and a woman's right to choose'. A leading health agency expressed a similar view.

11.5.10 Beth Wilson, the former Victorian Health Services Commissioner, also opposed any late term limits. She noted that screening is recommended to take place at 18–20 weeks in pregnancy and it is important that a woman who receives an unexpected or negative diagnosis after this test has time to access relevant information, and does not feel rushed to make a decision.[1096] Ms Wilson explained:

> There are many reasons why a pregnant person might not need, or be able to access, abortion care until later in pregnancy — including health risks, traumatic change in circumstances, delays because of limited health services in her region; or the violence and control of an abusive partner. Laws that provide for compassionate healthcare must recognise those complex and difficult circumstances and minimise barriers to access … Many abortions required in later terms of gestation involve women who may have disabilities and find it difficult to access health care. Some have been raped by carers. No law should ever place limits on a woman's access to abortion care in line with a threat to the woman's life or situation or an unlawful act.

11.5.11 A leading health agency similarly argued that there should be no gestational limits. It explained that 2.8% of abortions are performed in South Australia at or after 20 weeks gestation. Of the abortions performed at or after 20 weeks gestation; 43.3% are for 'congenital anomalies'. Other reasons for a late gestation abortion may be due to a late diagnosis of a serious maternal health issue, late diagnosis of pregnancy, reproductive coercion and problematic personal circumstances. It was said that 'imposing a gestational limit will act as a barrier in these and other situations where late gestation abortion is required'. It was explained that mandating a gestational limit puts increased pressure on the women and their family to make a decision 'in difficult and perhaps rushed circumstances with inadequate information for informed consent'. It also imposes unnecessary time pressures on the health practitioners providing their care. The health agency observed:

> The common and unnecessarily emotive argument for imposing gestational limits is that it prevents someone seeking 'abortion on demand' right up until due date. The reality is that 3rd trimester abortion is very rare and only performed for severe congenital abnormalities or a serious threat to the life of the parent. In these rare instances this decision is made by a team of health professionals and often in conjunction with an organisational ethics committee.

11.5.12 Professor De Costa outlined her view that late term abortions are inevitable in some situations and the 28 week limit should be removed. She explained:

> The remaining 5–6% of abortions are performed later in pregnancy and the majority of these occur because a diagnosis of a severe fetal abnormality, or less commonly a serious maternal medical

[1096] This view is consistent with those expressed to SALRI by a genetic counsellor and clinical geneticist who described the time required to conduct more in-depth genetic testing and raised the importance of allowing women time to process the outcomes of any testing so they can make an informed, and unhurried, decision about their pregnancy.

> condition, has been made later in the pregnancy, and the woman, in consultation with her medical advisers plus her partner, family and whoever else she relies on for support, has decided on termination of the pregnancy. Most of these diagnoses are made by 20 weeks of pregnancy but some cannot be made with certainty until later; in other cases the woman does not present earlier in the pregnancy, perhaps for geographic, social or medical reasons. In my years of practice, I have seen a small but significant number of the latter cases, which are often very complex. It is important that doctors have the flexibility to offer women in these very difficult circumstances the option of terminating the pregnancy. From my long experience of caring for pregnant women, I am very aware that women continuing with a normal pregnancy, even if the pregnancy was originally unintended, do not suddenly change their minds and request an ending to the pregnancy at > 20 weeks or later. The claim that having no gestational limit to abortion will result in an epidemic of 'full term abortion' is a furphy put out by opponents of safe abortion provision, an unsubstantiated piece of nonsense.

11.5.13 This theme was also raised in consultation by Ceduna health practitioners, who noted an upper limit was unnecessary as there is a need, although rare, for late term procedures and 'these are traumatic enough already for the families involved'. The Royal Australasian College of Physicians, Fair Agenda, the Human Rights Law Centre and the Southgate Institute also opposed late term limits.

11.5.14 The South Australian Abortion Action Coalition noted that interpretation of the present law and the 28 week 'born alive rule' (or rebuttable upper limit for the performance of an abortion) have given rise to many problems and a consequent effective service limitation to a 23 week and six day gestation limit for abortion in South Australia. It was explained that the advice of the Crown Solicitor's Office[1097] is that even emergency procedures may be criminal if the pregnancy is 'capable of being born alive'. 'Hence, services are not offered beyond 24 weeks gestation. Gestation becomes the determining factor rather than the health of the woman.'

11.5.15 The South Australian Abortion Action Coalition also noted that only a 'small minority' of abortions happen after 20 weeks and called for the removal of any late term limit:

> Women who present for a termination when they are past 20 weeks of pregnancy are a small minority of all those who seek an abortion. The current law regarding the upper limit of pregnancy after which a person can no longer have an abortion puts unnecessary pressure on their decision-making and can obstruct their access to care. Although clause 8 of s 82A of the *CLCA* specifies that 28 weeks is the upper limit, advice from SA Health to abortion providing services in recent years has meant than an abortion is only available up to 23 weeks and six days. This upper limit not only restricts women's access to appropriate health care but also compromises the care that health professionals can give. It can mean that decisions about the pregnancy must be made in haste and without all necessary diagnostic information, conditions that severely compromise decision making based on informed consent and the delivery of best care.

11.5.16 Fair Agenda affirmed the importance of no upper limit and providing for lawful abortions after 24 weeks:

> We note that the very rare situations in which terminations are sought after 24 weeks are often in relation to very unique and difficult circumstances that often involve foetal abnormality. The women who present for assistance at this point are often very vulnerable women living in the most complex and difficult circumstances. This includes women who due to youth, medical conditions, or family violence have been unable to access support earlier … the kinds of circumstances in which a woman might present seeking a termination at this point include those where there is a severe fetal abnormality; there has been a traumatic change in circumstances (for example, where

[1097] See also above n 367, below [11.5.40].

> a woman is diagnosed with a very serious illness), or where continuing with the pregnancy puts the woman's health or life at serious risk (for example if the woman is suicidal).[1098]

11.5.17 A number of lead clinicians stated to SALRI that 'fetal viability' needs to clearly be differentiated from 'capable of being born alive'. In this sense, 'signs of life' does not equate to viability and it was therefore suggested that the 'capable of being born alive' provision under s 82A(8) of the *CLCA* be removed. A number of factors, including gestational age, medical intervention required to sustain life and specific signs of life (heart beat and breathing), are among many factors used to determine the viability of a fetus.

11.5.18 Various parties favoured the removal of late term limits, emphasising both the rarity of later term abortions and the adverse implications of such limits.

11.5.19 The Australian Women's Health Network stated that the present upper limit (formally 28 weeks but 23 weeks in practice) should be removed as it restricts women's access to appropriate health care but also compromises the care that health practitioners can provide. 'It can mean decisions about the pregnancy must be made in haste and without all necessary diagnostic information, conditions that severely compromise decision making based on informed consent and the delivery of best care.'[1099]

11.5.20 Dr Erica Millar stated that upper term limits are 'arbitrary and highly problematic' and should be removed. She stated that late term abortions are inevitable, albeit in compelling circumstances, and referred to the 'fiction' and 'spurious claims' that women would willingly have an abortion at near term and that highly trained medical practitioners would be willing to perform such procedures. Dr Millar explained that to compel women to undergo a pregnancy unwillingly and to form a maternal relationship with a child they do not want 'has deleterious effects on their health, and the health of the children born, in the immediate and long term'. Dr Millar elaborated:

> Gestational cut-offs prevent women from deep reflection in consultation with an appropriate range of healthcare professionals.[1100] Gestational cut-offs compel women and their partners to make decisions without the necessary time or information to understand complex medical conditions and contemplate the wellbeing of their potential child and the consequences for their own lives of raising a child with a disability. As a result of gestational cut-offs, women can terminate pregnancies they would otherwise keep; they can keep pregnancies they would have otherwise terminated; and they can be forced to terminate a pregnancy before they are emotionally and psychologically prepared to end a pregnancy that was, until that time, wanted.

11.5.21 Associate Professor Catherine Kevin submitted that the upper limits should be removed. She submitted that about half of the limited number of late term procedures are due to the late identification of a fetal abnormality and the time it may take to gather, digest and come to terms with all the relevant information available (including some test results), before which time the upper gestational limit may be reached. Associate Professor Kevin pointed out that in South Australia this is made even more complex by the 'child destruction' provision which means that medical practitioners are unwilling to perform abortions after 23 weeks despite the upper limit being 28 weeks. 'This

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[1098] See also Women's Health Victoria, *Abortion After 24 Weeks* (Fact Sheet, May 2016) <https://whv.org.au/resources/whv-publications/abortion-after-24-weeks>.

[1099] A clinical geneticist similarly described to SALRI that gestational limits impact good medical practice and impedes a woman's choice. See Part 13 below for information on genetic testing and exome sequencing.

[1100] See also Lachlan de Crespigny and Julian Savulescu, 'Pregnant Women with Fetal Abnormalities: the Forgotten People in the Abortion Debate' (2008) 188(2) *Medical Journal of Australia* 100.

complexity in the law and the threat of prosecution it presents distracts from providing the best care for the most vulnerable women who are considering abortion.'

11.5.22 Many parties such as the Australian College of Midwives, in support of no formal gestation limit, cited the following approach of RANZCOG:

> RANZCOG strongly supports the availability of a legal late termination of pregnancy for those women in the rare circumstances where it is clinically unreasonable to compel decisions around termination of pregnancy at an earlier gestation.[1101]

11.5.23 Harrison's Little Wings, a specialist support group in this area, opposed late limits and saw a need to allow certain late term abortions:

> Women who receive a poor or fatal diagnosis in pregnancy are faced with making this extremely difficult and heartbreaking decision. Consistent feedback we receive is women feel rushed to make this decision when gestation age limits are imposed to when a termination can be done. It is extremely important that a women and her family are given the time needed to make this life changing decision. We recommend … no gestation limits are sought … This gives women the time required to make decisions about their pregnancy without feeling rushed and pressured. Harrison's Little Wings, supporting women with extreme complex pregnancies recommend that termination of pregnancy should be allowed for women who receive a poor or fatal diagnosis. Parents when making this difficult decision take into consideration their own personal family dynamics. They consider as parents, whether they have the emotional, physical, financial capacity to take care of a child who may have extensive health care requirements.

11.5.24 The contrary view, from parties such as Dr Šeman and Dr Turnbull, Advocates International, Cherish Life Australia and Genesis Pregnancy Support Inc, was that the present upper limit of 28 weeks is outdated and the law should be updated to restrict, if not preclude, abortions after 24 or 22 weeks (if not earlier)[1102] to reflect advances in medical science in relation to the gestational age and circumstances in which a child is capable of surviving independently.

11.5.25 Various stages were suggested beyond which abortion should be precluded.

11.5.26 Some parties raised 24, 22 or even 20 weeks[1103] as the stage at which abortion should be precluded or least restricted. A common theme was that these stages reflect medical advances as to viability.

11.5.27 A medical scientist, also noting medical and scientific advances, told SALRI that 'there is no health, social or economic reason that could justify third trimester abortions' and raised 'the nature of the procedure that is performed and that by and large society does not support second trimester abortions, in my view they should [also] cease to be performed entirely'. Dr Šeman and Dr Turnbull contended that abortions should be precluded (or at least greatly restricted) after 12 weeks gestation, arguing:

[1101] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Late Termination of Pregnancy* (RANZCOG Statements and Guidelines, 2016).

[1102] Several parties cited the heartbeat approach employed in several US states and asserted that abortions should be precluded after this point. Any such highly restrictive model is outside SALRI's Terms of Reference. In its operation, it would represent a severe restriction, if not reversal, of the current law.

[1103] See, for example, New South Wales, *Parliamentary Debates*, 17 September 2019, Legislative Council, 42–43 (Hon Scott Farlow); Jessica Glenza, 'How Anti-Abortion Activists Use Cutting Edge Science to Justify Ever Stricter Laws', *The Guardian* (online, 13 July 2018) <https://www.theguardian.com/world/2018/jul/13/how-anti-abortion-activists-use-cutting-edge-science-to-justify-ever-stricter-laws>.

> There are several reasons that it is reasonable for our society to draw a line on abortion after the first trimester. The second and third trimester foetus feels pain. Abortion after the first trimester is more dangerous for a woman. Almost all abortions after the first trimester are done for elective reasons. Women have ready access to abortion before the second trimester.

11.5.28 One submission stated the author's belief that a woman does not have the right to decide whether or not her unborn child lives. 'The child is not a part of the woman, like her arm or leg, but is another human being with rights whom she has the responsibility to care for and protect.'

11.5.29 One submission referred to the 'schizoid situation' of lawful abortions allowed at the same gestational stage when modern medicine strives to keep premature children alive:

> Much progress has been made due to advances in surgical procedures and discoveries in medical research made over the course of the last 40 years. The age of viability of unborn babies is currently around 22 weeks gestation, whereas around 40 years ago it was around 28 weeks and our archaic abortion laws need updating to reflect this medical advance. Quite astonishingly, it is still permissible to kill an unborn South Australian child in her mother's womb up until 28 weeks gestation.

11.5.30 A number of groups and individuals adamantly opposed later term abortions. The Lutheran Church stated no abortion should be permitted 'after the point of viability; at that point a baby's right to a chance at life should be indisputable'. Advocates International preferred a prohibition on lawful abortion after the first trimester and in the alternative that there should be at least a prohibition on lawful abortion after a child in the womb is sufficiently developed to be delivered and born alive. The Canberra Declaration proposed that abortion after 22 weeks should be 'outlawed'. Another person submitted: 'The thought that babies [after 22 weeks gestation], especially fully developed babies, can be killed just because of 'inconvenience' or even for some medical conditions, is heartbreaking and shows a loss of our humanity.' One party argued:

> [A]ny woman who has chosen to not use contraception and has fallen pregnant, should not be allowed to access abortion (especially late term abortion) as a convenience. These women are avoiding responsibility for their actions. If you want women to have choice and be empowered about their bodies then educate them on the many other forms of contraception which will work in stopping unwanted pregnancies and respect human life.

11.5.31 Genesis Pregnancy Support Inc asserted:

> [T]he right of 'my body, my choice' would no longer apply, as the baby is able to survive outside of the womb and could be removed alive, leaving the woman no longer pregnant. There is no justification to take the life of the baby. The right being upheld by this legislation could only be described as, 'My child, my choice' whether they live or die. This can surely never be sanctioned by a civilised and humane society … Legalising abortion up to birth, in any shape or form, takes our society to the arguable edge of infanticide.

11.5.32 One submission also opposed late term abortions and noted medical advances in reducing the concept of fetal viability and that 28 weeks needs reconsideration:

> Our abortion laws are outdated in allowing abortion up to a gestational age of 28 weeks, but I do not believe that abortion should be permitted up until the time of birth. Rather, if abortion is to take place at all, which sadly is already allowed, it should not be permitted after 24 weeks gestation or less as viable babies are now being delivered at much lower gestational ages than was previously the case. To permit abortion of what should be a viable baby capable of living independently of the mother's body is tantamount to infanticide.

11.5.33 A number of parties highlighted the 'inconsistency' involved in allowing late term abortions. As one submission noted:

> Many babies are born many weeks prematurely with perfectly formed bodies and grow into healthy adulthood. In the same hospital you would have great efforts being made, sparing nothing to enable a premature baby to survive and thrive, and in another ward a perfectly formed fetus being aborted. Where is the consistency?[1104]

11.5.34 Another person argued: 'I find the idea of allowing terminations right up until birth an extremely disturbing one. For me, medical advances means that we should be lowering the age the unborn child can be terminated, to at least 24 weeks, rather than raising it.' A medical scientist made a similar detailed submission to SALRI to this effect.

11.5.35 An intermediate position was also expressed by a number of parties to SALRI.

11.5.36 The Robinson Research Institute stated that beyond 22–24 weeks, 'abortion access should be restricted and provided only in the event there is a risk of serious or fatal fetal abnormality … or unreasonable risk to the mental or physical health of the mother' and the approval of two medical practitioners should be required'.

11.5.37 The Australian Lawyers' Alliance accepted that the ACT on request approach up to nine months is problematic as a number of conflicting legal and ethical issues arise when considering in what circumstances a woman should be able to request an abortion. The Australian Lawyers Alliance supported the availability of abortion on request 'in the earlier stages of pregnancy' (though noting views differed at where the dividing line should be) and the availability of late term abortions either in an emergency situation where it is necessary to save the life of the woman or another unborn child or it would 'otherwise be appropriate in all the circumstances'. To ensure that a late term procedure is only performed in appropriate circumstances, the Australian Lawyers Alliance suggested, it could be a requirement that a medical practitioner consult with another medical practitioner before an abortion can be carried out, one of those medical practitioners being a specialist medical practitioner.

11.5.38 There was significant support for Professor De Costa's suggested approach of having a legislative requirement for two medical practitioners to approve late term procedures (without formal criteria bar the procedure is medically appropriate).[1105]

11.5.39 A senior specialist obstetrician saw value in this approach, noting it would provide legislative support for clinical good practice and recognised that later term abortions are inevitably more sensitive and complex. A number of rural health practitioners also took this view. A number of lead clinicians viewed the legislative requirement for approval from a second medical practitioner as a 'safeguard' and 'facilitation of a second opinion encourages safe care'. Dr Roach of RANZCOG told SALRI that there should be no upper term limit and there is benefit in SALRI's alternative approach of formally requiring the approval of two medical practitioners to approve a late term abortion as medically appropriate. Dr Roach noted that this reflects and supports existing clinical practice. Dr Carol Portmann, an experienced Queensland medical practitioner in this field, also supported this approach. Dr Portmann viewed legislative criteria as problematic but favoured a legislative requirement for the approval of two medical practitioners for late term abortions. She commented this would

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[1104] Anna Walsh also made this point. 'Money and research spent on improving neonatology services to "save" the wanted premature baby sits awkwardly with law that permits the destruction of the "unwanted" unborn child of the same age.'

[1105] See above [11.2.31]–[11.2.33].

supplement and confirm good clinical practice and provide a measure of support for both the first medical practitioner and the woman. Dr Portmann was of the view that a requirement for the approval of two medical practitioners after 24 weeks would not lead to rushed decisions.

11.5.40 The Department for Health and Wellbeing noted the uncertainty and complexity of the present law[1106] and recommended that abortion should be lawful in South Australia until 21 weeks (plus six days) and abortion should also be legal from 22 weeks, but with the approval of two medical practitioners. It is considered that such a model 'is the most balanced approach to later term abortions'.

11.5.41 Children by Choice expressed its preference for the ACT approach, but noted:

> … we recognise that community opinion in some jurisdictions necessitates a staged approach. If a staged approach is recommended by SALRI, Children by Choice would be supportive of a staged approach such as that outlined in Victorian legislation. This staged approach must not delay access or impose an undue burden on distressed or disadvantaged women, pregnant people, and their doctors. For example, if the second doctor is required to support the termination of pregnancy then they must not be required to examine the patient requesting the termination as this could hinder and delay access especially for rural, regional or remote woman or pregnant people.

11.5.42 The AMA(SA) also supported a legal requirement for the approval of two medical practitioners for late term procedures, noting such a requirement would supplement and support existing clinical practice. It submitted:

> The AMA(SA) believes one qualified medical practitioner should be required for consultation and consent up to 24 weeks' gestation. At or after 24 weeks' gestation, the AMA(SA) believes that consultation with a second medical practitioner should be necessary. A serious foetal abnormality may not be detected until screenings at 19 or 20 weeks, the AMA(SA) believes that a requirement for a second medical practitioner to approve a termination should occur at the 24-week gestation point. This provision will allow an individual some time to decide a course of action without an added requirement. On the other hand, because there are significantly greater physical, ethical and psychological implications inherent in later term abortions, the involvement of a second medical practitioner after 24 weeks will give greater assurance that these physical, ethical and psychological implications have been considered. It will also assist our members: consultation between the qualified medical practitioners will enable them to both share and discuss their assessments and ensure that all appropriate matters are considered in the clinical decision-making process. The need for increased clinical input in later gestation also aligns with the clinical management policies of most health services in which terminations are provided, where the involvement of multidisciplinary teams is mandated in recognition of the increased complexities of later term abortions.

11.5.43 A number of parties such as Dr Jane Baird, Kate Marchesi, the Human Rights Law Centre, the Castan Centre for Human Rights Law, Professor Heather Douglas, Fair Agenda, Marie Stopes Australia, the Equal Opportunity Commissioner and the Central Adelaide Local Health Network (Pregnancy Advisory Centre) whilst expressing their preference for the ACT model, supported a two stage approach (preferably without criteria) in the alternative (with differing views as to whether 22 or 24 weeks should be adopted).

[1106] The Department of Health and Wellbeing explained to SALRI that the Crown Solicitor's Office have advised that the interpretation of the term 'capable of being born alive' in the current law requires a clinical decision from the medical practitioner including consideration of gestational age but also other factors relating to the fetus, which presents difficulties. Further, the issue of 'preserving the life of the mother' in s 82A(7) of the *CLCA*, and the distinction between this term and s 82A(1)(b) which refers to where 'the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman' also presents difficulties in the interpretation and application of the present law. See also above n 367, [11.2.5].

11.5.44 Dr Jane Baird, noted that if her preferred ACT approach is seen as a 'unicorn', an alternative approach of requiring the approval of two medical practitioners for abortion after 24 weeks (without formal criteria) represents a major improvement over the present law in South Australia and is a 'very sensible workable law'. The Castan Centre for Human Rights Law argued in the alternative that 'at the very least, we recommend that South Australia bring its legislation in line with that of Victoria which imposes a gestational limit of 24 weeks for "abortion on request"'. Many individual submissions, whilst opposing criteria and/or gestational limits, also supported the Victorian model as an alternative. Reproductive Choice Australia advised SALRI against restrictions or cut-off points at any gestation, 'as this can lead to women feeling pressured to make important decisions without sufficient time to gather and review adequate medical information', but if Parliament decides to impose any late term restrictions this should not occur before 24 weeks (based on the medical evidence as to viability). Many individual submissions also stated their support for the Victoria approach in the alternative to their preferred ACT approach.

11.5.45 Women's Electoral Lobby Australia considered it unnecessary to include gestational limits or specific grounds to allow an abortion, but their alternative view was that any abortion conducted after 24 weeks should only occur once considered appropriate by two consulting medical practitioners. They elaborated:

> Medical evidence indicates that there is no clear and certain consensus justifying establishment of a gestational limit. Despite this, WEL recognises significant pockets of concern regarding the rare occurrence of late termination. We would therefore support the introduction of a staged approach to decriminalisation, with one stage only at 24 weeks, after which the guidance would be that two medical practitioners confer, as with the law in Victoria … WEL would warn against including any specific grounds for a termination of pregnancy in any legislation. The fact is, terminations of pregnancy are necessary for a myriad of reasons. Restricting legislation so only women who meet set criterium can access abortion will create too many serious issues.

11.5.46 The Coalition of Women's Domestic Violence Services SA, whilst opposing gestational limits as unhelpful, acknowledged that, in later stages of gestation, health professionals might play an increased role, as in the current Victorian model in which abortions after 24 weeks gestation require increased medical consideration. However, the woman 'must remain the primary decision maker in accessing termination services at any stage'. One submission outlined that 'when the abortion is late term (ie when the fetus is potentially viable), then two medical professionals should be required to authorise the abortion and state the reasons'. The Australian College of Nursing in a follow up submission noted: 'We support having different criteria for late termination of pregnancy including a second medical practitioner consultation.'

11.5.47 Australian Lawyers for Human Rights, whilst stating their preferred approach was for no gestational limits and criteria, accepted:

> ALHR acknowledges the politicised and controversial nature of the issue of gestational limits. Whilst we submit that gestational limits should not be prescribed by legislation, if a gestational limit is to be legislated, ALHR submits that allowing for terminations of pregnancy to be performed on request until 24 weeks' gestation and thereafter with a greater level of medical oversight for terminations performed after 24 weeks gestation would be appropriate … If it was determined that terminations after a certain gestational point should only be performed with the approval of two practitioners, we submit that the Queensland model as set out above should be adopted (noting that ALHR recommends 24 weeks is more appropriate than 22 weeks). Consistent with the model adopted in Queensland, the second medical practitioner should not be required to physically examine the patient. This would create an unnecessary burden for people living in rural and remote areas.

11.5.48 It is also notable that parties in favour of decriminalisation of abortion in New South Wales overwhelmingly supported the Queensland/Victoria two stage approach for a second medical practitioner for late term procedures (including criteria) as opposed to the ACT approach.

11.5.49 However, the suggestion of a formal requirement for a second medical practitioner was not supported by other parties. One view from parties opposed to the decriminalisation of abortion was dismissive of the involvement of the second medical practitioner, dismissing it as a 'rubber stamp' and 'just a sham and a façade'.[1107] Real Choices Australia, for example, told the NSW Legislative Council Committee that there seems 'no real difference' in a model for after 22 (or 24 weeks) that requires a medical practitioner to 'consult' with a second practitioner. 'In practise this has little value when such a consultation can mean the exchange of paperwork for signing, a chat over coffee or a phone call, with no second consultation with the woman.'[1108] Women's Forum Australia was also unconvinced of the effect of the second medical practitioner. 'The consultation requirement gives the impression of "oversight"… but does not provide any meaningful safeguard.'[1109]

11.5.50 There was opposition expressed to SALRI from some parties supportive of the decriminalisation of abortion such as the South Australian Abortion Action Coalition and the Southgate Institute, to an approach (based on the Queensland model to involve two medical practitioners after 22 or 24 weeks but without criteria) and a preference expressed for the ACT approach and that there should be no legislative distinction between early and late term abortions.

11.5.51 Various parties[1110] opposed any different criteria for different stages of gestation. Some rural health practitioners also took this view. It was also the view of the roundtables with the disability sector and parties in favour of the decriminalisation of abortion (though a range of views were expressed at the roundtable with the legal and medial sectors). It was pointed out that it is already routine clinical practice in relation to later term abortions to consult with a second medical practitioner and other health practitioners, and legislative confirmation of this is unnecessary.

11.5.52 Other parties such as the Human Rights Law Centre commented that a legal requirement for two medical practitioners to approve a woman's decision singles out abortion for special provision and 'is inconsistent with an adult's usual role as the primary decision-maker about medical procedures to their own bodies' and serves to 'situates women as incompetent decision-makers, in need of protection, and doctors as gatekeepers'. For these reasons, the Human Rights Law Centre noted, 'any requirement for third party authorisation, should be strictly limited to pregnancies of more than 24 weeks'. The Human Rights Law Centre recommended the decriminalisation of abortion in a way that respects the autonomy of women and their right to control what happens to their bodies. 'Ideally, this

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[1107] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, February 2017) 27 [5.4.2].

[1108] Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) 3 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012%20Real%20Choices%20Australia.pdf >.

[1109] Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 29 [131] <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[1110] These parties included Dr Erica Millar, The Greens (SA), the Hon Tammy Franks MLC, the South Australian Council for Civil Liberties, the Australian Women's Health Network, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Human Rights Law Centre, Women Lawyers' Association of South Australia Inc, a leading health agency, a genetic counsellor, Marie Stopes Australia, the Southgate Institute and the South Australian Abortion Action Coalition.

would mean decriminalising abortion and refraining from having any requirement *in law* for women to seek approval from two doctors at any stage of pregnancy.' They elaborated:

> We understand that it is best practice for a multidisciplinary team to be involved in advising on later stage abortions … We agree that a multidisciplinary approach should be taken, as recommended by the medical experts at the roundtable. However, this does *not* need to be mandated in legislation. As with other medical procedures, professional guidelines and clinical directives (which can be updated promptly to keep up with advances in medicine) are sufficient to guide practitioners on how to manage a termination of a pregnancy.

11.5.53 The Southgate Institute did not support a legislative two stage scheme (with or without criteria) requiring a medical practitioner to consult with one or more medical practitioners before performing a late term abortion. The Southgate Institute explained:

> Not in law, but rather as clinically indicated or required, for two major reasons. First, women's legal right to give informed consent for any treatment (including additional examinations) is removed if she is forced to undergo medical examinations which are not needed in her individual circumstances in order to get access to care. This requirement would also give rise to ethical problems for doctors who are obliged only to provide care for which free and informed consent has been given and which in their judgment is clinically appropriate. Second, legal restrictions on health care should only be enacted when there are real problems to be solved, and the problem such a law would seek to solve is highly unlikely to be encountered in practice. For women with serious pre-existing health problems, and for later abortions, doctors are unlikely to make such decisions alone. These decisions are clinically (including psychosocially) complicated and more than one specialty/profession is likely to be involved, for example, genetic counsellors, fetal imaging specialists, mental health practitioners, family doctors. This reality is often spelled out in clinical guidelines, but should not be legislated, as such legislated requirements are likely to become outdated (for example, with more effective pre-natal diagnostics), and create unnecessary anxiety for all.

11.5.54 The South Australian Abortion Action Coalition and the Women Lawyers' Association of South Australia Inc stated the same procedure should apply at any stage of gestation. It stated that gestational limits (and criteria governing access to lawful abortion) are deeply unhelpful. They noted the typically 'distressing and traumatic' circumstances around late term abortions:

> These life circumstances are far from consistent with the idea that women who seek abortions after the first trimester have 'needlessly' delayed the timing of their decision or their access to appropriate health care. In these circumstances mandatorily regulated gestational limits in relation to the provision of abortion are contrary to women's best interests.

11.5.55 On the other hand, groups opposed to the decriminalisation of abortion such as Pregnancy Help Australia, Family Voice Australia and the Right to Life Association of South Australia, also opposed any distinction based on gestational criteria. This was also the view expressed by a number of attendees at SALRI's two roundtables with faith groups and NGOs.

11.5.56 The Lutheran Church, for example, opposed abortion at any gestational stage except to save the life of the mother. The Lutheran Church acknowledged that most Australians are attracted to what is known as a 'gradualist' or 'functionalist' view on the right to life of the unborn, namely that the more developed the baby is, the more its life must be respected.[1111] The Lutheran Church argued:

[1111] This is similar to the approach of the QLRC which, whilst refraining from the notion of a fetus having legal 'rights', accepted that a fetus has 'interests' and 'that, as the fetus develops, its interests are entitled to greater recognition

'While this view may be superficially appealing to many, in reality it is flawed and dangerous. If we say that a human life is not inherently valuable but only acquires value as it grows and develops, the criteria we use to assign value to that life will be completely arbitrary.'[1112]

11.5.57 Many attendees at SALRI's 12 June 2019 roundtable with faith groups and NGOs reiterated their belief, often in strong terms, that the life of a child should be recognised and protected at the point of conception, and therefore discussion of gestation periods and/or criteria was essentially irrelevant (or they supported as short a gestational limit as possible). One party at the 16 May 2019 roundtable with faith groups party noted their view that from a 'strict pro-life viewpoint, the foetus is a person from conception. So we wouldn't support any legislation that gave greater power to the mother than to the child.'

11.5.58 The complexity, uncertainty and problematic effect of the 28 week rebuttable upper limit was often raised in SALRI's consultation. These concerns are compounded by the fact that 28 weeks is now effectively read as 22 or 24 weeks in light of medical advances and legal advice. There was considerable support from parties supportive of the decriminalisation of abortion for the removal of the 28 week limit in the present law and that it should not be replaced. Associate Professor Baird noted: 'Recent interpretation of the "born alive" clause in the law has led to unnecessary and unhelpful constraints and pressure on people needing abortions later in pregnancy.'

11.5.59 The Central Adelaide Local Health Network (Pregnancy Advisory Centre) explained the effects of late term limits in South Australia:

> Currently the limitations of a gestational limit being imposed means that women who may find themselves in the very difficult circumstance of a diagnosis of fetal anomaly or complex psychosocial circumstances are forced to continue these pregnancies, or else seek support to access a service interstate or overseas. South Australian women should be able to have an assessment made of their situation without the burden of a gestational limit that could preclude a reproductive option for them. Gestation should not be the determining factor.

11.5.60 A particular concern raised to SALRI was the effects of the de facto 24 week (or 22 or 23 week) upper limit for the availability of an abortion in cases where a suspected fetal abnormality[1113] has

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and protection': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 94 [3.181]. See also: at 6 [1.29], 61–62 [3.48], 62–63 [3.52]–[3.53], 274 [18].

[1112] The Lutheran Church's submission included a Statement of its position prepared by the Commission on Theology and Inter-Church Relations and adopted by the General Synod at its 1970 Convention (edited June 2001). This suggests a perhaps more nuanced approach. '[A]bortion, in the sense of the artificial or induced termination of a pregnancy, is not justified. The Lutheran Church recognises that there are circumstances under which a termination of pregnancy may properly be considered, namely, when competent medical people are of the opinion that the life of the mother can be saved only by terminating the pregnancy. In such a case it's a question, humanly speaking, of choosing between one human life and another. A choice cannot be avoided. Before choosing to abort the child the mother should, if possible, seek both medical and pastoral guidance. There are other special cases — for example, pregnancies which result from incest, rape, or other perverted sexual relationships — and special problems with which parents and members of the medical and nursing profession have to wrestle. These special cases and situations must always be evaluated and decided in the light of the basic principle that the fetus is human life created by God.'

[1113] A retired specialist explained to SALRI the effects of this limit on the already difficult situation of the identification of a suspected fetal abnormality. '[M]y additional concern has been directed to those patients / couples seeking a late termination of pregnancy where the diagnosis of a significant major fetal congenital abnormality (genetic or acquired) cannot be made within the "required" time frame by the investigational methods currently available … at this time there is no alternative available to these women other than to go on with the pregnancy and deal with the consequences, both psychosocially and physically, for themselves and their child … I would support any change to the current directive and to the current Law as it stands which would enable more time for a more certain diagnosis of a significant fetal abnormality to be made and a prognosis to be given (no matter how

been detected. Of concern, both for those for and against gestational limits, was the risk of rushed decisions being made by the woman (and her partner) without proper consideration, often on the basis of incomplete prenatal testing. It was noted to SALRI by more than one health practitioner that upper limits may in fact lead to the abortion of a healthy fetus where, if there was time to undertake more comprehensive testing, an absence of the suspected disability could be revealed.[1114]

11.5.61 Some parties opposed to the decriminalisation of abortion adamantly opposed removing the upper limit and rather submitted that it should be reduced to reflect medical advances as to viability. It was also argued that late term procedures (especially after viability) are by their very nature unacceptable and cannot be categorised as a 'health' issue. As one party argued:

> Changing the intentional taking of a life to being viewed, under the guise of a medical procedure, does not change the intent which is the intentionally taking of a life of an unborn child … to change the act to make 'Full Term Abortion' a regulated medical procedure under health legislation as opposed to a criminal law issue. This attempt to minimalise full term abortion from being murder under criminal law, to being a simple medical procedure produces the same result which ends the life of a fully developed and viable unborn child.

11.5.62 Genesis Pregnancy Support Inc advanced a similar view:

> When considering gestational limits, at some stage abortion becomes an ethical and moral issue, as would be expected in any civilised society. To perform a termination of pregnancy, a human life must also be terminated. If that life has become viable outside of the womb, then the issue indisputably becomes a humanitarian one. No-one should be given the 'right' to decide whether another viable human being should live or die, for any reason. Gestational limits must apply. If our abortion law needs to be modernised in any way, it needs to be updated to reflect the gestational age of 'viability for life'. At the time that our current abortion law was implemented that limit was acknowledged to be 28 weeks. Due to significant medical advancements, this limit should now be amended and reduced to at least 24 weeks gestation, for the same ethical reasons.

11.6 SALRI's Observations and Conclusions

11.6.1 The submissions that SALRI received on the difficult issue of late term abortions can generally be divided into three broad categories; namely those who supported late term abortion with no gestational limit or criteria, those who supported late term abortion with a limit but no criteria, and those who opposed late term abortions under any circumstances.

11.6.2 SALRI acknowledges that late term abortions, though 'comparatively rare' are contentious. However, SALRI does not accept the suggestion that late term abortions are undertaken lightly as several parties contended. SALRI was provided with a host of powerful reasons why late term abortions are carried out. Every indication received by SALRI is that late term abortions (noting they are rare in practice) are only undertaken after careful consideration by the women involved, their partners and the consulting health practitioners involved. The submissions received by SALRI on this point indicate that late term abortions occur in only the most compelling of circumstances.

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inconclusive) as those fetal abnormalities associated with chromosomal and genetic disorders using sophisticated DNA and gene analysis may take some time to collate and collaborate, often at an international level, by our Geneticist colleagues.' See also below [13.11.5]. The importance of sufficient time to undertake detailed genetic testing, to communicate results of such testing to women and to allow them time to factor the results into their decision making, was also expressed to SALRI by clinical genetics experts.

[1114] See also below Part 13.

11.6.3 SALRI notes the views of the Women Lawyers' Association of South Australia Inc which argued for the removal of any late term limit:

> Although clause 8 of s 82A of the *CLCA* specifies that 28 weeks is the upper limit, advice from SA Health to abortion providing services in recent years has meant than an abortion is only available up to 23 weeks and 6 days. This upper limit not only restricts women's access to appropriate health care but also compromises the care that health professionals can give. It can mean that decisions about the pregnancy must be made in haste and without all necessary diagnostic information. These conditions severely compromise decision-making based on informed consent and the delivery of best care.

11.6.4 SALRI agrees with these comments. It is significant that other jurisdictions such as Victoria and Queensland (and the 2019 NSW Act) do not have a late term limit. SALRI considers that the present 28 week upper limit (or child destruction clause) in South Australia has been overtaken by medical advances. The prevailing view as to viability is between 22 and 24 weeks. SALRI considers that the present rebuttable 28 week upper limit should be removed, but without replacement. There should be no late term limit (as is the position in other States such as Victoria and Queensland and in the 2019 NSW Act). SALRI accepts that late term abortions are contentious within parts of the community and raise particular sensitivities, and the conduct of such procedures can be graphic and confronting in nature. However, SALRI is of the view that it would be inappropriate to impose any gestational limits on abortions for these (or indeed any other) reasons. SALRI reiterates its view in accordance with its research and consultation that late term abortion procedures are only carried out after careful consideration and professional clinical judgement as to the appropriateness of the procedure in all the circumstances.

11.6.5 SALRI reiterates that its preferred approach remains that of the ACT and this includes for late term abortions, which would also remain available at any gestational stage without the approval of a second medical practitioner.[1115] However, SALRI accepts that in light of the particular sensitivities and complications that arise, an alternative approach may be justified for late term procedures.

11.6.6 In the alternative to its preferred ACT style approach, SALRI's alternative approach would provide that up to 24 weeks gestation an abortion may be undertaken with the woman's consent, and if performed by an appropriate health practitioner. However, after 24 weeks gestation for an abortion to be performed it requires the first medical practitioner to consult with at least one other medical practitioner[1116] (whilst still recognising the autonomy of the woman) and for both practitioners to agree that an abortion is medically appropriate.[1117] The additional presence of two medical practitioners and requiring their approval after 24 weeks reflects current clinical practice[1118] and also

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[1115] See above Part 10. See especially Rec 21.

[1116] This would not preclude consultation if considered helpful with other health practitioners or others such as social workers or psychologists but this would be an issue for operational and clinical practice.

[1117] This is an adaption of the law in Queensland and Victoria, and in the 2019 NSW Act, but with no specific legislated criteria for when an abortion can be carried out. The question of whether a proposed procedure is medically appropriate is distinct from a conscientious objection and arises in relation to any medical procedure. To use a fictional example that arose in SALRI's consultation, a medical practitioner would be entitled to decline the request of a healthy patient to chop of their arm as that procedure would be medically inappropriate.

[1118] RANZCOG, for example, recognises the complexities associated with late term abortions and supports a process by which late term abortions can be lawfully performed. RANZCOG further submits 'that involvement of at least two doctors is reasonable … This may include, but not be limited to, feto-maternal medicine specialists, neonatologists, geneticists, social workers and mental health specialists'. See Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Submission No 39 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019)

'recognises that terminations at this later stage often involve disadvantage, distress, complexities and higher risks to the pregnant woman'.[1119]

11.6.7 This approach has the advantage of providing legislative confirmation of existing clinical good practice and the benefit of the 'second set of eyes'. More than one medical practitioner favoured this approach to SALRI as providing support and reassurance not just to the patient but also to them.

11.6.8 This version is an adaption of the approach that exists in Queensland and Victoria and that included in the 2019 NSW Act, but without the criteria as to why an abortion may be performed. SALRI notes this model was suggested by Professor De Costa and has the support of the AMA(SA) and various practitioners in this area such as Dr Portmann and Dr MacDonald.

11.6.9 SALRI sees no merit in specifying criteria for permitting access to lawful late term abortion, noting that access would still be subject to health law and professional practice and protocol. SALRI reiterates its view that criteria are unhelpful and incapable of covering the many situations that will arise and also undermine a woman's autonomy and shift decision making from the patient to the now outdated concept of the medical practitioner as the gatekeeper.[1120] The criteria that exist in Victoria and Queensland (and in the 2019 NSW Act) of 'appropriate in all the circumstances' are so vague as to provide little utility or real guidance. Such criteria received very little support in consultation, whether from parties supportive of or opposed to the decriminalisation of abortion. Such a term, as Ms Marchesi noted to SALRI, is 'essentially meaningless'. Rather the focus should be on, as noted by Dr Portmann and others, if the proposed late term procedure is medically appropriate.

11.6.10 SALRI suggests that the law should provide that a health practitioner may, in an emergency, perform an abortion on a woman at any time if the health practitioner considers it is necessary to perform the procedure to save the woman's life or, in the case of multiple pregnancy, another fetus. This would extend to a late term situation if SALRI's alternative approach is adopted.

11.6.11 There is no simple answer to the stage at which, especially if linked to viability, additional oversight to an abortion should apply. SALRI was told by a Port Augusta health practitioner that 'viability is changing all the time'. There was no consensus to SALRI on the present gestational stage of viability though the general view (especially amongst medical and other health practitioners) was it is between 22 weeks and 24 weeks with the majority supporting 24 weeks as opposed to 22 weeks to allow for greater consistency in fetal development. The Department of Health and Wellbeing identified 22 weeks. Dr Roach of RANZCOG noted that 22 weeks is 'perfectly reasonable' as a threshold based on viability for a different procedure to apply (ie the approval of two medical practitioners). Dr Jane Baird, the AMA(SA) and a genetics counsellor identified 24 weeks as preferable. When considering genetic testing SALRI noted that 24 weeks, particularly in rural areas, was preferred to allow for delays in service provision and to prevent any rushed decisions based on potential irregularities found in genetic screening.

11.6.12 It was also noted to SALRI by a specialist medical practitioner that despite any possible advancements in medical technology in the future it was unlikely consistent viability of a fetus would occur under 22 weeks and that it is unknown what future health and developmental impacts would be present for those born under 22 weeks gestation and kept alive.

<https://www.parliament.nsw.gov.au/lcdocs/submissions/64875/0039%20The%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Obstetricians%20and%20Gynaecologists.pdf>.

[1119] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 4 (Mr Greenwich).

[1120] See above [1.3.35]–[1.3.39].

11.6.13 In all of the circumstances SALRI considers that, although opinions differ, 24 weeks gestation is the appropriate threshold for a change, if any, to the consideration of undertaking an abortion procedure. This recommendation reflects not only current clinical guidelines and practice but also likely advancements in the future. SALRI reiterates its position that, in the alternative to its preferred approach based on the ACT (see Recommendation 22), the relevant law in South Australia should provide that up to 24 weeks gestation a lawful abortion can be performed by one health practitioner but, after 24 weeks gestation, and recognising the woman's autonomy, an abortion may be performed by a medical practitioner, but only after that medical practitioner has consulted with another medical practitioner and both are of the view that the proposed procedure is medically appropriate.

11.6.14 SALRI notes the criticisms that have been raised, both to it and elsewhere, of any legal requirement for either a specialist medical practitioner or a committee to approve a late term abortion and the particular implications of such a requirement for rural and remote access. As the Human Rights Law Centre observed:

> The law must not impose a requirement for referral to an ethics committee at any gestation, or for consultation with a specialist or for the pregnant person to themselves seek a second opinion or counselling. Such requirements create barriers that cause distressing delays and deny women the right to the best possible health outcomes, particularly for women in regional and remote locations.

11.6.15 SALRI does not favour a legislative requirement, if its alternative approach is adopted, of specifying that one or both of the approving medical practitioners should be a 'specialist'. Any such requirement is unnecessary and could also compound concerns for regional, rural, remote and Aboriginal access. This question is also better left to clinical practice and the individual situation. SALRI does not support the adoption in South Australia of the requirement in the 2019 NSW Act that the two medical practitioners to approve a later term abortion should be specialists.

11.6.16 A Western Australian style Ethics Panel or committee model found little support in SALRI's consultation.[1121] SALRI acknowledges the cogency of such criticisms, such as RANZCOG's recommendation that a panel 'not be introduced as obligatory as this has been shown to lead to delays and result in later termination of pregnancy'.[1122] SALRI does not support a formal requirement for an Ethics Panel or committee.[1123] Such a model is bureaucratic and cumbersome and may compound issues for rural and remote access.

11.6.17 SALRI also does not support the adoption in South Australia of the provision in the 2019 NSW Act that a specialist considering a later term abortion 'may ask from advice from a hospital advisory committee or disciplinary team'.[1124] There is a real risk that such a provision will not merely codify existing clinical practice and provide additional advice in complex situations,[1125] but may be read in practice by cautious medical practitioners or hospital administrators as 'shall', requiring reference of

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[1121] A few parties opposed to the decriminalisation of abortion support the notion. Cherish Life Australia, for example, claimed this option 'provides more complete professional support for the woman'.

[1122] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Queensland Abortion Law Reform* (Media Statement, 15 February 2017) <https://www.ranzcog.edu.au/news/Queensland-abortion-law-reform>. Dr Roach of RANZCOG confirmed to SALRI that but that any ethics panel or committee requirement to approve late term abortions is problematic and bureaucratic and should be avoided

[1123] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Queensland Abortion Law Reform* (Media Statement, 15 February 2017) <https://www.ranzcog.edu.au/news/Queensland-abortion-law-reform>.

[1123] SALRI understands from consultation that hospitals, both in South Australia and interstate, may choose to utilise multidisciplinary committees to determine later term abortions. SALRI does not wish to preclude such practices but such questions are better left for clinical and operational determination than legislative requirement.

[1124] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 59–65.

[1125] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 59–60 (Hon Damian Tudehope).

any late term abortion to a committee. Such a provision may produce the unsatisfactory Western Australia committee approach, especially compounding issues for rural and remote access.

11.6.18 Recommendations

Recommendation 22

SALRI recommends that the present rebuttable upper limit of 28 weeks for an abortion set out in s 82A of the *Criminal Law Consolidation Act 1936* is inappropriate and no upper limit for a lawful abortion should be provided for in any new law.

Recommendation 23

SALRI recommends that, in the alternative to Recommendation 21, the relevant law in South Australia should provide that up to 24 weeks gestation an abortion can be performed by one health practitioner but, after 24 weeks gestation, consistent with Recommendation 2 and recognising the woman's autonomy, an abortion may be performed by a medical practitioner, but only after that medical practitioner has consulted with another medical practitioner and both are of the view that the proposed procedure is medically appropriate.

Recommendation 24

SALRI recommends that a health practitioner may, in an emergency, perform an abortion on a woman at any time if the health practitioner considers it is necessary to perform the procedure to save the woman's life or, in the case of multiple pregnancy, another fetus.

Recommendation 25

SALRI recommends that any new law in South Australia should not include a requirement for an abortion (including a late term abortion) to be approved by a second specialist medical practitioner (such as a gynaecologist) or a panel or committee.

Part 12 - Counselling

12.1 The Role and Purpose of Counselling

12.1.1 Counselling plays an important role with respect to any decision to seek an abortion. Counselling proved a prominent topic in SALRI's consultation (as it also proved in debate surrounding the 2019 NSW Act).

12.1.2 Professional counselling 'is a safe and confidential collaboration between qualified counsellors and clients to promote mental health and wellbeing, enhance self-understanding, and resolve identified concerns.' Those providing professional counselling 'use empirically supported interventions and specialised interpersonal skills to facilitate change and empower clients.' Counselling may explore broad topics or be more focused and may vary in duration from short to long-term depending on the needs of the client.[1126]

12.1.3 Further, in their 2016 report about defining and delivering effective counselling and psychotherapy, the Australian Institute of Family Studies stated:

> effective counselling requires that the person deemed to be seeking help (the client) is, or becomes, willing to engage. That is, counselling is a facilitated process rather than something a counsellor does *to* the client.[1127]

12.1.4 The Australian Institute of Family Studies also specified, moreover, that counselling 'can only occur when clients are *co*-participants in the process rather than passive recipients of counsellor interventions.'

12.1.5 Counselling does not involve giving advice or seeking to persuade a client. When describing counselling to potential clients, it has been explained that 'advice frequently means telling people what they should or ought to do, and this has no place in counselling. The counsellor will help you to look at what is *possible*, and will not tell you what you should do.' Further, 'counselling is not persuading, prevailing upon, overcoming your resistance, wearing you down,' or 'bringing you to your senses'. Persuasion is in direct conflict with at least one principle of counselling — self-direction — 'your right to choose for yourself your course of action.'[1128]

12.1.6 These definitions and descriptions of counselling indicate that counselling is a process that requires the voluntary engagement of the client and differs profoundly from a medical practitioners' duty to provide information to assist a patient's informed consent. This is consistent with

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[1126] 'Definition of Counselling', *Psychotherapy and Counselling Federation of Australia* (Web Page) <https://www.pacfa.org.au/definition-of-counselling/>. It should be noted that many definitions of counselling have been noted to represent the perspective of the counsellor or counselling profession rather than the client. In offering a definition from the client perspective, 'Counselling is a purposeful private conversation arising from the intention of one person (couple or family) to reflect on and resolve a problem in living, and the willingness of another person to assist in that endeavour': See John McLeod, *An Introduction to Counselling* (Open University Press, 2013) 7.

[1127] Lawrie Maloney, 'Defining and Delivering Effective Counselling and Psychotherapy' (CFCA Paper No 38, Australian Institute of Family Studies, March 2016) 8.

[1128] William Stewart and Angela Martin, *Going for Counselling: Discover the Benefits of Counselling and Which Approach is Best for You* (Brown Book Group, 1999) 11.

many submissions to SALRI which also differentiated between providing information to enable informed consent and counselling.[1129]

12.1.7 Virtually all parties in SALRI's consultation saw value in the context of abortion in the role and availability of high-quality, impartial, non-directional counselling. The main three forms of counselling in this context included pre-abortion decision-making counselling, emotional support (at any time throughout the process) and post-abortion counselling; the latter two forms of counselling are both sometimes referred to as 'therapeutic counselling'.

12.1.8 Decision-making counselling, sometimes also referred to as 'options counselling', is:

> … non-directive, women-centred counselling that assists women through the process of making a decision about their pregnancy. Decision-making counselling involves consideration of three possible alternatives regarding the pregnancy: continuing the pregnancy, relinquishing for adoption, and abortion. Non-directive counselling allows a counsellor to support and listen to a woman's concerns without pushing her one way or another.[1130]

12.1.9 The National Alliance of Pregnancy Options Counsellors identified to SALRI that effective support for women making decisions in relation to abortion should be based on several best practice key principles:

- Women are the experts in their own life.
- Women have the right to be treated in a respectful, non-judgemental way when discussing all of their reproductive options.
- Women require access to accurate and evidence-based information about all the reproductive options they are considering.[1131]

12.1.10 SALRI notes that the aforementioned key principles are a sound underlying basis for best practice in this area.

12.1.11 RANZCOG indicates that 'a woman's physical, social, emotional and psychological needs should be taken into account in the course of counselling and decision-making'.[1132]

12.1.12 The VLRC described that, consistent with ethical standards, decision-making counselling 'aims to assist a person in making a decision by providing emotional support, space, and time to talk through options and consequences in the context of the woman's individual value system and relationships with others'.[1133]

[1129] See further below [12.5.21].

[1130] 'Decision-based Abortion Counselling and You', *Marie Stopes Australia* (Web Page, 3 February 2017) <https://www.mariestopes.org.au/your-choices/decision-based-abortion-counselling/>.

[1131] See also Rachel Gold and Elizabeth Nash, 'State Abortion Counselling Policies and the Fundamental Principles of Informed Consent' (2007) 10(40) *Guttmacher Policy Review* 6.

[1132] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Abortion' (RANZCOG Statements and Guidelines, March 2019) <https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Abortion-(C-Gyn-17)Review-March-2019.pdf?ext=.pdf>.

[1133] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 118 [8.68].

12.1.13 The VLRC also highlighted that while significant overlap can occur between pre-abortion information provision and decision-making counselling, they have differing purposes. They stated:

> As a matter of common sense, a woman cannot consider all her options without having adequate information, but if a woman has already reached a decision, she may not wish to have decision-making counselling and it cannot be forced upon her. Pre-procedure information may be all that is required.[1134]

12.1.14 Just as women may vary in their desire to undertake decision-making counselling, they may also vary in their desire and need for emotional support, sometimes also referred to as 'therapeutic counselling' before, during, or after an abortion. Counselling for the purposes of emotional support differs from that to aid decision-making. Instead, such counselling 'provides women with the opportunity, where needed, to further explore their values, strengths and capacities in relation to their potential pregnancy decision.'[1135] The focus is to assist the woman with any emotional and relationship issues that may arise in relation to her pregnancy and the decision she has made with regards to the management of that pregnancy.

12.1.15 In some instances, women may also desire support from a counsellor post-abortion. Such counselling, sometimes termed 'therapeutic counselling', may be short or long-term and allows women to seek support in relation to any psychosocial consequences of their decision.[1136]

12.2 Who Can Provide Counselling Services?

12.2.1 In Australia, counselling may be provided by health practitioners including psychologists, social workers, mental health nurses, or counsellors. However, the title 'counsellor' is not regulated or protected under law, and there is no requirement for an individual who provides counselling services to have qualifications or experience.[1137] Thus, any person may describe him/herself as a counsellor, and any organisation may portray themselves as offering counselling services. This has proved a source of concern in relation to abortion-related counselling.[1138]

12.2.2 Among those who provide counselling, the title 'psychologist' is protected and psychologists must be registered by the Psychology Board of Australia through AHPRA. To maintain registration, psychologists are required to develop and review an annual learning plan, undertake

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[1134] Ibid 118 [8.67].

[1135] This was noted to SALRI by the National Alliance of Abortion and Pregnancy Options Counsellors in their submission.

[1136] Some parties opposed to the decriminalisation of abortion argue that women experience significant adverse mental health effects following abortion. This contention is often disputed. A 2011 UK systematic review by the Academy of Medical Royal Colleges at the National Collaboration Centre for Mental Health found, when comparing outcomes for women who had an abortion to those who gave birth, after controlling for whether the pregnancy was planned or wanted, there was insufficient evidence to show an increased risk of depression, anxiety and non-psychotic illness following abortion; some limited evidence, only in the unplanned pregnancy group, was found to suggest higher rates of self-harm following an abortion; and some evidence of lower rates of psychotic illness after abortion existed. The study concluded: 'When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth': National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health* (Report, December 2011) 118 [7]. The research in this area is conflicting. See also above [2.1.42]–[2.1.52].

[1137] Parties both supportive and opposed to the decriminalisation of abortion indicated their preference to SALRI for counsellors to be suitably trained and qualified. See further below [12.5.24]–[12.5.30].

[1138] See further below [12.5.27]–[12.5.31] and [12.5.33]–[12.5.42].

continuing professional development and participate in regular supervision. Many psychologists also maintain membership of the professional association, the Australian Psychological Society.

12.2.3 While others who provide counselling are self-regulating and are not required by law to be registered through AHPRA, many choose to join an appropriate professional association that sets education and professional practice standards including continuing professional education requirements and/or to seek a non-mandatory form of registration.[1139]

12.2.4 The Australian Psychological Society has a published Code of Ethics for psychologists.[1140] The Code includes the three general principles; respect for the rights and dignity of people and peoples (including the right to autonomy), propriety, and integrity. It also includes ethical standards in relation to justice, respect, informed consent, privacy, confidentiality, release of information to clients, collection of client information from associated parties, competence, professional responsibility, and reputable behaviour.

12.2.5 Similarly, the Australian Association of Social Workers also has a published Code of Ethics for social workers which outlines general ethical responsibilities, responsibilities to clients, colleagues and workplaces and responsibilities in particular contexts.[1141] With regard to self-determination, it states: 'Social workers will promote the self-determination and autonomy of clients, actively seeking to enable them to make informed decisions on their own behalf'.

12.2.6 Client autonomy is also emphasised in the Psychotherapy and Counselling Federation of Australia Code of Ethics, which specifies six key ethical principles: trust; autonomy; beneficence; non-maleficence; fairness; and self-respect.[1142] The Code includes specific reference to counsellors having 'respect for the client's right to be self–governing' and that clients have the right to make choices about their health and care bearing in mind the concept of 'dignity of risk', where 'dignity of risk' means:

> respecting each individual's autonomy and self-determination (or 'dignity') to make choices for themselves. The concept means that all adults have the right to make their own choices about their health and care. Health professionals may be in discussion with a client about the potential impacts of the client's decision, but the decision remains the client's (or that of the client's legal guardian).

12.2.7 It is evident to SALRI that counsellors who are members of a professional body or association are required to adhere to a set of professional standards to ensure ethical practice including respecting the autonomy of clients to make their own decisions in relation to their health and wellbeing.

[1139] Counsellors may choose to be registered on the Psychotherapy and Counselling Federation of Australia (PACFA) National Register or the Australian Register of Counsellors and Psychotherapists, but according to PACFA, the Australian government 'treats us as "unregistered" because we are not covered by the mandatory registration requirements of AHPRA.' Such 'unregistered' groups and individuals should follow The National Code of Conduct for Unregistered Health Practitioners enacted by each state and territory which sets minimum standards for health practitioners not regulated by AHPRA. In South Australia, a Code of Conduct for Unregistered Health Practitioners was introduced on March 14th 2013. Counsellors in South Australia are required to display the Code of Conduct, their qualifications, and information about how clients can make a complaint to the Health and Community Services Complaints Commissioner.

[1140] Australian Psychological Society, *Code of Ethics* (Code of Conduct, 2007) <https://www.psychology.org.au/getmedia/d873e0db-7490-46de-bb57-c31bb1553025/APS-Code-of-Ethics.pdf>.

[1141] Australian Association of Social Workers, *Code of Ethics* (Code of Conduct, 2010) 25 <https://www.aasw.asn.au/document/item/1201>.

[1142] Psychotherapy and Counselling Federation of Australia, *PACFA Code of Ethics* (Code of Conduct, 2017) <https://www.pacfa.org.au/wp-content/uploads/2017/11/PACFA-Code-of-Ethics-2017.pdf>.

12.2.8 The Commonwealth presently funds up to three sessions of non-directive pregnancy support counselling through Medicare for a woman who is currently pregnant or who has been pregnant in the preceding 12 months.[1143]

12.2.9 The Commonwealth Department of Health defines non-directive counselling as:

> This is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The service involves the counsellor undertaking a safe, confidential process that helps the patient explore concerns they have about a pregnancy. This includes providing unbiased, evidence-based information about all options and services available to the patient, where requested. The service can address all pregnancy-related issues for which non-directive counselling is appropriate. An eligible person's partner may attend counselling sessions.[1144]

12.2.10 Under the current Commonwealth Department of Health policy, non-directive pregnancy support counselling can be provided by 'a medical practitioner (including a GP, but not including a specialist or consultant physician) who is registered with Medicare Australia as having completed non-directive pregnancy counselling training.' Psychologists, social workers and mental health nurses in private practice, registered with Medicare as having completed appropriate non-directive pregnancy counselling training, may also provide these services on referral from a General Practitioner.[1145]

12.2.11 The Commonwealth Department of Health also stipulates, that:

> GPs, psychologists, social workers and mental health nurses who have a direct pecuniary interest in a health service that has as its primary purpose the provision of pregnancy termination services cannot provide non-directive pregnancy support counselling services under Medicare.

12.2.12 The providers of pregnancy information and counselling services are a diverse group in South Australia (as in Victoria).[1146] These include public abortion providers,[1147] community-based sexual and reproductive health services, and non-government organisations (who may generally consider abortion to be morally wrong) such as Birthline Pregnancy Support Inc, Genesis Pregnancy Support Inc and Pregnancy Support SA. As noted previously, non-directive pregnancy counselling can also be provided by GPs, psychologists, social workers and mental health nurses who are registered with Medicare as having undertaken the appropriate training. Providers vary in their perspectives towards abortion and their level of regulation. They may be registered health professionals or

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[1143] Department of Health (Cth), *Medicare Benefits for Non-Directive Pregnancy Support Counselling Services* (Fact Sheet, October 2013) 1.

[1144] Ibid 1.

[1145] Ibid 1–2. In addition to having successfully undertaken non-directive pregnancy counselling training, health practitioners must meet other eligibility criteria as follows: 'Psychologists must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided and be certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling. Social workers must be a 'Member' of the Australian Association of Social Workers (AASW) and certified by AASW either as meeting the standards for mental health set out in AASW's "Practice Standards for Mental Health Social Workers", as in force on 8 November 2008 or as an Accredited Social Worker. Mental health nurses must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses (ACMHN).'

[1146] 'There is a diverse range of providers of pregnancy information and counselling services in Victoria. These include public and private abortion providers, community-based sexual and reproductive health services, and non-government organisations such as Family Planning Victoria. Counselling is also undertaken by pregnancy and family support organisations which consider abortion generally to be morally wrong': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 119 [8.73].

[1147] Unlike interstate, there are no private abortion clinics in South Australia.

'unregistered' health professionals. Some providers are members of professional bodies such as the Australian Psychological Society, PACFA, or the Association of Social Workers, with obligations to adhere to a code of ethics, while others are not.

12.3 Should Counselling be Optional or Mandated?

12.3.1 The question of whether counselling should be mandated in relation to abortion has been examined by various law reform agencies.

12.3.2 The New Zealand Law Commission, while supporting the role of counselling for those women who wished to utilise it, saw no need for mandated counselling.[1148]

12.3.3 The QLRC received various views on the role and scope of counselling and if it should be optional or mandated.[1149] They concluded that any law should not impose any requirement that a woman be either offered counselling or required to attend counselling before an abortion (or after a woman has had an abortion).[1150] The QLRC explained its reasoning:

> It is important that professional, unbiased, confidential and non-judgmental counselling is available and accessible to women who are contemplating a termination, and women who have undergone, or contemplated but decided against, a termination. Counselling is better addressed as a matter of clinical practice, rather than by legislation. Consistently with treating termination as a health matter, the decision to attend counselling should be one that is made by a woman in consultation with relevant health practitioners. Counselling is adequately and appropriately addressed by current clinical practice and guidelines relevant to the provision of termination services. The inclusion of counselling in guidelines acknowledges the importance of counselling while also giving a practitioner the flexibility to take into account each woman's individual circumstances. Professional regulation requires that medical and other health practitioners comply with clinical standards. Any legislative requirement in relation to counselling could be an additional barrier to accessing services for some women. It could also give rise to uncertainty regarding enforceability and lawfulness for health practitioners.[1151]

12.3.4 The VLRC also received a range of views regarding the role and content of counselling and whether it should be mandatory.[1152]

12.3.5 The VLRC noted it had not found 'evidence that forcing women into counselling is necessary or advisable. Abortion counselling is a clinical, service delivery issue rather than one to be directed by law.'[1153] The VLRC recognised that abortion is 'a decision of deep moral significance for many people' but the woman herself is the best person to make such a decision, 'including deciding upon the nature or extent of any counselling she needs, in consultation with her clinician.'[1154]

[1148] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 157 [9.54].

[1149] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 191–194 [6.10]–[6.15].

[1150] Ibid 194 [6.16].

[1151] Ibid 194 [6.17]–[6.20].

[1152] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 118–126 [8.60]–[8.140].

[1153] Ibid 124 [8.122].

[1154] Ibid 125 [8.124].

12.3.6 The VLRC ultimately recommended that: 'Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling.'[1155]

12.3.7 Furthermore, the VLRC stated:

> Mandating counselling also runs the risk of establishing a legal barrier to abortion because counselling services may not exist in a particular geographic area. Mandating counselling may result in women having to travel long distances for multiple medical assessments and counselling sessions before they can proceed. This would exacerbate existing inequities.[1156]

12.3.8 The NSW Legislative Council Committee received very divergent views regarding mandated counselling or mandated offering of counselling.[1157]

12.3.9 Professor Somerville testified to the Committee in favour of a requirement for counselling:

> We know that many women are unaware of the risks and harms of abortion. Likewise the provision for access to counselling is completely inadequate. In particular, there is a conflict of interest for doctors working in abortion clinics counselling women about abortion. Publicly available, independent counselling is essential.[1158]

12.3.10 Newcastle Pregnancy Support said 'our recommendation [is] that any person seeking a termination of pregnancy have appropriate counselling by an entity not associated with the abortion provider so that they are fully aware of all risks and options.'[1159] The Australian Christian Lobby similarly argued that to 'assist' a woman's decision: 'Pre-abortion counselling should be provided to all women seeking abortions. Any counselling process should also allow a period of a minimum of 72 hours between counselling and the termination of a pregnancy.'[1160]

12.3.11 This position was challenged by various parties before the NSW Legislative Council Committee. Wendy McCarthy of the NSW Pro-Choice Alliance, for example, submitted:

> I cannot think of any other health procedure that requires mandated counselling or [offer of] counselling. I would also comment that in my long experience, that people offered counselling at the institutional base mostly do not want it. They have taken counsel from their most intimate friends. This is a deeply intimate matter to women.[1161]

[1155] Ibid 126 Rec 6.

[1156] Ibid 125 [8.127].

[1157] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 37–40 [3.67]–[3.81].

[1158] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 60 (Professor Margaret Somerville, School of Medicine, University of Notre Dame).

[1159] Newcastle Pregnancy Support, Submission No 37 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64872/0037%20Newcastle%20Pregnancy%20Help%20Inc.pdf>.

[1160] Australian Christian Lobby, Submission No 33 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64869/0033%20Australian%20Christian%20Lobby.pdf>.

[1161] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 9 (Ms Wendy McCarthy, Campaign Chair of the NSW Pro-choice Alliance). This view was also taken by those NSW MPs who opposed any mandated requirement for counselling. 'While some of the members who are proposing mandatory counselling may be coming from a position of genuine concern for women and what could be a difficult decision, the notion that women need to be counselled before an abortion is offensive. We do not mandate

12.3.12 Adjunct Professor Ann Brassil of Family Planning NSW similarly stated:

> How do you mandate counselling? How do you do that? Is there such a thing? Women know whether they need advice and support about the decision making that they go through. Women, by the time they come to the decision that they want an abortion, have by and large been through that process. You cannot add anything to that process except fear and concern by having mandatory counselling.[1162]

12.3.13 The justification for mandatory counselling appears dubious. A 2013 study found that mandatory counselling would 'delay the process and for most women would be an unnecessary burden, whilst also diverting resources from those women who require counselling'.[1163]

12.3.14 As one study concluded:

> All women need evidence-guided information in order to make a fully informed decision. All women need a sympathetic and supportive milieu but few need formal counselling. Pregnancy options counselling should not be made mandatory as government policy or national law. It would appear that bringing all women requesting abortion back for further discussions after they have made initial contact with primary care services is both unnecessary and harmful. Similarly, building time into abortion services for all women to reflect on their options is also unnecessary and harmful. Attempts to introduce mandatory counselling into the law should be resisted on scientific grounds.[1164]

12.4 Submissions

12.4.1 Divergent views were expressed to SALRI on the role, concept and content of counselling and whether it should be mandatory. The Central Adelaide Local Health Network (Pregnancy Advisory Centre) explained the present arrangements in South Australia.[1165] They noted:

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counselling in law for any other procedure, including irreversible procedures like amputations and vasectomies. Women have the capacity and the right to make decisions about their bodies without interference and decide for themselves whether to seek counselling prior to an abortion': New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 3 (Mr Greenwich).

[1162] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 17–18 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW).

[1163] Sally Brown, 'Is Counselling Necessary? Making the Decision to have an Abortion: A Qualitative Interview Study (2013) 18 *European Journal of Contraception and Reproductive Health Care* 44.

[1164] Sam Rowlands, 'The Decision to Opt for Abortion' (2008) 34(3) *Journal of Family Planning and Reproductive Health Care* 175, 178. This point is made elsewhere. 'Few women currently use pre-abortion counselling services in the setting under investigation, stating that they are already certain of their decision regarding TOP and do not need additional support. Consequently, policies aimed at mandatory counselling would be a waste of resources and contrary to women's wishes': Charlotte Baron, Sharon Cameron and Anne Johnstone, 'Do Women Seeking Termination of Pregnancy Need Pre-Abortion Counselling?' (2015) 41 *Journal of Family Planning and Reproductive Health Care* 181, 185. Cf Joke Vandamme et al, 'Pre-Abortion Counselling from Women's Point of View' (2013) 18 *European Journal of Contraception and Reproductive Health Care* 309.

[1165] 'The Pregnancy Advisory Centre has always been and remains staffed by a counselling team of clinical social workers who provide self-determined/voluntary decision-making counselling, care and support pre and post operatively, safety assessments and post abortion care and support to clients who attend the centre. The counselling service provides support to clients who may be accessing services at other SA Health locations. The counselling service also works collaboratively with Maternal Fetal Medicine and the Clinical and Reproductive Genetics units of South Australian hospitals as needed, when referrals are made for clients who have a diagnosis of fetal anomaly and wish to proceed with a termination of pregnancy via services at the Pregnancy Advisory Centre. The counselling service is part of the multidisciplinary support team at The Pregnancy Advisory Centre that provides holistic care to its clients and is also routinely involved with the health care journey for clients who present with complex psychosocial needs, younger women, and women who are identified as having risks related

> The counselling service works from a position that determines that all women have the right to unbiased, comprehensive and high-quality professional counselling and information provision in relation to all pregnancy options. The counselling service is underpinned by a prochoice, woman centred framework that promotes women rights to make informed decisions about their health and wellbeing… It is our belief that services in South Australia already provide a robust, high quality counselling and support services to women who are considering or requesting an abortion. There does not need to be any mandatory requirements regarding counselling imposed upon women.

12.4.2 Several parties in SALRI's consultation disagreed with this assessment of the role and effect of existing abortion-related counselling in South Australia.[1166] These and other parties proposed detailed and mandatory counselling[1167] and linked requirements (such as mandated information)[1168] and the need to utilise an 'independent' counsellor. Birthline Pregnancy Support Inc suggested a requirement for a woman to be referred to an 'approved provider' for counselling.[1169]

12.4.3 Cherish Life Australia contended:

> … mandatory counselling should be provided to eliminate as far as possible the coercion of vulnerable women into abortions which they do not want and will regret for the rest of their lives. Women should also be given full informed consent, including the provision of an ultrasound image

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to safety or mental health. The counselling service at the Pregnancy Advisory Centre provided counselling, support and clinical information provision to 879 clients in 2018. The counselling service also responds on average to 50 messages per month from women or others contacting the centre requesting information and support about pregnancy options and decision making. The majority of clients access the counselling service voluntarily; sometimes clients attend the service and are referred to the counselling team for support via the nurses or doctors. This generally occurs if there are concerns related to the client's decision, where pressure or coercion related to the decision is present, if there are other concomitant psychosocial issues present or if safety issues are identified as part of routine screening for domestic and family violence… The counselling service regards women as the experts in their lives and that they are capable of making decisions about pregnancy. Counsellors may assist women by supporting exploration of her decision by taking a nonjudgmental approach and women centred position that does not place a higher value on one choice over another. This approach enables women to utilise their own strengths and resources in their decision making. This framework is supported by best practice evidence.'

[1166] Pregnancy Help SA asserted: 'The State Government should enact to change the name of South Australia's primary abortion clinic: the "Pregnancy Advisory Centre". The name should be changed to "SA Abortion Services". The current name "Pregnancy Advisory Centre" is deceptive and very misleading.' The Central Adelaide Local Health Network (Pregnancy Advisory Centre) disputed such assertions. It explained its role to SALRI as follows: 'The Pregnancy Advisory Centre is part of the Central Adelaide Local Health Network of SA Health and upholds the vision mission and values of SA Health. The Pregnancy Advisory Centre services are embedded within a philosophy of a pro-choice and reproductive autonomy framework. The services encompass a rights based approach to health care that recognises women as experts in their own lives and as such, that they are best placed to make decisions when faced with an unplanned/unwanted pregnancy. The key concern of the Pregnancy Advisory Centre is to minimise barriers to abortion created by both the social stigma and the politico-legal context of abortion in Australia.'

[1167] Parties who proposed detailed and mandatory counselling included Advocates International, the Australian Christian Lobby, the Right to Life Association of South Australia, Canberra Declaration, Family Voice Australia, Cherish Life Australia, Birthline Pregnancy Support Inc, the Lutheran Church, 40 Days for Life and Genesis Pregnancy Support Inc.

[1168] See, for example, the prescribed items suggested by 40 Days for Life. See below [12.4.8].

[1169] Birthline Pregnancy Support Inc submitted that an 'approved provider' should 'be subject to strict requirements to attain that status to avoid, among other things, the emergence of organisations who would seek to profit from referrals'. It submitted that an approved provider should be not-for-profit, with 'the primary focus on offering counselling and support services specifically to women who seek advice or assistance associated with a pregnancy'.

before they decide to go through with the abortion, and accurate descriptions and diagrams of the procedure.[1170]

12.4.4 40 Days for Life argued:

> Counselling should be mandatory, genuine counselling covering multiple options (incl adoption), not the virtual lack of counselling applying at present. There should be a Pregnancy Support Service associated with every clinic or prescribed facility where abortions are undertaken, including genuine informed consent.

12.4.5 There was also support at the 16 May and 12 June 2019 roundtables with faith groups and NGOs for appropriate counselling prior to proceeding with an abortion. It was noted that balanced and impartial information is essential and 'part of quality health care'. Some attendees supported mandated counselling by an 'independent' counsellor.

12.4.6 It was suggested at the 12 June 2019 roundtable that existing counselling focuses on abortion at the expense of other options. Several parties stressed that alternatives to abortion should be discussed as part of mandatory counselling, and that medical practitioners must inform patients about the location of pregnancy support centres. A number of attendees asserted that there is currently a lack of informed consent, with women seeking an abortion not being sufficiently informed of alternatives to abortion or warned about the abortion-related risks and the possibility of 'post-abortion grief'.[1171] It was said that this should be required in the law in order to protect women. Various (though not all) parties at the roundtable with faith groups and NGOs supported 'sidewalk counselling'.[1172]

12.4.7 At the 16 May 2019 roundtable with faith groups, the 'supportive' role of groups such as Genesis Pregnancy Support Inc, Birthline Pregnancy Support Inc and Pregnancy Help Australia was noted by some attendees who 'feel like they're fulfilling a need that shouldn't exist'. These attendees were critical of what they termed the partiality of existing counselling arrangements towards abortion, and supported mandatory 'independent' counselling. One attendee asserted that the current counselling is a 'sham' and fails to give women meaningful alternatives to abortion.

12.4.8 Various parties proposed detailed requirements to be the subject of mandatory counselling. 40 Days for Life, for example, argued:

> The existing counselling and support services are grossly inadequate, if not virtually non-existent. We propose that the legislation be amended to include, as a minimum, the following mandatory provisions, to be signed off by both health professionals and the pregnant woman before any abortion occurs: pre-abortion counselling and pregnancy decision assistance by independent, nonpartisan trained counsellors who have no pecuniary interest in the abortion process; fully educating a woman of the exact development of her baby and precise manner of what abortion is; how it will be performed in her case and the effect, including mandatory viewing of a brief video description of the abortion process eg Dr Anthony Levatino; mandatory viewing of an ultrasound by the pregnant women (not turned away from the woman as at present) accompanied by a full disclosure of the status of the fetus, including gestation level, presence of organs etc; non directive information about alternative options, including parenting, adoption, fostering; material resources as required; post-decision support (including parenting education and abortion recovery groups)… provide adequate care for a baby born alive after a failed abortion.

[1170] Other groups such as Advocates International, Pregnancy Help SA, and 40 Days for Life also recommended showing the ultrasound. See below [12.5.58]–[12.5.64]. The notion of patient autonomy is the central ethical feature of Australian health law and contemporary clinical practice. See *Rogers v Whitaker* (1992) 175 CLR 479.

[1171] See also above [2.1.43].

[1172] See further below [12.5.50]–[12.5.52], Part 18.

12.4.9 Pregnancy Help SA reasoned:

> There is no pregnancy support offered as an alternative to abortion. Pregnancy Help SA has helped and supported many pregnant women throughout South Australia for over 10 years, and have found that over 90% of these women did not want to have an abortion but were doing so primarily because they did not know where they could access pregnancy supporting services. This information is not easily accessible. And abortion clinics have a strong bias toward this type of information and supporting services… It should be mandatory that pregnant women attending doctor's surgeries, hospitals and abortion facilities be provided with all options including pregnancy support services and adoption services before being referred to an abortion provider and before an abortion is performed.

12.4.10 Some groups such as Cherish Life Australia, Canberra Declaration, Advocates International, the Australian Christian Lobby, the Right to Life Association of South Australia, Genesis Pregnancy Support Inc, Pregnancy Help Australia and Pregnancy Help South Australia supported a formal legal requirement to attend counselling before an abortion on the basis that it is a means of providing women with information about the procedure and the associated risks, or ensuring that a woman is entering into the procedure with her free and informed consent and not being pressured or coerced into an abortion.

12.4.11 Other parties who raised the need for mandatory counselling to ensure informed consent included Cherish Life Australia, Birthline Pregnancy Support Inc and the Lutheran Church. Birthline Pregnancy Support Inc suggested that 'a practitioner must, at a minimum, *offer* the woman the option of pursuing counselling or other support services *before* proceeding to a termination. The intention behind this suggested amendment would be to afford the woman an opportunity of making a fully informed decision'. The Lutheran Church said comprehensive counselling is required 'in order to meet the standard of full provision of information to enable informed consent, as with other medical or surgical procedures.'

12.4.12 These views were also held by Advocates International who argued:

> In addition to the obligations upon a medical practitioner, a woman contemplating an abortion should be referred to a counsellor as a component of ensuring that if the woman proceeds with an abortion, the consent she provides is fully informed and voluntary. That counsellor must be completely independent, in that he or she must not have any pecuniary or other interest in a health service which provides abortion… an independent counsellor has a role in ensuring that a woman is aware of alternatives to abortion, prior to undergoing the procedure. Unless a woman is aware of the alternatives to abortion, the woman cannot give fully informed consent.[1173]

12.4.13 Views were also expressed to SALRI that mandatory counselling is necessary to address what was said to be the very real issue of potential 'abortion coercion'.[1174] The Australian Christian Lobby indicated that counsellors may assist in 'identifying the existence of abortion coercion'. Anna Walsh noted: 'For some women abortion is not a matter of free choice, but rather the product of coercion or DV'. The Right to Life Association of South Australia also saw counselling as 'an opportunity to identify and assist women at risk of coercion'.

[1173] 'Impartiality' and 'truth in advertising' as to counselling are considered below. See below [12.5.24]–[12.5.49].

[1174] This should be more correctly described as reproductive coercion. SALRI consultation and research raised the issue of 'reproductive coercion' as a form of domestic violence and as a real concern. It is important to note that this concern arises in relation to both coercion to undertake and **not** undertake an abortion. See Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 382–383. See also below [19.3.1]–[19.3.34].

12.4.14 Genesis Pregnancy Support Inc argued:

> The value of pre-termination counselling cannot be understated. It can help to reveal coercion, procrastination, mental health issues, emotional instability, partner abuse, areas in need of support etc. At least one session should be compulsory. It would be safest to be conducted by a service not connected with the abortion provider and with a lapse of two weeks prior to the procedure in order to avoid reactive or impulsive decision making. This regime is much more likely to protect women's emotional and mental health around a procedure that most women say is essentially unwanted.

12.4.15 A contrasting perspective was presented by Dr Erica Millar who viewed restrictions on the availability of abortion as a form of reproductive coercion declaring:

> … state restrictions on abortion compel women to undergo pregnancy and birth unwillingly and to form a maternal relationship with a child they did not want. Compelling women to undergo a pregnancy unwillingly has deleterious effects on their health, and the health of the children born, in the immediate and long term.

12.4.16 Other parties such as Professor Heather Douglas and the Family Violence Legal Service Aboriginal Corporation SA presented a more expansive view of reproductive coercion, describing examples of 'experiences of pregnancy and termination being used as a means to exert coercive control by perpetrators of family violence'. They described instances of women 'being told by the perpetrator that if they choose to end the relationship they will also need to end the pregnancy' and conversely, 'Clients who have wanted to terminate have been prevented from taking this action and forced to maintain a pregnancy.'[1175]

12.4.17 SALRI is aware of the issue of reproductive coercion.[1176] However, SALRI agrees with the QLRC's approach: 'The Commission observes that these matters are generally addressed as part of the process of obtaining consent to medical treatment.'[1177]

12.4.18 The role and value of high-quality, impartial, non-directional and 'independent' counselling in relation to abortion was widely expressed to SALRI by parties both opposed and supportive to the decriminalisation of abortion. However, a diverse and conflicting range of views was expressed in relation to counselling, including whether counselling, or the offer of counselling, should be mandatory, who should provide counselling, and the nature and content of any such counselling.

[1175] The issue of the relationship between reproductive coercion and abortion is complex. A recent systematic review investigating reproductive coercion found that in relation to abortion women have been coerced both into terminating and into continuing pregnancies. Grace and Anderson in 2018 reported that four studies specifically described partner coercion in decisions to terminate with prevalence ranging from 0.1% to 4%. In contrast, one study reported an 8% prevalence of women being either pressured not to terminate or being prevented from seeking abortion services. Two of the included studies shared instances where women were threatened with harm or death by their partners if they had abortions. The review authors reported that the highest prevalence rates of reproductive coercion were self-reported by men in an exclusively male sample and therefore they concluded due to social desirability, true prevalence rates may actually be much higher. Additionally, the review highlighted, although only from one study, that when seeking an abortion, violence experienced by women at the hands of their partner was not associated with coercing abortions or continuing pregnancy, but rather was part of the woman's decision making in seeking an abortion as a way to end an abusive relationship. See Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 382–383.

[1176] See also below [19.3.1]–[19.3.34].

[1177] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 196 [6.21].

There were differences in what 'counselling' even involves.[1178] Concepts of 'independence' differed markedly.

12.4.19 Both those supportive and opposed to decriminalisation of abortion saw value in counselling but questioned the adequacy and impartiality of the information and counselling provided by the other. Parties on both sides cited examples to support their views.[1179]

12.4.20 The Human Rights Law Centre viewed counselling as beneficial stating: 'Counselling, when freely chosen, can be an important aspect of dealing with an unintended pregnancy. Accurate, confidential and impartial counselling about options should be available to all pregnant people.'

12.4.21 The Catholic Archdiocese of Adelaide also saw the value of counselling and noted: 'Too often, in the interests of expediency or costs, current pathways towards abortion have failed to offer an objective and personalised review of options. Too often, counselling services appears to be inadequate, if not a virtually non-existent option'.[1180]

12.4.22 The types of terms used in many submissions when describing the nature of counselling desired included 'independent', 'unbiased'/'non-bias', 'impartial', 'genuine', 'comprehensive', 'non-

[1178] Medical and health practitioners outlined to SALRI that an informed consent is different to counselling. As the South Australian Abortion Action Coalition noted: 'Informed consent supports people to understand health care procedures and any risks or side effects related to the procedure… Informed consent is already a standard required of all Australian health care services including current abortion services'. The Australian College of Midwives explained: 'By law, consent processes require the person to provide free, intentional and voluntary consent, free from coercion, pressure and delays. This requires full disclosure of information and the opportunity to consider this information prior to a decision being made. Counselling may therefore be in the form of information provided by the registered health care practitioner offering and facilitating abortion to women seeking this option'.

[1179] Pregnancy Help SA asserted: 'The current name "Pregnancy Advisory Centre" is deceptive and very misleading.' These criticisms have been repeated in relation to the 2019 NSW Act. '…a number of women who have shared their stories with Women and Babies Support claim they did not receive adequate counselling at abortion clinics: "Blankly they booked me in, took my money, gave me a five minute counselling session where basically they twisted everything to suggest abortion was my obvious best path, and I use the word "counselling" very loosely because someone asking, "Do you want to go ahead with this and you say 'Um, yes', is not counselling. Not one person warned me of the dangers, emotionally, physically, or spiritually... Not once, not once did they suggest perhaps I might need other support options or put me in touch with an independent counsellor"': 'Emma' quoted by Women and Babies Support, Submission No 36 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) 8 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64873/0036%20Women%20and%20Babies%20Support%20(WOMBS).pdf>. In contrast, the National Alliance of Abortion and Pregnancy Options Counsellors communicated examples about their experiences with anti-choice 'counselling services' and medical professionals: 'The counsellor told me I would be a failure as a wife and as a mother if I even considered abortion'; 'He [the GP] told me I couldn't have an abortion and that I had to wait a week to get an ultrasound. I didn't have a choice left after that.'; 'He [the GP] told me that if I had an abortion I would be murdering my baby.'; 'She [the counsellor] told me I would be a murderer.'; 'He [the GP] referred me for ante-natal appointments, and didn't give me any other information as said this was best for me.'; 'She [counsellor] told me I'd never get pregnant again.'; The mother of a pregnant 13 year old young woman seeking information regarding options for her daughter was told by a counsellor if her daughter adopted out her child it 'would be the worst thing she could do' and if she terminated 'well that's just killing the baby.' She was advised that there would be support for her daughter to keep the baby 'like cots and baby clothes.' She was also told the Government would give them money to keep the baby 'a few thousand.'; 'When we [woman and her partner] left [the counselling session] we were both anxious, angry and upset, with the counsellor and each other. We were told I would be at high risk of getting breast cancer if I had an abortion, that I could become infertile and that I would be psychologically traumatised.'

[1180] 40 Days for Life also concurred with the Catholic Archdiocese of Adelaide stating: 'We consider existing counselling and support services to be grossly inadequate, if not virtually non-existent.'

directive', 'non-judgemental', 'qualified', 'trained', 'professionally provided', and 'high-quality'. There was also a desire for all-options counselling for those who wished to access it.[1181]

12.4.23 Multiple submissions devoted attention to mandatory pre-abortion counselling. Less attention was given to post-abortion counselling. Birthline Pregnancy Support Inc stated that should a woman have an abortion through a surgical procedure, an obligation should be 'imposed' on the medical practitioner who undertook the abortion to offer post-abortion counselling, noting that some women currently report they do not feel they are able to or it is necessary to seek counselling after an abortion.[1182] The Lutheran Church similarly suggested that 'post-abortion counselling should be optional but highly recommended'.

12.4.24 There was extensive opposition in SALRI's submissions to any form of mandated counselling.[1183] This theme also emerged in the roundtables with the medical and legal sectors, the disability sector and parties in favour of decriminalisation. It was also the view of professional associations and the Central Adelaide Local Health Network (Pregnancy Advisory Centre). There was little support for mandated counselling in SALRI's discussions with medical and health practitioners. Of the survey respondents who answered this question, over half supported that counselling should be offered or available but not mandated, less than half believed that there is no need for a requirement to offer counselling services and only a small minority supported mandatory counselling.

12.4.25 One submission declared its strong opposition to any requirement for a person to be referred to counselling before they can access the care they need. The submission elaborated:

> I strongly oppose any moves to try and force a woman to undergo mandatory counselling in order to access abortion. I trust women to make the decision that is best for them and their family; and to decide on the nature or extent of any counselling they might want. I also recognise that there is an existing obligation on medical professionals to obtain informed consent from a patient prior to undertaking any medical procedure. Any counselling a woman may ask for ought to be made available to her, free of charge, free of bias, factually based, with all options including support she may reasonably obtain from government agencies (such as Centrelink, the Family Assistance Office, and NDIS etc) should she choose to continue the pregnancy, if she requests such counselling.

12.4.26 The Human Rights Law Centre accepted that counselling, when freely chosen, can be an important aspect of dealing with an unintended pregnancy, and 'accurate, confidential and impartial counselling' about options should be available but it was clear that 'no one should be compelled to receive counselling'. One survey response noted that it 'undermines the agency and autonomy of women to suggest that it should be mandatory for them to undertake counselling surrounding a

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[1181] Submissions that referred to at least some of these terms included Australian Lawyer's for Human Rights, Children by Choice, Central Adelaide Local Health Network (Pregnancy Advisory Centre), Coalition of Women's Domestic Violence Services, Marie Stopes Australia, The Human Rights Law Centre, the Australian Centre for Health Law Research QUT, Canberra Declaration, 40 Days for Life, Advocates International, and the National Alliance of Abortion and Pregnancy Options Counsellors.

[1182] Birthline Pregnancy Support Inc raised concerns that for women in these situations 'there is a lack of care and services offered to women at a time of great vulnerability.'

[1183] Parties who opposed any legislated counselling requirements included Professor Margaret Davies, the Australian College of Midwives, the Public Health Association of Australia, the South Australian Council for Civil Liberties, Fair Agenda, the Australian Women's Health Network, Women Lawyers' Association of South Australia Inc, the Robinson Research Institute, Marie Stopes Australia, South Australian Abortion Action Coalition, Human Rights Law Centre, Coalition of Women's Domestic Violence Services SA, Australian Lawyers Alliance, Women's Electoral Lobby, Australian Lawyers for Human Rights, Dr Erica Millar, the Law Society, Reproductive Choice Australia, Central Adelaide Local Health Network (Pregnancy Advisory Centre), National Alliance of Abortion and Pregnancy Options Counsellors, Children by Choice, Ms Susie Allanson, and the Australian Medical Association (South Australia).

decision that they are completely capable of making unassisted'. Another survey response submitted that friends, family and other resources, including professionals, government and internet, are available to a woman seeking support or assistance if that is what she wants. 'They do not need to be forced to discuss a very private and difficult personal decision with strangers who may who have their own agenda regarding the outcome of the counselling.'

12.4.27 The AMA(SA) opposed mandatory counselling:

> The AMA(SA) supports the autonomy of our patients. Any individual should be able to access the advice and support of a multi-disciplinary team, including counselling, if they wish to or believe they need such support. Information and advice must be available and easily accessible to allow an individual to make a decision about their pregnancy and to discuss that decision with a qualified medical practitioner or other health practitioner if they wish to do so. However, there should be no barrier to obtaining abortion services for individuals who do not wish to participate in counselling.

12.4.28 Fair Agenda, in its opposition to mandatory counselling, stated:

> We trust women to make the reproductive healthcare decision that is best for themselves and their families, including deciding upon the nature or extent of any counselling they may want. Fair Agenda supports the availability of independent, and unbiased counselling to those who request it. But we strongly oppose the requirement that it be mandatory.

12.4.29 The Law Society also opposed mandatory counselling:

> The SA Health website provides information with respect to over the phone and face-to-face counselling services available for women, partners and significant others, which are available on an optional basis. Counselling should be available for women to access on a voluntary basis, if wished.[1184]

12.4.30 Likewise, Australian Lawyers Alliance noted:

> We do not consider that it should be a mandatory requirement for medical or health practitioners to offer access to counselling services or to compel a woman's participation in counselling before they can access termination of pregnancy services.

12.4.31 Numerous reasons were given as to why counselling should not be mandated. It was pointed out that no other Australian jurisdiction has mandatory counselling and that this premise was rejected by the VLRC[1185] and the QLRC.[1186] The Australian Lawyers Alliance, Southgate Institute, the Public Health Association of Australia, the Family Planning Welfare Association of the Northern Territory and the Women's Electoral Lobby suggested that there was no need to legislate counselling as it is already part of health care and good clinical practice related to abortion services. The Family Planning Welfare Association of the Northern Territory stated: 'It is standard health practice to offer counselling to conflicted and ambivalent patients. This does not need to be codified', while the Women's Electoral Lobby noted: 'Offering counselling, and conducting informed consent counselling, is already a standard component of public and private termination of pregnancy services in Australia.'

12.4.32 Dr Erica Miller of La Trobe University explained:

[1184] Law Society of South Australia, Submission to the South Australian Law Reform Institute, *Review of abortion laws in South Australia*, 31 May 2019, 4 [20]–[21] <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

[1185] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 8.

[1186] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194 [6.16].

> … the idea that women should receive counselling before their abortions relies on several value-laden assumptions. Firstly, it presumes that women are uncertain about their decision, when health professionals and researchers note that the vast majority of women have a very high level of decisional certainty as they approach abortion and, afterwards, feel that abortion was the right decision for them in the short- and long-term. Secondly, requiring health professionals to offer women counselling for decisions pertaining to termination, and not for continuing with a pregnancy, establishes abortion as a problematic choice, which increases abortion stigma. Thirdly, the idea that health professionals should refer women seeking abortion to counselling feeds into the idea that abortion is emotionally and psychologically harmful to women. This anti-abortion claim contradicts scholarship on abortion and mental health. There is broad consensus that abortion is not associated with any profound or long-lasting effects. The most common emotional response from abortion is relief. Women who want to discuss their decision to terminate a pregnancy can already access federally-funded counselling and phone support services. Counselling is also integrated into existing abortion services.[1187]

12.4.33 Various parties noted that mandatory counselling is unnecessary and even harmful.[1188] The Southgate Institute explained that mandating counselling may result in adverse outcomes:

> The offering of counselling and advice is routine in current practice. Enacting a legal requirement would not be helpful, and could have unintended consequences, such as delays in treatment and compromising women's informed consent to treatment. The requirement for informed consent encourages the provision of adequate counselling and protects against abortions being conducted when women are not certain of their decision, with serious penalties for failure by the health professional.

12.4.34 Differing views were presented to SALRI with regards to the purpose or nature of abortion counselling. The National Alliance of Abortion and Pregnancy Options Counsellors stated:

> … we support Australian women having access to comprehensive, evidenced based counselling and support that places the woman as the expert in her life. This is turn supports the woman's full capacity to choose one of three pregnancy outcomes available: continuing the pregnancy to parent, abortion and continuing the pregnancy to adopt.

12.4.35 Several parties including Fair Agenda, Australian Lawyers Alliance, the Human Rights Law Centre, and Public Health Association Australia raised concerns that mandatory counselling would act as a barrier to equitable and effective access to abortion services, particularly for women in rural and remote communities.[1189] Australian Lawyers Alliance argued:

> Mandatory counselling may act as a barrier for women seeking to access termination of pregnancy services. It would likely reinforce the social stigma around termination of pregnancy services, it would create an additional step before a termination could be provided, women in rural and remote

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[1187] This accords with wider research. See, for example, Charlotte Baron, Sharon Cameron and Anne Johnstone, 'Do Women Seeking Termination of Pregnancy Need Pre-Abortion Counselling?' (2015) 41 *Journal of Family Planning and Reproductive Health Care* 181; Sally Brown, 'Is Counselling Necessary? Making the Decision to have an Abortion: a Qualitative Interview Study' (2013) 18(1) *European Journal of Contraception and Reproductive Health Care* 44; Sam Rowlands, 'The Decision to Opt for Abortion' (2008) 34(3) *Journal of Family Planning and Reproductive Health Care* 175, 178; Ann Moore et al, 'What Women Want From Abortion Counseling in the United States: A Qualitative Study of Abortion Patients in 2008' (2009) 50 *Social Work in Health Care* 424.

[1188] Women's Health West, noting personal experience of counselling in a mandatory setting indicated to the VLRC: 'Compulsory counselling not only reinforced a lack of control, it sparked anger among women that they were assumed to be incapable of making a considered decision': Victorian Law Reform Commission, *Law of Abortion*, (Report No 15, 2008) 123 [8.106].

[1189] This concern extends to Aboriginal communities, especially as to the availability of suitable counsellors.

> communities would probably have difficulties accessing counselling services and it would disadvantage vulnerable woman who were unable to attend for counselling.

12.4.36 The Public Health Association of Australia similarly maintained: 'Barriers and restrictions to access, such as requirements for mandated counselling should not be applied through legislation, regulation or policy.' The Human Rights Law Centre stated that reform to South Australia's abortion laws should ensure that women do not face additional legal barriers to access abortion and that requirements such as undergoing counselling 'create barriers that cause distressing delays and deny women the right to the best possible health outcomes, particularly for women in regional and remote locations.'

12.4.37 Parties including the Australian Lawyers Alliance and Dr Erica Millar, also raised concerns that mandatory counselling may reinforce or increase the stigma associated with abortion.[1190] Dr Millar noted that the idea that women should receive mandated counselling before an abortion relies on unsound and value-laden assumptions such that that women are uncertain about their decision.[1191]

12.4.38 Other parties such as Beth Wilson, the former Victorian Health Services Commissioner, indicated that mandated counselling fails to recognise a woman's autonomy to make her own decisions.[1192] She argued: 'Women should be able to make the decision that is best for them and their family; and to decide on the nature or extent of any counselling they might want.' Australian Lawyers for Human Rights similarly maintained: 'Individuals should be entitled to seek and engage in as much or as little counselling as they wish, either with personal networks or qualified counsellors.'

12.4.39 A Rabbi agreed that counselling should be optional and that 'every effort should be made to assure that the counselling that is offered is solely for the psychological benefit of the woman and not intended to try to persuade her to change her mind.'

12.4.40 Issues related to autonomy were also raised. It was noted to SALRI that, consistent with the VLRC,[1193] the notion of coerced counselling is at odds with the role and rationale of counselling. The South Australian Abortion Action Coalition highlighted the need for autonomy, supporting 'Australians having self-determined access to non-judgement, comprehensive, evidence based counselling and support that places the woman as the expert in their own life.' The Australian Centre for Health Law Research at QUT similarly outlined:

> A requirement for counselling presumes that women are incapable of making decisions without external guidance, and would further undermine their autonomy. Decisions to access such assistance prior to or following an abortion, as with any other medical procedure, should be a matter of personal choice for women, and should not be mandated.

[1190] Dr Millar noted to SALRI that requiring medical practitioners to offer women counselling for decisions pertaining to an abortion but not for continuing with a pregnancy, 'establishes abortion as a problematic choice, which increases abortion stigma'.

[1191] Dr Millar has noted that the 'vast majority of women have a very high level of decisional certainty as they approach abortion and, afterwards, feel that abortion was the right decision for them in the short- and long-term': Erica Millar, 'Mourned Choices and Grievable Lives: How the Anti-abortion Movement Came to Define the Abortion Experience' (2016) 28(2) *Gender and History* 501. See also Corinne Rocca et al, 'Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study' (2015) 10(7) *PLOS One* 1.

[1192] See also above [1.3.35]–[1.3.39].

[1193] 'It was argued that compulsion and counselling was an oxymoron, and that mandated counselling would be an unnecessary legal addition': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 123 [8.106], 125 [8.126].

12.4.41 The situation of women with disability and the pressure placed on them to undergo an abortion was also raised as a concern to SALRI by the disability sector and others. Women with disability have often been arbitrarily deemed to lack the capacity to make their own decisions.[1194] Australian Lawyers for Human Rights observed:

> A woman with disability may be forced to have an abortion by having her legal capacity removed, or as a result of stigma associated with the perceived capacity of people with disability to be parents. Article 12 of the CRPD (Committee on the Rights of Persons with Disabilities) provides the right for 'persons with disabilities enjoy legal capacity on an equal basis with others'. Forcing a woman with disability to have an abortion on the basis that she does not have legal capacity, because she has a disability, is discriminatory.

12.4.42 SALRI supports the view that a woman's autonomy to make decisions about her own body should also extend to women with disabilities.[1195]

12.4.43 It was additionally noted by the Family Planning Welfare Association of the Northern Territory that 'forced' counselling is not appropriate, and by Reproductive Choice Australia that 'forcing counselling can do more harm than good.' Beth Wilson stated:

> Compulsory referrals to counselling before access to abortions is tantamount to emotional blackmail and would be unlikely to be clinically called for or successful. Indeed, such a requirement would be detrimental to the development of a good therapeutic relationship that is critical to the provision of professional counselling services.

12.4.44 Other parties such as the South Australian Abortion Action Coalition, Professor Heather Douglas and Professor Caroline Da Costa, highlighted that most women are already firm in their decision when they seek an abortion. Professor Da Costa stated: 'Most women requesting early abortion have made an informed decision for themselves by the time they make their request and they do not wish or need to have counselling.'[1196] This point was also made to the VLRC[1197] and the NSW Legislative Council Committee.[1198]

12.4.45 In making a case against mandatory counselling, several submissions including that of the Women's Electoral Lobby, highlighted that counselling is not mandatory in any other Australian jurisdiction. The Australian Women's Health Network, the Women Lawyers' Association of South Australia Inc and the South Australian Abortion Action Coalition stated that 'counselling was not

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[1194] See, for example, Committee on the Rights of Persons with Disabilities, *General Comment No 3 (2016) On Women and Girls with Disabilities*, UN Doc CRPD/C/GC/3 (2 September 2016) [40]. See also below [13.3.4], [13.4.10]–[13.4.15].

[1195] See also below [13.3.4], [13.4.10]–[13.4.15].

[1196] The position that most women have already made their decision to terminate and do not require counselling to assist in their decision making is supported by a 2011 US study that detailed findings of interviews with 49 women about what they wanted from abortion counselling. The study found that 91.8% of women had already made their decision to seek an abortion prior to calling the health service that would perform the procedure and concluded that women are not looking for counselling about their options. The authors also noted that women were not seeking to emotionally confide in a counsellor. It was recommended that an approach to counseling should be adopted whereby women can seek the type of counselling that they wish. See further Ann Moore et al, 'What Women Want From Abortion Counseling in the United States: A Qualitative Study of Abortion Patients in 2008' (2009) 50 *Social Work in Health Care* 424–442.

[1197] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 120 [8.80]–[8.84].

[1198] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 38–40 [3.76]–[3.81]. See also Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 8 (Ms Sinead Canning, Campaign Manager, NSW Pro-Choice Alliance).

imposed on women as part of the 1969 law reform in South Australia and it should not be imposed now.' These three parties, along with Professor Heather Douglas, noted that no other Australian jurisdiction requires attendance at counselling before or after an abortion. The Women Lawyers' Association of South Australia Inc also observed that no other Australian jurisdiction has imposed counselling as part of decriminalisation of abortion, while the Women's Electoral Lobby highlighted that mandatory counselling is not a legislated requirement for lawful abortion in Canada, the UK or New Zealand.[1199]

12.4.46 Several parties did not specify that counselling attendance should be mandatory but indicated a preference for it to be mandatory to offer counselling. Marie Stopes Australia, for example, said: 'all options [of] counselling should be offered to any person accessing abortion and their support person, both pre and post procedure'. A similar perspective was held by the Public Health Association of Australia who suggested: 'Abortion service providers should offer optional, comprehensive pre and post-abortion counselling.'

12.4.47 In contrast, other parties including the Coalition of Women's Domestic Violence Services, Children by Choice, Australian Lawyers for Human Rights and the Women's Electoral Lobby objected to any mandatory requirement to offer counselling. The position is summarised by Children by Choice:

> We have concerns about legislating the requirement to offer counselling due to the lack of clarity in what this requirement would mean (for example, what sort of counselling and by whom), the lack of legislative requirements for transparency in pregnancy counselling, and the lack of necessity for the offer of counselling to be a legislative provision.

12.4.48 Australian Lawyers for Human Rights raised multiple concerns about mandated counselling or offer of counselling. These included concerns about the appropriateness of counselling in some circumstances, failure to recognise the deliberation that goes into a decision about abortion and additional burdens to treatment providers which would likely result in delays for women. For instance, they noted: 'There are also situations where counselling may be irrelevant and/or inappropriate, for example where a woman has used contraception but it has failed, or where a pregnancy has occurred as a result of rape.' Further, they noted 'that mandatory counselling, or a mandatory offer of counselling fails to recognise that individuals do not make reproductive decisions lightly. Often, these decisions are the result of much consultation and discussion between partners, family and friends.'

12.4.49 The Australian Lawyers Alliance also opposed any requirement to offer counselling. They stated: 'we do not consider that it should be a mandatory requirement for medical or health practitioners to offer access to counselling services or to compel a woman's participation in counselling before they can access termination of pregnancy services.' Their rationale included:

> As termination of pregnancy services should be treated as a health matter rather than as a criminal matter, there is no need to include legislative provisions requiring a medical or health practitioner

[1199] Several parties referred SALRI to the USA where a number of States have mandatory counselling. Such requirements are highly contentious. Fair Agenda commented: 'We note that in the United States mandatory counselling requirements have been used to shame women and make it more difficult to access abortion.'

'However, some states have specific abortion counselling provisions, and many of these laws require providers to give inaccurate or misleading information to women seeking abortion care in order to dissuade them from obtaining an abortion. These requirements violate the principles of informed consent, intrude on the provider-patient relationship, and infringe patients' right to receive relevant, accurate and unbiased information prior to obtaining medical care so they can make sound decisions about their treatment': 'Mandatory Counselling For Abortion', *Guttmacher Institute* (Web Page, August 2018) <https://www.guttmacher.org/evidence-you-can-use/mandatory-counseling-abortion>.

> to offer counselling services to a woman or to compel a woman to participate in counselling before a pregnancy is terminated... Women should be regarded as being capable of making an informed decision following an initial consultation with a provider of termination of pregnancy services... Mandatory counselling may act as a barrier for women seeking to access termination of pregnancy services. It would likely reinforce the social stigma around termination of pregnancy services, it would create an additional step before a termination could be provided, women in rural and remote communities would probably have difficulties accessing counselling services and it would disadvantage vulnerable woman who were unable to attend for counselling... The legislation in other jurisdictions does not require practitioners to offer a referral for counselling (except in Western Australia).[1200]

12.4.50 Strong opposition to any requirement to offer counselling was also provided by Dr Millar. She cited multiple difficulties arising from a requirement to offer counselling. Dr Millar argued:

> Directive counselling has been a key strategy of the anti-abortion movement since the 1980s, and the idea that women should receive counselling before their abortions relies on several value-laden assumptions… requiring health professionals to offer women counselling for decisions pertaining to termination, and not for continuing with a pregnancy, establishes abortion as a problematic choice, which increases abortion stigma.

12.4.51 Dr Millar added that the idea that health practitioners should refer women seeking abortion to counselling 'feeds into the idea that abortion is emotionally and psychologically harmful to women'.

12.4.52 Rather than mandatory counselling, there was strong support from many parties[1201] including the Women's Electoral Forum, the Australian Women's Health Network, Central Adelaide Local Health Network (Pregnancy Advisory Centre), Marie Stopes Australia, RANZCOG, the Australian Medical Association (South Australia), Professor Heather Douglas, the Public Health Association of Australia, the Royal Australian College of Psychiatrists (SA Branch), and the Australian College of Midwives that suitable counselling services should be available for women to access before and after an abortion 'as each woman chooses'. The RANZCP SA Branch, asserted that: 'Pregnant women seeking a termination may not want or need counselling, but where it is desired it should be readily available'. Further, RANZCOG stated:

> Pre and post termination counselling by appropriately qualified personnel should be routinely available for all women considering abortion, but it should be for the woman to decide whether she wishes to undergo counselling.

12.4.53 SALRI agrees with the reasoning of those parties in consultation, especially professional associations, that neither counselling, nor the offer of counselling,[1202] should be mandated. Rather, these questions are better left to clinical practice and individual choice. SALRI considers that mandatory counselling is both unnecessary[1203] and unhelpful. It undermines the autonomy of women

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[1200] The 2019 NSW Act includes a form of this provision. See below Part 22. See also New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 545–60.

[1201] Other parties who objected to mandatory counselling but supported counselling being readily available to those who choose to access it included Children by Choice, the Greens (SA) and the Australian Lawyers for Human Rights who stated: '… every provision should be made to facilitate and enable individuals who wish to access appropriate counselling to do so, in an accessible and timely manner'.

[1202] As one party told SALRI: 'I think that mandated offers of counselling and mandated requirements for counselling disrespect women and disrespect their own decision-making processes and their own values system.'

[1203] SALRI notes the comments of the National Alliance of Abortion and Pregnancy Options Counsellors. 'There is no evidence that women take any decision about an unintended pregnancy in a rushed or unconsidered way. It is

and the whole notion of 'mandatory' counselling is at odds with the role and rationale of proper counselling. Any requirement of mandated counselling would merely create 'unnecessary delays and burdens'.[1204]

12.4.54 It is significant that both the QLRC[1205] and VLRC[1206] found that neither counselling, nor the offer of counselling,[1207] should be mandated. As the VLRC found: 'Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm'.[1208] The VLRC concluded that counselling is a 'clinical matter best left to professional judgment based on a woman's circumstances'[1209] and opposed any requirement for mandated counselling. The QLRC similarly concluded that counselling is better addressed as a matter of clinical practice, rather than by legislation. 'Consistently with treating termination as a health matter, the decision to attend counselling should be one that is made by a woman in consultation with relevant health practitioners'.[1210] SALRI finds the reasoning and conclusion of the VLRC and QLRC compelling.

12.4.55 There is clearly value in appropriate counselling being available on a voluntary basis to women who wish to utilise such a service in relation to abortion (whether before or after the procedure). As the WHO recommends, counselling should be available to women who desire it and it should be 'voluntary, confidential, non-directive and by a trained person'.[1211]

12.5 Other Counselling-Related Issues

Provision of relevant mandated information

12.5.1 General health law and practice (reinforced in South Australia by statute)[1212] provides that, to obtain a patient's free and informed consent, medical practitioners must provide information that a patient would consider reasonably relevant before deciding whether to have a particular medical procedure (which includes abortions). This includes the nature, risks, and benefits of any medical procedure and availability of alternatives.[1213]

12.5.2 A number of parties opposed to the decriminalisation of abortion proposed to SALRI that the law should require the further provision of additional mandatory information in cases of

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the experience of *NAAPOC* counsellors that women weighing up their pregnancy options do so in a considered and deeply thoughtful manner'.

[1204] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 18 (Adjunct Prof Deborah Bateson, Medical Director, Family Planning NSW). See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194 [6.20].

[1205] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194–195 [6.16]–[6.21].

[1206] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 126 Rec 5.

[1207] As one party told SALRI: 'I think that mandated offers of counselling and mandated requirements for counselling disrespect women and disrespect their own decision-making processes and their own values system.'

[1208] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 125 [8.125].

[1209] Ibid 126 [8.139].

[1210] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194 [6.18].

[1211] World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2016) 36 <https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/>.

[1212] *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

[1213] *Rogers v Whittaker* (1992) 175 CLR 479.

abortion. They proposed various items that should be included such as visual images of the fetus,[1214] ultrasounds,[1215] an account of what an abortion involves[1216] and a list of the purported medical risks involved be provided to women before they can proceed to an abortion.

12.5.3 SALRI was often told in consultation by parties opposed to the decriminalisation of abortion that the health profession is currently failing to advise women of the full risks of abortion. These include what they said are the strong links between abortion and breast cancer, infertility, depression and other adverse mental health outcomes (including 'post-abortion syndrome').[1217]

12.5.4 The provision of mandated information is closely linked to the question of mandatory counselling.

12.5.5 The suggestion of mandated information was opposed by a number of health and medical practitioners and other parties as not only unnecessary and better left to clinical practice, but as a form of pressure and coercion. It was noted that no such requirement exists in any Australian jurisdiction or in New Zealand or the United Kingdom.

12.5.6 The New Zealand Law Commission[1218] and the QLRC[1219] viewed any requirement of mandated information as unnecessary and an issue better left to clinical practice.

12.5.7 The VLRC was unconvinced of any rationale or need for mandated information. The VLRC noted that there is a risk that mandated information may seek to convince women to reach a particular decision and that the experience of mandated information in the USA 'is that the policy purpose is to dissuade women from proceeding with abortion. This does not fit the policy aim of allowing people to make informed decisions based on accurate information'.[1220]

12.5.8 The VLRC concluded:

> Requiring mandated information to be given to women before they can access abortion does little to further the underlying values of the existing law. It would be a symbolic measure only. Mandating abortion-specific information risks opening the law to ongoing controversy, as to both the mode and content of the information. Information may be contested, inaccurate, or not germane… The current law that governs all medical procedures deals appropriately with the issues of information, consent, and the clinical appropriateness of the procedure. The Commission is therefore of the view that there is no requirement for mandated information provisions within any new law of abortion.[1221]

12.5.9 SALRI finds the reasoning of the VLRC compelling. Any requirement for mandated information is both unnecessary[1222] and unhelpful.

[1214] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 116 [8.40].

[1215] The VLRC commented: 'It is doubtful that many people would support women having to view what most would consider distressing images': Ibid 117 [8.57]. See also below [12.5.58]–[12.5.64].

[1216] The graphic account provided by a Dr Levatino to a Kansas legislative committee was noted by several parties.

[1217] Ibid 117 [8.55].

[1218] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 143 [9.10].

[1219] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 195 [6.21].

[1220] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 117 [8.58].

[1221] Ibid 117 [8.53]–[8.54], [8.59].

[1222] As Reproductive Choice Australia noted: 'The general standard of disclosure by a medical practitioner (informed consent) embodies the principle that doctors must provide all relevant information that a patient should consider before deciding whether to have a particular medical procedure. This includes the nature, risks, and benefits of

Mandatory 'cooling off' or waiting periods

12.5.10 No formal 'cooling off' or waiting periods exist in Australia in relation to abortion. Such provisions exist in some states in the United States but are highly contentious.[1223]

12.5.11 Parties such as the Australian Christian Lobby, Genesis Pregnancy Support Inc, Family Voice Australia, Right to Life South Australia and the Lutheran Church raised to SALRI required waiting periods for women seeking abortions.[1224] The rationale of this suggestion is to avoid 'rash' decisions and allow women time for 'more reasoned decisions' on such a serious and emotionally charged decision.[1225] The Lutheran Church asserted 'pre-abortion counselling should be followed by a mandatory waiting period to allow women time to properly digest the information they have received and to reflect on their situation'. The Right to Life Association also argued in favour of a 'period of time for reflection', explaining:

> Ambivalence about an abortion decision is common, so there should be a period of time set in place to ensure all matters have been taken into account before an abortion can take place. Time for consideration is built into legislation about many major decisions, such as when someone wishes to purchase a house or land. Surely, time for considering aborting an unborn child should attract at least the same?

12.5.12 However, this idea received little support in SALRI's consultation. Parties such as the Women Lawyers' Association of South Australia Inc, Central Adelaide Local Health Network (Pregnancy Advisory Centre), the Australian Women's Health Network and the South Australian Abortion Action Coalition opposed mandatory waiting periods for women accessing abortion. Ms Marchesi said the notion of a waiting period not only undermines the autonomy of women and does not result in either good law or good medical practice but is 'one of the most futile and utterly pointless' of suggestions.

12.5.13 Reproductive Choice Australia also dismissed such a proposal, observing:

> The concept of 'cooling off' periods is ignorant and patronising given the reality of women's lives, the urgency of a problem pregnancy and the barriers and time delays already experienced by women. Imposed cooling-off periods may delay access to safe first trimester abortion. This is of particular concern for rural and regional women who could face additional travel and accommodation costs.

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any medical procedure and availability of alternatives. Current law requires practitioners to inform women of the nature, risks, and benefits of medical procedures, including abortion.'

[1223] See, for example, Sam Rowlands, 'The Decision to Opt for Abortion' (2008) 34(3) *Journal of Family Planning and Reproductive Health Care* 175, 178; Brooke Calo, 'The Violence of Misinformation: Compulsory "Independent" Counselling' (2007) 19 *Women Against Violence: An Australian Feminist Journal* 10. 'Opponents of waiting periods believe they do little to improve the welfare of women. At best, according to many pro-choice advocates, waiting periods have no effect on women's decisions. At worst, the delay magnifies a woman's mental anguish in dealing with the unwanted pregnancy, as well as extending the period of physical stress. Often, they claim that waiting periods are simply a device used to increase the cost and effort involved in securing an abortion…. waiting periods are at least an annoyance and might cause significant emotional or psychological harm as women are kept from exercising their rights': Jonathan Klick, 'Mandatory Waiting Periods for Abortions and Female Mental Health (2006) 16 *Health Matrix* 183, 185.

[1224] Some parties did not suggest a specific timeframe; Family Voice Australia and the Australian Christian Lobby and suggested a 'cooling off' period of 72 hours. Genesis Pregnancy Support Inc raised two weeks. Parties suggested to the VLRC cooling off periods between 24 hours and three weeks. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 127 [8.145].

[1225] Jonathan Klick, 'Mandatory Waiting Periods for Abortions and Female Mental Health (2006) 16 *Health Matrix* 183, 184–185.

12.5.14 The National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC) also objected to mandatory waiting periods. They argued:

> Mandatory counselling and mandatory cooling off periods undermine the expertise of medical and health professionals providing care for women and suggests that the state does not trust women, as a specific group of the population, to make responsible, autonomous and competent decisions... NAAPOC believes that mandatory cooling off periods are offensive and discriminatory to women because they negate women's autonomy, competency and self-determination to make their own decisions about their health and their life-circumstances... Correspondingly, men are not required to undergo mandatory cooling off periods for male-specific medical procedures.

12.5.15 The VLRC expressed a similar view. It noted that it had received 'strong opposition to legislated cooling-off periods. It was felt that the notion of "cooling off" was 'unnecessary' or 'dangerously naïve and disrespectful, given the reality of women's lives, the urgency of the problem pregnancy and the barriers and time delays already experienced by women'.[1226] There was particular concern about further delays and costs for rural and regional women.[1227]

12.5.16 The VLRC reasoned:

> To fully consent, a woman needs capacity, free choice, and adequate, appropriate information to make her decision. The time taken to make the decision is unique to each woman because every woman and her circumstances are different. 'Cooling off' implies that a decision would otherwise be made abruptly or in the heat of the moment. It assumes the woman's judgment is flawed or that she requires further time or information to reach a different decision… The Commission believes that women should be able to take the time they need to reach their own decision about whether to have an abortion. This matter should be governed by good clinical practice rather than legislation… The Commission believes the current law governing all medical procedures deals appropriately with the timing of consent. No further legislative requirement is necessary.[1228]

12.5.17 The VLRC therefore recommended that 'any new abortion law should not contain a compulsory delay or cooling off period before an abortion may be lawfully performed'.[1229] The New Zealand Law Commission[1230] reached a similar view.

12.5.18 The suggestion of mandated waiting periods also proved contentious in recent comments to the NSW Legislative Council Committee. The suggestion was criticised as 'very problematic',[1231] 'horrendous and unnecessary',[1232] 'ridiculous in that it is unnecessary',[1233] a 'very detrimental

[1226] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 127 [8.148].

[1227] Ibid 127 [8.149].

[1228] Ibid 127 [8.150]–[8.154].

[1229] Ibid 127.

[1230] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 143–145.

[1231] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 53 (Ms Janet Loughmann, Women's Legal Service NSW).

[1232] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 53 (Dr Philip Goldstone, Marie Stopes Australia).

[1233] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 39 (Ms Sally Jope, Board Director, Central Coast Community Women's Health Centre).

measure',[1234] creating 'unnecessary delays and burdens'[1235] and as 'nothing other than punishment for making that dreadful decision [to have an abortion]'.[1236] Dr Goldstone noted: 'I really do not see any benefit. I only see harm from a cooling-off period.'[1237] The NSW Legislative Review Committee observed that 'a number of parties to the inquiry argued that a 72-hour cooling off would be very unfair to women, especially women in regional areas, or women escaping domestic and family violence, who often seek an abortion at the end of their decision making process'.[1238]

12.5.19 The adverse effects of any waiting period in the context of rural access and domestic violence are significant.[1239] The comments of Ms Canning to the NSW Legislative Council Committee are pertinent:

> When it comes to cooling-off periods, that is really dangerous. For women that are fleeing violence, for women that are in rural, regional and remote areas, a 72-hour cooling-off period could actually make the difference between accessing the service or not. In terms of women fleeing violence, they might get to their GP, they might get to the clinic and they are able to do it today or tomorrow. They need to do it in a certain time frame because sometimes a termination of pregnancy is actually part of their plan to escape the violent relationship. For people in rural and regional areas, they only have a specific amount of time that they can come to a more metropolitan area to access a termination of pregnancy. Having then to return to their community and come back for the termination of pregnancy—it is just not workable for them. I think that sometimes this misses as well that pregnancies are a time-sensitive issue. The vast majority of terminations of pregnancy happen before nine weeks pregnant and that would mean that they would be able to access a medical termination of pregnancy. Making them wait another three days would mean that they might have to access a surgical termination and the difference in cost there is ridiculous. It is about $400 difference in cost and that increases however far you get into gestation. I would… just add that I think these amendments would be hugely problematic, that they would create unacceptable barriers to women accessing reproductive health rights and indicate a fundamental lack of distrust, both in women and doctors, in making these decisions.[1240]

[1234] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 53 (Ms Janet Loughmann, Women's Legal Service NSW).

[1235] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Deborah Bateson, Medical Director, Family Planning NSW).

[1236] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Ms Karen Willis OAM, Executive Office, Rape and Domestic Violence Services Australia).

[1237] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 53 (Dr Philip Goldstone, Marie Stopes Australia).

[1238] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 40 [3.82]. The Committee also noted the evidence of the Rev Dr Peter Stuart, Anglican Bishop of Newcastle. 'Parliament needs to be alert to some of the United States [US] experience where informed consent and counselling have been implemented in ways which have caused manifest distress to the woman': at 40, [3.83], See also Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 61 (Revd Dr Peter Stuart, Anglican Bishop of Newcastle).

[1239] See Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 53 (Ms Janet Loughmann, Women's Legal Service NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 8 (Ms Melanie Fernandez, Co-convener, Pro-Choice NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Deborah Bateson, Medical Director, Family Planning NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Ms Karen Willis OAM, Executive Office, Rape and Domestic Violence Services Australia).

[1240] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 8 (Ms Sinead Canning, Campaign Manager, NSW Pro-Choice Alliance).

12.5.20 SALRI agrees with such reasoning and does not support the establishment of waiting periods. The notion of waiting periods to access abortion is inappropriate and objectionable.

Informed consent

12.5.21 Informed consent is clearly an important issue and one which proved of concern to parties both supportive and opposed to the decriminalisation of abortion.[1241] Some parties including the National Alliance of Abortion and Pregnancy Options Counsellors and the Central Adelaide Local Health Network (Pregnancy Advisory Centre) highlighted differences between interactions among women and health practitioners for the purposes of obtaining informed consent and therapeutic counselling.[1242] The Central Adelaide Local Health Network (Pregnancy Advisory Centre) stated:

> When considering a client's counselling needs, it is important to note the difference between 'therapeutic counselling' and the 'informed consent' process in the context of pregnancy options and abortion counselling. Informed consent counselling supports women to understand the abortion procedure and any risks or side effects related to the procedure… The provision of informed consent is a standard required for any health care procedure including abortion health care and is routine for all women attending the Pregnancy Advisory Centre requesting abortion. Therapeutic counselling in comparison provides women and their support people with the opportunity, where needed, to further explore their values, strengths and capacities in relation to their potential pregnancy decision.

12.5.22 In advocating against mandatory counselling, parties such as the South Australian Abortion Action Coalition, the Women Lawyers' Association of South Australia Inc, Children by Choice and the Women's Electoral Lobby maintained that informed consent is already a standard component of abortion care. Children by Choice noted:

> As with other medical procedures, informed consent counselling is a standard part of public and private termination of pregnancy services in South Australia, and is additionally addressed in clinical guidelines, best practice principles and the licensing and distribution conditions for medical abortion determined by the Therapeutic Goods Administration. Any uncertainty, ambivalence, or distress regarding the decision should be identified and responded to appropriately by termination providers as part of gaining informed consent, and it is therefore, unnecessary for a mandatory offer of counselling to be included in any proposed legislative amendments.

12.5.23 Additionally, the Australian Lawyers for Human Rights noted that medical practitioners already have a duty to provide information on options and risks as part of the requirement for informed consent for any medical treatment.

[1241] SALRI's view is that it is unnecessary to make specific legislative provision for informed consent in relation to abortion as it is already an integral aspect of health law and practice. See also New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 142 [9.5]. As Children by Choice noted: 'Informed consent counselling seeks to ensure that the patient understands the nature and the purpose of a medical procedure, its alternatives, the possible complications, and the likelihood of these complications occurring. It also ascertains that the patient is making the decision to proceed with the treatment voluntarily. As with other medical procedures, informed consent counselling is a standard part of public and private termination of pregnancy services in South Australia, and is additionally addressed in clinical guidelines, best practice principles and the licensing and distribution conditions for medical abortion determined by the Therapeutic Goods Administration.' See also below [19.1.1]–[19.1.23].

[1242] Similar views were held by the South Australian Abortion Action Coalition who stated: 'It should be noted that an informed consent is different to counselling.'

Partiality, qualifications and truth in advertising for pregnancy options counselling

12.5.24 It is evident to SALRI that parties both supportive and opposed to the decriminalisation of abortion support women having access to impartial and independent counselling, although they differ in their understandings of 'impartiality' and 'independence', and in their opinions about the role and content of such counselling and who should deliver such counselling services.

12.5.25 Among some groups there was specific reference to counselling services being delivered by people not associated with abortion providers. The Lutheran Church, for example, stated: 'Persons performing pre-abortion counselling should be independent from commercial providers of abortion services.' This view was supported by Advocates International who specified '… a counsellor must be independent of the health service which provides the abortion procedure'. 40 Days for Life argued counsellors should have 'no pecuniary interest in the abortion process.' The Right to Life Association of South Australia made a similar point. This point was also raised to the NSW Legislative Council Committee.[1243]

12.5.26 Many submissions from both sides of the debate made specific reference to the qualifications, or lack thereof, of counsellors indicating a preference for counsellors to be appropriately trained. Those in support of such measures included Australian Lawyers for Human Rights, 40 Days for Life, Advocates International and Women's Electoral Lobby Australia. The Australian College of Nursing and RANZCOG indicated that counselling should be provided by 'appropriately qualified' professionals, while the Coalition of Women's Domestic Violence Services indicated counselling should be 'provided by tertiary trained professionals.' Likewise, the Australian Centre for Health Law Research QUT noted: 'We also believe any counselling offered should be through impartial, independent, appropriately qualified sexual health and reproduction counsellors and organisations.'

12.5.27 Parties such as Advocates International, the Women's Electoral Lobby and the National Association of Abortion and Pregnancy Options Counsellors highlighted that at present there is no requirement for a counsellor to hold any specific qualifications and training.[1244] Advocates International stated: 'Given the gravity of the matters the counselling role must address, there should be requirements in qualifications and experience in order to provide this counselling, and at present there are none'. They recommended: 'Counsellors should be required to meet minimum standards of qualifications and experience'.

12.5.28 The VLRC also noted that counselling should be provided by 'only those counsellors operating within the professional and ethical standards'.[1245]

12.5.29 Similarly, Women's Electoral Lobby Australia, when describing current counselling practices, noted:

> There is a distinct lack of legislative requirements for transparency in pregnancy counselling, and there is no necessity for the offer of counselling to be from a professional with a university degree or any other further education, thus rendering any proposal of including counselling requirements in a Bill to be particularly harmful.

[1243] See, for example, Anna Walsh, Submission No 21 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64858/0021%20School%20of%20Law,%20University%20of%20Notre%20Dame%20Australia.pdf.>.

[1244] See above [12.2.1].

[1245] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 123 [8.112].

12.5.30 The Canberra Declaration also highlighted the lack of requirements relating to the training of counsellors: 'As yet, there is no law in Australia that requires abortion clinic counsellors to be qualified. This is in need of serious review by South Australian lawmakers.'

12.5.31 In relation to who should be able to offer abortion counselling services, Marie Stopes Australia stated:

> It is important that the counselling is non-biased, non-judgmental and trauma informed. We recommend that only counsellors that are members of the National Alliance of Abortion and Pregnancy Options Counsellors be permitted to provide and advertise that they provide abortion and/or pregnancy options counselling.

12.5.32 The notion of 'independence' was widely raised to SALRI, especially by parties opposed to the decriminalisation of abortion. However, the implications of such a requirement perhaps escaped those arguing for it. The VLRC noted that since most women use in-house counselling services (in South Australia this would mean either public hospitals or the Woodville clinic) and any legal requirement that counselling be limited to 'independent' external providers would result in a significant change in current practice. Women seeking counselling would have to access at least two services - the medical provider and a separate counsellor - creating a more complex and costly care pathway.[1246] The VLRC elaborated:

> A prohibition on counselling in abortion provider settings would mean that abortion would stand alone as a medical procedure where those with the most experience in a procedure are viewed as those least able to talk to patients about it. Such a requirement would potentially apply to major public providers, including the Women's. It would also require a prohibition on pregnancy counsellors who are morally opposed to abortion, as this would equally offend the principle of independence.[1247]

12.5.33 As noted previously, parties both supportive and opposed to decriminalisation raised concerns about adequacy of counselling. The South Australian Council for Civil Liberties shared concerns about counselling quality and recommended services be assessed for their appropriateness. They stated:

> Women are well aware that there are numerous counselling services available to them and are easily available as a google search. There is however, in our opinion, an issue of the quality of those services and would suggest a further enquiry into the appropriateness of some so-called counselling services purporting to offer pregnancy counselling. In particular, we refer to services that are biased to the providers views rather than their obligation to the women they are counselling.'

12.5.34 A number of parties both supportive and opposed to the decriminalisation of abortion expressed concern to SALRI about what they perceived as bias in the provision of counselling services and the absence of any legal requirement to disclose any preconceived bias, preference or interests that may influence the counselling provided to women in relation to abortion.

12.5.35 Such concerns have been raised elsewhere.[1248] The 2016 Queensland Parliamentary Committee received similar concerns including from the Australian Association of Social Workers who expressed concern that the absence of transparency in the philosophies of counselling services 'denies women the right to access non-judgemental and objective counselling services', while Cherish Life

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[1246] Ibid 124 [8.119].

[1247] Ibid 124 [8.120].

[1248] Senate Community Affairs Legislation Committee, Parliament of Australia, *Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005* (Final Report, 17 August 2006).

Queensland raised concerns about a potential conflict if the facility providing counselling would gain financially from the woman's decision.[1249]

12.5.36 As occurred during the VLRC's review,[1250] parties also reported concerns to SALRI regarding 'truth in advertising' for abortion-related counselling services.

12.5.37 Children by Choice observed that pregnancy counselling services in Australia are not legally required to disclose if they are run on an anti-abortion basis, and are not subject to trade practices laws that regulate misinformation and false advertising. They noted:

> This allows services to provide inaccurate and sometimes intentionally misleading information about abortion and its availability to women experiencing an unplanned or unwanted pregnancy. This can make it extraordinarily difficult for women and pregnant people to know that they are accessing a genuine all options service, and for medical professionals to be confident that is what they are referring patients to, particularly when the names of such services provide no hint of their position.[1251]

12.5.38 The National Association of Abortion and Pregnancy Options Counsellors submitted:

> … the quality and availability of appropriate counselling in Australia is unreliable. This is largely due to counselling in Australia not being government regulated. A large range of people are legally able to call themselves counsellors without appropriate qualifications or training. This has consequences for anyone seeking counselling and undermines the profession for those counsellors who are trained appropriately, access clinical supervision, who uphold and are guided by professional practice standards and ethics. There are a number of organisations that purport to provide counselling services to women facing unplanned or unwanted pregnancy in Australia. Colloquially known as false-providers or anti-choice providers, the aim of these false pregnancy counselling providers is to talk women out of abortion. They do so by providing misleading, inaccurate or false information about the option of abortion and will not provide information about where a woman can obtain information about abortion access. They use tactics that seek to shame, scare and manipulate women who contact them seeking support and information about abortion… anti-choice services should publicly state their anti-choice stance in all published materials so that any reasonable health-consumer would be able to determine whether or not the service is pro-choice. As the national advertising law stands, there is no requirement for purported pregnancy options services to be transparent about their stance on abortion.

12.5.39 Fair Agenda noted that some pregnancy-counselling services in Australia have previously been accused of misleading women, and promoting information that is incorrect or biased around

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[1249] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland* (Report No 24, 2016) 84 [15.2.1].

[1250] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 123 [8.107]. Susie Allanson, 'Pregnancy/abortion Counselling: False Providers, Mandatory Counselling' (2007) 19 *Women Against Violence: An Australian Feminist Journal* 5; 'anti-choice organisations (i.e. right to life/ pro-life) purport to provide pregnancy or post-abortion counselling to women. The goal of anti-choice 'counselling' is to ensure that a woman will continue her pregnancy and will not access abortion providing services, that is, false providers violate the most basic and central ethical and professional tenets of counselling, are not regulated by any credentialed professional body or legislature, and yet may receive a range of government funding.

[1251] Children by Choice provided as an example: 'Pregnancy Counselling Link is a service funded by the Queensland Government which offers "counselling by qualified professionals" and support with "difficult decisions" and "unplanned pregnancy" according to their website... Their "abortion information brochure" contains in small print at the bottom of the second page that "Pregnancy Counselling Link does not provide referrals for abortion". The brochure must be downloaded from their website as a pdf… and is not otherwise accessible. The information about refusal to refer is not stated in any other place on their website.'

abortion.[1252] Fair Agenda observed it was 'extremely concerned that if counselling or referral to counselling becomes legislatively mandated, that women may be directed to counselling services that provide biased information regarding pregnancy termination.'[1253] Women's Electoral Forum Australia supported 'laws requiring truth in advertising for pregnancy counselling services'. Kate Marchesi, drawing on her criticism of the role of 'sidewalk counselling',[1254] saw 'a desperate need for truth in advertising for pregnancy counselling to ensure that anyone considering seeking counselling is able to make an informed decision and is aware of the ideological stance of the body offering counselling.'

12.5.40 Australian Lawyers for Human Rights highlighted the issues surrounding truth in advertising for pregnancy counselling. They commented:

> Not all providers offering pregnancy counselling are qualified or supportive of all options. Pregnancy counselling should be independent, all options counselling by qualified counsellors. If counselling, or an offer of counselling is required, not only would this result in delay for the patient accessing pregnancy termination services, it would be necessary to ensure any counselling services that patients are referred to provide independent, all options counselling by qualified counsellors and are adequately resourced to meet these demands.

12.5.41 For example, Family Planning Alliance Australia stated:

> FPAA advocates for transparency in advertising for unintended pregnancy support services. Consumers may be unknowingly misled by promotional materials that do not disclose an organisation's 'pro-life' bias. FPAA believes that everyone has a right to access non-biased, non-judgmental information and support, and transparent advertising of support services is essential to this.

12.5.42 Pregnancy Help SA and others indicated concerns related to the transparency of services:

> The State Government should enact to change the name of South Australia's primary abortion clinic: the 'Pregnancy Advisory Centre'. The name should be changed to 'SA Abortion Services'. The current name 'Pregnancy Advisory Centre' is deceptive and very misleading.

12.5.43 The Women's Electoral Lobby noted: 'There is a distinct lack of legislative requirements for transparency in pregnancy counselling' and recommended the 'Introduction of laws requiring truth in advertising for pregnancy counselling services'. Likewise, the Coalition of Women's Domestic Violence Services recommended: 'pregnancy counselling organisations receiving government funding be required to publicly disclose if they are anti-abortion, and/or will not refer for abortion services'.

12.5.44 It is apparent that there is a link between counsellor qualifications, regulation and advertising of services, with those health practitioners registered with AHPRA, such as psychologists, being held to strict standards with regards to advertising. For those advertising a regulated health

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[1252] Bridie Jabour, 'Anti-Abortion Websites Masquerade as Pregnancy Counsellors', *The Guardian* (online, 4 September 2014) <https://www.theguardian.com/world/2014/sep/03/anti-abortion-websites-masquerade-as-pregnancy-counsellors>.

[1253] Fair Agenda also noted its concern that any requirements around counselling could create additional barriers and difficulties to access services. 'We note that in the United States mandatory counselling requirements have been used to shame women and make it more difficult to access abortion. In that context, counselling requirements have hit low-income people and those in rural areas particularly hard; because many families live hours from the nearest clinic, and attendance at a mandatory counselling appointment increases the costs, lost wages and time involved in getting the treatment they seek. Given the size of South Australia, and distance between many facilities, we imagine that similar challenges may be faced if such a requirement were put in place in South Australia. Finally, we note that any requirement to attend counselling could also pose additional barriers and distress at a later gestation if they delayed access to treatment, which may also be quite time sensitive'.

[1254] See below [12.5.51].

service under National Law, and practice guidelines, there is an obligation to use factual information in advertising. Specifically, 'Section 133 of the National Law prohibits advertising that: is false, misleading or deceptive or is likely to be so'.[1255]

12.5.45 Similarly, the Psychotherapy and Counselling Federation of Australia (PACFA) also provide guidelines to members regarding the advertising of their services.[1256] The organisation drew from the AHPRA guidelines and stated: 'Practitioners should consider whether their advertising is factual and verifiable and ensure that it does not breach the requirements of the PACFA Code of Ethics'. Specific information that they argued should be accurate and factual includes services offered and qualifications and experience.

12.5.46 Both the AHPRA and PACFA's guidelines also contain provisions relating to the use of scientific information in advertising. They state:

> To not mislead or create false impressions, caution should be taken when using scientific information in advertising. When a practitioner chooses to include scientific information in advertising, the information should: be presented in a manner that is accurate, balanced and not misleading; use terminology that is understood readily by the target audience; identify clearly the relevant researchers, sponsors and the academic publication in which the results appear, and; be from a reputable (eg peer reviewed) and verifiable source.[1257]

12.5.47 The issue of transparent advertising for pregnancy counselling has been previously considered in the Australian Senate as a 2005 Private Members Bill by Natasha Stott Despoja in 2005. The Bill sought to:

> prohibit misleading and deceptive notification and advertising of pregnancy counselling services, regardless of whether the service is provided free-of-charge or for a fee; promote transparency by mandating that pregnancy counselling services which do not refer for terminations of pregnancy must provide a statement to this effect in any advertising material; legislate that telephone carriage service providers may only list non-directive pregnancy counselling services on 24 hour health and help call pages.[1258]

12.5.48 The Transparent Advertising and Notification of Pregnancy Counselling Services Bill ultimately lapsed with concerns expressed that the Commonwealth may not possess the constitutional power to introduce such a law and that this was more appropriately left as a matter for the States. However, this Bill potentially contributed to the Commonwealth introducing a new Medicare item for pregnancy support counselling that commenced on 1 November 2006.[1259]

12.5.49 While the previous attempt to legislate transparent advertising of pregnancy options counselling did not proceed, parties both supportive and opposed to the decriminalisation of abortion

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[1255] Australian Health Practitioner Regulation Agency, *Guidelines for Advertising Regulated Health Services* (Code of Conduct, 2014) <https://www.ahpra.gov.au/Publications/Advertising-resources/Legislation-guidelines/Advertising-guidelines.aspx>.

[1256] Psychotherapy and Counselling Federation of Australia, *Guidelines for Advertising Counselling & Psychotherapy Services* (Code of Conduct, 2014) <https://www.pacfa.org.au/guidelines-for-advertising-therapeutic-services/>.

[1257] Australian Health Practitioner Regulation Agency, Guidelines for Advertising Regulated Health Services (Code of Conduct, 2014) 12 [7.6] <https://www.ahpra.gov.au/Publications/Advertising-resources/Legislation-guidelines/Advertising-guidelines.aspx>.

[1258] Senate Community Affairs Legislation Committee, Parliament of Australia, Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005 (Final Report, 17 August 2006) 1 [1.4].

[1259] See also above [12.2.8].

described a desire for women to have transparency about the attitudes towards abortion of those providing counselling services.

12.5.50 With regard to the nature of counselling, some parties maintained that 'sidewalk counselling'[1260] near premises providing abortion services is of benefit and should be permitted. Family Voice Australia, for example, argued that sidewalk counselling 'provides women with support and a last chance to seek out assistance during a difficult time' and should not be banned.[1261]

12.5.51 However, this view was widely challenged.[1262] Kate Marchesi, for example, was critical of the role and partiality of 'sidewalk counsellors':

> The claim of benign 'sidewalk counselling' is very disingenuous. The practice of unqualified people approaching women who are entering an abortion clinic and offering unwanted and often medically inaccurate advice couldn't be further from the definition of professional counselling. The principles of proper counselling require that it is independent, unbiased, and entered into freely by choice. On the contrary, the aim of 'sidewalk counselling' is plainly all about convincing someone not to have an abortion. Those who engage in this practice make claims like: 'We can help you. We can offer you support. We can offer you resources.' These 'counsellors' are hardly going to be there for the next 18 odd years to help financially support any child. There is a desperate need for truth in advertising for pregnancy counselling to ensure that anyone considering seeking counselling is able to make an informed decision and is aware of the ideological stance of the body offering counselling. It is especially upsetting to see 'sidewalk counsellors' target vulnerable women. One example [in Queensland] I witnessed was a woman who did not speak English as a first language and who assumed that the anti-abortion 'sidewalk counsellors' were connected with the clinic and were there to assist her in accessing the clinic.

12.5.52 SALRI does not necessarily agree with the benign categorisation of 'sidewalk counselling' and considers that it is one of the activities that it proposes should be capable of falling within its recommendations for safe access zones.[1263] It is also worth noting that permitting 'sidewalk counselling' appears at odds with submissions from parties both supportive and opposed to the decriminalisation of abortion that counsellors should be suitably trained and impartial. Sidewalk counselling, given its likely fundamental objections to abortion cannot realistically be regarded as 'impartial'.

Culturally appropriate pregnancy options counselling

12.5.53 It is important that any counselling in relation to abortion should be culturally appropriate to the woman seeking the service.

12.5.54 The Family Violence Legal Service Aboriginal Corporation SA stated that in addition to their view that independent, non-faith based, counselling services should be offered to all women before and after an abortion, it should be a legal requirement that counselling services be culturally appropriate.

[1260] 'Footpath counselling' (also referred to as 'sidewalk counselling') may include conduct such as handing out information, telling women entering the clinic that there is an alternative to termination, praying or proselytising. Footpath counsellors view themselves as providing support, assistance or an alternative to women and are generally opposed to terminations': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 155, n 1. SALRI does not doubt the sincerity of such groups but is unable to accept the benign categorisation of the effects of such conduct. See below [12.5.52], [18.6.3].

[1261] See also above [12.4.7]; below [18.3.22]–[18.3.23], [18.5.19]–[18.5.20], [18.5.48], [18.5.55].

[1262] See also below [18.3.24]–[18.3.25], [18.3.35]–[18.3.37], [18.5.15]–[18.5.16], [18.5.49]–[18.5.54],

[1263] See also below Part 18, especially [18.6.3], [18.6.19].

12.5.55 The VLRC supported culturally responsive and professional counselling:

> Counselling should be individually tailored to the needs of the woman and responsive to her cultural and social identity, economic or material circumstances, and personal values system… The ability of a woman to obtain counselling should not be constrained by her geographic location, disability, language, cultural background, or age. To achieve the goal of access and equity in service provision, more resources may be required. The commission encourages DHS to initiate the development of uniform standards of practice to inform pregnancy and abortion counselling services, and to encourage accountability and quality. These could potentially form part of a more comprehensive set of best practice standards. While such benchmarks are not a legal matter, they could promote best practice in the field.[1264]

12.5.56 The Australian Psychological Society, recommend cultural competence training, and in their ethical guidelines for the provision of psychological services for, and the conduct of research with, Aboriginal and Torres Strait Islander peoples, state:

> When providing psychological services to Indigenous clients, psychologists are aware of and sensitive to both cultural and contextual factors associated with Indigenous mental health, and social and emotional wellbeing. Where practical and/or when requested, psychologists seek guidance from an appropriate Indigenous cultural consultant. [1265]

12.5.57 Additionally, the Australian Psychological Society note:

> Psychologists are aware of, and show due acknowledgment and respect for, the value systems and authority structures operating in Indigenous communities. Psychologists recognise and value the strength and resilience of Indigenous peoples and communities. They are sensitive to their clients' wider responsibilities to kin, elders and community that operate in Indigenous cultures, and practise accordingly.[1266]

Mandatory viewing of an ultrasound

12.5.58 While not all content areas suggested for coverage during counselling require specific exploration, one such area that warrants further examination is the viewing of ultrasound images by a woman considering abortion. Several parties opposed to the decriminalisation of abortion contended to SALRI that this should be mandatory. Indeed, more than one medical practitioner told SALRI that they will show a woman the ultrasound in an effort to dissuade her from proceeding to an abortion.[1267] Both sides of the debate raised the issue of women viewing ultrasound images as part of counselling with opposing views reported.

12.5.59 Whilst Australian legal requirements do not require the viewing of an ultrasound, Advocates International described that in the United States, 'to ensure that women are properly informed about their pregnancy prior to abortion' in some States there are 'Ultrasound Before

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[1264] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 123–124 [8.111]–[8.115].

[1265] Australian Psychological Society, *Ethical Guidelines Aboriginal and Torres Strait Islander Peoples* (Code of Conduct, 2015) 10 [4.1].

[1266] Ibid 8 [2.2].

[1267] More than one medical practitioner opposed to the decriminalisation of abortion told SALRI that they viewed their medical role as validly extending to explaining the rationale of their conscientious objection and seeking to discourage the patient from proceeding with an abortion (this extended, SALRI heard, to even showing the patient an ultrasound to reinforce their discouragement). Any such conduct seems at odds with professional protocols and the notion of impartial and non-directional counselling or medical care. According to the AMA, the suggestion of a counsellor or medical practitioner showing (let alone this been mandated) a patient contemplating an abortion an ultrasound to discourage the patient is inappropriate.

Abortion Bills' where women are required to twice see the ultrasound before abortion. They described this process as follows:

> At least 24 hours before an abortion, the woman must receive from the abortion provider a list of places that offer free ultrasound services. If the woman returns, the abortion provider must perform an ultrasound at least 2 hours before the abortion to determine fetal viability and issues related to the woman's health. At that ultrasound, the woman must be read a script that gives her three options: to view the ultrasound screen; to hear an explanation of the images; or to get a print out of the image of her child in the womb. There is no such legal requirement in Australia. It is necessary that the mother and, if present, the father should understand that they have a live baby in the womb and the intention of the procedure is to remove the baby from the womb and end its life.

12.5.60 Parties such as Pregnancy Help SA, Advocates International, Cherish Life Australia and 40 Days for Life specified that viewing of ultrasounds prior to abortion should be mandatory. Pregnancy Help SA expressed that it should be 'mandatory that all women be required to have, and view, their ultra sound. This should not be done by the abortion provider, but by an independent body which does not carry a bias'. Advocates International recommended: 'Healthcare legislation should require medical practitioners to obtain and show an ultrasound of the child in the womb to the woman, as a precondition to fully informed consent.' 40 Days for Life similarly said counselling should include 'mandatory viewing of an ultrasound by the pregnant women (not turned away from the woman as at present) accompanied by a full disclosure of the status of the fetus, including gestation level, presence of organs etc.'

12.5.61 However, any suggestion of mandated showing of ultrasounds was strongly opposed in SALRI's consultation as inappropriate and coercive. Ms Marchesi described any such practice to SALRI as 'outright bullying' and a 'blatant effort in emotional blackmail' by 'a health practitioner taking advantage of a position of trust to impose their own moral views'. A lawyer similarly said: 'I do not agree with this at all. This is a very subjective subject matter and morally driven. These viewpoints should not enter the equation. This should be an objective analysis and take into account the big picture analysis of the many issues at interplay'. Reproductive Choice Australia acknowledged that the routine performance of ultrasounds was to confirm gestation and to assess medical complications such as ectopic pregnancy. However, they were adamant in their opposition to mandatory viewing of ultrasounds for women considering an abortion. They stated:

> There is no reason for the woman to be forced to view this. Such measures are designed only to distress and punish women and to coerce them to continue a pregnancy. Imagine compulsory viewing of ultrasound in a scenario where a woman who has been informed her planned, wanted pregnancy has resulted in catastrophic fetal abnormality, or that her own life is at stake if the pregnancy is not terminated. This is an already extremely distressing situation – to force a woman already distressed at losing a wanted pregnancy to view an ultrasound would be cruel in the extreme.

12.5.62 SALRI notes the strong criticisms that have been directed at laws in the United States requiring the showing of an ultrasound to women considering an abortion.[1268] SALRI shares the

[1268] See, for example, Caitlin Borgmann, 'Abortion, the Undue Burden Standard, and the Evisceration of Women's Privacy' (2010) 16 *William and* Mary Journal of Women and the Law 291, 312–315, 320, 322–323; Carol Sanger, 'Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice' (2008) 56 *University of California Los Angeles Law Review* 351; Nadia Sawicki, 'The Abortion Informed Consent Debate: More Light, Less Heat' (2011) 21 *Cornell Journal of Law and Public Policy* 1, 16–18; James Rocha, 'Autonomous Abortions: The Inhibiting of Women's Autonomy through Legal Ultrasound Requirements' (2012) 22(1) *Kennedy Institute of Ethics Journal* 35; Caroline Corbin, 'Compelled Disclosures' (2014) 65 *Alabama Law Review* 1277.

concerns over any suggestion (let alone law) to compel the showing of an ultrasound to women considering an abortion. Such a practice or law is inappropriate and coercive and undermines a woman's autonomy. As one author notes: 'Mandatory ultrasound laws… intrude upon a woman's decision-making about her pregnancy in an effort to convince her not to choose abortion.'[1269]

12.5.63 Carol Sanger argues:

> What then is the purpose of requiring ultrasound for women who do not intend to remain pregnant? The answer seems clear: to produce a confrontation, whether actual or notional, between the pregnant woman and her fetus that will result in a change of heart regarding the abortion… Whatever one's thoughts about abortion-and most people have thoughtful views on the subject-something about mandatory ultrasound seems intuitively unsavoury, a use of state power that is somehow both too intrusive and too transparently manipulative… mandatory ultrasound improperly burdens the ability of women to make decisions about abortion and does so in ways that far exceed other techniques of state persuasion such as informational brochures. Mandatory ultrasound disrupts the law's traditional respect for privacy, bodily integrity, and decisional autonomy in matters of such intimacy as reproduction, pregnancy, and family formation. It is harassment masquerading as knowledge.[1270]

12.5.64 SALRI accepts the cogency of such criticisms. It is inappropriate and coercive and also at odds with the modern concept of non-directional patient centred care for a health practitioner to show an ultrasound to a patient as part of an effort to convince them not to undertake an abortion.

Funding for pregnancy options counselling

12.5.65 Whilst it is acknowledged that non-directive pregnancy counselling services can be provided under Medicare and organisations such as Marie Stopes Australia, Birthline Pregnancy Support Inc and Genesis Pregnancy Support Inc provide services free of charge, some parties argued to SALRI that consideration should be given to ensure adequate funding exists for pregnancy-options counselling.

12.5.66 Reproductive Choice Australia maintained: 'Unbiased pregnancy options counselling should be adequately funded so as to be available to all women with a problem pregnancy.' The AMA(SA) similarly suggested sufficient funding should be made available for all services related to abortion. They stated:

> Clinical, counselling and information services should be adequately funded and made available in all regions of the state to ensure that individuals are able to access the information they need to make informed decisions and to procure from qualified medical practitioners the services they need to act on their decisions safely and without criminal penalty or social recrimination.

12.5.67 40 Days for Life also indicated that existing NGOs could provide comprehensive counselling services if provided with 'additional government funding' and that additional funding would allow organisations already working in the field 'to expand their services', while Family Voice Australia called for additional funding, stating: 'More government funding should be provided to pregnancy counselling services to better support women'.

12.5.68 SALRI accepts the benefit of high-quality, impartial, non-directive and non-mandated counselling but funding in this context is an issue with Commonwealth (noting Medicare) and State implications and is beyond the remit of this reference.

[1269] Caitlin Borgmann, 'Abortion, the Undue Burden Standard, and the Evisceration of Women's Privacy' (2010) 16 *William and Mary Journal of Women and the Law* 291, 314.

[1270] Carol Sanger, 'Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice' (2008) 56 *University of California Los Angeles Law Review* 351, 359–360.

12.6 SALRI's Observations and Conclusions

12.6.1 The notion of professional, impartial and non-directive counselling received virtually universal support in SALRI's consultation from parties both supportive and opposed to the decriminalisation of abortion. SALRI concurs with the QLRC and others that it is important that 'professional, unbiased, confidential and non-judgmental counselling' is available and accessible to women who are contemplating an abortion, contemplated but decided against an abortion, or underwent an abortion.[1271]

12.6.2 However, SALRI does not support any suggestion of mandated counselling or mandated offer of counselling. SALRI highlights the comments of Professor De Costa: 'Women may be offered counselling, but counselling should not be mandatory. Most women requesting early abortion have made an informed decision for themselves by the time they make their request and they do not wish or need to have counselling'.[1272]

12.6.3 SALRI agrees with the reasoning and conclusions of both the QLRC[1273] and VLRC[1274] that neither counselling, nor the offer of counselling[1275] should be mandated. As the VLRC found: 'Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm.'[1276] The VLRC concluded counselling is a 'clinical matter best left to professional judgment based on a woman's circumstances'[1277] and opposed any requirement for mandated counselling. SALRI finds the reasoning and conclusion of the VLRC compelling. SALRI considers that mandatory counselling or mandatory offer of counselling is both unnecessary[1278] and unhelpful. Any such requirement would merely create 'unnecessary delays and burdens'.[1279]

12.6.4 SALRI supports the position that counsellors offering and providing abortion counselling services should be appropriately qualified but does not support the suggestion that only members of the National Alliance of Abortion and Pregnancy Options Counsellors (without meaning any criticism of this association or its members) should be permitted to offer assistance in this area. To support this suggestion would prevent other suitably qualified counsellors from offering services, and in turn likely lead to delays in access to counselling.

12.6.5 Rather, SALRI recommends that high-quality, impartial and non-directive counselling be available to any woman who chooses to access it and that any such counselling should be provided

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[1271] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194 [6.16].

[1272] See also above n 1187.

[1273] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, June 2018) 194–195 [6.16]–[6.21].

[1274] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 126 Rec 5.

[1275] As one party told SALRI: 'I think that mandated offers of counselling and mandated requirements for counselling disrespect women and disrespect their own decision-making processes and their own values system'.

[1276] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 125 [8.125].

[1277] Ibid 126 [8.139].

[1278] SALRI notes the comments of the National Alliance of Abortion and Pregnancy Options Counsellors. 'There is no evidence that women take any decision about an unintended pregnancy in a rushed or unconsidered way. It is the experience of *NAAPOC* counsellors that women weighing up their pregnancy options do so in a considered and deeply thoughtful manner.'

[1279] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 18 (Adjunct Prof Deborah Bateson, Medical Director, Family Planning NSW). See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 194 [6.20].

within professional health settings by appropriately trained counsellors who are members, or eligible for membership, of their relevant health professional body. Counselling is preferably dealt with as a matter of clinical practice and individual preference than through any legislative requirement.

12.6.6 SALRI further agrees with the reasoning and conclusion of the VLRC and the New Zealand Law Reform Commission in relation to waiting or 'cooling off' periods. SALRI considers that any new law in South Australia should not contain a compulsory delay or waiting period before an abortion may be lawfully performed. Any such requirement is unnecessary and inappropriate and undermines the autonomy of the woman and appears designed to act as a barrier to accessing abortion than serve any positive purpose.

12.6.7 The adverse effects of any waiting period in the context of rural access and domestic violence are very significant. SALRI notes the recent comments to the NSW Legislative Council Committee, especially Ms Canning.[1280] The imposition of unnecessary mandatory counselling would further increase barriers to abortion for women in regional, rural, and remote communities, including and especially for Aboriginal women.

12.6.8 There was virtually universal support to SALRI for the notion of professional, impartial and non-directive counselling from parties both supportive and opposed to the decriminalisation of abortion. There was also support for the premise of 'truth in advertising'. However, parties disagreed on the role and content of counselling in relation to abortion and there were regular assertions that one proponent in the area was 'biased' and was not providing independent counselling.[1281]

12.6.9 SALRI acknowledges the concerns about the ambiguity that exists in the promotion and advertising of abortion-related counselling services. Given the varying attitudes to abortion held by counselling service providers, SALRI is of the view that counselling services should be required to be transparent about their underlying views when advertising and offering counselling services related to abortion, in order to enable the woman to make an informed decision about any counselling she may or may not choose to undertake.

12.6.10 SALRI, given the central features of patient autonomy and non-directional medical treatment or counselling in Australian health law and practice, concurs with Reproductive Choice Australia with regard to opposing any mandatory requirement for women to view an ultrasound prior to abortion. Indeed, such a practice to pressure women in itself raises concern, in the absence of any legislative or other requirement.

12.6.11 SALRI supports the notion that counselling services should be culturally sensitive and appropriate. SALRI particularly acknowledges the importance of access to culturally appropriate counselling services for members of Aboriginal communities.

12.6.12 SALRI supports the views of the Australian Psychological Society with regards to providing culturally appropriate counselling services to Aboriginal communities and believes such an approach can apply to all counsellors.

[1280] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 8 (Ms Sinead Canning, Campaign Manager, NSW Pro-Choice Alliance).

[1281] A senior specialist obstetrician drawing on their wide experience told SALRI that they had encountered 'very directional counselling' working both ways to persuade a woman to have or not have an abortion. Such counselling may 'put a lot of their own bias in it'.

12.6.13 Recommendations

Recommendation 26

SALRI recommends that any new abortion law in South Australia should not contain mandated information provisions.[1282]

Recommendation 27

SALRI recommends that there should not be any further requirements beyond existing general health law and practice in any new law in South Australia for informed consent by the woman to have an abortion.[1283]

Recommendation 28

SALRI recommends that any new law in South Australia should not contain a compulsory delay or waiting period before an abortion may be lawfully performed.

Recommendation 29

SALRI recommends that high-quality, impartial and non-directive counselling should be available to any woman who chooses to access it and that any such counselling should be provided within professional health settings by appropriately trained counsellors who are members, or eligible for membership, of their relevant health professional body.

Recommendation 30

SALRI acknowledges the benefit of impartial and non-directional counselling in the context of abortion, but it should be for the woman concerned to decide on receiving or undertaking any counselling and who she chooses to see, or not see. SALRI recommends any new law should not contain a requirement for mandatory counselling or mandatory referral to counselling.

Recommendation 31

SALRI acknowledges concerns about the ambiguity that exists in the promotion and advertising of abortion-related counselling services. Given the varying attitudes to abortion held by counselling service providers, SALRI recommends that counselling services should be required to be transparent about their underlying views when advertising and offering counselling services related to abortion, in order to enable the woman to make an informed decision about any counselling she may or may not choose to undertake.

[1282] This recommendation is not intended to impede patients continuing to receive the product disclosure material for medication and information as to the treatments to be performed and potential side effects as would be provided with any other medical prescription or surgical procedure. It is also not intended to impede the provision of culturally appropriate information.

[1283] Informed consent is already an integral aspect of health law and practice in South Australia to the performance of any medical procedure, including an abortion. Any specific legislative requirement for informed consent to abortion is unnecessary, if not unhelpful. See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Rogers v Whitaker* (1992) 175 CLR 479.

Recommendation 32

SALRI supports the notion that counselling services should be culturally sensitive, appropriate and competent for all cultural groups. In particular, SALRI recommends that counsellors providing abortion-related counselling to Aboriginal women have undertaken cultural awareness training, are sensitive to cultural and contextual factors, and the values systems and authority structures of Aboriginal communities, and provide services in a flexible manner so as to meet the cultural needs of Aboriginal women who may choose to access high-quality, impartial and non-directive counselling.

Part 13 - Disability

13.1 Introduction[1284]

13.1.1 A particular area of sensitivity that has consistently troubled law reform agencies as well as many parties in this reference relates to the various implications of abortion in a disability context. This is raised in South Australia by s 82A of the *CLCA* which provides that it is a defence if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman, that there is a 'substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such *physical or mental abnormalities* as to be *seriously handicapped*.'[1285] These terms (as in the UK Act) are undefined. This provision is based on the *Abortion Act 1967* (UK).[1286]

13.1.2 There are four primary concerns raised within the abortion and disability context:

1. The role and implications of prenatal screening;[1287]
2. The role of abortion as a vehicle to potentially perpetuate discrimination against persons with disability;
3. The operation of international human rights in this area; and
4. The exercise of reproductive autonomy for women with a disability.[1288]

13.1.3 SALRI accepts that these concerns reflect only four of the many issues raised in this reference that have implications in a disability context. There was universal acknowledgement to SALRI that this is a highly sensitive area. The exercise of a woman's reproductive autonomy acknowledges the disability issues raised, as the decision to have an abortion requires careful consideration and availability of appropriate and tailored (though not mandated) counselling should a woman choose to access it. However, the prevailing (though not universal) view in SALRI's consultation was that ultimately the autonomy of the woman is paramount but that specific legislative grounds for lawful abortion based on disability are both discriminatory and unnecessary. Rather the

[1284] SALRI is grateful for the generous input of Olga Pandos and representatives of the disability sector to this Part.

[1285] The construction of s 82A(8) and its application to late term abortion is another factor to be considered. See above Part 11. Western Australia includes similar language, with reference to a 'severe medical condition' in the *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3). New Zealand's current abortion law allows abortion up to 20 weeks gestation if there is a substantial risk that the child, if born, would be 'so physically or mentally abnormal as to be seriously handicapped': *Crimes Act 1961* (NZ) s 187A(1)(aa).

[1286] A medical scientist told SALRI in consultation that this similar provision in the 1967 UK abortion law arose from the thalidomide tragedy of the late 1950s and early 1960s, where the drug was prescribed for nausea in pregnant women resulting in some babies being born with birth defects (including some being born without limbs).

[1287] SALRI is not considering the specialist area of Pre-Implantation Genetic Diagnosis (PGD) in light of the growing body of literature relevant to this specific area. Future work should consider the impact of PGD on disability rights.

[1288] See also below Part 19.

difficult question of whether to have an abortion on the ground of fetal abnormality[1289] should be left to general law and practice (whatever approach is ultimately adopted) to deal with this issue.[1290]

13.2 Current Law

13.2.1 The present law in South Australia allows an abortion if the child would suffer from such *physical or mental abnormalities* as to be *seriously handicapped*. This aspect raised extensive concern in SALRI's consultation, consistent with wider research,[1291] from parties both in favour and adverse to the decriminalisation of abortion. Indeed, there was a large degree of consensus that the present provision is outdated and, whatever else may happen in this area, this provision should be repealed.

13.2.2 The terms 'physical or mental abnormalities' and 'seriously handicapped' and their implications are problematic in various respects.[1292] There are two preliminary concerns with this provision.

13.2.3 The first preliminary concern is the language, which SALRI was often told (notably at the roundtable session with the disability sector), is outdated and now regarded as offensive. The Australian Christian Lobby noted that the term 'abnormality' is 'problematical because it has a pejorative import which can lead to a conclusion that the interests of the child are deserving less consideration than a child without "abnormalities"'. They emphasised 'the offensive language in the section and the harm that does to people with disability' and the use of terms like 'abnormalities' and 'seriously handicapped' are 'outdated and reflect a medical model of disability'. Australian Lawyers for Human Rights pointed out that the *CRPD* adopts 'a social model of disability' where 'disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'.[1293] Australian Lawyers for Human Rights noted that language that is inconsistent with this social model is unacceptable.

[1289] SALRI, drawing on the VLRC, adopts the term 'fetal abnormality' as it is used by medical practitioners to indicate a positive test for genetic conditions, and in doing so, reiterates that it does not wish to suggest that a fetus diagnosed with a genetic condition is 'abnormal'. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 5.

[1290] This accords with the approach of both the VLRC and QLRC. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 46 [3.94]–[3.95]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 97–101 [3.195]–[3.213].

[1291] See Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) [5.41]–[5.46], [3.64]–[3.95], 78 [5.59]–[5.62]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 83–85 [3.133]–[3.140], 98-99 [3.202]; New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 59–60 [3.47]–[3.52], 179–181 [12.21]–[12.29].

[1292] See, for example, Julian Savulescu, 'Is Current Practice Around Late Termination of Pregnancy Eugenic and Discriminatory? Maternal Interests and Abortion' (2001) 27 *Journal of Medical Ethics* 165; Sally Sheldon and Stephen Wilkinson, 'Termination of Pregnancy for Reason of Fetal Disability: Are there Grounds for a Special Exception in Law?' (2001) 9(2) *Medical Law Review* 85; Rosamund Scott, 'Interpreting the Disability Ground of the Disability Act' (2005) 64(2) *Cambridge Law Journal* 388; Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 12 (1) *University of New South Wales Law Journal Forum* 42 ; Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207; Sheelagh McGuinness, 'Law, Reproduction and Disability: "Fatally Handicapped"' (2013) 21(2) *Medical Law Review* 213.

[1293] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) preamble e.

13.2.4 The second preliminary concern is that the definition or concept of a 'serious disability' is undefined.[1294]

13.2.5 The sensitive issue of abortion on the basis of disability and the notion of serious disability were addressed in the UK case of *Jepson v Chief Constable of West Mercia*[1295] in relation to the performance of an abortion post 24 weeks gestation following the diagnosis of a bilateral cleft lip and palate.[1296] The abortion was performed under the similar UK law as South Australia. The authorities declined to prosecute the medical practitioners involved and stated that the abortion had been lawfully performed. Rev Jepson[1297] sought judicial review and challenged the decision not to prosecute.[1298] Jackson J and Rose LJ granted leave for the application as to whether the decision should be reconsidered. They noted that a definition of serious handicap was not available to practising medical practitioners. Jackson J noted that Jepson faced 'substantial evidential hurdles and substantial legal hurdles' to bring her claim but it was not precluded.[1299] Jackson J and Rose LJ held that the case raised significant legal and policy issues, which were of great public importance and which ought to be examined.[1300]

13.2.6 This case highlighted problems in the law,[1301] including the lack of clarity as to the term 'serious disability' and the need for a clear and comprehensive definition. Although the definition of a serious handicap was ultimately not resolved or clarified in *Jepson*,[1302] the court questioned whether a cleft lip and palate constituted a 'serious handicap' under the English law.[1303]

[1294] *Jepson v Chief Constable of West Mercia* [2003] EWHC 3318. See also Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap"? *Jepson v Chief Constable of West Mercia:* A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 290; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 83–84 [3.137].

[1295] *Jepson v Chief Constable of West Mercia* [2003] EWHC 3318.

[1296] See also Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap"? *Jepson v Chief Constable of West Mercia*: A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 290.

[1297] The claimant 'is a Church of England curate who was herself born with a significant facial impairment, which has been successfully treated. She is also opposed in principle to abortion. The claimant came to learn of the Birmingham case through reading the abortion statistics for 2001, as published by HMSO. The claimant considered that cleft lip and palate could not amount to a serious handicap within the meaning of section 1(1)(d) of the *Abortion Act 1967*, and that accordingly the abortion must have been unlawful': *Jepson v Chief Constable of West Mercia* [2003] EWHC 3318, [2].

[1298] [2003] EWHC 3318, [15]. The English courts, unlike Australia (see *Maxwell v R* (1996) 184 CLR 501), allow the judicial review of prosecution decisions not to prosecute on principles of administrative law but it has been often emphasised that this is an 'exceptional' remedy (see *R (L) v DPP* [2013] EWHC 1752 (Admin); *R (Monica) v Director of Public Prosecutions* [2018] EWHC 3508 (Admin)). To add to Jepson's difficulties were the court's understandable qualms to overturn the view of medical practitioners in such a contentious area. 'Not only would it be a bold and brave judge… who would seek to interfere with the discretion of doctors acting under the *Abortion Act 1967* (UK), but I think he [or she] would really be a foolish judge who would try to do any such thing, unless, possibly, where there is clear bad faith and an obvious attempt to perpetrate a criminal offence': *Paton v BPAS Trustees* [1979] QB 276, 282 (Baker P). See also *C v S* [1988] QB 135, 153.

[1299] [2003] EWHC 3318, [15].

[1300] Ibid [16].

[1301] See, for example, See Rosamund Scott, 'Interpreting the Disability Ground of the Abortion Act' (2005) 64(2) *Cambridge Law Journal* 388; Anna Grear, 'The Curate, a Cleft Palate and Ideological Closure in the Abortion Act 1967: Time to Reconsider the Relationship between Doctors and the Abortion Decision' (2004) 4 *Web Journal of Current Legal Issues;* Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap"? *Jepson v Chief Constable of West Mercia*: A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 290.

[1302] The CPS, 'following an extensive review of evidence of various kinds', in due course confirmed that it would not prosecute the medical practitioners and Jepson declined to pursue her challenge. See Rosamund Scott, 'Interpreting the Disability Ground of the Abortion Act' (2005) 64(2) *Cambridge Law Journal* 388, 388–389.

[1303] See *Abortion Act 1967* (UK) s 1(1)(d). See also Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap*"? Jepson v Chief Constable of West Mercia*: A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 290.

13.2.7 Both the House of Commons and House of Lords have also raised that the scope and intention of this term needs further scrutiny. UK parliamentary debates noted the absence of any clear guidance as to the term 'serious handicap' may result in abortions 'to destroy… [a fetus] for any reason at all, from hare lip to hair colour'.[1304] The House of Lords identified that the legislative grounds for an abortion owing to a 'serious handicap' means a 'severely damaged' child, who 'cannot lead a meaningful life'.[1305]

13.2.8 The New Zealand Law Commission also raised the issue of the varying degrees of disability.[1306] The Commission's consultation found a fear of abortions being performed for fetal abnormalities that some may consider 'insufficiently severe to justify abortion'.[1307] It raised a cleft lip and palate or a club foot as examples of a disability which may be considered 'insufficiently severe' to warrant abortion.[1308]

13.2.9 SALRI's consultation also revealed the difficulty in identifying degrees of disability and that the perception of a disability is inherently subjective. What may be viewed as a serious disability to one person, may not to be to another. More than one medical practitioner acknowledged to SALRI that they have felt personal unease on occasion about performing an abortion in the case of an 'insufficiently severe' disability and that they may not have reached that same conclusion had they been in the position of the woman and her partner.[1309] However, these medical practitioners also emphasised that degrees of disability are inherently subjective and different views will be taken by different persons.

13.2.10 SALRI was further told that what may be viewed as a serious disability in a remote or rural location without local specialist support, may not be viewed as such in a metropolitan location with access to appropriate medical care and support. These practitioners added that the woman's autonomy remains paramount and it would be wrong for them to usurp the woman's decision and impose their perception and one should not underestimate the effect on a particular woman's health that having a child with disability would be likely to produce.

13.2.11 It is clear that, apart from the objectionable and outdated terminology, the notion of 'serious handicap' (especially noting the absence of any definition) in itself is elusive and subjective.

13.3 **Other Issues**

13.3.1 However, there are wider concerns with this aspect of the present law. The provision has been criticised as 'a relic of an overly medicalised approach to disability and abortion'.[1310] The reference to 'seriously handicapped' may distinguish a fetus based on characteristics aligned with society's

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[1304] Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap"? *Jepson v Chief Constable of West Mercia*: A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 293, quoting United Kingdom, *Parliamentary Debates*, House of Commons, 21 June 1990, vol 174, col 1188 (Frank Doran).

[1305] Grant Gillett, 'Is a Cleft Lip and Palate a Serious "Handicap"? *Jepson v Chief Constable of West Mercia*: A Legal and Ethical Critique' (2014) 22 *Journal of Law and Medicine* 293, quoting United Kingdom, *Parliamentary Debates*, House of Lords, 18 October 1990, vol 522, col 1075 (Baroness Warnock).

[1306] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 179.

[1307] Ibid 180 [12.24].

[1308] Ibid.

[1309] One medical practitioner noted the example of a missing digit as where the parents had sought an abortion.

[1310] Sheelagh McGuinness, 'Law, Reproduction and Disability: "Fatally Handicapped"' (2013) 21(2) *Medical Law Review* 213.

concept of 'normal' and 'abnormal'. This creates an ethical dilemma, in that access to a lawful abortion is contingent upon the fetus having a 'disability'.[1311]

13.3.2 From a policy perspective, the South Australian provision may be said to promote the notion that a fetus with a disability is 'intrinsically less valuable' than a healthy fetus.[1312] This theme was strongly raised to SALRI, especially at the roundtable with the disability sector.

13.3.3 The disability specific provision gives the 'dangerously false impression that abortion law concerns the fetus when it does not'.[1313] The VLRC noted that a law 'that specifically allows abortion for fetal abnormality is open to criticism for devaluing the existence of people who live with disabilities'. [1314] The UK Disability Rights Commission has argued that 'it reinforces negative stereotypes of disability'.[1315] The inclusion of a disability specific provision as in the present law raises concerns of selective abortion and the erosion of disability rights. It also arguably detracts from the need for any abortion law to be primarily concerned with the reproductive autonomy of the woman.

13.3.4 A vital underlying issue in regard to abortion and disability remains the autonomy of the woman. The premise remains that of reproductive autonomy and self-determination, in that a woman should be free to decide which course of action and medical procedures or treatments to pursue.[1316] This theme also widely emerged in SALRI's consultation. Australian Lawyers for Human Rights, for example, supported laws which safeguard reproductive health rights, allowing women to exercise autonomy over their own body. 'Bodily autonomy is an essential human right and women must have the power to decide whether and when they will have children and the manner of their birth and upbringing.' Australian Lawyers for Human Rights and parties in the disability sector highlighted to SALRI that this position applies to all women, including, and especially, women with disabilities.

13.3.5 However, this right to reproductive autonomy may be at odds with disability rights and the concern of 'eugenic' practices.[1317] Petersen described the varying tensions:

> … the decision to abort [following a diagnosis of fetal impairment] does not necessarily reflect a societal policy of trying to prevent the birth of persons with disabilities. Rather, it might reflect compassion for the pregnant woman, respect for her right to physical autonomy, or recognition that she is in the best position to determine whether she should continue the pregnancy. However, many disability rights scholars and activists would argue that society does not simply allow pregnant women to make their own decisions. Instead, the medical profession and other powerful

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[1311] Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207.

[1312] Ibid; New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 59–60 [3.47]–[3.52], 179–181 [12.21]–[12.29].

[1313] Kate Gleeson, 'Bracket Creep in Australian Abortion Indications: When did Rubella Arrive?' (2007) 15 *Journal of Law and Medicine* 423, 433.

[1314] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.91]. See also Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 12 (1) *University of New South Wales Law Journal Forum* 42.

[1315] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.91].

[1316] A strong theme, especially from parties supportive of the decriminalisation of abortion, is the importance of the woman's autonomy in the context of abortion. See also above [1.3.35]–[1.3.39].

[1317] See, for example, Emily Jackson, 'Abortion, Autonomy and Prenatal Diagnosis' (2000) 9(4) *Social and Legal Studies* 467; Marsha Saxton, *'Why Members of the Disability Community Oppose Prenatal Diagnosis and Selective Abortion*' in Erik Parens and Adrienne Asch (eds), *Prenatal Testing and Disability Rights* (Georgetown University Press, 2000) 147 164; Marsha Saxton, 'Disability Rights and Selective Abortion' in Leonard Davis (ed), *The Disability Studies Reader* (Routledge, 2nd ed, 2006) 105–116; Rosamund Scott, 'Prenatal Testing, Autonomy and Reasons: The Relationship between the Law of Abortion and Wrongful Death' (2003) 11 *Medical Law Review* 265.

institutions actively encourage disability-selective abortion by recommending genetic screening and prenatal testing and then counselling prospective parents in a manner that discourages them from continuing a pregnancy if the tests reveal fetal impairment.[1318]

13.4 The Notion of Disability

13.4.1 The concept and definition of disability is elusive with differing views.[1319] It is unrealistic to formulate a concise definition of 'disability'. Rather, disability is a social, medical, legal and political construct.[1320] The specific construct to be applied in any given context, will then dictate how the issue of disability should be addressed.

13.4.2 The precise meaning of 'disability' has considerable weight in any consideration of the law in the area of abortion, raising issues concerning the extent and seriousness of the disability.

13.4.3 Two main models of disability, the Medical Model and the Social Model,[1321] are important to consider in the context of the four primary concerns related to disability and abortion. A brief discussion of these models highlights the complexity of disability and provides insight into the negative connotations traditionally attached to disability.

Medical Model

13.4.4 This model indicates disability is a 'harmful condition', inherent within the individual.[1322] From a medical viewpoint, disability is characterised as 'an abnormality of form or function, the cause of which lies in the biology of the individual'.[1323] This definition is said to perpetuate the negative stigma traditionally attached to disability and to make a value statement regarding capacity and ability to enjoy life. Commentators such as Harris, argue disability is a condition which an individual 'has a strong rational preference not to be in'.[1324] This definition is problematic, raising eugenic overtones and associating disability as a disadvantage, which needs to be avoided.[1325] Harris, in response to criticisms, emphasised that an individual 'harmed' by a disability does not derogate from their status as equal individuals in society.[1326] Harris noted that 'no disability however slight nor however severe implies

[1318] CJ Petersen, 'Reproductive Justice, Public Policy, and Abortion on the Basis of Fetal Impairment: Lessons from International Human Rights Law and the Potential Impact of the Convention on the Rights of Persons with Disabilities' (2015) 28(1) *Journal of Law and Health* 121, 137.

[1319] One of the authors of this Report was closely involved with the South Australian *Disability Justice Plan* and can confirm this from previous work in this area.

[1320] See, for example, Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915; Kristin Savell and Isabel Karpin, 'The Meaning of "Serious Disability" in the Legal Regulation of Prenatal and Neonatal Decision-Making' (2008) 16 *Journal of Law and Medicine* 233, 245.

[1321] See generally Deborah Kaplan, 'The Definition of Disability: Perspective of the Disability Community' (2000) 3 *Journal of Health Care Law and Policy* 352; Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193.

[1322] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915; Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193, 194–195.

[1323] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915.

[1324] Ibid 916. See also John Harris, 'One Principle and Three Fallacies of Disability Studies' (2001) 27 *Journal of Medical Ethics* 383, 384.

[1325] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915, 916.

[1326] John Harris, 'One Principle and Three Fallacies of Disability Studies' (2001) 27 *Journal of Medical Ethics* 383, 384.

lesser moral political or ethical status, worth or value'.[1327] Despite this, the medical model has been criticised for its emphasis on 'harm' and implying a need for medical treatment.[1328] The medical model labels individuals with disability as 'the other', creating a discriminatory delineation between 'normal' and 'abnormal'.

Social Model

13.4.5 In contrast, the social model recognises social and environmental impacts as the driving force influencing attitudes toward disability.[1329] It is based on the idea that disability is 'located outside the body' and negative experiences are caused in society by 'social barriers and discriminatory attitudes'.[1330] One commentator noted that the social model:

> [S]ignals that the experience of disabled people is dependent on social context, and differs in different cultures and at different times. Rather than disability being inescapable, it becomes a product of social arrangements and can thus be reduced, or possibly even eliminated.[1331]

13.4.6 This distinction between biological causes of disability and the social/environmental impacts of having a disability are important and absent from the medical model. Further, the social model does not equate disability with impairment.[1332] Rather, the model argues having a disability can be 'disadvantageous in a non-inclusive society'.[1333] The social model of disability, as SALRI was told by Australian Lawyers for Human Rights and the disability sector underpins international human rights law in this area, especially the *CRPD*.

13.4.7 Criticisms of the social model relate to its ideology surrounding impairment. [1334] Shakespeare, for example, argues the model suggests that impairment is not a medical issue and fails to recognise the subjective nature of disability and individual experience.[1335] The nature and clinical implications of a disability lie on a spectrum. A model which recognises the medical implications, personal experience and social barriers perpetuating discrimination and stigma, must be adopted.

[1327] Ibid 383.

[1328] I Brittain, 'Perceptions of Disability and Their Impact Upon Involvement in Sport for People with Disabilities at All Levels' (2004) 28 *Journal of Sport and Social Issues* 429, Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915, 916; Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193, 196.

[1329] Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193, 196–197. See generally Mike Oliver, 'The Social Model of Disability: Thirty Years On' (2013) 28 *Disability and Society* 1024.

[1330] Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193, 196–197; Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915, 916.

[1331] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 Journal *of Law and Medicine* 915; Tom Shakespeare, *Disability Rights and Wrongs* (Routledge, 2006) 29.

[1332] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915, 916.

[1333] Ibid 917.

[1334] Justin Haegele and Samuel Hodge, 'Disability Discourse: Overview and Critiques of the Medical and Social Models' (2016) 68(2) *Quest* 193, 197–198

[1335] Michelle de Souza, 'Regulating Preimplantation Genetic Diagnosis in Australia: Disability and Parental Choice' (2015) 22 *Journal of Law and Medicine* 915, 917–918.

13.4.8 These models inform society's views and attitudes to disability, which is a key tenet in relation to disability and abortion. It provides context and insight into the reasons why individuals perceive disability in different ways.

13.4.9 Three of the four primary concerns raised within the abortion and disability context, namely prenatal screening, disability selective abortions and international human rights,[1336] are examined in turn below.

13.4.10 The importance of recognising and respecting reproductive autonomy for women with disability was emphasised to SALRI by various parties such as the Equal Opportunity Commissioner and Australian Lawyers for Human Rights and at SALRI's roundtable with the disability sector.

13.4.11 This theme was also raised to the VLRC:

> There was specific concern that the decision-making capacity of women with a disability be respected. Negative stereotypes about the parenting abilities of people with a disability, together with attitudes that question the capacity of women with a disability to make reproductive decisions, were identified. The Victorian Women with Disabilities Network also expressed concern that there may be coercion to continue with a pregnancy from groups opposed to abortion.[1337]

13.4.12 The Victorian Women with Disabilities Network and the Centre for Reproductive Rights emphasised to the VLRC that the exercise of reproductive autonomy for all women, including women with disability, must be safeguarded.[1338] The Centre for Disability Law and Policy has recently reiterated that law and practice must 'ensure respect for reproductive autonomy', so that a human rights approach to abortion should not limit access in any way.[1339] Amnesty International has also advocated against abortion on the basis of disability and has called for 'a legal and medical framework for abortion that respects the reproductive rights and decisions of women and girls'.[1340] Furthermore, Amnesty International proposed that:

> The best way for governments to promote the rights of people with disabilities and combat discrimination against them is to put into place laws and policies that support the autonomy and rights of all people with disabilities… This includes providing families with the correct information

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[1336] The fourth concern of coercion and capacity in relation to women with disability is discussed below in Part 19.

[1337] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 137 [8.238].

[1338] See Centre for Disability Law and Policy, Submission to Committee on the Rights of Persons with Disabilities, *General Comment on Article 6: Right to Life*, June 2015, 4. See, for example, Human Rights Committee, *Views: Communication No 1608/2007*, 101st sess, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011) ('*LMR v Argentina*'). This case concerned a young pregnant woman with an intellectual disability which rendered her mental age between 8 to 10 years. It was held that her inability to obtain a lawful abortion violated Article 7 of the *ICCPR* ('No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'). The court held 'the State's failure to exercise due diligence in safeguarding a legal right to a procedure required solely by women, coupled with the arbitrary action of the medical staff, resulted in discriminatory conduct that violated LMR's rights. In relation to article 7, forcing LMR to continue with her pregnancy, when she should have been afforded protection was held to be cruel and inhuman treatment. This case indicated 'the court will analyse the right of a person with a disability under Article 7 in a way which heightens the recognized impact of the violation': Ibid. This case highlights the importance of implementing safeguards for women with disabilities, especially in the context of abortion.

[1339] Centre for Disability Law and Policy, *Submission to the Citizens' Assembly on Repeal of the Eighth Amendment to the Constitution* (December 2016) 7.

[1340] 'What is Amnesty International's position on abortion on the basis of disabilities?', *Amnesty International* (Web Page)<https://www.amnesty.ie/abortion-faq/>.

and support they need to raise children with disabilities and ensuring that people with disabilities can participate as equal members of society.[1341]

13.4.13 A concern raised to SALRI, notably at the roundtable with the disability sector, is the risk of negative stereotypes and coercion on women with disability to undertake an abortion and the need to recognise the capacity and choice of women with disability and the role of wider education and other changes.[1342] This point was emphasised, for example, by the Equal Opportunity Commission.[1343]

13.4.14 These views are consistent with the United Nations Committee on the Rights of Persons with Disabilities, who concluded:

> It is particularly important to reaffirm that the legal capacity of women with disabilities should be recognised on an equal basis with that of others and that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children.[1344]

13.4.15 The importance of reproductive autonomy for women with disability was often pointed out to SALRI by many parties both supportive and opposed to the decriminalisation of abortion. It was also emphasised by the disability sector.

[1341] Ibid.

[1342] 'Women with disabilities may also be denied access to information and communication, including comprehensive sexuality education, based on harmful stereotypes that assume that they are asexual and do not therefore require such information on an equal basis with others. Information may also not be available in accessible formats. …. including safe abortion and post-abortion care': Committee on the Rights of Persons with Disabilities, *General Comment No. 3 (2016) On Women and Girls with Disabilities*, UN Doc CRPD/C/GC/3 (2 September 2016) [40].

[1343] The insightful submission to SALRI from Ms Tricia Spargo, Manager of Policy on behalf of the Office of the Commissioner for Equal Opportunity, for example, commented:

> 'The concern is that moving to an individualist model of autonomy, that says that the woman gets to decide the basis for carrying on with the pregnancy or not, presents a real challenge to prospective parents living with disability. We have to acknowledge that… people with disability face discrimination in many aspects of their lives including sexual and reproductive health. This discrimination is widespread and rooted in disability stigma and harmful stereotypes that perpetuate ideas that the lives of people with disability are less valued or that they lack agency to decide on their own lives and futures. Throughout history, people with disability, particularly women and girls with disability, have been targeted by eugenics policies and forced or coerced into not reproducing; denied their bodily, sexual and reproductive autonomy; and prevented from accessing the information, education and means to exercise their sexual and reproductive rights. [There are] … various forms of pressure that can affect a woman's ability to choose according to her value system. Even if such pressure is not directly coercive, it can influence a woman's decisions indirectly — alternatives are structured in such a way that certain options are never considered as viable, while other decisions must be made. We have to ensure that providers are offering evidence-based information to pregnant people neutrally and without bias during the prenatal screening and diagnostic process. Professional and ethical standards and medical education must ensure that providers are trained on the rights and lived experiences of people with disability or are able to refer to relevant people who can provide this information. Also, we must support the autonomy and self-determination of women and girls with disability (including those with restricted legal capacity), to decide on matters related to their reproductive health, including whether to continue pregnancies. For some providers, this may involve developing robust supported decision making policies and processes… The only way of supporting all prospective parents with disability to make informed decisions about continuing or terminating their pregnancies is through affirmative measures, such as combating stereotypes in prenatal screening and diagnostic and counselling processes, ensuring all parents are operating in an enabling environment and have the social and economic supports they need to raise any child (including a child with disability), and promoting the rights and inclusion of people with disability in all spheres of public and private life.'

[1344] Ibid 36.

13.5 Prenatal Screening

13.5.1 Medical advances enable routine prenatal screening to detect and diagnose conditions which may result in disability after birth.[1345] Prenatal screening 'is a routine aspect of antenatal care, offered to all women'.[1346] This testing allows women to make an informed decision about continuing with their pregnancy if there is a diagnosis of fetal abnormality.[1347] An important consideration that may be overlooked is the way in which future parents perceive a diagnosis — 'what is critical is the perception of the relevant diagnosis and what it means for them'.[1348]

13.5.2 The role and benefits of prenatal testing are clear. However, such testing poses questions of disability rights. The concept of 'disability' often informs important medical decisions, including abortion following prenatal diagnosis.[1349] It has been suggested that a holistic view should be taken when assessing the implications of abortion on individuals living with a disability. In the event a genetic abnormality is detected, the way in which the fetus is viewed arguably undermines the status of people living with a disability.[1350] It has been suggested that prenatal screening may promote the practice of 'selective abortion' by identifying a fetus with an abnormality, which is then viewed as an acceptable justification to seek an abortion.[1351] One commentator explains:

> … interest in the moral legitimacy of a woman's reasons for wanting to terminate her pregnancy seems to be intensifying. Concerns arising from the increasing availability of precise prenatal tests have led to suggestions that access to abortion should be further restricted in order to prevent the cavalier use of abortion for reasons that might seem trivial or misguided.[1352]

13.5.3 Despite these arguments, prenatal screening is widely perceived as promoting informed decision making and reproductive autonomy, suggesting 'abortion is a legally and morally defensible means of exercising that right'.[1353]

What is Prenatal Screening?

13.5.4 Various methods of screening are now available to ascertain whether a fetus has a higher risk of carrying a genetic defect.[1354] Following screening, diagnostic tests can be undertaken to definitively diagnose specific defects. Such testing is now routine and promotes informed reproductive

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[1345] SALRI did hear accounts in consultation of some parents who make a conscious decision not to utilise such testing.

[1346] Philip Baker (ed), *Obstetrics by Ten Teachers* (Oxford University Press, 18th ed, 2006) 105.

[1347] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 42 [3.69].

[1348] This was stated to SALRI by a senior specialist.

[1349] Kristin Savell and Isabel Karpin, 'The Meaning of "Serious Disability" in the Legal Regulation of Prenatal and Neonatal Decision-Making' (2008) 16 *Journal of Law and Medicine* 233.

[1350] Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207, 216.

[1351] See, for example, Stefanija Giric, 'Strange Bedfellows: Anti-Abortion and Disability Rights Advocacy' 3(3) (2016) *Journal of Law and the Biosciences* 736; Marsha Saxton, 'Why Members of the Disability Community Oppose Prenatal Diagnosis and Selective Abortion' in Erik Parens and Adrienne Asch (eds), *Prenatal Testing and Disability Rights* (Georgetown University Press, 2000) 147–164; Marsha Saxton, 'Disability Rights and Selective Abortion' in Leonard Davis (ed), *The Disability Studies Reader* (Routledge, 2nd ed, 2006) 105–116.

[1352] Emily Jackson, 'Abortion, Autonomy and Prenatal Diagnosis' (2000) 9(4) *Social and Legal Studies* 467.

[1353] Erik Parens and Adrienne Asch, 'Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations' (2003) 9 *Mental Retardation and Developmental Disabilities Research Reviews* 40, 41. See also Rebecca Stangl, 'Selective Terminations and Respect for the Disabled' (2010) 35(1) *Journal of Medicine and Philosophy* 32.

[1354] For further information on available prenatal screening methods, see Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 41.

autonomy. Indeed, there are ongoing scientific advances.[1355] In its 2018 Report, the New Zealand Law Commission highlighted the limited availability of whole genome sequencing of a fetus.[1356] Genetic analyses following whole genome sequencing now enable the identification of susceptibility genes – pathogenic genes which confer a risk of disease.[1357] As a result, the Commission noted this may 'redefine what is understood as a normal and healthy pregnancy'.[1358] The increased sophistication of prenatal screening methods are enhancing diagnostic tools to detect genetic abnormalities.

13.5.5 Such advances in the detection of a fetal abnormality or disability prompt difficult questions about whether to seek an abortion as was explained to SALRI by various medical practitioners.[1359]

13.5.6 Prenatal screening is often recommended to detect fetal aneuploidy (the presence of an abnormal number of chromosomes). Aneuploidy translates to diagnoses of trisomy 13, 18 and 21 (Down Syndrome).[1360] The following tests are examples of prenatal screening methods offered to women.

Ultrasound/Nuchal Translucency

13.5.7 At 11-13 weeks' gestation, an ultrasound can examine the nuchal translucency of the fetus (measurement of the fetus' neck).[1361] The nuchal translucency, coupled with a blood test, can diagnose approximately 85-90% of fetuses with Down Syndrome.[1362]

[1355] A genetic counsellor raised Mackenzie's Mission to SALRI. Following the tragic story of Mackenzie Casella, who was born with spinal muscular atrophy, a severe inherited neuromuscular disease, a new research study has been instigated. Mackenzie's parents were unknown carriers of this condition, which led to their daughter inheriting the disease. Consequently, Mackenzie's Mission is a reproductive carrier screening project, which is offered to individuals who have been identified as having a higher risk of children with severe genetic conditions. This carrier test is undertaken prior to conception or early in pregnancy, enabling couples to make an informed decision about conception or continuing with pregnancy. The test involves a blood test or mouth swab and detects approximately 500 recessive and X-linked conditions. Recessive conditions are those where an individual does not have the condition but is a carrier. In contrast, X-linked conditions are inherited from the mother. Therefore, males show a higher frequency than females of disease as they inherit the one X chromosome. The test will be available later this year in Victoria, New South Wales and Western Australia, with the remainder of States and Territories to follow in late 2020.[1355] This carrier testing will shift the paradigm of genetic testing, enabling the risk of genetic conditions to be determined even prior to conception. These developments are likely to raise new concerns for those who with misgivings about prenatal testing. See further 'MacKenzie's Mission', *Australian Genomics Health Alliance* (Web Page) <https://www.australiangenomics.org.au/our-research/disease-flagships/mackenzie-mission/>.

[1356] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, 2018) 180 [12.25].

[1357] Ibid.

[1358] Ibid.

[1359] See also Belinda Bennett, 'Prenatal Diagnosis, Genetics and Reproductive Decision-Making' (2001) 9 *Journal of Law and Medicine* 28, 29. Screening procedures, such as exome sequencing, have become more sophisticated and provide comprehensive results covering a wide range of genetic conditions. These procedures offer women the opportunity to receive accurate results, within approximately three weeks, to make an informed decision regarding their pregnancy. Due to morphology scans occurring later in pregnancy and current gestational limits, this three week timeframe will likely impact good medical practice and impede a woman's choice. See also above Part 11.

[1360] See Department of Health, 'Prenatal Screening and Diagnostic Tests', *Government of Western Australia* (Web Page, 2011) <https://www.health.wa.gov.au/docreg/Education/Prevention/Genetics/HP3131_prenatal.pdf>.

[1361] 'Prenatal Screening for Chromosomal and Genetic Conditions', *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Prenatal-Screening-for-Chromosomal-and-Genetic-Con>.

[1362] Ibid.

Cell-free DNA Screening (Non-invasive Prenatal Testing (NIPT))

13.5.8 From 10 weeks' gestation, this blood test uses the DNA of the fetus found in the mother's serum, to screen for aneuploidy.[1363] One specialist in the area told SALRI this as an 'assurance test'. In addition to establishing the risk of aneuploidy, in the context of Down Syndrome, NIPT has reported a sensitivity of 99.5% and specificity in diagnosis of 99.8%.[1364]

Amniocentesis

13.5.9 From 15 weeks' gestation, an amniocentesis can be performed.[1365] This diagnostic test follows screening where a high risk of genetic abnormality has been reported. There is a low risk of miscarriage with amniocentesis (<0.5%).[1366] Amniocentesis involves the extraction of a sample of amniotic fluid from the womb, using a needle and ultrasound.[1367] Using this sample, the chromosomes of the fetus can be mapped, to determine whether the fetus carries an abnormal number of chromosomes. This test is not confined to diagnoses of Down Syndrome - other disorders, including Cystic Fibrosis and Fragile X Syndrome, can also be detected.[1368]

Chorionic Villus Sampling (CVS)

13.5.10 CVS is a diagnostic medical procedure which can be conducted from 11 weeks' gestation to detect genetic abnormalities, including Down Syndrome or hereditary diseases.[1369] This test is often advised if a woman is identified as having a higher risk of carrying a fetus with a genetic condition or abnormality.[1370] CVS involves the insertion of a needle through the abdomen to extract a sample of cells from the placenta.[1371]

Fluorescence In Situ Hybridisation (FISH)

13.5.11 FISH is a cytogenetic technique which enables the detection of chromosomal abnormalities. Its clinical application in prenatal diagnosis makes use of specific probes to target known

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[1363] 'Prenatal Screening for Chromosomal and Genetic Conditions', *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Prenatal-Screening-for-Chromosomal-and-Genetic-Con>; 'DNA-based Noninvasive Prenatal Testing For Fetal Aneuploidy', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2015) <https://www.ranzcog.edu.au/news/DNA-based-Noninvasive-Prenatal-Testing-for-Fetal-A>.

[1364] Lisa Hui and Jon Hyett, 'Non-Invasive Prenatal Testing for Trisomy 21: Challenges for Implementation in Australia' (2013) 53(5) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 416, 424.

[1365] 'Amniocentesis', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Amniocentesis>.

[1366] 'Prenatal Screening for Chromosomal and Genetic Conditions', *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Prenatal-Screening-for-Chromosomal-and-Genetic-Con>; 'Amniocentesis', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Amniocentesis>.

[1367] 'Amniocentesis', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, 2017) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Amniocentesis>.

[1368] Better Health, 'Pregnancy Tests — Amniocentesis', *Victorian Government* (Web Page) <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/pregnancy-tests-amniocentesis>.

[1369] 'Chorionic Villus Sampling (CVS)', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page) <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Chorionic-Villus-Sampling-(CVS)>.

[1370] Ibid.

[1371] Ibid.

genetic abnormalities.[1372] FISH can also detect chromosomal rearrangements and microdeletions.[1373] This test is undertaken from 10-13 weeks' gestation using either CVS or amniotic fluid and, unlike other techniques, provides rapid results within 24-48 hours.[1374] Like amniocentesis, the results from FISH are then used to obtain a karyotype (a map of chromosomes).[1375]

13.5.12 It is important to note that some conditions or disabilities (or their full extent) are only detectable at a late gestational stage[1376] (as SALRI was also often told by specialists who practise in this area). As the VLRC explained:

> Diagnosis of many fetal abnormalities is not possible until later gestation. Throughout the reference we heard from doctors that accurate diagnosis of fetal abnormality, and the implications of the abnormality, is an extremely complex area. 'Diagnosis' often relates more to the level of risk of existence of an abnormality, rather than certainty. Ultrasound screening is offered to all women at 18–20 weeks because the fetus is almost fully developed and is large enough to study. Many structural abnormalities are not apparent until at least this gestation. Some serious abnormalities are not diagnosable until even later, sometimes much later. The existence, and significance, of some abnormalities only becomes apparent at later gestation. For example, it may not be apparent that a fetus is seriously affected by cytomegalovirus infection (a common herpes virus) until the late second or early third trimester. Another example is mild dilation of the cerebral ventricles. Most babies will be normal, but a few will develop severe hydrocephalus. Which group a particular fetus belongs to will not be known until approximately 32 weeks gestation. The woman is in a very difficult situation if she is forced to make a decision about abortion long before this because she will receive uncertain prognostic information rather than the more accurate diagnostic information at later gestation.[1377]

13.5.13 As previously noted, late-term abortions are 'extremely rare'[1378] in practice,[1379] but are already sensitive due to the increased risk and complexity and implications of the procedure and

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[1372] This point was made to SALRI by a medical specialist.

[1373] 'Interphase FISH Analysis', *Victorian Clinical Genetics Services*, (Web Page) <https://www.vcgs.org.au/order/tests/630>.

[1374] Ibid; Eugene Pergament et al, 'The Clinical Application of Interphase FISH in Prenatal Diagnosis' (2000) 20(3) *Prenatal Diagnosis* 215.

[1375] 'Interphase FISH Analysis', *Victorian Clinical Genetics Services*, (Web Page) <https://www.vcgs.org.au/order/tests/630>.

[1376] 'Major structural malformations such as spina bifida, major cardiac or neurological malformations and major limb defects are usually not diagnosable before the 18–20 week scan. Nor is hydrocephalus ('fluid on the brain') which is one of the most common birth defects. Many structural malformations are associated with a substantial risk of genetic disorder, which parents will want diagnostic testing to verify before considering abortion. Some conditions, like cytomegalovirus (CMV) infection and mild ventriculomegaly, result in serious disability in only a small percentage of cases, for example, 10% for CMV, and a "normal" or only mildly disabled child in most cases. Serious long-term disability will not be apparent until approximately 32 weeks': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 43, n 109.

[1377] Ibid 43–44 [3.78]–[3.80].

[1378] Family Planning NSW, Submission No 15 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64849/0015%20Family%20Planning%20NSW.pdf >.

[1379] See Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, 2018) 38 [2.110]. For example, the VLRC quoted 2005 data in Victoria, which recorded 309 abortions post 20 weeks' gestation (of this total, 129 abortions were for a diagnosis of fetal abnormality). Of these 129 abortions, 105 were at 20–22 weeks' gestation, 23 were at 23–27 weeks' gestation, and one was post–28 weeks: Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.84]. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, 2018) 38 [2.110]. Family Planning NSW notes 'most abortions

psychological and/or physical pressures.[1380] The issue of fetal abnormality compounds an already difficult question.

Prenatal Diagnosis

13.5.14 In some situations, prenatal screening will result in the diagnosis of a fetal abnormality. The diagnosis of an abnormality raises difficult questions for the parents and the health practitioners involved and on a wider level, which type and/or degree of disability justifies an abortion.[1381] An amalgamation of the medical and social model would suggest that the nature and/or extent of the disability would be dependent on clinical outcomes and social barriers negatively impacting the future quality of life of the fetus.

Late-term Abortions[1382]

13.5.15 Despite the routine availability of prenatal testing, the existence and significance of some fetal abnormalities will only become apparent at later gestation.[1383] It is significant that some serious fetal anomalies are only likely to be detected in later gestational stages, with the timing of diagnosis influencing a women's decision to seek an abortion.[1384] Certain screening tests may only occur at 19 or 20 weeks of gestation, with further investigations often being required to form a confident clinical picture regarding the nature of the anomaly. About 30% of abortions for fetal anomaly are performed after 20 weeks gestation.[1385]

13.5.16 In consultation, SALRI was informed about the comprehensive information that can now be obtained through further clinical genetics testing after a fetal abnormality is first identified. However, it was reported that such tests require time to conduct and for women to consider the information they receive prior to making a decision about their pregnancy. One retired specialist indicated that the removal of South Australia's de facto 24 week (or 22 or 23 week) upper limit for the availability of an abortion:

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take place during in the first trimester, with 91.2 to 95% of abortions occurring before 14 weeks gestation'. See also above Part 11.

[1380] 'Despite the fact that later term abortions comprise only a tiny, tiny fraction of those abortions that will be performed, they will, no doubt, take on the major feature of public debate on this Bill': South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2426 (Hon Tammy Franks MLC). See above Part 11.

[1381] See also John Harris, 'One Principle and Three Fallacies of Disability Studies' (2001) 27 *Journal of Medical Ethics* 383, 385.

[1382] See also Part 11.

[1383] Victorian Law Reform Commission, Law of Abortion (Report No 15, March 2008) 43–44 [3.78]–[3.79].

[1384] The VLRC quoted 2005 data showing here was a total of 309 abortions post 20 weeks in Victoria, 129 of which were for fetal abnormality. Of these, 105 occurred between 20 and 22 weeks gestation, 23 between 23 and 27 weeks gestation, and one post 28 weeks. See Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 44 [3.85].

[1385] See Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, June 2018) 47 [178]; referring to Evidence to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, Brisbane, 28 October 2016, 27 (Prof M Permezel, President, RANZCOG). Screening and diagnostic testing for fetal anomalies may be carried out at various stages of pregnancy, including ultrasound and blood test screening at 11–13 weeks, sampling and testing of the amniotic fluid at 15 weeks and ultrasound screening for structural anomalies at 18–22 weeks. Results of some tests may take approximately one week to be returned. Where a major structural anomaly is detected, additional testing and counselling may be required before diagnosis and advice about prognosis can be given; each case must be considered individually with the help of a multi-disciplinary team, including maternal fetal medicine specialists, before the parents can reach an informed decision about how to proceed: Information provided by RANZCOG Queensland, Submission to QLRC, *Review of Termination of Pregnancy Laws* (30 November 2017).

would then allow adequate counselling to be given and a considered and discerning decision to be made by the patient / couple without the pressure of a 'time constraint' being placed on them or their medical, midwifery and paramedical attendants.

13.6 Eugenics

13.6.1 A genetic counsellor eloquently summarised to SALRI the dilemma raised by modern prenatal screening – 'genetics conjures up eugenics'. The VLRC noted that the routine practice of prenatal screening raises eugenics issues. They indicated a decision to seek an abortion due to a diagnosed fetal abnormality may not be for a eugenic purpose. Rather, it may reflect a woman's perceived inability to raise a child with disability. The VLRC reinforced this point, emphasising a decision to seek an abortion '[may not reflect a] eugenic unwillingness to bring disabled people into the world, but because of the social implications of bringing up a disabled child'.[1386]

13.6.2 As one author insightfully commented:

> The formulation of public policy and law about abortion on the basis of fetal characteristics is quite different from a woman deciding that in her circumstances she is unable to take on the tasks of raising a child. An individual woman seeking an abortion is not necessarily making a judgment about the intrinsic value of life with disabilities. Few people would want to underestimate the difficulties and sorrows often involved in raising children, with or without disabilities.

13.6.3 Prenatal diagnosis has been linked with eugenics — a practice that denotes the enhancement of 'genetic characteristics of a population' and promotes reproductive control.[1387] This eugenic approach — the desire to select traits or characteristics deemed fit or preferable, has been linked to selective abortion. Some disability rights advocates argue that prenatal diagnosis enables future parents to have an abortion to avoid a child with disability, while justifying this decision as an assertion of reproductive autonomy.[1388] Prenatal diagnosis is said to be 'eugenic', as the decision to undertake an abortion where there is a fetal abnormality creates a dilemma by the practice of genetic enhancement.[1389] Further, diagnosis to specifically detect disability using prenatal testing is even said to provide a means to eliminate disabled individuals.[1390] Prenatal testing can also be construed as de-humanising the fetus, through medical labelling of 'normal' or 'abnormal', 'healthy' or 'defective'.[1391] This 'geneticisation of identity' based on the presence of a genetic abnormality, may also de-humanise the fetus.[1392]

13.6.4 The practice of selective abortion is also said to raise eugenic undertones.[1393] Parens and Asch, for example, note prenatal screening allows for selection against 'disabling traits', which conveys

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[1386] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.89], quoting John Wyatt, 'Medical Paternalism and the Fetus' (2001) 27(2) *Journal of Medical Ethics* ii,15.

[1387] *Macquarie Dictionary* (6th ed, 2013) 'eugenics'.

[1388] See Stefanija Giric, 'Strange Bedfellows: Anti-Abortion and Disability Rights Advocacy' 3(3) (2016) *Journal of Law and the Biosciences* 736, 737.

[1389] Ibid.

[1390] Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 29(2) *University of New South Wales Law Journal* 261, 265.

[1391] Ibid.

[1392] Isabel Karpin, 'Choosing Disability: Preimplantation Genetic Diagnosis and Negative Enhancement' (2007) 15 *Journal of Law and Medicine* 89, 100.

[1393] Marsha Saxton, 'Why Members of the Disability Community Oppose Prenatal Diagnosis and Selective Abortion' in Erik Parens and Adrienne Asch (eds), *Prenatal Testing and Disability Rights* (Georgetown University Press, 2000)

an intolerance for disability.[1394] This indicates that 'a single trait stands in for the whole [and] the trait obliterates the whole'.[1395] The known presence of a trait, which confers an abnormality, becomes sufficient to warrant an abortion.[1396] This is known as the expressivist argument — which addresses active discrimination through selective abortion.[1397] Critics of the expressivist position note the same argument could be applied in circumstances where a woman has an abortion because it would be her fourth child[1398] (or an examples presented to SALRI that the child will have a certain eye colour). This highlights that the reason for an abortion, whether for a fetal abnormality or not, should not prevail over a woman's fundamental exercise of reproductive autonomy. In response to disability-related abortion, some parties opposed to abortion on this ground argue there are other means to prevent disability. This includes taking folic acid to prevent spina bifida or avoiding medications that carry a risk of interfering with the developing fetus, such as growth of limbs or organs.[1399] However, more than one medical practitioner in SALRI's consultation noted that such reasoning is simplistic. There will be unavoidable situations where the woman (and her family) and the health practitioners are confronted with a very difficult situation decision.[1400]

13.6.5 The detection of fetal abnormality has been likened to a 'double-edged sword'.[1401] The detection of an abnormality places individuals in a 'difficult and distressing position' if the results are not as expected.[1402] Despite the diagnosis of a fetal abnormality, a majority of women decide to continue the pregnancy however.[1403] The VLRC highlighted a theme which also repeatedly emerged in SALRI's consultation – 'the decision is an extremely distressing one, and there is no indication it is taken lightly by parents or doctors.'[1404] There is no straightforward solution.

147–164; Marsha Saxton, 'Disability Rights and Selective Abortion' in Leonard Davis (ed), *The Disability Studies Reader* (Routledge, 2nd ed, 2006) 105–116.

[1394] Erik Parens and Adrienne Asch, 'Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations' (2003) 9 *Mental Retardation and Developmental Disabilities Research Reviews* 40, 42.

[1395] Ibid.

[1396] Ibid.

[1397] Ibid.

[1398] Ibid.

[1399] Ibid. This argument was also raised to SALRI by parties such as Advocates International, the Australian Christian Lobby and Cherish Life Australia.

[1400] Such examples were raised to both SALRI and in relation to the 2019 NSW Act. On some occasions, the parents made the decision not to have an abortion. Other times they will not. As the NSW Health Minister noted: 'I have sat with women who have had the absolute desire to have their baby but medical circumstances have intervened. I sat for two hours with one young woman after which she gave me a huge hug with tears flowing down her face. She had hoped the baby would survive but the baby's organs were growing outside its body. It was first diagnosed at 12 weeks but she hoped for a miracle. When she was checked at just over 20 weeks it became obvious that she had to have a termination. That is the circumstance in which those types of terminations occur… It is not an easy decision for the woman and it is not an easy decision for the medical practitioner': New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019 22–23 (Minister for Health).

[1401] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45.

[1402] Ibid 45 [3.89]. See also Clare Williams et al, 'Women as Moral Pioneers? Experiences of First Trimester Antenatal Screening' (2005) 61(9) *Social Science and Medicine* 1983.

[1403] 'Abortion is not an automatic outcome after a diagnosis of fetal abnormality at any stage. Of all the women referred with fetal abnormalities to the [Victorian] Women's Fetal Management Unit, only 10% choose to terminate their pregnancy': Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 43 [3.76]. Further, 2005–06 Victorian figures reported 350 abortions were for fetal abnormality, while 2600 birth defect cases were recorded in 2005, indicating the true abortion rate was 13%: at 44 [3.85]. Some parties in SALRI's consultation questioned the reliability and basis of this figure and how wide was their definition of 'disability'.

[1404] Ibid 45 [3.88].

13.6.6 The New Zealand Law Commission noted the implications of ever more sophisticated prenatal screening and abortions on the ground of fetal abnormality (and gender):[1405]

> These matters are complex. Ultimately, the broader societal concerns and implications of abortions sought on the grounds of sex or fetal impairment are outside the scope of the advice the Commission has been asked to provide. These matters are also inseparable from the law and policy around prenatal screening, which is likewise beyond the scope of this briefing paper. These are matters the Government may wish to consider further.[1406]

13.6.7 SALRI concurs with the VLRC's view that 'the ethical issues raised by fetal testing and abortions for fetal abnormality are 'extremely complex and difficult to resolve.'[1407] However, prenatal screening is now (and increasingly will be) a routine part of antenatal care and promotes informed reproductive autonomy.[1408] As the Hon Tammy Franks MLC notes: 'Prenatal screening is a means to an amazing amount of information for fetal health'.[1409]

13.7 Abortion on the Basis of Disability and International Human Rights Law

13.7.1 The reference in the present law in South Australia to 'seriously handicapped' raises consideration of the *Convention on the Rights of Persons with Disabilities* (*CRPD*). As a means to achieve equality, parties should amend or abolish existing laws that discriminate against persons with disabilities.[1410] The presence of a disability specific abortion law is arguably discriminatory,[1411] as selection against disability is implicit (if not explicit) within the South Australian provision. This terminology can be characterised as 'offensive and discriminatory', whilst also perpetuating the 'stigma' attached to disability.[1412] The discriminatory nature of such a provision also suggests that a fetus deemed to be 'seriously handicapped' is an unwanted condition, which refers to the notion that the fetus is of intrinsically less value than a healthy fetus.[1413]

13.7.2 This point is forcefully made by Pringle who disapproves of the South Australian law:

> One of the criteria for the lawful performance of abortion in South Australia [is] the opinion of two doctors that, if born, the child would 'suffer from such physical or mental abnormalities as to be seriously handicapped'. I argue that there should be no special legal or policy provisions

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[1405] See below Part 14.

[1406] New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 181 [12.29].

[1407] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.89].

[1408] SALRI notes the comments of Professor Caroline De Costa in relation to any suggestion of somehow restricting such testing. 'I believe that, as elsewhere in Australia, a majority of pregnant women have these tests, and where a significant abnormality is detected the majority of women choose to terminate the pregnancy. So whatever views some people may have on a possible eugenics slant to it, there would be enormous and understandable opposition to stopping antenatal screening. Every jurisdiction in Australia currently has the screening, the diagnostic testing, and the possibility of termination, in place.'

[1409] South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2782 (Hon Tammy Franks MLC).

[1410] *Convention on the Rights of Persons with Disability*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008). art 4(b) & 5.

[1411] See Committee on the Rights of Persons with Disabilities, *Comments on the Draft General Comment No 36 of the Human Rights Committee on Article 6 of the International Covenant on Civil and Political Rights* (2017).

[1412] Centre for Disability Law and Policy, Submission to Committee on the Rights of Persons with Disabilities, *General Comment on Article 6: Right to Life* (June 2015) 4.

[1413] Ibid.

> distinguishing fetuses in terms of disability, or defining access to abortion by reference to fetal characteristics. The South Australian provisions endorse, as a matter of public policy, the view that life with disabilities is intrinsically less valuable or worthy of being lived than other lives. The special provision for disability creates 'handicap' as a category of intrinsic vulnerability, and hence its significance also goes beyond questions about abortion and the unborn.
>
> Whatever approach in policy and law is adopted to abortion, there should be no special provisions distinguishing fetuses on the basis of their characteristics or of their actual or potential 'suffering'.[1414]

13.7.3 The Committee on the Rights of Persons with Disabilities[1415] has stated on more than one occasion that laws which explicitly allow abortion on the grounds of fetal impairment violate the *CRPD*,[1416] notably articles 4,[1417] 5[1418] and 8.[1419] The Committee expressed its concern that assessments of impairment conditions may prove inaccurate. Even if they are accurate, the assessment 'perpetuates notions of stereotyping disability as incompatible with a good life'.[1420]

13.7.4 This position was reinforced by a 2018 Report by the Committee on the Elimination of Discrimination against Women, which noted:

> In cases of severe foetal impairment, the Committee aligns itself with the Committee on the Rights of Persons with Disabilities in the condemnation of sex-selective and disability-selective abortions. This stems from the need to combat negative stereotypes and prejudices towards women and persons with disabilities. While the Committee consistently recommends that abortion on the ground of severe foetal impairment be available to facilitate reproductive choice and autonomy, States parties are obligated to ensure that women's decisions to terminate pregnancies on this ground do not perpetuate stereotypes towards persons with disabilities. Such measures should include the provision of appropriate social and financial support for women who choose to carry such pregnancies to term.[1421]

13.7.5 The QLRC observed the effect of international human rights in this area:

[1414] Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207, 207, 217.

[1415] Committee on the Rights of Persons with Disabilities, *Comments on the Draft General Comment No 36 of the Human Rights Committee on Article 6 of the International Covenant on Civil and Political Rights* (2017).

[1416] Committee on the Rights of Persons with Disabilities Consideration of reports submitted by States parties under article 35 of the Convention: *Concluding Observations of the Committee on the Rights of Persons with Disabilities: Spain*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011) [17]–[18]; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Hungary*, 8th sess, UN Doc CRPD/C/HUN/CO/1 (22 October 2012) [17]–[18]; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Austria*, 10th sess, UN Doc CRPD/C/AUT/CO/1 (30 September 2013) [14]–[15].

[1417] The duty on states parties to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities.

[1418] The recognition that all persons are equal before and under the law, and the duty on states parties to prohibit all discrimination on the basis of disability.

[1419] The duty on states parties to raise awareness on respect for the rights and dignity of persons with disabilities, including combatting stereotypes, prejudices and harmful practices relating to persons with disabilities.

[1420] Committee on the Rights of Persons with Disabilities, *Comments on the Draft General Comment No 36 of the Human Rights Committee on Article 6 of the International Covenant on Civil and Political Rights* (2017).

[1421] Committee on the Elimination of Discrimination against Women, *Report of the Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland Under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women*, UN Doc CEDAW/C/OP.8/GBR/1 (23 February 2018) [62]. See also *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

> Although the *CRPD* does not expressly recognise rights before birth, the United Nations Committee on the Rights of Persons with Disabilities (the 'CRPD Committee') has raised concerns about abortion laws in some countries that permit termination of pregnancy on the basis of fetal impairment. The CRPD Committee has not released a General Comment canvassing this issue, but has called on some countries to amend their laws to abolish distinctions based solely on disability. In light of this, the Committee recommended the abolition of legislative distinctions which deem an abortion lawful on the basis of disability.[1422]

13.7.6 Understandable unease has been expressed at the implications of 'routine' abortions simply on account of disability.[1423] Queensland Advocacy Incorporated told the QLRC that 'issues surrounding the human rights of unborn fetuses are not settled', but expressed concern that 'discriminatory stereotypes and myths have historically shaped the decision-making landscape' and there is a 'need for a change in policy, training and culture in this regard'[1424] (reflecting a theme also expressed at SALRI's roundtable with the disability sector). The Queensland Advocacy Incorporated stated to the QLRC:

> … extreme care must be taken with drafting, and with the explanations attendant to the introduction of law reform, to ensure that discriminatory stereotypes are not further entrenched. We emphasise the importance of drawing a distinction between a right to terminate based upon a fetal abnormality and a right to terminate based upon the mental health of the woman (which may include a diagnosis of fetal abnormality). All law and policy reform must be grounded in an explicit acknowledgement of the human rights of all people with disability to equality and non-discrimination. … [Queensland Advocacy Incorporated] does not support legislation that makes an exception to legalise termination of pregnancy on the basis of fetal abnormality and potential disability in circumstances where termination of pregnancy is otherwise unlawful. We note that our position in this regard is consistent with the United Nations Committee on the Rights of Persons with Disabilities, which has emphasised the need to ensure that termination of pregnancy laws do not draw distinctions based solely on disability.[1425]

13.7.7 Law reform agencies have been troubled by disability specific provisions to allow an abortion. The New Zealand Law Commission raised the concern that legislative provisions that allow abortion because the child would be born with disabilities 'endorse, as a matter of public policy, the view that a life with disabilities is intrinsically less valuable than other lives'.[1426] The New Zealand Law Commission referred to the fear that abortions will be performed if fetuses are affected by conditions some would consider insufficiently severe to justify abortion. They noted concerns expressed in other

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[1422] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 254 [85]–[86]. The CRPD Committee has made these comments in relation to Spain, Hungary and Austria, See further Committee on the Rights of Persons with Disabilities, *Concluding Observations of the Committee on the Rights of Persons with Disabilities: Spain*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011) [17]–[18 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Hungary*, 8th sess, UN Doc CRPD/C/HUN/CO/1 (22 October 2012) [17]–[18]; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Austria*, 10th sess, UN Doc CRPD/C/AUT/CO/1 (30 September 2013) [14]–[15].

[1423] See, for example, Marsha Saxton, 'Why Members of the Disability Community Oppose Prenatal Diagnosis and Selective Abortion' in Erik Parens and Adrienne Asch (eds), *Prenatal Testing and Disability Rights* (Georgetown University Press, 2000) 147–164; Marsha Saxton, 'Disability Rights and Selective Abortion' in Leonard Davis (ed), *The Disability Studies Reader* (Routledge, 2nd ed, 2006) 105–116.

[1424] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 84, n 188.

[1425] Ibid 84–85 [3.139].

[1426] New Zealand Law Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, 2018) 59 [3.39].

jurisdictions where late-term abortions have been performed because fetuses were diagnosed with conditions such as a cleft lip and palate or a club foot.[1427]

13.7.8 Both the VLRC[1428] and the QLRC[1429] unsurprisingly found little support for 'the inclusion of a ground referring to 'the serious medical condition of the fetus'.[1430]

13.7.9 The VLRC commented of its consultation:

> There was no support for the inclusion of fetal abnormality as a specific ground for lawful abortion in future legislation. Those opposed to abortion rejected it on the argument about fetal interests. Those in favour of autonomy-based decriminalisation did not find it necessary. Disability organisations, including the Victorian Women with Disabilities Network, rejected it on the basis that it may promote an attitude that termination of pregnancy is the only option if fetal testing indicates a possible disability. However, these organisations did not preclude women making a decision to terminate a pregnancy following fetal testing, and supported autonomy-based legislation.[1431]

13.7.10 Both the VLRC and the QLRC opposed disability specific provisions. The QLRC observed that to include fetal abnormality as a specific ground to access a lawful abortion 'would not only be offensive to people with disability, but might suggest that a diagnosis on its own is sufficient reason to terminate without consideration of the individual circumstances'.[1432] The VLRC was troubled by the premise of abortion on the ground of fetal disability, especially in the context of modern prenatal testing. 'The ethical issues raised by fetal testing and abortions for fetal abnormality are extremely complex and difficult to resolve'.[1433] The VLRC noted that screening for fetal abnormality placed women in a difficult and distressing position when the results of screening are not as they had hoped and such screening had been described as a 'double-edged sword'.[1434] The VLRC observed:

> The prevalence and acceptance of prenatal screening and testing raise concerns about eugenics, as well as arguments that parents decide to abort 'not because of a eugenic unwillingness to bring disabled people into the world, but because of the social implications of bringing up a disabled child'. This issue is broader than the Commission's terms of reference. As a community we have probably not yet directly confronted the full social ramifications of the increased use of fetal testing.[1435]

13.7.11 The VLRC was especially troubled by the suggestion of a specific legal ground of serious fetal abnormality:

[1427] Ibid 180 [12.24]. A Parliamentary Inquiry in the United Kingdom heard evidence about cases where abortions were performed because the fetus suffered from conditions like cleft lips and club foot: Parliament of the United Kingdom, *Parliamentary Inquiry into Abortion on the Grounds of Disability* (July 2013) [22] and [30].

[1428] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 46 [3.94].

[1429] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 83–84 [3.137].

[1430] Ibid.

[1431] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 78 [5.59]–[5.61]

[1432] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 99 [3.202].

[1433] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.89]

[1434] Ibid, quoting Clare Williams et al, 'Women as Moral Pioneers? Experiences of First Trimester Antenatal Screening' (2005) 61 *Social Science and Medicine* 1983

[1435] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.88]–[3.89], quoting John Wyatt, 'Medical Paternalism and the Fetus' (2001) 27(2) *Journal of Medical Ethics* ii, 15.

> The Commission is strongly of the view that this step should not be taken. While there was generally no support in consultations and submissions for the inclusion of a specific ground of fetal abnormality, there was support for legislation to be framed to allow for the continuation of current medical practice that provides for such abortions. The commission believes that the most appropriate legal approach to fetal abnormality is to relate it to the psychological and emotional impact on a pregnant woman of maintaining or terminating her pregnancy.[1436] Three possible options for abortion law reform are outlined... If new legislation is based on one of the options that allows an abortion to be lawfully performed only when particular grounds are satisfied, serious fetal abnormality is most accurately characterised as a matter that has an impact upon the health of the women concerned. This characterisation would allow an abortion to be lawfully performed without the need to specify fetal abnormality as a ground. If legislation is based on one of the options that allows abortion to be lawfully performed on the basis of the woman's consent [alone], the most appropriate way to deal with fetal abnormality is to regard it as one of the many matters that may influence a woman's private decision to terminate her pregnancy.[1437]

13.7.12 There is no straightforward solution to this difficult question but SALRI finds the reasoning of the VLRC compelling. In other words, whilst a disability specific provision allowing abortion on that basis is inappropriate, any law that allows abortion to be lawfully performed on the basis of the woman's free and informed consent and/or a medical practitioner's decision or approval (if SALRI's alternative approach for late term abortions is adopted) that an abortion is medically appropriate, fetal abnormality can be regarded as one of the many matters that may properly influence a woman's private decision or the practitioner's decision/approval to undertake an abortion. This approach is also consistent with international human rights law that a woman's rights may be contravened if she is denied access to an abortion in the event of a fatal abnormality[1438] or a severe impairment.[1439]

13.8 The Role of Counselling

13.8.1 Counselling is considered at length elsewhere,[1440] but there is broad consensus that access to high-quality, impartial and non-directive counselling and support are important for women when

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[1436] The VLRC noted a similar argument was formulated 50 years ago by Glanville Williams: Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber, 1958): Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47, n 137.

[1437] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 46 [3.94]–[3.95].

[1438] *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27. The majority of the UK Supreme Court held that the law in Northern Ireland is incompatible with the right to respect for private and family life, guaranteed by article 8 of the *ECHR*, insofar as it prohibits abortion in cases of fatal foetal abnormality. Lord Kerr and Lord Wilson also held that it is incompatible with the right not to be subjected to inhuman or degrading treatment, guaranteed by article 3 of the *ECHR*. The majority concluded that there is no community interest in obliging a woman to carry a pregnancy to term where the fetus suffers from a fatal abnormality: at [28], [133], [326], [368] and [371]. See also Human Rights Committee, *Views: Communication No 2324/2013*, 116th sess, UN Doc CCPR/C/116/D/2324/2013 (17 November 2016) (*Mellet v Ireland*); Human Rights Committee, *Views: Communication No 1153/2003*, 85th sess, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) (*KL v Peru*).

[1439] *RR v Poland* (2011) 53 EHRR 31. Contra *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27. The UK Supreme Court held it is not possible to impugn as disproportionate and incompatible with Art 8 of the *ECHR* a law that prohibits abortion of a foetus diagnosed as likely to be seriously disabled. A disabled child should be treated as having equal worth in human terms as a non-disabled child. See at [31], [133] and [331].

[1440] See above Part 12.

considering their options, particularly when faced with a diagnosis of a significant fetal abnormality or serious maternal illness.

13.8.2 Given the complexities already outlined in the case of fetal abnormality, specialist counselling services are available for women faced with a diagnosis of a significant fetal abnormality to support them in their decision making and with any negative psychological reactions they may encounter post-abortion. In South Australia, a natural referral pathway to a clinical genetics service exists, where counselling is provided by genetic counsellors and clinical geneticists. Interstate organisations such as Harrison's Little Wings also provide valuable support to families.[1441] The importance of 'providing support for women who wish to carry an impaired foetus to term' cannot be overlooked. Counselling and support must be professional and impartial to avoid being discriminatory.[1442]

13.8.3 There was extensive support to SALRI from parties both supportive and opposed to the decriminalisation of abortion for non-directional, impartial and independent counselling.[1443] There was further support from parties representing both sides of the decriminalisation of abortion debate for specialist and tailored counselling in the context of disability.[1444] Many submissions from parties both supportive and opposed to the decriminalisation of abortion advocated the importance of availability and access to counselling in the difficult context of disability.[1445]

13.8.4 Some parties such as Cherish Life Australia, the Australian Christian lobby, Advocates International and Dr Šeman and Dr Turnbull supported mandatory counselling for all women, especially in the context of the identification of a fetal abnormality or disability.

13.8.5 Advocates International for example recommended that 'expert and independent counselling about all relevant treatment options (such as intrauterine or neonatal surgery) and PPC [perinatal palliative care], must be provided.'

13.8.6 Counselling is considered elsewhere at length,[1446] but SALRI agrees with the view of the VLRC that counselling, whilst beneficial (especially in the disability context), must be optional and cannot be mandated. 'Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling.'[1447]

13.8.7 The VLRC's reasoning is apt. 'Abortion counselling is a clinical, service delivery issue rather than one to be directed by law.'[1448] While a diagnosis of fetal abnormality adds greater

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[1441] Harrison's Little Wings is a not for profit organisation that supports women and their families who have received a diagnosis in their pregnancy, or whether there is a maternal health issue which puts the life of the woman or her baby at risk. At present they only operate in Queensland but are hoping to expand to other states and territories. SALRI notes the valuable role performed by such agencies in this area.

[1442] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016) 85–86 [15.4.2].

[1443] See also above [12.1.1]–[12.1.5]. Though views differed as to the precise definition and scope of such a role in relation to abortion related counselling. See further above [12.4.1]–[12.4.52].

[1444] See below Rec 35

[1445] See further below [13.8.3] and [13.8.10] RANZCOG Statement 1 (Recommendation 3) and Statement 2, (Recommendation 2), [13.8.3].

[1446] See above Part 12.

[1447] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 8.

[1448] Ibid 124 [8.122].

complexity, nonetheless, this does not change the view that counselling should remain a matter of clinical service delivery.

13.8.8 SALRI concurs with the position of the National Alliance of Abortion and Pregnancy Options Counsellors that there should be no requirements for mandated counselling, as opposed to 'access to comprehensive, evidenced based counselling[1449] and support that places the woman as the expert in her life'. Any counselling a woman may choose to access should be impartial and non-directional and facilitate informed decision making so a woman can choose from three options available, 'continuing the pregnancy to parent, abortion and continuing the pregnancy to adopt'.[1450]

13.8.9 SALRI's position on counselling, particularly when there is a family history of genetic conditions or fetal abnormality has been detected through prenatal screening where a genetic cause is possible, is also consistent with that of professional associations, notably RANZCOG who have published a number of statements intended for healthcare professionals including clinicians — obstetricians, general practitioners and clinical geneticists and scientists. These statements outline a number of recommendations based on different aspects of obstetrics, including prenatal screening and diagnosis and pre-pregnancy counselling.

13.8.10 Recommendations published by RANZCOG in three relevant statements are provided to indicate proper clinical practice.

Statement 1: 'Prenatal screening and diagnostic testing for fetal chromosomal and genetic conditions'[1451]

This statement was developed in conjunction with the Human Genetics Society of Australasia. Specific recommendations relating to prenatal screening include:

RANZCOG Recommendation 1:

'All pregnant women should be provided with information and have timely access to screening tests for fetal chromosome and genetic conditions. Prenatal screening options should be *discussed and offered* in the first trimester whenever possible.'[1452]

[1449] NAAPOC outlined the distinction between 'informed consent counselling' and 'therapeutic counselling'. They defined 'informed consent counselling' as supporting a woman to 'understand the abortion procedure and any risks or side effects related to the procedure', facilitating an autonomous decision. In contrast, 'therapeutic counselling' is an opportunity to discuss available options and the woman's values, strength and capacity in making the decision about their pregnancy. This type of counselling is appropriate in circumstances where a fetal abnormality has been diagnosed and the woman may desire an opportunity to discuss the diagnosis and available options to aid her in making an informed decision. See also [12.4.34] above.

[1450] In cases where an abortion was performed at a late term following a diagnosis of fetal abnormality, women experienced negative psychological outcomes consistent to those who have had miscarriages or stillbirths. The National Alliance of Abortion and Pregnancy Options Counsellors noted that support services provided by genetic counsellors are available in these circumstances.

[1451] 'Prenatal Screening and Diagnostic Testing for Fetal Chromosomal and Genetic Conditions C-Obs 59', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, July 2018) <https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Prenatal-screening_1.pdf?ext=.pdf>.

[1452] Ibid (emphasis added).

RANZCOG Recommendation 2:

'Screening or diagnostic testing for fetal chromosomal and genetic conditions is voluntary and should only be undertaken as an *informed decision by the pregnant woman*.'[1453]

RANZCOG Recommendation 3:

'If a screening test result indicates an increased chance of a chromosome or genetic condition, the woman should have *access to genetic counselling* for further information and support. The available options for prenatal diagnosis should be discussed and offered.'[1454]

These recommendations promote the autonomy of the woman and encourage genetic counselling to be sought if a woman is at a higher risk of carrying a fetus with an abnormality.

Statement 2: 'Pre-pregnancy counselling' in cases where there is high-risk of chromosomal or genetic disorder[1455]

Specific recommendations include:

RANZCOG Recommendation 2:

Reproductive carrier screening. If there is a high risk of a chromosomal or genetic disorder based on the family history or ethnic background then *pre-pregnancy genetic counselling should be offered* to determine the couple's risk of an affected child and to provide information about options for carrier screening, preimplantation genetic diagnosis, prenatal diagnosis and postnatal management.[1456]

13.8.11 This recommendation highlights the importance and potential benefit of genetic counselling. It shows that genetic counselling should be available, but not mandatory, to all women, especially in circumstances where there is a family history of genetic conditions or fetal abnormality has been detected through prenatal screening where a genetic cause is possible. This enables women to gain information and discuss all available options to facilitate informed decisions.

13.8.12 It should be for the woman concerned to decide on undertaking any genetic counselling. In the event she wishes to access a clinical genetics service, referral pathways for such services already exist in South Australia. Therefore, SALRI is of the view that any new law should not contain a requirement for mandatory genetic counselling or mandatory referral to genetic counselling.

[1453] Ibid (emphasis added).

[1454] Ibid (emphasis added).

[1455] 'Pregnancy Counselling C-Obs 3(a)', *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists* (Web Page, July 2017)<https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Pre-pregnancy-Counselling-(C-Obs-3a)-review-July-2017_1.pdf?ext=.pdf>.

[1456] Ibid (emphasis added).

Statement 3: 'Prenatal Screening for Fetal Genetic or Structural Conditions'[1457]

RANZCOG Recommendation 4:

In discussing counselling, RANZCOG advised the following information to be provided:[1458]

* 'The difference between screening and diagnostic testing.'

* 'The relative advantages and disadvantages of the available screening tests.'

* 'Details of the nature, purpose, limitations and consequences of screening.'

* 'That the decision whether to undertake screening or not is entirely that of the woman. Practical aspects of screening including the conditions that are being screened for, the type of tests, the timing of tests and the approximate costs involved.'

* 'The possibility of diagnosing fetal genetic or structural conditions other than those for which the screening programs are designed.'

* 'The nature of results (often expressed as a numerical probability estimate) and the offer of a follow up diagnostic test if an 'increased' probability' result is obtained.'

* That continuing or not continuing the pregnancy are both options in the event that a fetal genetic or structural condition is diagnosed.'

* 'An assurance that continuation of the pregnancy is a valid option should a fetal genetic or structural condition be diagnosed, and that couples will receive appropriate counselling and care in preparation for birth.'

RANZCOG Recommendation 5:

The Statement also includes a mechanism for referral to other professionals, such as genetic counsellors or specialists. Referral within a reasonable time frame following a diagnosis of fetal abnormality is advised 'for the following reasons':[1459]

* 'To take into consideration the expected time required for the primary referrer to receive the initial report, discuss the findings and refer for a second opinion where required.'

* 'To allow time for additional genetic investigations to be performed where necessary; in some cases testing requires transfer of samples to laboratories interstate or overseas and requires specific genetic counselling concerning the findings.'

* 'New and advanced imaging modalities (ie advanced ultrasound and MRI) used in prenatal diagnosis of fetal structural conditions will commonly require specific timing for complex booking arrangements and sub-specialty expertise.'

* 'Timely evaluation to allow full counselling of the results allows women and partners a full range of options, considering the local legislation for termination of pregnancy.'

[1457] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Prenatal Screening for Fetal Genetic or Structural Conditions: C-Obs 35* (Report, March 2019); The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, website accessed 1 August 2019 (no longer accessible).

[1458] Ibid.

[1459] Ibid.

13.9 The Role of Genetic Counselling

13.9.1 One consideration highlighted to SALRI raised the particular role of genetic counselling and its ability to supplement and support other forms of counselling and address the eugenics concern in relation to abortion on the basis of disability. Genetic counselling, as with any other form of counselling, should be impartial and non-directional.[1460] But it has wider application in a disability context. Genetic counselling seeks to counteract any 'eugenic' concerns by adopting a non-coercive and supportive approach when undertaking prenatal testing.[1461] A genetic counsellor emphasised to SALRI the need for 'unbiased and non-directional counselling'.[1462] It was raised to SALRI that the importance of genetic counselling should not be underestimated — it has the capacity to reshape the way in which abortion and disability is addressed in society.

What is Genetic Counselling?

13.9.2 The Human Genetics Society of Australasia defines genetic counselling as:

> [A] communication process, which aims to help individuals, couples and families understand and adapt to the medical, psychological, familial and reproductive implications of the genetic contribution to specific health conditions.[1463]

13.9.3 SALRI notes that The Human Genetics Society of Australasia requires genetic counsellors to comply with a professional Policy Code of Ethics. Under this Code, the principles of confidentiality and client rights to self-determination and autonomy are recognised. Further, services must be delivered in a culturally sensitive manner.

13.9.4 Genetic counselling was described to SALRI in consultation as a powerful tool in understanding prenatal diagnoses and facilitating informed decision-making in the context of disability and abortion. In South Australia, genetic counsellors operate as an independent service, providing accurate information and discussing all available options. Information is conveyed in an unbiased, non-directional manner, to ensure any decision is made freely and autonomously. It was noted that the medical jargon associated with prenatal tests and results can be confusing and overwhelming — a genetic counsellor is able to simplify this language to help clients understand their options.[1464]

13.9.5 A genetic counsellor may work with individuals, couples or families who present to them for two primary reasons — first, to undergo prenatal screening or learn more about their options or secondly, after receiving results from testing.[1465] In the event the decision is made to continue with a

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[1460] See above [12.1.1]–[12.1.5].

[1461] Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 29(2) *University of New South Wales Law Journal* 261, 265.

[1462] Statement of Senior Obstetrician, 31 May 2019.

[1463] Human Genetics Society of Australasia, *Policy Code of Ethics for Genetic Counsellors* (Code of Conduct, August 2018) <https://www.hgsa.org.au/documents/item/9589>.

[1464] Genetic Counsellors have specific qualifications which include a Masters of Genetic Counselling. Entry to this degree is typically reliant on having completed an undergraduate degree – often in a health-related discipline, such as genetics, psychology, social work, law, nursing/midwifery or science, and having had experience in counselling and/or genetics. This provides a genetic counsellor with the requisite qualifications, knowledge and skillset to undertake adequate and objective genetic counselling. 'Genetic Counselling Training and Accreditation', *Human Genetics Society of Australasia* (Web Page, 2019) <https://www.hgsa.org.au/education-training/genetic-counselling/genetic-counselling-training-and-accreditation>.

[1465] See National Society of Genetic Counsellors, *Making Sense of Your Genes: A Guide to Genetic Counselling* (Media Release, 2008) 5.

pregnancy following a diagnosis, the role of a genetic counsellor extends to discussions about raising a child with 'special needs'.[1466]

13.9.6 An example of a typical appointment will cover topics such as:

- Family and medical history;[1467]
- Determine and discuss the risks of having a child with a genetic condition;[1468]
- Outline and explore options for prenatal screening before or during pregnancy;[1469]
- Assist in the interpretation of results;[1470]
- Provide information about issues identified during pregnancy to aid in understanding possible options;[1471]
- Provide emotional support and counselling;[1472] and
- Refer to other support/advocacy organisations.[1473]

13.9.7 Genetic counselling, as a genetic counsellor told SALRI, may prove effective to help alleviate some of the concerns associated with 'eugenics' and discrimination against disability. It promotes reproductive autonomy in decision-making, ensures all decisions are informed and is unbiased in practice. This arguably safeguards the rights of all women, including women with a disability. SALRI notes that greater awareness and understanding of the role and purpose of genetic counsellors is important in the context of this reference. The role of genetic counselling may not be as widely known as it could be. The benefit of impartial genetic counselling, especially given the advances in prenatal screening, is notable. It promotes accurate and informed decision making and addresses some of the 'eugenic' concerns in relation to abortions on the basis of disability.

13.9.8 At present, in South Australia two clinical genetics services exist. The paediatric and reproductive genetics unit is located at the Women's and Children's Hospital,[1474] while the adult genetics unit is based at the Royal Adelaide Hospital. Both services offer services at other metropolitan hospitals and outreach locations.

13.9.9 The paediatric clinical genetics service provides genetic counselling services to women and their families. The genetic counsellors are also involved with Support After Fetal Diagnosis of Abnormality (SAFDA), an organisation created to support parents and families before and after an abortion owing to the presence of a fetal abnormality. Supports offered by this organisation include support groups, counselling, newsletters, and education for health professionals.

[1466] Ibid.

[1467] Ibid 7.

[1468] Ibid.

[1469] Ibid.

[1470] Ibid.

[1471] Ibid.

[1472] Ibid.

[1473] Ibid.

[1474] Women's and Children's Hospital, 'SA Clinical Genetics Service', *SA Government* (Web Page, April 2019) <http://www.wch.sa.gov.au/services/az/divisions/labs/geneticmed/index.html>.

13.9.10 The adult clinical genetics service provides a state-wide service for the genetic assessment, counselling and testing of adults and their families with genetic/familial disorders.[1475] Specific services include: familial cancer genetic diagnosis and counselling, Huntington Disease predictive testing service, clinical/genetic diagnosis of syndromic connective tissue disorders and aortopathies (eg Marfan, Loeys-Dietz and Ehlers-Danlos syndromes) and genetic assessment of familial endocrine disorders.

13.9.11 With only two such specialised services available, all referrals need to be triaged and prioritised according to urgency. This may lead to waiting periods for some people who desire access to genetic counselling.

13.9.12 SALRI recommends that access to a clinical genetics service should be available to all women where there is a family history of genetic conditions or where fetal abnormality has been detected through prenatal screening where a genetic cause is possible. It should be for the woman concerned to decide on undertaking any genetic counselling however, and SALRI therefore recommends any new law should not contain a requirement for mandatory genetic counselling or a mandatory referral to a clinical genetics service. The promotion and provision of genetic counselling could be further enhanced through:

a. the development or amendment of current medical frameworks and/or guidelines relating to the effective and timely referral to a clinical genetics service endorsing best clinical practice;

b. raising community awareness about clinical genetics services and the role of a genetic diagnostics and counselling service;

c. increasing access for all pregnant women to information about clinical genetics services and how to access such services; and

d. ensuring adequate resources are available to meet a likely increase in clinical genetic diagnostics and counselling service requests arising from changes to guidelines/frameworks and greater community understanding of such services.

13.10 **Submissions**

13.10.1 The topic of disability and abortion proved a prominent theme in consultation and one that troubled almost all respondents, regardless of their position on the decriminalisation of abortion.

13.10.2 A strong (though not universal) theme in consultation was the fundamental importance of autonomy and the woman's capacity to make her own decisions in relation to abortion and criticism of what was viewed as the outdated medical 'gatekeeper' model to access an abortion.[1476]

13.10.3 In relation to the inclusion of specific grounds for lawful abortion, there was almost universal opposition in SALRI's consultation, from parties both supportive and opposed to the decriminalisation of abortion, to a disability specific provision for allowing an abortion. There was divergent reasoning.[1477] Those opposed to the decriminalisation of abortion rejected a disability specific provision for allowing abortion (or indeed abortion generally) on the basis of what they saw as the

[1475] Royal Adelaide Hospital, 'Clinical Genetics (Adult Genetics Unit)', *SA Government* (Web Page, 2019) <https://www.rah.sa.gov.au/health-professionals/clinical-services/medical/clinical-genetics>.

[1476] See also above [1.3.35]–[1.3.39].

[1477] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 78 [5.59]–[5.61].

rights of the unborn child, especially in the context of disability. Those in favour of autonomy-based decriminalisation of abortion viewed such a provision as unnecessary or inappropriate and considered that the difficult decision as to abortion on the basis of a fetal abnormality should be left to general health law and practice and, crucially, the woman's autonomy.

13.10.4 There was virtually no support from parties favouring the decriminalisation of abortion for criteria of any sort, let alone criteria relating to disability. This included medical, professional and legal associations, and disability groups as well as SALRI's roundtables with the legal and medical sectors, parties supportive of decriminalisation and the disability sector. Criteria were widely viewed as undermining a woman's autonomy, as no criterion can ever capture all possible circumstances in which a woman may seek an abortion.[1478]

13.10.5 Australian Lawyers for Human Rights stated to SALRI that the current 'seriously handicapped' provision 'disproportionately targets disability'. Australian Lawyers for Human Rights concluded that the present provision is at odds with the *ICPR*. The removal of the legislative criteria for abortion was also urged by the Castan Centre for Human Rights Law, which asked to 'refrain from imposing… specific grounds for abortion' and to view abortion as a medical procedure. They argued that the particular presence of grounds 'stigmatises abortion by casting such procedures in a deviant light'. The Queensland Advocacy Institute made it clear it does not support any law that makes an exception to legalise abortion on the basis of fetal abnormality and potential disability in circumstances where abortion is otherwise unlawful.

13.10.6 A senior specialist obstetrician acknowledged there are circumstances when they may be uneasy about performing an abortion if the disability is 'insufficiently severe', but ultimately it remains the woman's choice which should be respected and a medical practitioner cannot impose their views on a patient. Ms Marchesi noted:

> The question of disability and abortion is very difficult. But ultimately it must remain a question of bodily autonomy and a woman cannot be compelled to have a child with disability. You can't force someone into that situation. Any criteria to govern access based on disability are flawed and unworkable.

13.10.7 It was pointed out to SALRI that, difficult a decision as it is, the consequences may well prove more profound and adverse if an abortion is not undertaken. SALRI notes the following powerful account provided in the NSW parliamentary debate by 'Georgia':[1479]

[1478] See above Part 10.

[1479] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 74–75 (Ms Jenny Leong, quoting 'Georgia'). See also South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2426–2427 (Hon Tammy Franks MLC quoting Ashleigh Foley).

Personal account by 'Georgia':

In September 2010, I fell pregnant with my first child. I was excited and nervous. I took all the vitamins. I stopped drinking alcohol and coffee. Resentfully gave up soft cheese. I went to my doctor. Got all my tests and scans. Everything was fine … At the 20 week scan it all looked good. The fetus was moving about too much, so it took a long time and the person doing it was worried she wasn't getting all the shots she needed but all was fine. The next day the ultrasound place called and said that they didn't get the profile shot they needed so could I come back. I said I could a few days later, and tried to dissuade my partner from coming as it seemed unnecessary. He came anyway. There was a moment, in the second scan, when they brought a fetal health specialist in to review things. No-one had said anything to indicate there was anything wrong. At this point, we still thought the fetus was moving about too much. But there was a moment, without anything being said, where tears sprung to my eyes in a way they never had before. I didn't feel myself crying but tears were streaming down my face. I didn't know what was wrong, but I knew instinctively that something was.

Soft-markers are a term I'd never heard before. It means that they can see some things that might indicate something is wrong, but they're not so significant that they're sure. The doctor said he was very conservative and that it may be nothing so we shouldn't get ahead of ourselves. He referred us to the hospital.

The next day at the hospital we had another scan, with another doctor, who said she shared the first doctor's concerns …. We asked what would happen. If it was really bad, what would happen? She said that abortion at this point was illegal but we might be able to get it signed off by multiple doctors depending on the results as we proceeded. I understood the laws, I understood what she meant by illegal and that knowledge meant that I didn't take her comment to heart.

In the mean time I was showing and getting congratulations and being asked when I was due. … All the joy of the pregnancy was gone. I wished I wasn't showing. …We had more scans. It was four weeks of limbo. After one scan we were told it was all fine, only to get a call from the specialist the next day to say it was not.

Our specialist had a gentle, brutal conversation with us. Our baby would likely die in utero. It would be a question of waiting for the movements to stop one day, never knowing when that day would be. If we made it to term, the baby would not live for long. We had an option to put the baby to sleep and then I would labour it. It required multiple doctors to sign off and us to speak with a social worker. We chose that option.

Making this choice was the hardest thing I ever had to do. But I was so, so grateful I had the choice. I didn't want to walk through the world with a growing tummy, meeting people offering joyous congratulations when I knew there would be nothing to celebrate. I didn't want to spend each day waiting for the kicks to stop. I didn't want my child to suffer for one second …

On Friday March 15th they put our baby to sleep …On Monday March 18th I laboured for 15 hours and gave birth to my baby girl Rosa in the early hours of Tuesday morning. The midwives and doctors were very kind. They wrapped her in blankets and took photos of us holding her. We lay in the maternity ward, listening to mothers labouring with their living children and new born babies crying, and wept.

Between 0.7- 2.8% of abortions happen after 20 weeks. I am one of those people. It is one of the most horrific experiences you can have. No one does it lightly. No one chooses to labour a dead child. **You have a late term abortion because it's the best option out of a bunch of terrible options. If we work from that basis that people making this choice are doing so in the worst of circumstances we should create a regulatory framework that supports these people, that trusts these people, that enables these people to go through this experience in the most supportive environment possible. This means we don't impose hoops for them to jump through that are unnecessary, we don't treat them like perpetrators of a terrible act, we don't force them to travel to big cities, away from their homes and families and friends**':

13.10.8 The present disability specific provision for lawful abortion presented serious concerns at SALRI's roundtable with the disability sector. Further, '[s]uch a specific ground was also seen as misplaced to people with disability and their families, [it] could be discriminatory or … promote disability-selective termination as the norm, rather than carefully exploring all options'.

13.10.9 A formal ground based on fetal abnormality was also said to promote the notion that a diagnosis on its own is sufficient to seek an abortion, regardless of other relevant considerations. An attendee stated '[t]he current model based on disability is making value statements, the value of a future person's life'. Discussion ensued in which attendees preferred an appropriate balance between making an informed decision following a prenatal diagnosis and respecting the woman's autonomy.

13.10.10 Prenatal screening was said to raise eugenic issues, promoting selective abortions. The solution proposed was not legislative change, limiting access. Rather, society's views and attitudes to disability and abortion must be challenged. Some attendees noted it was inappropriate to place legal restrictions to prevent abortion on the basis of fetal abnormality. A decision to proceed with an abortion should be made by the woman, after thoughtful consideration.

13.10.11 Different views were expressed in relation to the implications of the identification of a potential fetal abnormality.

13.10.12 One view was that abortions on the basis of even severe fetal abnormality should not be permitted. Cherish Life Australia, for example, opposed lawful abortion on the ground of fetal abnormalities and noted that misdiagnosis of abnormalities can occur. Cherish Life Australia argued:

> We do not allow the disabled to be killed after birth, so why should this happen before both. It is a sad indictment on the medical profession and on our society that about 90% of Down syndrome babies in Australia are killed by abortion.

13.10.13 Pregnancy Help Australia also commented:

> No, there are too many instances of incorrect or inconclusive diagnosis of abnormalities. Support and education are preferable. Families have reported that the grief and trauma associated with a neonatal death or severe abnormality has been lessened somewhat, with support offered to them, in comparison to those families who opted to abort the baby. Also, the child, whether suffering a disability or not, should have a right to live, even if that life is short.

13.10.14 Other parties took a very different perspective. Professor Sally Sheldon of the University of Kent, for example, emphasised the difficult decision confronting parents when a disability is identified but ultimately it must remain a decision for the woman involved (and her partner) in careful consultation with the relevant health practitioners. Professor Sheldon observed that the solution to the understandable concern of abortions on the basis of an 'insufficiently severe' disability is not criteria (especially legislative) restricting the circumstances in which an abortion can be obtained, but to respect the woman's autonomy and ensure that the woman has access to the necessary information and supports to come to an informed decision. Professor Sheldon elaborated:

> Regarding issues with the disability sector, and women choosing to terminate pregnancies once they find out, for example, that their child has a mild or serious disability, I would say that abortion for disability is the issue I personally find hardest. I think the problem with our laws at the moment is we have this list of state validated reasons for why it's alright for a woman to want to end a pregnancy, and including disability on that list feels wrong, it feels discriminatory. If you get rid of that model and say, it's up to women to make the decisions that they want to make, if you take women's autonomy seriously, then I think you have to say that women have to decide the basis

for carrying on with the pregnancy or not, so that decision has to be for them, however I think what you would want to do is make sure they get very good information.

I have got a lot of sympathy for, and I don't think this is the case in Britain so much anymore but it certainly was the case, if you think back to the 90s and see the information that was given to women there, there was a real sense that if there was an anomaly or disability you were on the conveyer-belt to a termination and actually what should happen at that point is that women should be given all the information that they need to make a decision and that disabled people aren't treated as one of our commentators puts it, as 'genetic spelling mistakes', so that that information is there. To come at it from the other direction, is treating women as incubators. If we're really worried about disability discrimination, we should be giving women good information and providing services and support which allow them and empower them to carry on with the pregnancy.

13.11 Late Term Abortion and Gestational Limits in the Context of Disability

13.11.1 The Human Rights Law Centre highlighted to SALRI that late-term abortions after 24 weeks are rare and constitute approximately 2% of all abortions in South Australia. These abortions are completed in complex medical circumstances, in cases of a fatal fetal abnormality diagnosis in a wanted pregnancy. Australian Lawyers for Human Rights submitted that 43.3% of late-term abortions performed after 20 weeks' gestation were due to congenital abnormalities. The Australian Lawyers Alliance noted the possibility of a new law to allow for late-term abortions when circumstances deem this procedure necessary. It was submitted this option would be adaptable to cater for women seeking late-term abortions in circumstances other than severe fetal abnormality, such as pregnancy following sexual assault.

13.11.2 Professor De Costa submitted 5-6% of abortions occur later in pregnancy, due to serious fetal abnormalities or a maternal health condition. This decision is not made lightly, often involving much consultation with medical advisors and family.

13.11.3 In submissions from those working in legal and medical fields, it was emphasised that late-term abortions should not dominate the narrative of this reference. Parties opposed to the decriminalisation of abortion raised particular concern in relation to late-term abortions, however, especially in the context of disability.

13.11.4 Where a woman requires a late-term abortion, RANZCOG advocated to SALRI for a multi-disciplinary approach and supported the availability of such abortions when medically necessary. The decision to pursue a late-term abortion is complex, in light of specific fetal abnormalities, 'late recognition of pregnancy, advancing gestational age, multiple pregnancy and pre-existing maternal disease'.

13.11.5 The AMA(SA) advocated for gestational limits to be removed, which would enable access to late-term abortions secondary to medical conditions. A retired specialist acknowledged that a small proportion of women request late-term abortions for cogent psychosocial or personal reasons and these should be considered and supported. The specialist's primary concern related to the current gestational limit, where a late-term abortion, in cases where a 'significant major fetal congenital abnormality' has been diagnosed, cannot be performed within the required time frame.[1480] SALRI was told that, although not a legislative requirement, post 23 weeks' gestation, a complex process is required

[1480] Ibid.

to gain approval (which is far from guaranteed) for late-term abortions, requiring committee approval from medical and non-medical professionals based at the Women's and Children's Hospital. The retired specialist supported the extension of the current time frame, to allow for a definitive diagnosis of a 'significant fetal abnormality' and to further evaluate prognosis 'no matter how inconclusive'. The genetic methods and analyses required to obtain said diagnosis often takes time and must be collated and interpreted by geneticists.[1481]

13.11.6 It was suggested by one attendee at the 12 June roundtable that most abortions are performed before viability. However, when late-term abortions are performed, there is a myriad of powerful reasons why women feel they are unable to have a child. The possibility of some significant disabilities or health conditions being detected at a later term of pregnancy was raised. This attendee stated that it should be an issue for the woman concerned who would make any such very difficult decision very carefully. This attendee supported allowing late-term abortions to prevent the suffering of a child.

13.11.7 Parties opposed to the decriminalisation of abortion largely opposed allowing abortion on the ground of serious (or even fatal) fetal abnormality.

13.11.8 The Lutheran Church of Australia, for example, opposed abortion even in the case of the identification of a fatal condition and unequivocally contended to SALRI:

> Babies with irreparable and lethal anomalies can be allowed to die naturally in the womb and then stillborn or be induced after 24 weeks and born vaginally or by caesarean when doctors consider it safest. Those that survive birth but which can be expected to die within hours or days should receive palliative care until their short lives end. We commend this approach in what are tragic situations as it allows mothers (and fathers and siblings and so on) to hold their babies, name them and process their emotions in a healthy way. It is also healthier for the medical staff involved. It is preferable to killing them via abortion and disposing of their remains without ceremony, as if they never existed—actions that are likely to cause long term guilt and remorse.

13.11.9 This approach is too rigid and is one that SALRI cannot support. It is significant that this approach was not shared by parties within the disability sector, as well as many of the parties otherwise opposed to the decriminalisation of abortion.

13.11.10 The Australian Christian Lobby emphasised to SALRI the difficult ethical implications of abortions on the basis of fetal abnormality. They asserted that these ethical issues cannot be resolved by placing the decision of whether to proceed with an abortion with the woman. They identified several concerns including access to information regarding support services in circumstances where a woman has decided to proceed with the pregnancy. In light of its concerns, the Australian Christian Lobby advocated for 'informed consent'[1482] in circumstances surrounding fetal abnormalities. Informed consent can be facilitated through access to information on the specific disability and consultation with disability support groups. The Australian Christian Lobby also noted informed consent could be achieved through other means, including perinatal palliative care and intrauterine surgery.

13.11.11 The Catholic Archdiocese of Adelaide and Port Pirie acknowledged that any laws should treat abortion as a 'woman's health issue'. However, the Archdiocese emphasised this medical procedure still 'ends the life of a fetus', which the Archdiocese believes should be 'protected and loved, not terminated and discarded'. The Archdiocese's concluding remarks drew upon the Pope's recent announcement that '[p]renatal diagnosis for selective purposes should be discouraged with strength,

[1481] See also above [11.5.60].

[1482] See also below [19.1.1]–[19.1.23].

because it is an expression of an inhuman eugenics mentality, which takes away the possibility of families welcoming, embracing and loving their weakest children'.

13.11.12 Advocates International opposed allowing abortion on the ground of disability. They noted the availability of alternative medical options to address a diagnosis of a fatal fetal abnormality, such as perinatal palliative care. It was also noted that abortion following diagnosis of a fetal abnormality results in 'significant mental harm, including persistent grief, depression and post-traumatic stress'.[1483] They proposed that grounds for fetal abnormalities 'should be subject to general restrictions', to prevent the elimination of persons with disability. They urged that that abortion for fetal disability or LLFC (such as anencephaly), should be prohibited.

13.11.13 A similar view was expressed by 40 Days for Life which commented: 'Even if the baby were handicapped, invariably the parents love them and do not regret their birth. And if the baby dies prematurely, at least the parents are able to grieve and provide a proper burial.' Another submission noted 'I have friends that are disabled and to say that they would have had no right to be born is an absolute outrage and discrimination'.

13.11.14 Another party commented:

> I do not believe that a woman has the right to decide whether or not her unborn child lives. The child is not a part of the woman, like her arm or leg, but is another human being with rights whom she has the responsibility to care for and protect. Regarding disability, many disabled people live very worthwhile, fulfilling and inspiring lives. Surely such people have the right to live.[1484]

13.11.15 Genesis Pregnancy Support Inc powerfully argued:

> Serious concerns arise when it comes to disabilities and determining who should live and who should die. Due to understandable inexperience and ignorance about people with disabilities, opinions are often ill-informed. It is assumed that the disabled are generally miserable because they do not look or function as we do. But their life experience is vastly different from ours. It is a serious misconception to assume that their lives are less fulfilling. This can lead to the misguided conclusion that we are doing them a favour to deprive them of their life, rather than accept, support and embrace them on equal terms. Only the disabled themselves are qualified to speak on their own behalf in order for us to understand their reality, rather than the one we perceive them to have… To have disability as grounds for termination also sends a cruel double message to the precious disabled in our society ('You shouldn't be here'), and opens the way for abuse regarding the degree of disability (missing limbs, mild cerebral palsy, facial deformity … hair lip … It is worth considering what this legalised choice would say to those many disabled people who already live amongst us, or to those who 'acquire' a disability through accident or illness, about whether their life is worth living? What words will we use to reassure them of their intrinsic worth and value to us and to society, when our law says otherwise?

13.11.16 SALRI acknowledges that this is a difficult issue with views from different perspectives.

[1483] This view though overlooks, as stated to both SALRI and the NSW Parliamentary debates, that the alternative of not having an abortion may well prove more traumatic. SALRI again notes the powerful account provided in the NSW debate by 'Georgia': New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 74–75 (Ms Jenny Leong, quoting 'Georgia'). See also South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2426–2427 (Hon Tammy Franks MLC quoting Ashleigh Foley).

[1484] See also Giovanni Rubeis and Florian Steges, 'A Burden from Birth? Non-Invasive Prenatal Testing and the Stigmatisation of People with Disabilities' (2019) 33(1) *Bioethics* 91.

Direct Experience

13.11.17 SALRI received submissions from persons with direct personal experience of electing to have an abortion due to the identification of a fetal abnormality but also due to their own existing disability. One powerful submission read:

> I am a South Australian with a disability who recently had an abortion. I both wanted the abortion, and needed it because of my disability. I could not raise a child and could not live with giving it away. This was my choice but was also something absolutely necessary for my health … the law feels absolutely wrong and oppressive … I believe medical abortion should be easily available to be taken at home by themselves under medical advice, and later through pregnancy than currently available. Otherwise people like me can be excluded from access to legal abortion. I ended up having an abortion … It took me a long time to organise it, I felt rushed and stressed. I could easily have taken much longer, especially if I found out I was pregnant later. Women need plenty of time to plan and get an abortion. Late term abortions need to be available. Women should not be restricted from making this decision for themselves. Any restrictions make it difficult for people with the many varied personal circumstances to get access, such as disability, violence, distance, and health reasons.

13.11.18 There were differing accounts, notably pointing out that prenatal diagnosis may not prove wholly reliable.[1485] One party highlighted the inherent risk associated with prenatal screening – the diagnosis and predicted prognosis may not be accurate. Like any other medical procedure or test, in some cases, prenatal screening can only provide a calculated risk of diagnosis and associated prognosis. This party provided the positive narrative of a young boy, who was diagnosed with Dandy Walker Malformation at 22 weeks' gestation.[1486] Despite the poor prognosis, his parents decided to proceed with the pregnancy. Following his birth, the diagnosis of Dandy Walker Malformation was revoked. However, an abnormality in the nerve fibres of the brain was diagnosed. Early intervention has led to this young boy, now five years old, attending kindergarten.

13.11.19 However, SALRI heard that not all parents would reach the same decision.

13.11.20 One senior specialist obstetrician pointed out to SALRI that such decisions are very difficult and personal and will depend on the precise circumstances. It was noted to SALRI by a senior specialist obstetrician and a number of other practitioners that one family will come to a different conclusion than another confronting the same fetal disability. For example, a family living in a metropolitan location with ready access to specialist support and medical assistance may well chose to

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[1485] Another party in consultation also raised the issue of the risks and prognosis determined from prenatal diagnosis:

> 'For parents where genetic disability is carried in families or pregnancy tests indicate the possibility of genetic defects, Cerebral Palsy, Downs Syndrome etc other moral dilemmas and personal circumstances also come into play in decision making. As a personal example we had a pregnancy fraught with medical problems, with tests indicating that our child-to-be would be mentally/ physically disabled if carried to full term and we were advised to consider abortion. Our Christian beliefs and strength of faith ruled out abortion as an option for us and we went ahead to full term despite all the issues. We gave birth to healthy baby boy who has now grown into a fully functional and valuable member of society. My point here is that as a society we demand and rely too heavily on tangibles, on scientific/medical evidence and carelessly ignore the fact that 'science and the medical profession' don't always get it right. We demand 'perfection' and often make responses on material/monetary values and convenience without considering the intangibles — what blessings and joys the child might bring to their parents, their family and their society.'

[1486] Dandy Walker Malformation is a brain condition which results in a small cerebellum, enlargement of the fossa and dilation of ventricles (causing fluid in the brain). The future parents of this child were informed of the poor prognosis, including surgery following birth, 'developmental delays in motor and language skills', 'poor muscle tone, balance, and coordination', 'seizures', 'vision and hearing impairment' and issues with eye movement.

continue a pregnancy, whilst a family in a remote or rural location without such ready (or even any) access to specialist support and medical assistance may come to a different conclusion.

Roundtable Discussions - Disability Sector

13.11.21 The roundtable discussion with the disability sector was significant. Another concern related to the availability of accurate information following diagnosis of a fetal abnormality. It was noted information should not exaggerate the diagnosis and its clinical implications, nor should it encourage abortion.

13.11.22 The implications of late-term abortion within a disability context was discussed. The issues raised in cases where fetal abnormalities are diagnosed at a later term were also discussed.

13.11.23 There was reiteration of the very difficult discussion and decision for all involved in the situation where a fetal abnormality is identified, especially at a late stage. There was discussion of the sensitivities involved. One attendee noted that in an 'ideal world' with more modern and nuanced understanding of the nature of disability, one would hope that decisions would not be made lightly to have an abortion on the grounds of disability but ultimately one has to respect the autonomy of the woman involved and the law should not interfere with her decision. A woman may be unable to raise a child with a disability. The woman should be free to either proceed with the pregnancy or not.

13.11.24 A discussion relating to specific criteria to access late-term abortions revealed that attendees opposed the hybrid model — one medical practitioner at 22–24 weeks and two practitioners post 22–24 weeks. It was argued this model transfers the decision-making power from the woman to another person. An attendee noted, even in the context of late-term abortions, the 'premise…should be the woman's right to choose'.[1487]

13.11.25 Gestational limits were argued to present additional barriers to access, especially for women with disabilities. In some cases, a supporting decision-maker may be required.[1488] It was noted '[t]his may not align with gestational periods enumerated in law. There is pressure to conform to an established timeframe for decision-making'. For women with disabilities requiring support in their decision-making, gestational limits could be characterised as coerced abortions. Attendees agreed the imposition of gestational limits was inappropriate, limiting access to abortion and hastening difficult decisions. Following a diagnosis of fetal abnormality, attendees agreed a multi-disciplinary approach, adhering to best clinical practice, was required.

13.11.26 The severity of disability was discussed — an attendee questioned whether 'legal grounds [could] be reframed to prevent eugenic practices'.

13.11.27 The prevailing view was that grounds based on fetal abnormality should be removed from legislation and appropriate safeguards must be implemented to ensure the autonomy of women with disabilities is maintained.

Other roundtable discussions

13.11.28 At SALRI's roundtable with the legal and medical sector, several attendees were of the view that gestational limits restrict women's autonomy. An attendee noted gestational limits conveyed the message that 'women can't be trusted to make decisions about their bodies'. The general consensus amongst attendees was that a woman's autonomy should dictate any decisions regarding abortion. In

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[1487] See above Part 11.

[1488] An attendee noted the capacity to use the *Guardianship and Administration Act 1993* (SA) as a means to 'perpetuate paternalistic views on sub-groups of people, including with disability' was a concern in need of consideration.

relation to late-term abortions, attendees noted this issue should not dominate discussions as this procedure only occurs in very rare circumstances.

13.11.29 At SALRI's roundtable with faith groups, on 16 May 2019, different views were expressed. One attendee noted they had done some work on this they had 'at least three actual examples where mothers were advised to terminate and the child has been born alive and is doing very well now'. Another attendee questioned such assertions. 'You've given me the numerator but not the denominator. Three out of how many?' This attendee emphasised you cannot simply compel a woman to continue with a pregnancy if a real foetal abnormality is identified. It was explained:

> This would be one situation where if anything I as an individual medical practitioner would place more weight on the public's view than the medical view. At this point in the pregnancy this is not an unwanted baby. We as a community run the risk of being cruel to the parents in this situation if we don't have some reason to address that. Once recognising the very real concerns, limitations and so on, I think there should be in law some mechanism for managing that. This is a major medical and life crisis and needs to be managed as such.

13.12 SALRI's Observations and Conclusions

13.12.1 SALRI reiterates that the question of abortion and disability is difficult.

13.12.2 It is notable that virtually every party in SALRI's consultation regardless of their position on decriminalisation opposed any formal criteria for abortion on the grounds of disability. Particular objections were expressed by the disability sector. SALRI agrees with these wide criticisms in consultation that the present disability specific provision in s 82A of the *Criminal Law Consolidation Act 1935* (SA) as to when a lawful abortion is available, is objectionable and discriminatory.

13.12.3 The inclusion of a disability specific provision perpetuates the stigma attached to disability and portrays disability as an unwanted condition. SALRI agrees with the view of the VLRC that a law 'that specifically allows abortion for fetal abnormality is open to criticism for devaluing the existence of people who live with disabilities'.[1489] Such a ground is also outdated and offensive to the disability sector, as well as being uncertain, if not unworkable, in practice.

13.12.4 SALRI is of the view that the present disability specific provision should be repealed and should not be included in any future law; whatever model may be ultimately adopted in South Australia. SALRI notes the comments of the Committee on the Rights of Persons with Disabilities (CRPD Committee):

> The Committee is concerned about perceptions in society that stigmatize persons with disabilities as living a life of less value than that of others and about the termination of pregnancy at any stage on the basis of fetal impairment. The Committee recommends that the State party amend its abortion law accordingly. Women's rights to reproductive and sexual autonomy should be respected without legalizing selective abortion on the ground of fetal deficiency.

13.12.5 SALRI is of the view that, whilst a disability specific provision allowing abortion on that basis is inappropriate, any law that allows abortion to be lawfully performed on the basis of the woman's free and informed consent and/or a medical practitioner's decision or approval (if SALRI's alternative approach for late term abortions is adopted) that an abortion is medically appropriate, fetal abnormality can be regarded as one of the many matters that may properly influence a woman's private decision or the practitioner's decision/approval to undertake an abortion. SALRI acknowledges this is

[1489] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 45 [3.91].

a contentious area and would not wish to encourage 'eugenic' practices. However, it must ultimately be a decision for the woman involved and her family in consultation with her health and other advisers.

13.12.6 SALRI recommends that access to a clinical genetics service should be available (but not mandated) to all women where there is a family history of genetic conditions or where fetal abnormality has been detected through prenatal screening where a genetic cause is possible.

13.12.7 SALRI supports inclusive and accessible health care for all, as well as principles of autonomy. As such, SALRI recommends that counsellors providing abortion-related counselling to women with disabilities should be knowledgeable about disability awareness to ensure a sensitive, safe and inclusive environment for women with disabilities who may choose to access high-quality, impartial and non-directive counselling.

13.12.8 Recommendations

Recommendation 33

SALRI recommends that the present disability specific provision in s 82A of the *Criminal Law Consolidation Act 1935* (SA) as to when a lawful abortion is available should be removed, and should not be included in any new law.

Recommendation 34

SALRI recommends that access to a clinical genetics service should be available to all women where there is a family history of genetic conditions or where fetal abnormality has been detected through prenatal screening where a genetic cause is possible. It should be for the woman concerned to decide on undertaking any genetic counselling however, and SALRI therefore recommends any new law should not contain a requirement for mandatory genetic counselling or a mandatory referral to a clinical genetics service. The promotion and provision of genetic counselling could be further enhanced through:

a. the development or amendment of current medical frameworks and/or guidelines relating to the effective and timely referral to a clinical genetics service endorsing best clinical practice;
b. raising community awareness about clinical genetics services and the role of a genetic diagnostics and counselling service;
c. increasing access for all pregnant women to information about clinical genetics services and how to access such services; and
d. ensuring adequate resources are available to meet a likely increase in clinical genetic diagnostics and counselling service requests arising from changes to guidelines/frameworks and greater community understanding of such services.

Recommendation 35

SALRI supports inclusive and accessible health care for all, as well as principles of autonomy. As such, SALRI recommends that counsellors providing abortion-related counselling to women with disabilities should be knowledgeable about disability awareness to ensure a sensitive, safe and inclusive environment for women with disabilities who may choose to access high-quality, impartial and non-directive counselling.

Part 14 - Gender Selective Abortion

14.1 Submissions to SALRI and the NSW Legislative Council Committee

14.1.1 The practice of abortion on the basis of gender has been the subject of strong concern by international human rights bodies, particularly in the context of violence and discrimination against women.[1490]

14.1.2 The United Nations Special Rapporteur on violence against women, its causes and consequences has raised concerns:

> Cultural biases placing greater value on sons than daughters, as well as economic concerns (such as, for example, the perception that male children are more likely to provide financial support in the future) can lead to sex-selective abortions.[1491]

14.1.3 In their joint statement on gender selective abortion, OHCHR, UNFPA, UNICEF, UN Women and WHO stated:

> Sex selection in favour of boys is a symptom of pervasive social, cultural, political and economic injustices against women, and a manifest violation of women's human rights. Such injustices must be addressed and resolved without exposing women and children to the risk of death or serious injury through denying them access to needed services – and thus further violating their rights.[1492]

14.1.4 SALRI notes that concerns surrounding gender selective abortion were raised by a number of parties in its consultation.

14.1.5 Similar concerns were expressed in the context of the 2019 NSW Act. Both the NSW Legislative Assembly[1493] and Legislative Council,[1494] whilst deploring the practice of gender selective abortions, rejected, for various reasons, amendments seeking to preclude gender selective abortions.

14.1.6 Parties opposed to the decriminalisation of abortion in particular, such as Cherish Life Australia, the Australian Christian Lobby, Advocates International, Dr Šeman and Dr Turnbull and 40 Days of Life, suggested to SALRI that unregulated abortion laws may increase the risk of abortion on the basis of gender selection occurring in Australia. These parties supported a formal prohibition on gender selective abortions. They expressed concerns that gender selective abortion is particularly weighted against females, as preferences for males are prevalent in certain migrant communities.[1495]

[1490] See, for example, World Health Organisation, *Preventing Gender-Biased Sex Selection: An Interagency Statement OHCHR, UNFPA, UNICEF, UN Women and WHO* (Report, 2011).

[1491] Rashida Manjoo, *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences, Mission to Azerbaijan*, UN Doc A/HRC/26/38 (18 June 2014) [19]. See also Rashida Manjoo, *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences, Mission to India*, UN Doc A/HRC/26/38 (1 April 2014); Human Rights Council, *Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences on Her Mission to Georgia*, UN Doc A/HRC/32/42 (22 July 2016).

[1492] World Health Organisation, *Preventing Gender-Biased Sex Selection: An Interagency Statement OHCHR, UNFPA, UNICEF, UN Women and WHO* (Report, 2011).

[1493] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 87–95.

[1494] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 44–78.

[1495] See for example Aisha Dow, 'The "Missing Girls" never born in Victoria', *The Age* (online, 12 August 2018) <https://www.theage.com.au/national/victoria/the-missing-girls-never-born-in-victoria-20180811-p4zwxe.html>.

14.1.7 40 Days for Life and Canberra Declaration indicated to SALRI that abortion for gender selective purposes should be 'explicitly outlawed'.

14.1.8 In its submission to SALRI, Advocates International argued:

> In relation to sex-selective abortion … distinct trends have been identified between different communities. Specifically, 100 boys to every 100 girls were born to an Australian-born woman, while 125 boys to every 100 girls were born to women from certain migrant communities. This gender bias suggests women in those communities are undergoing abortion at a higher rate if it is determined they would deliver a female child.

14.1.9 Parties raising concerns (especially Dr Šeman and Dr Turnbull) cited to SALRI the example of Dr Hobart, a medical practitioner, who faced investigation by the Medical Board of Victoria and received a formal caution after refusing to provide a referral for an Indian couple who wanted an abortion on the basis of sex selection.[1496]

14.1.10 The Australian Christian Lobby, noting that the practice of gender selective abortion is generally opposed in Australia, argued that 'there should be a provision that sex selective abortion is not allowed and there should be sanctions for any person involved in sex selective abortion'. Indeed, the Australian Christian Lobby in its submission to the NSW Legislative Council Committee submitted:

> Sex-selection of babies is highly prevalent in some cultures and the preference is mostly for boys. These trends, amongst certain ethnic groups, are also happening in Australia. There is also growing pressure to allow sex-selection for 'family balancing'. It is abhorrent that a healthy child is aborted on the basis of sex. The proposed [NSW] Bill has no safeguards against sex-selection, opening the way to 'daughter slaughter'.[1497]

14.1.11 SALRI heard little evidence of gender selective abortion occurring in South Australia and these incidents were generally related to an alternate issue or concern where the gender was a factor.

14.1.12 One experienced medical specialist volunteered that during their many years of practice in this field involving 'literally hundreds' of patients they had never encountered a request or case of gender selective abortion. Another experienced medical practitioner acknowledged that they had encountered this situation more than once but emphasised these situations could be explained by legitimate concerns of a gender specific genetic medical condition.

14.1.13 SALRI notes that the issue of gender playing a role in whether a baby could inherit a genetic condition was raised by a number of parties in SALRI's consultations as a valid and justifiable reason for abortion based on gender. SALRI also heard from a clinical geneticist who noted this was a real concern for some families and testing could be undertaken to establish the risk of this occurring

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[1496] See Dr Mark Hobart, Submission No 885 to Health, Communities, Disabilities Services and Domestic and Family Violence Prevention Committee, *Health (Abortion Law Reform) Amendment Bill 2016* (5 October 2016) <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/18-HealthAbortion/submissions/885.pdf>; Miranda Devine, 'Doctor Risks his Career after Refusing Abortion Referral', *Herald Sun* (online, 5 October 2013) <https://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5>; Henrietta Cook, 'Abortion law changes eyed as Dr Mark Hobart probed', *The Age* (online, 7 November 2013) <https://www.theage.com.au/national/victoria/abortion-law-changes-eyed-as-dr-mark-hobart-probed-20131107-2x2rg.html>.

[1497] Australian Christian Lobby, Submission No 33 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64869/0033%20Australian%20Christian%20Lobby.pdf>.

however such testing took time and could not occur until later in gestation and as such was effectively redundant in South Australia due to the current upper limit for abortion procedures.

14.1.14 It has also been raised that currently in Australia women undergoing IVF can choose the sex of embryos, where doing so may reduce the risk of transmitting a serious genetic condition.[1498]

14.1.15 The general view raised in SALRI's consultation is that while most Australians would not agree with the practice of gender selective abortion for non-medical purposes, there is little evidence that this occurs and further, it should not be enforced within the framework of the criminal law but, rather, is sufficiently capable of being monitored and controlled by health law and practice.

14.1.16 The issue of gender selective abortions and the case for a legislative prohibition was a prominent theme surrounding the 2019 NSW Act.[1499] An amendment moved in the NSW Legislative Assembly to include a legislative prohibition on gender selective abortion 'to send a clear message that this Parliament will never support such an abhorrent practice'.[1500] The amendment was described as 'alarmist and unnecessary'[1501] and was not accepted (though an amendment requiring a review by the NSW Department of Health into the issue within 12 months was accepted).[1502] A similar amendment in the Legislative Council to prevent gender selective abortions was also not accepted[1503] (though an amendment requiring the Department of Health Review to include guidance to prevent gender selective abortions and authority for the Department of Health to issue such guidelines was accepted).[1504]

14.1.17 The concern over gender selective abortions was reiterated in some submissions to the NSW Legislative Council Committee. Pregnancy Help Australia submitted that the prevention of gender selective abortion must be ensured. 'It is absolutely abhorrent that a civilised country such as Australia should ever have to deal with this issue'.[1505] The Catholic Bishops of New South Wales argued that it is 'incongruous' that assisted reproductive technologies are not permitted to be used for sex selection, but that sex selection may occur by reason of abortion.[1506]

[1498] See National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (Report No 79, 2017) 72 [8.14.14] <www.nhmrc.gov.au/guidelines/publications/e79>: 'Sex selection techniques may not be used unless it is to reduce the risk of transmission of a genetic condition, disease or abnormality that would severely limit the quality of life of the person who would be born'. The National Health and Medical Research Council acknowledges the views of the Australian Health Ethics Committee that, in some circumstances, there may be no ethical barrier to the use of sex selection for non-medical purposes. However, there is limited research into the question of whether Australians support the use of sex selection for non-medical purposes, and until such research is conducted the current guidelines will stand.

[1499] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 87–97.

[1500] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 89 (Mr Ray Williams).

[1501] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 92 (Ms Jenny Leong).

[1502] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 87–97. This amendment also included a legislative declaration 'that this House opposes terminations being performed for the sole purpose of gender selection'.

[1503] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 44–54, 55–78.

[1504] New South Wales, *Parliamentary Debates*, Legislative Council, 19 September 2019, 73–81.

[1505] Pregnancy Help Australia, Submission No 9 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64830/0009%20Pregnancy%20Help%20Australia%20Ltd.pdf>.

[1506] Catholic Bishops of New South Wales Submission No 20 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 8

14.1.18 The ability to select the gender of a child by Assisted Reproductive Technology (ART) is a complex issue and beyond the scope of this Report.[1507]

14.1.19 There were suggestions from a number of parties to the NSW Legislative Council Committee that gender selective abortions are a real issue in Australia and a legislative prohibition is justified and necessary.[1508] Mr Flynn of the Australian Christian Lobby in giving evidence before the NSW Legislative Council Committee raised his 'genuine concerns'.[1509] Mr Flynn explained:

> There are cultural concerns that have been raised. We see it in China and India, where tens of millions of girls are missing because of a preference for boys over girls. We see that overseas and we hear La Trobe University saying, 'There are missing girls', and we hear Dr Mark Hobart saying,

<https://www.parliament.nsw.gov.au/lcdocs/submissions/64853/0020%20Catholic%20Bishops%20of%20New%20South%20Wales.pdf>.

[1507] In their 2017 review of ethical guidelines on the use of ART in clinical practice and research, the National Health and Medical Research Council (NHMRC) stated: 'Sex selection techniques may be used to reduce the risk of transmission of a genetic condition, disease or abnormality that would severely limit the quality of life of the person who would be born, when there is evidence to support claims that the condition, disease or abnormality affects one sex significantly more than the other, that the risk of transmission is greater than the general risk of the condition, disease or abnormality occurring within the general population': National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (Report No 79, 2017) 69 [8.13.1] <www.nhmrc.gov.au/guidelines/publications/e79 >. However, the NHMRC did not support sex selection for non-medical purposes indicating this should not occur 'until such time that wider public debate occurs and/or state and territory legislation addresses the practice'; at 72 [8.14]. In the NHMRC's 2015 public consultation, for the first time, the majority of submissions were in favour of non-medical sex selection. Submissions from the public were reviewed by Taylor-Sands and colleagues (2018), although they note that the attitudes expressed via a consultation process by nature are self-selective and may not represent the true views of Australian society more generally. Taylor-Sands et al found that 59% of publicly available submissions (65% of submissions which shared views about non-medical sex selection) were positive towards non-medical sex selection (NMSS) and supported it being allowed in Australia. When analysed thematically, the authors identified positive and negative attitudes towards NMSS. Positive views included themes related to parental reproductive autonomy, desire for a specific gender and family balancing, and harm minimisation arguing it would be safer for Australians to have this treatment here rather than travelling overseas to countries where NMSS is allowed. In contrast, negative views included concerns about gender discrimination (mainly regarding choosing one sex over another), valuing sex over gender, child welfare, and that to allow it would be a 'slippery slope towards designer babies'. The authors stated: 'This study highlights a potential shift in perception towards the issue of NMSS. The submissions analysed as part of our study demonstrate a permissive stance towards NMSS, running contrary to many of the views outlined in the scholarly literature, which generally adopt a restrictive approach…. The overarching permissive approach identified in the publicly available submissions is noteworthy, suggesting that many of the scholarly arguments against NMSS are potentially unsubstantiated.' It was also noted that the 'hypothetical concern' that NMSS would adversely impact sex ratios due to a preference for male children, was not found in the submissions. The authors suggested 'a more nuanced approach to regulation… rather than blank prohibition'. See Michelle Taylor-Sands et al, 'Non-Medical Sex Selection in Australia: Public Views and Bioethical Concerns' (2018) 18(2) *QUT Law Review* 44, 76.

[1508] See, for example, Australian Christian Lobby, Submission No 33 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64869/0033%20Australian%20Christian%20Lobby.pdf>; Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>. Right to Life NSW, Submission No 13 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64847/0013%20Right%20to%20Life.pdf>.

[1509] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 26 (Mr Dan Flynn, Chief Political Officer, Australian Christian Lobby).

'This happened in my clinic'. This is all evidence that can be pointed to, which, in my submission, should lead the Legislative Council to ban sex-selective abortions for the sake of young girls.[1510]

14.1.20 Women's Bioethics Alliance similarly contended:

> Sex-selective TOP is one of the many deeply ingrained cultural practices that exist around the world, including in Western countries, to devalue female human beings from their very inception.[1511] We already know that sex-selective practices in Australia are used to eliminate or avoid female fetuses among Indian and Chinese migrant families, according to a study of all births in Australia over a recent time period, and backed up by Australian Bureau of Statistics data, as well as international research.[1512] We note that there are those who believe sex selective terminations will not be an issue in New South Wales. We disagree.[1513]

14.1.21 However, the proposed amendment to the recent NSW Bill to prohibit gender selective abortion attracted extensive criticism as unnecessary and unworkable. In response to suggestions of abortion being utilised as a way of gender selection, the reported advice from the NSW Chief Obstetrician was that gender selection abortion does not take place in NSW.[1514] Family Planning NSW also agreed 'there is no evidence that gender selective abortions occur in NSW'.[1515] Other parties such as the NSW Pro-Choice Alliance shared this view. Marie Stopes Australia opposed the inclusion of gender selection in any law and the need for strong caution as the issue of gender selection and abortion is not grounded in evidence. 'Further public debate or amendments on this issue has the potential to discriminate against multicultural and diverse communities in Australia and would unfairly target people who already face barriers in accessing abortion care.'[1516]

[1510] Ibid 27.

[1511] The New Zealand Law Commission raised a concerning UK example. 'The British Pregnancy Advisory Service (BPAS) notes that some women in minority ethnic communities in the United Kingdom may face abuse or even murder if they give birth to a girl. BPAS observes that criminalisation of sex selective abortion does nothing to address these issues; in fact it is more likely to expose vulnerable women to the risk of further victimisation and potentially place the babies they are forced to carry to term in danger of neglect or harm': New Zealand Law Reform Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 181, n 25.

[1512] Kristina Edvardsson et al, 'Male-Biased Sex Ratios in Australian Migrant Populations: a Population-Based Study of 1,191,250 births 1999–2015' (2018) 47(6) *International Journal of Epidemiology* 2025. Whether this study actually bears out this interpretation is doubtful. See below [14.1.35]–[14.1.36].

[1513] Women's Bioethics Alliance, Submission No 49 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (19 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64931/0049%20Women%27s%20Bioethics%20Alliance%20ORIGINAL.pdf>. Indeed, one party claimed to the NSW Committee that 'it is estimated that at least 300 girls were selectively aborted in the communities under study in Victoria': Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) 7, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012%20Real%20Choices%20Australia.pdf>

[1514] Alexandra Smith, 'Berejiklian Backs "Gender Selection" Abortion Ban Amid Pressure', *Sydney Morning Herald* (online, 14 August 2019) <https://www.smh.com.au/politics/nsw/berejiklian-backs-strengthening-of-abortion-bill-amid-pressure-from-conservative-mps-20190814-p52gub.html>.

[1515] Family Planning NSW, Submission No 15 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64849/0015%20Family%20Planning%20NSW.pdf>.

[1516] Marie Stopes Australia, Submission No 14 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64848/0014%20Marie%20Stopes%20Australia.pdf. See also>.

14.1.22 Rape and Domestic Violence Services Australia stated:

> Since our organisation's formal establishment in 1974 as a women's collective providing trauma specialist counselling services for those who have experience sexual, domestic and family violence, we have not heard from a client that used abortion as a way of gender selection. Nor has our organisation come across any research suggesting gender selection as a factor when women consider accessing an abortion… The decision to have an abortion is not made lightly, nor without careful consideration of all possible options.[1517]

14.1.23 The NSW Council of Social Services also stated its opposition to any legislative prohibition on gender selective abortion. It described any such provision as 'an unnecessary amendment that was introduced on the highly prejudiced and completely unfounded notion that some cultural communities may choose abortion based on gender'.[1518] The NSW Council of Social Services cited a 2013 Senate Inquiry in response to a Bill before the Commonwealth Parliament seeking to restrict Medicare funding for gender selective abortions. The Senate Inquiry found there was no evidence this practice was taking place in Australia, hence the response should be community education, especially given that some genetic conditions are gender specific so any legislative prohibition could prevent access to abortions where there is a real risk of genetic medical conditions.[1519]

14.1.24 The Human Rights Law Centre expressed to the NSW Legislative Council Committee its concern about 'unsubstantiated claims' that decriminalising abortion and improving access to safe and quality abortion services in NSW would increase the number of gender selective abortions. They noted that they were unaware of evidence to show there is such a problem. 'However if there was, abortion bans are certainly not the appropriate way to deal with it.'[1520]

14.1.25 The Human Rights Law Centre further explained why in its view any legislative prohibition was not only unnecessary, but unhelpful. Its reasoning is worth setting out in full:

> Bans on sex-selective abortions will have unintended consequences that hurt women and block timely access to healthcare. A ban would require a doctor to interrogate a woman's reasons for seeking an abortion at any stage of pregnancy, thus completely undermining the spirit of the Bill to provide women with control over their own body. **There are hundreds of sex-linked conditions that vary in severity and can present devastating diagnoses**.[1521] In application, a ban on sex-selective abortions would place a burden on providers to scrutinise a patient's pregnancy choices and second-guess patients' reasons for seeking an abortion, thus discouraging honest, confidential conversations and interfering in the provider-patient relationship. The ban

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[1517] Rape and Domestic Violence Services Australia, Submission No 38 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64874/0038%20Rape%20and%20Domestic%20Violence%20Services%20Australia.pdf>.

[1518] NSW Council of Social Services, Submission No 44 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64880/0044%20NSW%20Council%20of%20Social%20Service.pdf>.

[1519] Finance and Public Administration Legislation Committee, Parliament of Australia, *Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013* (Report, 2013).

[1520] Australian Human Rights Law Centre, Submission No 25 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 14 [67] <https://www.parliament.nsw.gov.au/lcdocs/submissions/64857/0025%20Human%20Rights%20Law%20Centre%20ORIGINAL.pdf.>

[1521] This is a particularly compelling point and accords with SALRI's research and consultation.

> could discourage a woman who is a carrier of a sex-linked condition from having honest, confidential conversations about her concerns with her doctor out of fear that she could be forced to proceed with a pregnancy that would lead to the birth of baby who will suffer and then die. We are concerned that a ban would likely lead to marginalisation, and even racial profiling, of women from culturally and linguistically diverse backgrounds at the hands of health practitioners unsupportive of abortion, based on negative and wrongful stereotypes. We note that unsubstantiated conclusions were drawn about particular ethnic communities during the Legislative Assembly parliamentary debate, which highlights our concerns about the interaction between a legislative ban and the stereotyping of women from culturally and linguistically diverse backgrounds. While nominally aimed at combatting gender and racial discrimination, these laws could actually work to make quality reproductive healthcare less accessible by causing some women to fear they will be treated with suspicion. As a result, women may withhold vital information from healthcare providers or not feel they can seek care at all.[1522]

14.1.26 The view that any legislative prohibition on gender selective abortion is both unnecessary and fundamentally unworkable was also expressed by medical practitioners and associations to the NSW Legislative Council Committee.

14.1.27 Adjunct Professor Brassil noted that, as there is 'no evidence' that sex selection occurs in NSW, it would be 'irresponsible' to introduce rulings in relation to gender selection and 'we would be in a situation where we are making it up and we could create enormous harm'.[1523] Dr Philip Goldstone of Marie Stopes Australia said he wanted to dispel the 'myth' that decriminalisation will lead to gender selective abortion, explaining,

> As a doctor with more than 20 years of experience in providing abortions, I can tell you that gender is rarely an issue that is raised. In fact, the vast majority of abortions occur before gender can be readily determined. I believe that if we are to talk about sex selection, it must be grounded in evidence and some of the discussion I have heard on this issue this week unfairly discriminates and targets women from certain multicultural communities who may already face barriers to accessing abortion care.[1524]

14.1.28 Dr Bateson similarly told the NSW Legislative Council Committee:

> We have no evidence [of sex selective abortion]. Any legislation around this would be impossible to put into practice. As a doctor, the thought of having to interrogate a woman about her intentions, as it has been quoted, you know, to read her mind, will act as a deterrent to doctors providing abortions, it will act as a deterrent to women potentially seeking abortions. I think we have to act on the wisdom of the World Health Organisation, who has looked at the issue of gender imbalances across the globe and, in fact, the law is no way to tackle this. These are social issues, if at all they are occurring. I have worked in this area for many years and I have never come across a woman who has asked.[1525]

14.1.29 RANZCOG made clear that it did not support abortion on the basis of gender, but emphasised the importance of patient autonomy and insisted that health questions should be between a woman and her medical practitioner. RANZCOG further commented that it was unaware of any

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[1522] Ibid 14–15 [68]–[70].

[1523] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 23 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW). Professor Brassil noted that the La Trobe University review is 'inconclusive': at 24.

[1524] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Dr Philip Goldstone, Marie Stopes Australia).

[1525] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW).

evidence that gender selective abortions occur in practice and that 'current medical practice and ethical frameworks would make it highly unlikely that doctors would agree to perform a termination solely on the basis of gender'.[1526] On this basis, RANZCOG did not support specific legal provisions prohibiting gender selective abortion.[1527]

14.1.30 It was also observed in the debate as to the 2019 NSW Act that to include a formal prohibition on gender selective abortion would undermine the normal professional relationship between a medical practitioner and a patient and would require 'a doctor to move beyond a carer to a patient to become a mind reader.'[1528]

14.1.31 Dr Roach, the President of RANZCOG, in his evidence to the NSW Legislative Council Committee explained not only was there no evidence that gender selective abortions took place in Australia but any purported prohibition on such abortions amounted to 'offensive' 'racial profiling'.[1529]

14.1.32 The AMA(NSW) took a similar view. It reaffirmed its strong view that the issue of gender selective abortion 'is important for discussion but not within the framework of abortion legislation'. The AMA(NSW) noted it is unaware of any evidence showing that gender selective abortion is a real problem in practice and further said that existing health regulations and codes of conduct are sufficient to govern the safe and ethical practice of medicine.[1530] The AMA(NSW) elaborated:

> As technologies advance, the sex of a fetus can be identified earlier (currently 9-10 weeks). If prohibitions on gender selection are built into NSW law, it would make any request for an abortion after that point suspect. This would, in the best-case scenario, lead to delays and, in the worst-case scenario, to no treatment at all. Laws banning abortion for gender selection would not guarantee this would not happen but they would guarantee greater difficulty for women to access healthcare services and a fraught legal framework for doctors… if gender selection prohibition is

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[1526] RANZCOG, Submission No 39 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64875/0039%20The%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Obstetricians%20and%20Gynaecologists.pdf>. See also Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

[1527] Ibid. RANZCOG did however express support for the review of this issue to be conducted by the Ministry of Health. RANZCOG noted that it would reconsider its position should evidence indicate that the practice is of significant concern in Australia.

[1528] Danielle McMullen, 'Gender Selection Has Nothing to Do with Decriminalising Abortion: AMA', *Sydney Morning Herald* (online, 15 August 2019 <https://www.smh.com.au/national/nsw/gender-selection-has-nothing-to-do-with-decriminalising-abortion-ama-20190814-p52h2z.html>.

[1529] Dr Roach explained: 'the discussion and debate in the lower House around the issue of gender selection was that there was a huge reference to overseas populations in their own countries and in New South Wales. One of the things I found very concerning was that the discussion around the amendments effectively suggested we should concentrate on gender in a way that would end up with racial profiling. Frankly, that is offensive. It was interesting because in the discussion around gender selection the word "offensive" was thrown around all the time and when we talk about abortion we talk about the term "offensive". I think we should add in the fact that racial profiling is absolutely offensive and is not something that this country or Parliament should accept. This would end up precluding people from seeking care. We already know that women in general will be anxious about seeking care around abortion because of all the stigma associated with it. To have women who happen to have a certain racial background or religious background walking into a doctor's office assuming that the doctor may well be questioning them on that basis would be a huge disservice': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

[1530] Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>.

> built into NSW law, it would perversely lead to a situation that is worse for both women and doctors, even though abortion would no longer be on the *Crimes Act*. It's important to note that under current arrangements and, indeed, under the Bill, a doctor would be within their rights to refuse an abortion requested specifically on the grounds of gender selection.[1531]

14.1.33 This refusal could be on either medical grounds or conscientious objection.[1532]

14.1.34 Dr Danielle McMullen from the NSW Branch of the AMA, speaking in both a personal capacity and on behalf of the AMA, expanded on these strong concerns in her evidence before the NSW Legislative Council Committee:

> In the light of the recent media, we felt the need to highlight that particularly amendments regarding gender selection would cause us deep concern. That is not because we are blind or uncaring, unethical or immoral: It is that we know that any complication of this legislation will impede access for women seeking termination for any reason. We also hold deep concerns regarding the ramifications for doctors. If such amendments were to pass it would potentially make any doctor providing abortion services after nine weeks party to a crime. That is because we can now, with technological advances, find out fetal sex from about nine weeks gestation and that this is becoming relatively common practice. Therefore, if a women seeks termination of pregnancy after this point, any laws prohibiting gender selection as a reason would require doctors to be mind-readers of sorts to ensure no crime was being committed. This would have the effect of delaying or preventing the delivery of care. We would also say, as we heard before, that there is nowhere evidence of women approaching their doctors seeking termination of pregnancy on the grounds of gender selection. If there was evidence that this was happening, we are confident that under current arrangements or under the Bill as proposed doctors would be within their rights to refuse a termination based on gender selection being the primary reason. A gender selection ban would not result in its ostensibly desired outcome, but what it would do is delay and prevent treatment for the women of New South Wales.[1533]

14.1.35 Parties arguing to SALRI and/or the NSW Legislative Council Committee for a formal prohibition on gender selective abortion placed considerable weight on a La Trobe University study.[1534] This study considered the male to female children born to migrant families from China, India and South East Asia. The study examined the male to female ratio of children at birth according to the mother's country of birth for all registered births in Victoria between 1999 and 2015. The study also compared the male female ratio among births to mothers born elsewhere to that of mothers born in Australia, stratified by time period and parity. The study found that, compared with the naturally occurring male ratio as well as to the male to female ratio among births to mothers born in Australia, there was an increased ratio of male births to mothers born in India, China and South-East Asia. The

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[1531] See also below Part 17.

[1532] Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>.

[1533] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 25, 28 (Dr Danielle McMullen, Vice President, Australian Medical Association (NSW)); Danielle McMullen, 'Gender selection has nothing to do with decriminalising abortion: AMA', *Sydney Morning Herald* (online, 15 August 2019) <https://www.smh.com.au/national/nsw/gender-selection-has-nothing-to-do-with-decriminalising-abortion-ama-20190814-p52h2z.html>.

[1534] Kristina Edvardsson et al, 'Male-Biased Sex Ratios in Australian Migrant Populations: a Population-Based Study of 1,191,250 births 1999–2015' (2018) 47(6) *International Journal of Epidemiology* 2025.

most male-biased sex ratios were found among multiple births to Indian-born mothers, and parity of two or more births to Indian and Chinese-born mothers in 2011–2015.[1535] The authors concluded:

> This study provides evidence that prenatal sex selection may be taking place following migration to Australia. It is important that health policy makers support and strengthen population-based surveillance systems that allow for monitoring of birth outcomes, birth sex ratios (also by parity), and other relevant indicators for gender discriminatory practices in pregnancy and childbirth, to reinforce social policies to tackle gender discrimination in all its forms, including son preference, and to evaluate the adherence and effectiveness of such policies.[1536]

14.1.36 SALRI notes that the La Trobe University study does not bear the selective interpretation placed on it by parties opposed to the decriminalisation of abortion.[1537] The study makes it clear that 'it is important to note also that we are unable to draw conclusions about the individual contribution of assisted reproduction versus pregnancy termination to our findings'.[1538] The lead author, Dr Kristina Edvardsson, has reiterated that the study did not cover abortion and does not present any conclusive evidence that gender selective abortion takes place in Australia.[1539] Dr Edvardsson noted that 'the findings from our study have been discussed in a range of forums, and we find that findings have been misinterpreted or misrepresented in some of these discussions'.'[1540]

[1535] Ibid.

[1536] Ibid 2036.

[1537] Kristina Edvardsson et al, 'Male-Biased Sex Ratios in Australian Migrant Populations: a Population-Based Study of 1 191 250 births 1999-2015' (2018) 47(6) *International Journal of Epidemiology* 2025, 2036. La Trobe University recently told the ABC of the study: '… the epidemiologist who carried out the research, Dr Kristina Edvardsson, is worried her findings have been misconstrued. She wasn't available for interview, but the university told The World Today her research is inconclusive about whether gender selective abortions are actually happening in Australia': Isobel Roe, 'NSW Abortion Debate Moves to Gender Selection Concerns', *The World Today* (ABC Radio National, 15 August 2019) <https://www.abc.net.au/radio/programs/worldtoday/nsw-abortion-debate-moves-to-gender-selection/114164666>. The Human Rights Law Centre told the NSW Legislative Council: 'Critically, the study found that, from over 1 million births **in Victoria**, the overall ratio of boys to girls was appropriate. While it identified higher numbers of boys born to mothers from a handful of countries, it **could not draw conclusions** on the contribution that overseas assisted reproductive services or abortion had on the findings. The study made no recommendations about abortion laws. Rather, its conclusions emphasise the importance of health policy makers reinforcing "social policies to tackle gender discrimination in all its forms"': Human Rights Law Centre, Submission No 25 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 14 [66], quoting Kristina Edvardsson et al, 'Male-Biased Sex Ratios in Australian Migrant Populations: a Population-Based Study of 1,191,250 births 1999–2015' (2018) 1(13) *International Journal of Epidemiology* 12.

[1538] Kristina Edvardsson et al, 'Male-Biased Sex Ratios in Australian Migrant Populations: a Population-Based Study of 1,191,250 births 1999–2015' (2018) 47(6) *International Journal of Epidemiology* 2025, 2036.

[1539] 'We have evidence to say that sex ratios at birth were male-biased in some communities in Victoria during the specified time periods and our findings are consistent with findings from a number of other western high-income countries, including the United States, UK, and Canada. However, as stated in our publication, we were unable to draw conclusions about the individual contribution of assisted reproduction versus pregnancy termination to our findings, and we do not know whether any procedures occurred in Australia or elsewhere': Dr Kristina Edvardsson quoted in Samantha Maiden, 'Key La Trobe Study "Misrepresented" in NSW abortion debate "gendercide": claim Authors', *New Daily* (online, 22 August 2019) <https://thenewdaily.com.au/news/national/2019/08/22/abortion-debate-nsw-study/>.

[1540] Ibid. It has been suggested that the disparity may be due to gender selective ART employed outside Australia. As early as 2013, Associate Professor Bowman, Medical Director at Genea IVF, stated: 'the ban on social sex selection in Australia had done little to change decisions by couples, and merely motivated them to seek treatment overseas.'

14.2 SALRI's Observations and Conclusions

14.2.1 SALRI shares the strong concerns expressed as to the performance of abortions purely on the basis of gender. Any such practice is deplorable and discriminatory.[1541]

14.2.2 However, SALRI considers that suggestion of a formal prohibition in South Australia on gender selective abortion is inappropriate and should not be adopted. There are strong reasons against any such provision.

14.2.3 SALRI is of the view that, on the available evidence, any such prohibition is unnecessary. Whatever may be the situation overseas, there appears little, if any, evidence that abortions purely on the basis of gender are a real issue in Australia. SALRI had limited material presented to it on this question but the evidence presented to the NSW Legislative Council Committee, notably from the AMA(NSW),[1542] also bears out abortions purely on the basis of gender are not a real issue in Australia. The La Trobe University study is inconclusive.

14.2.4 Any such prohibition would be likely to restrict or delay access to abortion services.

14.2.5 SALRI considers that any legislative prohibition on gender selective abortions is likely to prove unworkable and simply unenforceable. It would place medical practitioners in a difficult, if not impossible, position. They would effectively become detectives or required to investigate the unexpressed motivations of patients in their care. Any prohibition against gender selective abortion may lead to the situation where women do not need to provide a reason for requesting an abortion, but contrarily would need to establish that their request is not on the basis of gender selection. Alternatively, the onus may be on the medical practitioner to establish that a woman is not seeking an abortion for this reason. AMA (NSW) suggests that this 'would perversely lead to a situation that is worse for both women and doctors'. Any legislative requirements to confirm that an abortion is not requested on the basis of gender selection would undermine patient autonomy and the existing frameworks that govern the safe and ethical practice of medicine.

14.2.6 There may be legitimate reasons for an abortion on account of gender. As the Human Rights Law Centre noted: 'It should be recalled that there are hundreds of sex-linked conditions that vary in severity and can present devastating diagnoses.'

14.2.7 Any prohibition on gender selective abortions also gives rise to concerns of 'racial profiling' as suggested by Dr Roach of RANZCOG and the Human Rights Law Centre to the NSW Legislative Council Committee.

14.2.8 SALRI acknowledges that any suggestion of gender selective abortion raises concern, but any legislative prohibition on gender selective abortion is unnecessary, as well as likely to be unenforceable, and therefore recommends that there should be no legislative prohibition in South Australia on gender selective abortion.

[1541] World Health Organisation, *Preventing Gender-Biased Sex Selection: An Interagency Statement OHCHR, UNFPA, UNICEF, UN Women and WHO* (Report, 2011).

[1542] See also Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>.

14.2.9 SALRI suggests that any concerns about gender selective abortion practices should be considered as part of the recommended future review of this law after five years.[1543]

14.2.10 Recommendation

Recommendation 36

SALRI notes that any suggestion of gender selective abortion raises concern, but any legislative prohibition on gender selective abortion is unnecessary, as well as likely to be unenforceable, and therefore recommends that there should be no legislative prohibition in South Australia on gender selective abortion.

[1543] See above Recommendation 1.

Part 15 - Access and Availability

15.1 Metropolitan and Regional Access

15.1.1 A vital consideration, reflecting SALRI's Terms of Reference, is to examine equitable and effective regional, rural and remote access in comparison to metropolitan services. This was a strong theme in SALRI's consultation. A consistent theme emphasised to SALRI (especially during its consultation trips to Port Augusta, Whyalla, Ceduna and Port Lincoln) were the problems arising from 'the tyranny of distance' (often compounded by the present law) in relation to regional, rural and remote access. This is not an issue confined to South Australia.[1544]

15.1.2 An abortion is available in South Australia at no cost to Medicare Card holders at a public facility. This is unlike the situation interstate where private providers dominate.

15.1.3 The public provision of abortion services in South Australia was singled out by many parties in consultation such as the Castan Centre for Human Rights Law and the Australian Women's Health Network as a commendable aspect of present practice that must be retained.[1545] As one submission noted: 'I believe that abortion is an essential health care service. In South Australia we are fortunate to have most abortions performed in metropolitan public hospitals, generally free of charge.' The South Australian Abortion Action Coalition observed that, 'despite its outdated and restrictive laws, South Australia has excellent specialised abortion services in metropolitan Adelaide which have been described by interstate counterparts as the gold standard model for abortion service delivery'.[1546]

15.1.4 Service availability in Adelaide is not without restrictions however, with the Pregnancy Advisory Centre (PAC) being the only legally prescribed facility in Adelaide where abortion consulting is available Monday to Friday each week and appointments can be obtained promptly. The PAC however is no longer able to provide surgical abortion procedure with all patients being referred to the Queen Elizabeth Hospital.[1547] Other facilities only provide limited abortion consultation, for instance the Flinders Medical Centre currently has a two week wait for abortion appointments, and the practice only consults for half a day a week. Abortion procedures occur only one morning each fortnight.[1548]

[1544] See, for example, Frances Doran and Julie Hornibrook, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16 *Rural and Remote Health* 3538; Frances Doran and Julie Hornibrook, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 15 *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 1; Ainslie Drewitt-Smith and Melinda James, 'Abortion Services Lacking in Regional NSW, placing Stress on Women', *ABC News* (online, 2 November 2018) <https://www.abc.net.au/news/2018-11-02/abortion-services-in-regional-lacking-case-workers-say/10455510>.

[1545] Associate Professor Barbra Baird explained to SALRI that the 1969 reform 'opened the way for the development of mostly good services which through the 1970s and 1980s were increasingly provided in the public sector. After community activism and government investigation of declining accessibility of services in the 1980s the Pregnancy Advisory Centre was established in 1992 as part of the QEH and has become a centre for excellence in abortion care. It currently provides about 60% of all abortion services in SA. That SA has been committed to publicly provided abortion care distinguishes it from every other jurisdiction, to our great credit.'

[1546] A leading health agency supported the maintenance and strengthening of the public provision of abortion in South Australia.

[1547] Rebecca Puddy, 'Concerns for women after SA closes two centres for surgical abortion', *ABC News* (online, 19 September 2019) <https://www.abc.net.au/news/2019-09-19/abortion-services-cut-in-south-australia/11517836>.

[1548] SALRI notes the submission of the University of Sydney Policy Reform Project.

15.1.5 Metropolitan services have further been impacted by the Women's and Children's Hospital in North Adelaide, which is the location of central Adelaide's public obstetric services, no longer providing abortion services on site and transferring all abortion services to the PAC and Queen Elizabeth Hospital. This led to a significant increase in wait times for women seeking abortion services and some women requiring a surgical abortion due to the delays associated with this change.[1549]

15.1.6 One specialist medical practitioner told SALRI that a series of recently trained medical practitioners who were recruited to provide abortions in South Australia have resigned, lost their jobs or withdrawn from providing abortions. This has left 'a small embattled cohort working very hard to meet demand'. The specialist medical practitioner explained that the high attrition rate demonstrates that things are getting worse (rather than better) for the relatively few medical practitioners in South Australia who are still able and willing to perform abortions. It was noted that succession planning has become difficult for providers who are concerned for the welfare of younger colleagues who may take over their work.[1550]

15.1.7 Despite the restrictions and recent changes there was noted to still be a distinct difference between the services and supports available between metropolitan and regional areas.

15.1.8 The importance of access to abortion advice and services in South Australia (as elsewhere) is vital.[1551] It is especially important that rural, remote and regional (and Aboriginal) communities are not disadvantaged in this context. The QLRC noted:

> United Nations treaty bodies have recognised that full enjoyment of the right to health, including sexual and reproductive health, requires access to the full range of health services without discrimination, including availability, physical and geographical accessibility, and affordability, particularly for women in rural areas.[1552]

15.1.9 There is a strong indication that present law and practice in relation to abortion in South Australia disadvantages parties in rural, remote and regional locations. In 2016, 672 women who resided in country South Australia underwent an abortion. Only 85 of those (12.6%) were able to have an abortion in their country area, with the rest needing to travel to the metropolitan area for the procedure. Of those that had an abortion in the city, 21 % (141 of the 672) had a medical abortion and so ideally could have been offered the service closer to home. This leads to costs incurred for travel and accommodation (generally for two nights) for country women, including social costs of leaving supports and family responsibilities.

[1549] Rebecca Puddy, 'Concerns for women after SA closes two centres for surgical abortion', *ABC News* (online, 19 September 2019) <https://www.abc.net.au/news/2019-09-19/abortion-services-cut-in-south-australia/11517836>.

[1550] One of the primary reasons for this attrition was said to be the workplace harassment and lack of support for those willing to provide abortion services.

[1551] The importance of proper access is important. The closure of Tasmania's main abortion provider, for example, forces women to travel to Melbourne, having particular impact on low income women. See Sue Bailey, 'Tasmanian Women Face Big Costs if They Travel Interstate for Abortions', *Sydney Morning Herald* (online, 8 March 2018) <https://www.smh.com.au/national/tasmanian-women-face-big-costs-if-they-travel-interstate-for-abortions-20180308-p4z3il.html>; Rhiannon Shine, 'Abortion Rally at Tasmanian Parliament ups pressure on Hodgman Liberal Government', *ABC News* (online, 24 May 2018) <https://www.abc.net.au/news/2018-04-28/abortion-rally-at-parliament-ups-pressure-on-state-government/9707190>.

[1552] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 26 [93]. See also at 102–103 [23]–[25], 104 [29]–[30].

15.1.10 The delays which can be caused by the need to make arrangements to travel to a metropolitan area, as well as the costs associated with being away from home can also cause to women requiring, or electing to have, a surgical abortion as opposed to a medical abortion.

15.1.11 However, various parties and health practitioners told SALRI that some (but not the majority) of women from regional or rural areas who travel to Adelaide for an abortion do so for reasons of confidentiality and anonymity. Although this is a choice for some women this should not diminish major problems in terms of access for women from regional, rural and remote and Aboriginal communities.

15.1.12 Both the VLRC[1553] and the QLRC[1554] expressed concerns in various contexts regarding remote, regional and remote access to abortion services.[1555] The VLRC found that Victorian women who live outside the Melbourne metropolitan area generally have to travel to Melbourne to obtain an abortion.[1556] There are no private clinics operating in rural and regional Victoria and very few public providers. In areas where there is a public hospital service, some women may have concerns about privacy and confidentiality.[1557]

15.1.13 In its submission to the VLRC, Women's Health Victoria highlighted the problems that lack of access to services cause for women in rural and regional Victoria, including the difficulty, stress, inconvenience and cost of travel to obtain an abortion.[1558] Access problems for women in rural and regional Victoria were widely raised to the VLRC in its consultation, the problems included difficulty obtaining information or referral to abortion services; the cost and inconvenience of having to travel to Melbourne (or even interstate) to obtain an abortion; lack of information about and access to fetal testing; delays in obtaining test results because of medical availability; availability of counselling and privacy.[1559] The VLRC noted that as impediments to access abortion cause delays, it is likely that this results in later abortions.[1560]

[1553] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 42 [3.71], 47 [3.100]–[3.103], 53 [3.134], 78 [5.67], 114 [8.28], 127 [8.149]. See also Carolyn Nickson et al, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329.

[1554] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 41 [2.115]–[2.117], 41 n 83, 56 [3.29], 91 [3.167], 92 [3.170], 102 [3.221], 105 [3.124]–[3.125], 125 [4.42], 143 [4.129], 145 [4.134], 146 [4.141], 151 [4.172]–[4.173], 181 [5.118]. See also further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016) [12.6.3]–[12.6.5].

[1555] See also Frances Doran and Julie Hornibrook, 'Rural New South Wales Women's Access to Abortion Services: Highlights from an Exploratory Qualitative Study' (2014) 22(3) *Australian Journal of Rural Health* 121.

[1556] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47 [3.100]. See also Carolyn Nickson et al, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30 (4) *Australian and New Zealand Journal of Public Health* 329.

[1557] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47 [3.100].

[1558] Ibid 47 [3.101].

[1559] Ibid 47 [3.102]. Women's Health Victoria told the VLRC 'that women living in rural and regional areas are more likely to experience anti-choice attitudes by medical practitioners. Hospitals and doctors are more readily able to avoid their responsibility to provide reproductive health services, including termination of pregnancy, because it is difficult to attract health professionals to these areas. As a consequence, those that do provide services to these areas have significant influence over what information is made available to pregnant women. This coupled with the indeterminate legal status of termination presents doctors in rural and regional areas with the opportunity to deny women access and information about these services': at 47 [3.102].

[1560] Ibid 47 [3.103]. See also Elly Taylor, *'The Difficulties Young Rural Women Face in Trying to Obtain Surgical Terminations of Pregnancy'* (PGDipWGS, The University of Melbourne, 2007) 29–30.

15.1.14 The presence of conscientious objection in Victoria has been noted as further compounding and limiting rural access.[1561] The UK Parliamentary Committee report on abortion services in the UK also found that conscientious objection by medical practitioners, to the extent of not referring the patient to another medical practitioner for information and advice on the issue, contributes to delay in women presenting for abortions.[1562]

15.1.15 Parties also raised to the QLRC 'the geographical and current service requirements within Queensland mean that there are issues with the accessibility and availability of abortion services in rural, regional and remote areas.'[1563] One recent study observed that 'women who are socially, geographically and economically disadvantaged, have limited choice and access to abortion'.[1564] Women in rural, regional and remote areas may have to travel long distances access abortion services and face additional financial costs (for example, the cost of travel and accommodation).[1565]

15.1.16 It has been suggested that the current law in Queensland 'has created uncertainty among doctors about how the law works in practice' and that the possibility of prosecution 'acts as a deterrent to doctors, impeding the provision of a full range of safe, accessible and timely reproductive services for women'.[1566] This may disproportionately impact on women who are already disadvantaged, including women in low socio-economic groups, women in rural, regional and remote areas and Aboriginal women.[1567]

15.1.17 The Northern Territory Family Planning Welfare Association said that the Northern Territory is a designated remote area with limited health resources, and in their view 'the reformed [abortion] law has and will make a positive difference to the lives of women living in rural and remote areas'.

15.1.18 The themes outlined above and expressed in Victoria, Queensland and the Northern Territory were reiterated in SALRI's consultation as also being significant areas of concern in South Australia. Health practitioners in Port Augusta, Whyalla, Ceduna and Port Lincoln highlighted the 'tyranny of distance' in relation to equitable and effective access to abortion (and other health services) for rural, regional, remote and Aboriginal communities.

15.1.19 Submissions to the NSW Legislative Council Committee also highlighted problems in rural and regional access. Family Planning NSW observed:

> Women in rural and remote communities often need to travel hundreds or thousands of kilometres or even interstate in order to access an abortion. In a number of regional areas, access to abortion services is severely limited. In areas where the local general practitioner (GP) does not provide this

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[1561] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47 [3.102]–[3.103], 114 [8.28].

[1562] Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967* (House of Commons Paper No 12, Session 2006–07) 36. Several parties confirmed to the VLRC that this was also a problem in Victoria: Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47, n 147.

[1563] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 56 [3.29].

[1564] Mridula Shankar et al, 'Access, Equity and Costs of Induced Abortion Services in Australia: a Cross–Sectional Study' (2017) 41(3) *Australian and New Zealand Journal of Public Health* 309, 313; Frances Doran and Julie Hornibrook, 'Rural New South Wales Women's Access to Abortion Services: Highlights from an Exploratory Qualitative Study' (2014) 22 *Australian Journal of Rural Health* 121.

[1565] Carolyn Nickson, Anthony Smith and Julia Shelley, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329.

[1566] See further Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016) [12.1.1].

[1567] Ibid [12.6.3]–[12.6.5]. SALRI is especially keen to ensure that Aboriginal communities are not disadvantaged.

service, or the pregnancy is beyond nine weeks and medical abortion is not possible, women rely on their doctors to advocate for them to access an abortion.[1568]

15.1.20 It was widely stated to SALRI that present law and practice particularly impacts women in regional, rural and remote areas of South Australia in several ways. Firstly, the fact that any abortion procedure must be carried out in a 'prescribed hospital'.[1569] Secondly, the fact that any procedure requires the involvement and consent of two medical practitioners who are available to personally examine the woman.[1570] 'The third barrier is that the provision of abortion is limited to "medical practitioners"'.[1571] A further problem is the effect of conscientious objection[1572] and its high uptake in rural, regional and remote areas, which can have a drastic effect on availability.[1573]

[1568] Family Planning NSW, Submission No 15 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64849/0015%20Family%20Planning%20NSW.pdf >. The submission further noted one regional GP in a regional area who was interviewed as part of a research project told researchers about a 15 year old patient with an intellectual disability who was pregnant as a result of rape: 'Eventually I got one from… one of the obstetricians here. I first of all had it declined and then I rang them up and it was only because I started crying that he agreed to do the termination because he's known me for a long time. He basically sort of said oh, for God's sake …, I'll do it, but I'm not doing it again.'

[1569] 'The current law requires that all abortions must be performed in 'a prescribed hospital'. Originally very well intentioned to ensure the safe provision of surgical abortion, the global emergence of safe and effective early medication abortion (EMA) in 1988 means that the current interpretation of prescribed hospital is now out of step with evidence based best care practices… SA women are not able to use telemedicine services for EMA. To access EMA in South Australia, a woman must attend a prescribed hospital for those two or more visits. Stories abound of women who inappropriately walked from a GP surgery to a prescribed hospital or were incomprehensively required to find overnight babysitters, drive many hundreds of kilometres to access EMA while cramping in the car, take several days off work or stay in a hotel or rely on supportive friends who have a spare couch. Our laws do not serve those women. If they do not live close to a prescribed hospital, they are not served. They are given barriers to their health care. Across other Australian jurisdictions, EMA services are provided according to best practice guidelines of leading health authorities. These guidelines enable women to take the prescribed medication at home with support and follow-up care if required. The impact of the current legal requirement for all abortions to be performed in a prescribed hospital is felt most keenly by women living in regional SA where abortion services are scarce. The majority of women living in regional SA who have an abortion within the current law need to travel and this involves delays, stress and an undue financial burden… These experiences are totally avoidable and this is certainly not 21st century health care': South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2423–2428 (The Hon Tammy Franks MLC). See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.124]–[3.125]

[1570] 'Barrier number two is the requirement for an examination and certification by two doctors. In SA, abortion is the only health procedure that requires examination and certification by not one but two legally qualified medical practitioners in order to make the procedure lawful. One doctor is not lawful. This is unnecessary and archaic and underscores and reminds all involved, especially those doctors that in our healthcare system abortion are still firmly placed within a criminal context… It can contribute to delay in access when a second doctor may not be available to certify that procedure. In fact, some medical practitioners identify the location of abortion in the criminal law as a reason for their reluctance to be the second examiner': South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2423–2428 (The Hon Tammy Franks MLC).

[1571] 'International research demonstrates that abortion can be safely and effectively provided by appropriately trained healthcare providers, not only by medical practitioners… By precluding these providers from supporting women in this way, the current law yet again constrains the possibilities for best health care': South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2424 (The Hon Tammy Franks MLC).

[1572] See above Part 17.

[1573] See, for example, Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1; Charlotte King, 'Rural Women Face "Alarming" Abortion Service Gaps, Study Finds', *ABC News* (online, 5 October 2017) <https://www.abc.net.au/news/2017-10-02/access-gaps-to-abortion-services-in-victoria/9007024>. A Melbourne University survey into the approach of rural GPs in the Grampians and Wimmera regions of western Victoria's west to abortion found 38% of the GPs who responded claimed they would conscientiously object to facilitating a medical or surgical abortion. It was noted that the national average is thought to be about 15%.

15.1.21 Many submissions to SALRI highlighted the problems in access under the present law.[1574] The Department of Health and Wellbeing identified many of the current legal restrictions are out of step with current clinical practice and 'require removal or amendment in order to improve access for all women to abortion services'. The Department of Health and Wellbeing suggested removing the requirement for two medical practitioners to examine a pregnant woman prior to an abortion, the need for a prescribed facility,[1575] the residency requirement and in person examination. This view was also repeated by many medical and other health practitioners (especially in rural and remote locations) and at SALRI's roundtables with the disability sector, the legal and medical sectors and parties favouring the decriminalisation of abortion.

15.1.22 There was particular criticism to SALRI of the requirements for a personal examination by two medical practitioners at a prescribed hospital. These requirements were seen as unnecessary and outdated. Associate Professor Catherine Kevin, for example, was critical of the two doctor rule:

> This is an insult to a woman's reproductive autonomy as it assumes that she is not in a position to assess her own reproductive health needs. It is also an inefficient use of precious health resources. The two signatures can make abortion more difficult to access in smaller communities where there may be only one doctor committed to abortion provision. It also increases the time spent undertaking administrative requirements and therefore runs the risk of delaying the procedure when time is of the essence.

15.1.23 The Hon Tammy Franks saw the need for both a prescribed hospital and a second medical practitioner as unnecessary and a waste of public resources.[1576] The Central Adelaide Local Health Network (Pregnancy Advisory Centre) described the current requirement that two medical practitioners personally examine the woman as 'unnecessary, expensive and poor use of medical resources. It can contribute to delay in access where doctors might not be available.'

15.1.24 Dr Erica Millar observed:

> The discrimination against women living outside of Adelaide is built into two specifications of the current criminal law: the requirement that two medical practitioners must assess and approve of an abortion; and the requirement for abortion to be 'carried out in a hospital". Women who are living in rural and remote communities do not always have ready access to two doctors, let alone two doctors who would support their decision to terminate their pregnancy … The hospital requirement in the current law should be removed. It is also outdated because it does not account for the development of medical abortion, which is less invasive than surgical abortion and does not require the use of anaesthetics. This requirement has also led to a gross inequality of access to abortion services between women living in Adelaide and those living in rural and regional communities. It is essential that the law in South Australia allow for the provision of abortion by

[1574] This point was especially made to SALRI by the Hon Tammy Franks and the submission of the University of Sydney Policy Reform Project.

[1575] The Department of Health and Wellbeing noted that this historic legislative requirement was introduced in 1969 when surgical abortion was the only available method. Due to the nature of that procedure a list of prescribed medical facilities where the surgical procedure could be carried out was included in the law. This legal requirement does not reflect current clinical practice and the proportion of abortions being carried out using medication is now rising annually, with over one third of all abortions in South Australia in 2016 completed using prescribed medications. The Department of Health and Wellbeing said allowing medical abortions from appropriately qualified practitioners to be conducted in the community will improve access to abortion services, in particular for South Australian women in rural areas.

[1576] Ms Franks also noted: 'This requirement also enforces the inefficient overuse of our scarce medical resources. It can contribute to delay in access when a second doctor may not be available to certify that procedure. In fact, some medical practitioners identify the location of abortion in the criminal law as a reason for their reluctance to be the second examiner.'

> telemedicine and all suitably trained and accredited health professionals in order to ensure equality of access to this essential health service.

15.1.25 The South Australian Abortion Action Coalition said any formal requirement for two medical practitioners 'is completely out of step' with the principles of informed consent for adults as exists for the provision of any other medical procedure in South Australia and 'demeans women's decision-making authority and creates significant barriers and additional loss of privacy for South Australian women living in regional and rural areas'. It noted such a requirement can cause delays and extra costs and 'is not consistent with women's human rights and should not be a feature of any future legislation'. The South Australian Abortion Action Coalition also 'strongly submitted' that the prescribed hospital requirement is unnecessary and should be removed:

15.1.26 This was a recurring theme in consultation. As one submission urged:

> We should improve access to both surgical and early medication abortion to people in rural and regional areas. The 'two doctor' rule is unnecessary and out of line with current health care practice, evidence and standards. Abortion should be treated like any other health care.

15.1.27 A contrasting view that SALRI heard was that people who choose to live in a rural or remote location cannot expect the same level of service as in urban areas. Genesis Pregnancy Support Inc, for example, argued:

> Convenience does not, nor should it ever, supersede best health care. There are many health issues where appropriate treatment poses inconveniences. (Those who live rurally, accept that to do so will necessitate compromise regarding time and travel for a variety of issues, including accessing health care for themselves and their children.) They are no more disadvantaged by having to travel for abortion than for any other medical treatment.

15.1.28 It was also argued by a number of parties opposed to the decriminalisation of abortion that the two doctor rule should be retained given the nature of the procedure and what were perceived as its inherent risks and implications.

15.1.29 This assertion was strongly challenged in SALRI's consultation, especially by regional, rural and remote health practitioners. One highly experienced medical practitioner highlighted the major problems in effective and equitable health care for rural communities, especially for Aboriginal communities. Ceduna health practitioners also did not support those in their area receiving less of a service and noted that the three primary issues were access to primary care (delay in seeing a GP), waiting delays at the local clinic and transport costs. It was their view that SA Health could assist with these issues and should be proactive with regard to resources to minimise the disadvantage experienced by those in rural, regional and remote areas as opposed to those in Adelaide.

15.2 **Residency**

15.2.1 Presently in South Australia it is a requirement that, unless in an emergency situation, a woman must have resided in South Australia for two months to be able to access abortion services.

15.2.2 Heath and Mulligan explain that this requirement 'was designed to prevent South Australia from becoming the abortion capital of the country at a time when the passage of these reforms would have made lawful abortion more readily available in South Australia than in any other state or

territory'.[1577] It is significant that, even in 1969, this clause was contentious, and passed 'in the face of passionate advocacy from Joyce Steele, in particular, that the clause placed women's health in danger and should be removed'.[1578]

15.2.3 There was overwhelming support in SALRI's consultation for the removal of the residency requirement and no valid reason was seen for its retention. The situation of international students was often highlighted. The Southgate Institute identified interstate residents who may need to visit South Australia for medical treatment. The Department of Health and Wellbeing urged the removal of the residency requirement, noting it originated with the outdated 1969 fear of 'abortion tourism' and now 'provides a barrier to access abortion services to women who are recent arrivals to South Australia, international students and women located nearby jurisdictional borders'.

15.2.4 The Central Adelaide Local Heath Network (Pregnancy Advisory Centre) submitted that the residency requirement should be removed:

> This requirement has concerning impacts on newly arrived migrants, refugees, tourists, overseas students and residents from locations near to South Australian borders. Clients from regions such as Mildura, Broken Hill, Darwin and remote locations in the Northern Territory often travel to South Australia for specialist medical treatment for other health care needs and specialist treatment. Abortion healthcare should not be precluded if South Australia is the closest or preferred specialist location. Ensuring the public health system in South Australia is not overburdened however is essential and health policy planning to ensure reciprocal health care agreements that manage and fund these arrangements for interstate residents would need to be developed.

15.2.5 The vast majority of survey respondents who commented on the residency requirement supported its removal.

15.2.6 Associate Professor Baird noted:

> The residency requirement … obstructs the provision of care to those over the border and newly arrived. Other States provide abortion services and Adelaide is not a destination for those seeking an abortion.

15.2.7 Another respondent noted: 'Residency requirements disadvantage international students, recent arrivals and women living near the SA border.'

15.2.8 Yet another said: 'It is a medical procedure, like any other, and people who are traveling, immigrants or otherwise transient, should all be treated the same.'

15.2.9 One response noted that such a requirement could impact on women who are fleeing domestic or family violence and 'there should also be considerations for international students and those on visas to access abortion services with the same level of ease as those with Medicare'.

15.2.10 SALRI concurs with these objections to the residency requirement to access lawful abortion. This requirement serves no useful purpose and is unhelpful to proper health care. The

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[1577] Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37 *Adelaide Law Review* 41, 52.

[1578] Ibid. See also South Australia, *Parliamentary* Debates, House of Assembly, 4 December 1969, 3680 (Joyce Steele). A further effort to remove this clause failed in the Legislative Council. See South Australia, *Parliamentary Debates*, Legislative Council, 3 December 1969, 3513.

requirement is especially unhelpful for international students.[1579] This requirement dates back to the 1969 fear of 'abortion tourism' and any rationale for its retention has long since vanished.[1580]

15.2.11 Interstate and international mobility and movements are now facts of life and, with abortion now being regulated across the country, the fear of South Australia being an abortion tourism destination is no longer a relevant consideration.

15.2.12 There are also serious constitutional doubts as to the validity of a law that restricts access to a vital health service on the basis of residency in that state.[1581] In the leading authority, *Street v Queensland Bar Association,*[1582] the High Court considered s 117 of the Constitution and held that a State cannot discriminate on the basis of State of residence.[1583]

15.3 Telehealth

15.3.1 The provision of self-administered medical termination through telemedicine has received international approval[1584] for women who are underserved by their regional and remote clinics.[1585] Studies have found results of telemedicine abortion were comparable to face-to-face provision, but with improved availability and timeliness of access, greater efficiency of resources, reduced costs of travel and stress associated with procedure.[1586] One recent study found that the direct-to-patient telemedicine medical abortion service was effective, safe, inexpensive and satisfactory and it disproportionately served women in parts of Australia with limited access to abortion facilities. This experience was said to be instructive for others desiring to use telemedicine to enhance access to abortion.[1587] The SA Department of Health and Wellbeing supported the role of telemedicine,

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[1579] This theme especially emerged in SALRI's consultation.

[1580] One medical practitioner who was one of the first practitioners involved in this area after the 1969 South Australian Act came into effect told SALRI: 'One of the reasons why this clause was inserted more than forty years ago was the fear that South Australia could become the abortion centre of Australia and that patients from all over Australia would come to Adelaide to seek such services. This is no longer an issue as virtually all states now including the Northern Territory have legalised this procedure and this service is readily available in other parts of Australia without the need to come to South Australia.'

[1581] See *Street v Queensland Bar Association* (1989) 168 CLR 461.

[1582] (1989) 168 CLR 461.

[1583] (1989) 168 CLR 461. The High Court accepted the dissenting view of the operation of s 117 articulated by Stephen J in *Henry v Boehm* (1973) 128 CLR 482, 502.

[1584] Abigail Aiken, Rebecca Gomperts and James Trussell, 'Experiences and Characteristics of Women Seeking and Completing at-home Medical Termination of Pregnancy through Online Telemedicine in Ireland and Northern Ireland: a Population-Based Analysis' (2016) 124 *Royal College of Obstetricians and Gynaecologists* 1208; Daniel Grossman et al, 'Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine' (2011) 118(2) *American College of Obstetricians and Gynaecologists* 296.

[1585] The Tabbott Foundation, Australia's first abortion telemedicine service (medical abortion by post and phone), found that 60% of women who received their services lived in regional and remote communities, compared to 29% of metropolitan residents. See Paul Hyland, Elizabeth Raymond and Erica Chong, 'A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 months' (2018) 58 *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* 335, 339.

[1586] Frances Doran and Susan Nancarrow, 'Barriers and Facilitators of Access to First-Trimester Abortion Services for Women in the Developed World: A Systematic Review' (2015) 41 *Journal of Family Planning and Reproductive Health Care* 170, 175; Angela Dawson et al, 'Towards Comprehensive Early Abortion Service Delivery in High Income Countries: Insights for Improving Universal Access to Abortion in Australia' (2016) 16 *BioMed Central Health Services Research* 612, 619.

[1587] Paul Hyland, Elizabeth Raymond and Erica Chong, 'A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 months' (2018) 58 *Royal Australian and New Zealand College of Obstetricians and Gynaecologists* 335. See also Abigail Aikin, Rebecca Gomberts and James Trussell, 'Experiences and Characteristics of Women Seeking and Completing at-home Medical Termination of Pregnancy through Online

especially to medical abortion that does not require in-person examination, and said this 'would provide the opportunity to make abortion services more accessible and cost-effective. Studies have shown that telemedicine provision is not inferior to in-person provision for medical abortions of pregnancy.' It should be noted, as pointed out to SALRI by Dr Heather McNamee, that telehealth may involve Skype and/or phone.

15.3.2 The University of Sydney policy reform project submitted to SALRI that telehealth could be used to address the two primary issues in regard to rural and regional barriers to service, namely access and cost.[1588] Professor Heather Douglas also made this point, noting also the value of telehealth for women living in outer suburban areas with low incomes and poor public transport links.

15.3.3 However, the practicalities of s 82A of the *CLCA*[1589] impedes women's health options as it does not allow for the home administration of MS-2 Step. Due to South Australia's 'archaic' legal provisions and the possibility of criminal prosecution,[1590] telemedicine abortion services are provided in every Australian state except South Australia.[1591]

15.3.4 There was strong, though not universal,[1592] support in SALRI's consultation for the role and rationale of telehealth services. One party said: 'People should be able to access healthcare delivered via electronic or telephone service so no one is disadvantaged by ability or location.' The AMA(SA) stated:

> Telehealth is among the technological and other digital innovations supporting the provision of safe, qualified medical services in Australia and elsewhere. Legislation should reflect that such services exist to increase the accessibility of termination services provided by medically led teams, especially in a state such as South Australia where many people live in rural and remote areas.

15.3.5 Several parties highlighted a need for caution. The Australia Christian Lobby noted: 'Such a service is not a panacea for access issues.' 40 Days for Life stated the use of telehealth in relation to medical abortion is 'fraught with danger' owing to the risks involved and a 'complication' rate of 9.8%.

Telemedicine in Ireland and Northern Ireland: a Population-Based Analysis' (2017) 124(8) *British Journal of Medicine* 1208.

[1588] SALRI notes the helpful student submission of the University of Sydney Policy Reform Project.

[1589] Abortion can only be carried out in a hospital of a prescribed class in South Australia.

[1590] Anne O'Rourke, Suzanne Belton and Ea Mulligan, 'Medical Abortion in Australia: What Are the Clinical and Legal Risks? Is Medical Abortion Over-Regulated?' (2016) 24 *Journal of Law and Me*dicine 221, 237.

[1591] 'Medical Abortion by Phone (Tele-Abortion)', *Marie Stopes Australia* (Web Page, July 2019) <https://www.mariestopes.org.au/abortion/home-abortion/>.

[1592] One view was the nature and risks of abortion procedures, especially early medical procedures, dictated against the involvement of other than medical practitioners and telehealth. Genesis Pregnancy Support Inc, for example, argued: 'An extremely high complications rate of 9.8% is reported when administering Mifepristone and Misoprostol (RU486). This indicates that almost 1 in 10 women who have a medical abortion will experience complications. The most common complication is 'retained products', and second most common is 'haemorrhage'. These are both serious, possibly life-threatening complications. Of 173 total complications from all forms of abortion in SA, 142 were from RU486. 86% of these required a further surgical procedure! These are extremely significant statistics that should not be ignored. In order to provide women with safe and effective health care, medical terminations should be strictly monitored, administered only by a doctor and within close proximity of emergency health services. Consultation and distribution via telehealth or other electronic services does not provide the medical supervision necessary to protect women from statistically recorded, serious complications. Rural women should not be alone or remotely located from expert medical care under these dangerous circumstances.'

15.3.6 However, there was wide support[1593] for the role and value of telehealth, especially to address issues of access in rural, regional and remote areas. There was extensive support amongst the health practitioners that SALRI spoke to in Port Augusta, Whyalla, Port Lincoln and Ceduna for telehealth, especially to address rural and remote access to medical abortion. It was often noted that telehealth is not new or novel and is an established aspect of Australian health care and other significant medical procedures are already effectively carried out by telehealth. Dr Heather McNamee, for example, told SALRI that fears as to telehealth and the use of MS 2-Step are overstated: 'we do not want to restrict access based on a fake fear.' Dr McNamee added that telehealth is especially effective when using Skype, which is 'a more holistic consultation' as health practitioners can see how a patient reacts and whether they have understood the information provided. Dr McNamee also pointed out that telehealth is particularly beneficial for Aboriginal women, given the 'increased shame and a need for privacy' that is often experienced as it allows them to seek support outside of their immediate community.

15.3.7 The Hon Tammy Franks also noted the benefit of telehealth in relation to early medical abortion:

> Further, SA women are not able to use telemedicine services for EMA. To access EMA in South Australia, a woman must attend a prescribed hospital for those two or more visits. Stories abound of women who inappropriately walked from a GP surgery to a prescribed hospital or were incomprehensively required to find overnight babysitters, drive many hundreds of kilometres to access EMA while cramping in the car, take several days off work or stay in a hotel or rely on supportive friends who have a spare couch. Our laws do not serve those women. If they do not live close to a prescribed hospital, they are not served. They are given barriers to their health care… The solution of accessing EMA from a GP or via telehealth, such as that offered by Marie Stopes to women across almost every other Australian jurisdiction, is simply not available to South Australian women.

15.3.8 Dr Caroline De Moel at La Trobe University, drawing on her PhD research, supported telehealth, especially in the role of nurses and the use of medical abortion:

> Abortion is still considered a crime in New South Wales and in South Australia, and abortion provision remains predominantly confined to private clinics in metropolitan areas, which highly restricts abortion access for women residing in regional and rural areas. One approach to improve this inequitable situation is to shift the provision of EMA into the primary health care sector and particularly into general practice. EMA is not only very effective, but also efficient and one of the safest procedures in contemporary medicine. Another approach is the use of telemedicine, which was, since recently, available through the Tabbot foundation in all jurisdictions except South Australia. EMA is an ideal fit for telemedicine as contraindications can be easily assessed with a telephonic interview, and pathology tests can be arranged at a convenient location. Over the years, international and national studies have shown that this service is as effective and safe when compared to in-person provision. Additionally, primary health care nurses (PHCNs) can be used

[1593] These parties included Dr Erica Millar, a retired specialist, a specialist medical practitioner, a number of lead clinicians, the Australian Medical Association (SA), Australian Lawyers' Alliance, Children by Choice, the Coalition of Women's Domestic Violence Services SA, Professor Heather Douglas, the Equal Opportunity Commissioner, the South Australian Abortion Action Coalition, the Australian Women's Health Network, Fair Agenda, Family Planning Welfare Association of the Northern Territory, the Human Rights Law Centre, South Australian Council for Civil Liberties, the Southgate Research Institute, the Central Adelaide Local Health Network (Pregnancy Advisory Centre), Marie Stopes Australia, the Public Health Association of Australia, Women's Electoral Lobby Australia, Women Lawyers' Association of South Australia Inc, the Hon Tammy Franks MLC, Professor De Costa, Professor Margaret Davies, the Castan Centre for Human Rights Law, RANZCOG and a leading health agency. Beth Wilson AM, whilst supportive of telehealth noted: 'However, they should not further discriminate against the regions by being used as an excuse for limiting face to face services. This should be about choice.'

for the delivery of EMA services. This evidence-based practice is already extensively implemented in a range of developed countries, including the US, France, Great Britain and Sweden, but not yet integrated in Australian practice. PHCNs in Australia, however, have proven to be capable of making autonomous decisions, and to deliver safe, effective and equitable PHC services. Moving beyond specialist physicians and allowing other health workers, such as PHCNs, to be involved with abortion provision can be an essential public health strategy that ensures an optimisation of the health workforce, improve health outcomes, is cost effective, and increases access to services, especially in service-poor areas. A nurse-led EMA model approach not only addresses the shortage of physicians but also the time-intensive aspect of the EMA process. Furthermore, it provides women with choice and flexibility, which is indispensable to their reproductive autonomy and, thus, to their overall welfare.

15.4 Patient Assistance Transport Scheme (PATS)

15.4.1 The Patient Assistance Transport Scheme ('PATS')[1594] provides subsidies towards the cost of travel and accommodation[1595] when rural and remote South Australians have to travel to see their nearest medical specialist. PATS assistance is intended for patients where specialist services are not available locally, through visiting specialists, or by using telehealth.

15.4.2 To be eligible for PATS a patient must:

a. live more than 100 km away from the nearest treating specialist;
b. be undertaking a treatment claimable under Medicare; and
c. have claimed any available benefits from their private health fund.

15.4.3 The Application[1596] has four parts which require completion:

a. one to be completed by the Local Doctor (referrer);[1597]
b. one to be completed by the specialist;[1598]
c. one to be completed by the patient;[1599] and
d. in the case of block treatments, one to be completed by the patient and specialist.[1600]

15.4.4 PATS will only reimburse a patient travelling to the nearest specialist unless:

a. the time-frame to be seen locally is clinically unacceptable;
b. the patient's clinical risks cannot be managed in country health facilities; or
c. the patient cannot be treated in South Australia.

15.4.5 PATS pays the most economical form of travel which can include air travel. Air travel can also be used where the referring medical practitioner determines it is required on the basis of active clinical management, pain management, clinical urgency or restricted mobility.[1601]

[1594] SA Health, 'PATS', *SA Government* (Web Page, 6 August 2019) <www.sahealth.sa.gov.au/pats>.

[1595] Subsidies of up to $40 (plus GST) are available for commercial accommodation

[1596] Application forms must be lodged within six months of the specialist appointment and can be submitted online or via post.

[1597] See Appendix E.

[1598] See Appendix F.

[1599] See Appendix G.

[1600] See Appendix H.

[1601] PATS Guidelines for Assessment set out the full eligibility criteria and further explanation of the criteria listed.

15.4.6 Approved escorts are also eligible for PATS. The referring medical practitioner must certify that an escort is required on the basis of impairment, active role of carer, child, necessary assistance, as an alternative to air travel.

15.4.7 It is not sufficient when considering whether a carer is required that this person is to provide emotional support or to act as a support.

15.4.8 When accommodation is requested, the specialist is required to authorise the number of nights for which accommodation is required in connection with the treatment for both the patient and the escort.

15.4.9 Any necessary follow-up appointments are required be arranged in the patients local area using telehealth, a visiting specialist, or country hospitals to prioritise treatment and recovery close to the patient's home.

15.4.10 Currently, women undertaking an abortion procedure are not eligible for PATS, on the basis that it is not classified as a specialist appointment.

15.5 Submissions

15.5.1 There was overwhelming opposition from parties both supportive and opposed to the decriminalisation of abortion to any suggestion that the law should be different for rural or remote as opposed to metropolitan areas to facilitate rural, regional or remote access. A number of lead clinicians told SALRI that there should not be different laws to facilitate access in rural and regional areas as 'the state laws should be in place for all areas of South Australia'. The Women Lawyers' Association of South Australia Inc also opposed the suggestion of differing laws based on a woman's location and 'supports all women being able to access high quality abortion in South Australia'. Dr Erica Millar said abortion should be regulated under the law like all other medical procedures:

> There should not be separate laws governing the regulation of abortion for women in rural and urban areas. Legislation that enables women to access abortion via telehealth and all suitably trained medical professionals would help alleviate some of the current inequalities of access.

15.5.2 A strong theme in SALRI's consultation, especially in its rural and regional consultation, was the fact that present law and practice acts as an unnecessary barrier to effective and equitable access to abortion services. Three rural GPs outlined:

> Studies show that women living in rural areas of Australia are more likely to have later term abortions and are less likely to attend follow up, mainly due to geographical factors and associated costs. For these reasons we are in favour of reforms that allow improved access to abortion services for women in rural locations. Current law states that both medical and surgical terminations must be carried out in a hospital setting. We advocate for a change for removing the restriction that medical abortions must be carried out in a hospital setting, which would allow for an increased number of trained rural general practitioners to be involved in providing a early medical termination service, thereby reducing barriers of access for women within their community, as well as reducing costs to the public health system by reducing medically unnecessary inpatient hospital stays. Multiple studies have shown that early medical abortions can be safety undertaken in a community setting, provided that there is access to emergency services if required. We also feel that the requirement for abortions to be sanctioned by two medical officers is an unnecessary restriction which disadvantages women, particularly those in rural areas where there may be limited access to medical officers working in this field.

15.5.3 The South Australian Abortion Action Coalition (and indeed most parties) stated their lack of support for differing laws based on a woman's location. The Coalition outlined:

> SAAAC supports all women being able to access high quality abortion in South Australia. To improve access for rural women, including Aboriginal women and women from interstate or overseas, SAAAC strongly supports the removal of the requirement that only medical practitioners can perform abortions, any requirement for residency for women to access abortion services in South Australia, the requirement for an abortion to be performed in a prescribed hospital and the requirement for a woman to see two doctors.

15.5.4 Though misgivings were expressed by some parties,[1602] there was extensive support in both consultation and in the survey responses for suitable health practitioners such as nurses, midwives[1603] and Aboriginal health workers to exercise an enhanced role in relation to at least medical abortion.[1604] There was strong support for this at the roundtables with the disability sector, the legal and medical sectors, parties supportive of the decriminalisation of abortion[1605] and from most professional associations and amongst the health practitioners that SALRI spoke to in Port Augusta, Whyalla, Ceduna and Port Lincoln.[1606] There was recognition that any movement in this area is influenced by Commonwealth health laws and rules regarding health services and prescribing rights. It was often identified to SALRI as beneficial to 'futureproof' the eligible health practitioners.[1607]

[1602] Parties such as Advocates International, 40 Days for Life, the Australian Christian Lobby and Cherish Life Australia opposed to the decriminalisation of abortion did not support allowing anyone other than medical practitioners to carry out surgical or medical abortions. They raised the complications and risks said to be inevitably associated with such procedures, especially in rural or remote context. As 40 Days for Life argued, 'this suggestion is fraught with danger… Rather than providing "safe" and world class pregnancy support services, this approach would provide a reduced level of care and clearly fail to provide the level of care expected in the 21st century.' A number of lead clinicians stated that the 'termination of pregnancy is a medical procedure and may result in medical and / or psychological complications, and thus should be undertaken by a qualified, trained and registered medical practitioner'.

[1603] The Australian College of Midwives was of the view that surgical termination should be undertaken by qualified, registered medical practitioners with the assistance of other qualified health practitioners. They further stated: '[The] provision of abortion services be made available in line with medical ethics and in accordance with the World Health Organisation recommendations that suggest that appropriately trained registered health professionals, including registered nurses and midwives, should be able to offer and facilitate abortion services… the scope of a midwife extends to sexual and reproductive health advice and support.'

[1604] This support was not unqualified. The Australian College of Nursing, for example, observed: 'ACN believes only a medical practitioner should be able to perform an abortion. As it is a health procedure that entails risks it should not be performed by an unqualified person. Registered nurses and midwives should be authorised to assist in performing lawful terminations of pregnancy in South Australia provided they are working within their scope of practice. Registered nurses may also be involved in pre and post-surgical care by providing education and advice to women.'

[1605] These parties included Reproductive Choice Australia, Australian Lawyers' Alliance, the Australian Women's Health Network, Children by Choice, Women's Electoral Forum Australia, Marie Stopes Australia and the Central Adelaide Local Health Network (Pregnancy Advisory Centre).

[1606] A number of health practitioners told SALRI that, whilst they would exercise a conscientious objection, they had no objection to their colleagues performing or assisting such procedures.

[1607] This point was highlighted by various parties such as Women's Electoral Forum Australia, Fair Agenda and Children by Choice. The South Australian Abortion Action Coalition said: 'It is critical that reform of abortion law in South Australia is "futureproofed" and does not create restrictive or prescriptive laws that would become outdated or stop technological and medical advances from delivering best practice abortion care.' The Women's Electoral Lobby similarly noted: 'There is a need to "futureproof" legislation in this area, as medical advances increasingly allow for supervised prescription of medication and where the pregnant person could safely rely on assessment and oversight by an accredited clinical nurse practitioner. It is therefore recommended that instead of specifying what roles are qualified to provide termination of pregnancy in legislation, the terms 'health practitioner' and/or 'medical practitioner' be utilised as appropriate instead.' See also above [7.7.4]–[7.7.5].

15.5.5 A leading health agency detailed how allowing suitable health practitioners in the use of medical abortion would help address current problems in rural, regional and remote access:

> … [we] agree that this would increase the choices for people seeking abortion services. Appropriately trained health professionals could provide EMA services outside of Adelaide which would reduce the time and costs associated with travel and assist in the person's day to day need to care for other family members and to work. Our experience is that people from regional towns who want to access abortion services often need to travel for abortion care. They are particularly frustrated when their preference is for EMA and they learn that they will need to travel to Adelaide for this service. They would much rather receive all abortion care from a local health professional… [we have] sometimes connected people with Marie Stopes in Melbourne to receive a timely service.[1608]

15.5.6 The Australian Nursing and Midwifery Federation SA Branch said health practitioners in this context must include nurse practitioners. The AMA(SA) noted its 'firm belief that abortions should only be performed by qualified medical practitioners, or suitably trained nurses working under the direct supervision of qualified medical practitioners.'

15.5.7 The Public Health Association of Australia explained:

> Health practitioners other than medical practitioners may have a useful role to play in providing services in accordance with their expertise, and should not be prevented from doing so by special laws. There is no case to treat the ordinary work of different health professions in unusual ways in regard to terminations. There is strong evidence that other practitioners can provide safe, high quality abortion care and post abortion contraception abortion. The safety of early aspiration abortions performed by nurse practitioners, certified nurse midwives, and physician assistants has been found to be equivalent with those provided by physicians in America[1609]… Medical abortion provided by nurse-midwives is more cost-effective than provision by physicians. Shifting early induced medical abortion and vacuum aspiration abortion tasks to nurses and midwives also facilitates equitable and timely access to care and addresses geographical access challenges that promotes care that better serves women's needs. Pharmacists and health providers such as Aboriginal and Torres Strait Islander health workers and/or practitioners could play roles in specific components of care (eg, assessing gestational age and providing information on the appropriate use of drugs). Although provision of abortion care in later pregnancy remains a more specialised skill, facility-based non-physician health workers can play supportive roles — for example providing cervical priming before dilatation and evacuation or in caring for women in the interval between administration of medications and completion of the abortion process. Workforce planning for abortion service provision should be undertaken on the basis of evidence-based guidance to inform the qualification and skill level for the most appropriate provider. Regulatory and service delivery developments relating to the provision of medical abortion presents an opportunity to improve geographic and economic access to early abortion. Legislation and policy change is therefore required to allow these nurses, midwives and mid-level providers to perform early aspirations to expand access to abortion care.

[1608] Australian Lawyers for Human Rights noted: 'Health practitioners other than medical practitioners being able to provide medical terminations would greatly improve access for South Australians living in rural and remote locations.'

[1609] Research from Sweden shows that effectiveness of provision of medical abortion by nurse-midwife providers was superior to that provided by medical practitioners and safety was equivalent. In this study, women who had a consultation with a nurse-midwife were more likely to select this provider in the future if they were to seek a medical abortion. See H Kopp Kallner et al, 'The Efficacy, Safety and Acceptability of Medical Termination of Pregnancy Provided by Standard Care by Doctors or by Nurse-Midwives: a Randomised Controlled Equivalence Trial' (2015) 122(4) *International Journal of Obstetrics & Gynaecology* 510.

15.5.8 Dr Carole De Moel of La Trobe University supported an enhanced role for nurses, especially in the context of early medical abortion and remote and rural access. She stated that health practitioners other than medical practitioners should be permitted to authorise or perform, or assist in performing, abortions in South Australia and there should be no specification of the precise types of health practitioners who can provide abortion care. She raised the importance of medical abortion provision by primary health care nurses to improve abortion access in underserved areas. She observed:

> Currently, the extent of the primary health care nurses' involvement in the delivery of EMA services is limited by federal legal restrictions that do not allow PHCNs to prescribe abortion medication. Should the TGA change this regulation, then it needs to be assured that there are no legal impediments in the new South Australian abortion law.

15.5.9 The role and benefit of health practitioners other than medical practitioners in rural and remote areas was highlighted. The Northern Territory Family Planning Welfare Association observed that where a woman would otherwise be able to have an abortion but does not have local access to do so, another qualified health practitioner such as a registered nurse should be permitted to undertake this procedure. 'Most remote area health services are run this way in Australia. There are very few medical doctors in rural and remote areas and teams work together to supply all types of health care.'

15.5.10 One party observed:

> If the termination of pregnancy can be achieved by medication in the early stages or a morning-after pill given to avoid possible pregnancy then that should be able to be authorised, not only by a doctor, but also by a suitably qualified health professional such as pharmacist, nurse or midwife and can by electronically authorised so as to assist those in rural areas.

15.5.11 The Southgate Research Institute, whilst supportive in principle of a potential enhanced role for different health practitioners (beyond medical practitioners) to reflect future changes in clinical practice, saw no need for any legislative provision. It noted that there is strong existing regulation in the health system in relation to expanded scopes of practice and 'there is no need for an additional law to safeguard the public, and such a law could act as a brake on the introduction of appropriate clinical innovation'. A similar view was expressed by the South Australian Abortion Action Coalition.

15.5.12 A number of parties noted that changing the law, whilst important, is not conclusive in addressing problems and issues in relation to abortion services.[1610] Associate Professor Baird described how changing the law will not address operational issues and service delivery,[1611] explaining.

> It should be noted that decriminalisation in other jurisdictions has not necessarily resolved problems with the delivery of health care nor women's access to abortion services[1612] … Most State and Territory Governments fail to address the issue of adequate abortion care in their health policy and operations. The training of doctors, and their willingness or lack of to provide abortion care, and the willingness or lack of by public hospitals to prioritise abortion care are other key factors. It is only when decriminalisation removes specific parts of law that have been restrictive that there is any necessary improvement in the provision of services. This was the case in the ACT

[1610] See also Ben Smee, 'Queensland's Abortion Law Change Improved Access but "Postcode Lottery" Remains', *The Guardian* (online, 6 August 2019) <https://www.theguardian.com/australia-news/2019/aug/06/queenslands-abortion-law-change-improved-access-but-postcode-lottery-remains>.

[1611] See also Rebecca Puddy, 'Concerns for Women after SA Closes Two Centres for Surgical Abortion', *ABC News* (online, 19 September 2019) <https://www.abc.net.au/news/2019-09-19/abortion-services-cut-in-south-australia/11517836>.

[1612] Barbara Baird, 'Decriminalisation and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights* 197.

> and the NT … Decriminalisation in SA will not immediately create change to address problems of access, except presumably for those who would not meet current residency requirements, but it will immediately remove the obstructions to change. The new environment will continue to be regulated by health policy, clinical guidelines, professional codes of ethics and so on, as it should be… the challenge will be to persuade and enable doctors to offer EMA, for health teams to develop protocols and skills for the optimal care of women and others needing abortions later in their pregnancies that are unconstrained by legally imposed limits, and for government and the professions to educate all about the new legal environment and so to contribute to the end of abortion stigma.[1613]

15.5.13 A number of submissions and SALRI's regional visits to Ceduna, Whyalla, Port Augusta, Port Lincoln and with Aboriginal[1614] health providers highlighted the very real problems posed for rural, regional and remote communities in relation to effective access to health services, particularly relating to abortion.[1615] These powerful concerns should not be overlooked.

15.5.14 The role and limitations of the Patient Assistance Transport Scheme (PATS) were highlighted by most parties that SALRI spoke to in regional areas.[1616]

15.6 SALRI's Observations and Conclusions

15.6.1 SALRI notes that by having restrictive abortion laws and failing to ensure women have access to reproductive health services, women experience worse health outcomes — including being forced to carry an unwanted pregnancy to term, delays in obtaining needed health services, or resorting to unsafe abortion options. These risks are heightened for women whose circumstances make accessing health services more difficult, including young women and girls, women living remotely, women with a disability, Aboriginal women, women of culturally or linguistically diverse backgrounds and women who cannot afford to travel to jurisdictions with more liberal abortion laws.

15.6.2 A vital issue in SALRI's consideration, reflecting the Terms of Reference, has been the need for proper regional, rural and regional access. SALRI has heard that many members of the community (including health practitioners) find the current law and practice relating to abortion to be complex and inaccessible, particularly in rural, regional and remote areas.

15.6.3 The present requirement for two medical practitioners to personally examine a patient does not account for current clinical practice, including telehealth and other remote forms of consultation. It is an outdated and unnecessary requirement and restricts equitable and effective access to abortion services, particularly in rural, regional and remote areas. There is no cogent reason for retaining this requirement and SALRI recommends that the 'two doctor' rule should be removed.

[1613] Associate Professor Baird raised two issues that are beyond the law in South Australia that should be addressed to maximise access to appropriate and adequate abortion care, namely the South Australian Government should seek to have the TGA remove restrictions on the prescription of EMA drugs so that not only medical practitioners can prescribe it and they should seek to have an item number added to the Medicare schedule that is specific to EMA. A leading health agency also noted that for EMA, there is a need for a specific Medicare item number to provide this care. 'The current Medicare item number used at the moment for EMA is inadequate and for many doctors is not financially viable so they will not offer the service. We acknowledge that this issue is outside of the legislation being discussed in this submission but also needs to be addressed in the broader provision of abortion services nationally.' SALRI concurs with these suggestions. See above Part 8, especially recs 17 and 18.

[1614] See below Part 16.

[1615] Rebecca Puddy, 'Concerns for Women after SA Closes Two Centres for Surgical Abortion', *ABC News* (online, 19 September 2019) <https://www.abc.net.au/news/2019-09-19/abortion-services-cut-in-south-australia/11517836>.

[1616] In particular, see below [16.5.5] (the views of the Family Violence Legal Service Aboriginal Corporation).

15.6.4 The present requirement that a woman must have been a resident in South Australia for a period of two months prior to an abortion procedure serves no useful purpose as the circumstances of 1969 regarding abortion tourism no longer exist and the requirement raises constitutional implications. SALRI is of the view that the residency requirement is outdated and should be removed.

15.6.5 If a surgical abortion is unable to be performed due to a lack of service provision in a woman's local area and she is unable to access an early medical abortion due to (a) her stage of gestation and/or b) it being counter indicated as assessed by her treating health practitioner, SALRI recommends that a woman should be eligible to access the Patient Assistance Transport Scheme (PATS) to travel to the nearest location where a surgical abortion can be performed

15.6.6 SALRI notes the benefit of telehealth medicine to address rural, regional and remote access issues in relation to abortion and recommends that any new law in South Australia should not prevent or restrict the use of telehealth medicine when appropriate, based on current clinical practice and procedures.[1617]

15.6.7 SALRI agrees there is real benefit, as raised in consultation by parties such as the Equal Opportunity Commissioner and Australian Lawyers for Human Rights, of an impartial and comprehensive government website to provide reliable, accurate and objective material on the various legal, ethical and medical issues and implications to anyone considering abortion. This could build on the existing useful information provided online by SA Health. It is vital to avoid, in any such website, the polarised views and selective and incomplete information that often features in abortion references.

15.6.8 SALRI commends the present SA Health website and suggests that it be maintained and developed on an ongoing basis to provide South Australians with reliable, objective and impartial information on abortion procedures and access to abortion services, including contact information for advisory services, counselling support and medical centres.

15.6.9 SALRI notes the particular issues in South Australia relating to rural, regional and remote access and recommends the following changes to practice.

15.6.10 Recommendations

Recommendation 37

SALRI recommends that the present requirement that a woman must have been resident in South Australia for a period of two months prior to the procedure serves no useful purpose and should be removed.

Recommendation 38

SALRI recommends that where a surgical abortion is unable to be performed due to a lack of service provision in a woman's local area and she is unable to access an early medical abortion due to:

a) her stage of gestation; and/or

b) it being counter indicated as assessed by her treating health practitioner;

then the woman should be eligible to access the Patient Assistance Transport Scheme (PATS) to travel to the nearest location where the surgical abortion can be performed.

[1617] See also above [15.3.1]–[15.3.8].

Recommendation 39

SALRI notes the benefit of telehealth medicine to address rural, regional and remote access issues in relation to abortion and recommends that any new law in South Australia should not prevent or restrict the use of telehealth medicine when appropriate, based on current clinical practice and procedures.

Recommendation 40

SALRI recommends that the SA Health website be maintained on an ongoing basis so as to provide South Australians with reliable and impartial information on abortion procedures and access to abortion services, including contact information for advisory services, counselling support and medical centres.

Part 16 – Aboriginal Practice

16.1 Aboriginal Population in South Australia

16.1.1 Based on the Australian Bureau of Statistics data for 2016, 2.46% of the population of South Australia identify as Aboriginal.[1618]

16.1.2 For the purpose of the statistics, the Commonwealth three-part definition for identification is applied,[1619] namely:

- descent (the individual can prove that a parent is of Aboriginal or Torres Strait Islander descent);
- self-identification (the individual identifies as an Aboriginal or Torres Strait Islander); and
- community recognition (the individual is accepted as such by the Aboriginal or Torres Strait Islander community in which he/she lives).

16.1.3 The Aboriginal population in South Australia, as in the rest of the nation, has a lower median age than the non-Aboriginal population and this is reflective of the higher fertility rates recorded for Aboriginal women and higher mortality rates overall.[1620]

16.1.4 A significantly higher portion of Aboriginal people live in areas which are considered Outer Regional (approximately 12% more than non-Indigenous people in the same area), Remote (approximately 6% more than non-indigenous people in the same area) or Very Remote (approximately 11% more than non-Indigenous people in the same area). Aboriginal people are almost 30% less likely to live in a Regional area.

16.1.5 For this reason, the Aboriginal population are more likely to be impacted by issues surrounding regional and rural access as discussed in Part 15 of this report.

16.1.6 This may be evidenced by the fact that Aboriginal people in South Australia experience poorer health outcomes than other South Australians,[1621] based on a range of indicators and greater exposure to risk factors. This was a regular theme in SALRI's consultation.

16.1.7 The Australian Institute of Health and Welfare estimates that 39% of the lower health outcomes experienced by the Aboriginal population is directly linked to social detriments experienced by them.[1622]

[1618] Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016* (Catalogue No 3238.0.55.001, 18 September 2018) <https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>.

[1619] Department of Aboriginal Affairs, *Report on a Review of the Administration of the Working Definition of Aboriginal and Torres Strait Islanders* (Final Report, 1981).

[1620] Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016* (Catalogue No 3238.0.55.001, 18 September 2018) <https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>.

[1621] Australian Institute of Health and Welfare, 'Indigenous Australians', *Australian Government* (Web Page, 2018) <https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview>. In relation to this reference, see also Elizabeth Comino et al, 'Risk and Protective Factors for Pregnancy Outcomes for urban Aboriginal and Non-Aboriginal Mothers: the Gudaga cohort' (2011) 1693) *Maternal and Child Health Journal* 569.

[1622] Australian Institute of Health and Welfare, The Health & Welfare of Australia's Aboriginal & Torres Strait Islander People, Australian Government (Web Page, 2017) <https://www.aihw.gov.au/reports-data/health-welfare-overview/indigenous-health-welfare/overview>.

16.1.8 Approximately half of all Aboriginal adults live in rented accommodation with almost one third over the age of 15 years being unemployed.[1623] The high unemployment rate and reliance on government assistance impacts the population's ability to access health care which requires travel.

16.1.9 Aboriginal Australians are also twice as likely to be profoundly disabled as non-Aboriginal Australians[1624] which further limits the likelihood of them being ability to navigate a complex health system or travel to obtain medical services.

16.2 Culturally Sensitive Access to Services

16.2.1 In March 2018, the Australian Healthcare and Hospitals Association, Public Health Association of Australia, Consumers Health Forum of Australia and National Rural Health Alliance issued a joint statement confirming the need for culturally safe healthcare for Indigenous communities:

> Cultural safety in this context involves health professionals examining their own beliefs, behaviours and practices, as well as issues such as institutional racism, in ensuring that their services are perceived as safe — by the patient rather than the provider.[1625]

16.2.2 This statement supported the release of a similar statement by the five leading national nursing and midwifery bodies.[1626]

16.2.3 Generally, cultural safety is defined as 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together'.[1627]

16.2.4 It is this belief that encouraged the development of the Aboriginal Community Controlled Health Service (ACCHS) which is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).

16.2.5 During its consultation, SALRI met with a number of staff members at ACCHS locations across the State and they consistently reinforced the importance of Aboriginal people, particularly

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[1623] SA Health, South Australian Aboriginal Health Survey (Media Release, 2012) <https://www.sahealth.sa.gov.au/wps/wcm/connect/726b3c004e738b798bbfdff5fd919c54/Aboriginal+People+REGION-SAAHS-Informationmangement-06022013.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-726b3c004e738b798bbfdff5fd919c54-mMAbhzz>.

[1624] Australian Institute of Health and Welfare, The Health & Welfare of Australia's Aboriginal & Torres Strait Islander People, Australian Government (Web Page, 2017) <https://www.aihw.gov.au/reports-data/health-welfare-overview/indigenous-health-welfare/overview>.

[1625] Joint statement of the Australian Healthcare and Hospitals Association, Public Health Association of Australia, Consumers Health Forum of Australia and National Rural Health Alliance, 'Cultural Safety Crucial in Aboriginal and Torres Strait Islander Healthcare' (Media Release, 26 March 2018) <https://ahha.asn.au/news/cultural-safety-crucial-aboriginal-and-torres-strait-islander-healthcare>.

[1626] Joint Statement of the Nursing and Midwifery Board of Australia, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Australian College of Midwives, Australian College of Nursing and the Australian Nursing & Midwifery Federation, 'Cultural Safety: Nurses and Midwives Leading the Way for Safer Healthcare', (Media Release, 5 April 2018) <https://www.nursingmidwiferyboard.gov.au/News/2018-03-23-joint-statement.aspx>.

[1627] Robyn Williams, 'Cultural Safety: What Does it Mean for our Work Practice?' (1999) 23(2) *Australian and New Zealand Journal of Public Health* 213.

women, having access to cultural support when considering having an abortion. Currently there is no ACCHS in South Australia which is listed as a prescribed place for an abortion procedure to take place.

16.2.6 The ACCHS's do not have the facilities to undertake surgical terminations or late term medical abortions. However, they do have medical practitioners who would be able to facilitate medical abortions in the early stages of gestation.

16.2.7 Some ACCHS locations, where there are no other local facilities for women to access an abortion, raised concerns about being identified as an 'abortion clinic' and the impact that may have on the staff and the community.

16.2.8 Other ACCHS locations welcomed the opportunity to ensure that their community had access to culturally sensitive support in all aspects of their health care, including reproduction.

16.2.9 In many rural communities in South Australia, Aboriginal health workers[1628] attend the local hospitals and specialise in pregnancy support and midwifery. These health workers generally indicated a desire to be able to assist women who were considering undergoing an abortion or who required an abortion. Such procedures, however, are only able to occur at the hospital and concern was raised to SALRI whether this was culturally sensitive to the needs of Aboriginal women.

16.2.10 Some hospitals in rural South Australia who have a large Aboriginal population are particularly alert to cultural sensitives and an example was provided to SALRI of the Ceduna Hospital arranging a smoking ceremony on the hospital ward after the death of a patient, however, cultural awareness alone will not equate to better health care.[1629]

16.3 Aboriginal Health Generally

16.3.1 SALRI was informed by Aboriginal health providers that Aboriginal health is taken to mean not just the physical well-being of an individual, but refers to the social, emotional and cultural

[1628] The role of the Aboriginal and Torres Strait Islander Health Workers (ATSIHWs) is crucial to improving health outcomes of Aboriginal and Torres Strait Islander people. They play a vital role in the primary health care workforce, providing clinical and primary care for individuals, families and community groups. Aboriginal and Torres Strait Islander Health Workers across Australia work in a variety of environments. While a large majority are employed in Aboriginal Community Controlled Health Organisations (ACCHOs) or the Government Health Sector, many also work within mainstream services such as general practices and other non-government organisations. Aboriginal and Torres Strait Islander Health Worker roles exist in metropolitan, regional and remote areas. Aboriginal and Torres Strait Islander Health Practitioners must be registered with the Australian Health Practitioners Registration Agency (AHPRA). Aboriginal and Torres Strait Islander Health Practitioner is a protected title under s 113 of the *National Law*. The Certificate IV in Aboriginal and/or Torres Strait Islander Health Care (Practice) is the qualification for registration as an Aboriginal and/or Torres Strait Islander Health Practitioner. There are a number of titles used to describe the job roles of Aboriginal and Torres Strait Islander Health Workers. These titles vary significantly across Australia and may or may not describe the specialty of an Aboriginal and Torres Strait Islander Health Worker or their level of training. The following list is an indication of Aboriginal and Torres Strait Islander Health Workforce have various roles including: Health Worker (Generalist), Outreach Worker, Mental Health Worker, Family Health Worker, Sexual Health Worker, Education Officer, Hospital Liaison Officer, Drug and Alcohol Worker, Environmental Health Worker, Community Worker, Healthy Living Worker, Vascular Health Worker, Pharmacy Health Worker, Maternal and Perinatal Health Worker, Otitis Media Health Worker, Nutrition Health Worker, Eye Care Coordinator, Primary Health Care Practice Manager. 'Aboriginal Health Worker Role', *Aboriginal Health Council SA* (Web Page, 2019) <https://ahcsa.org.au/our-programs/aboriginal-health-worker-role/>.

[1629] This incident was unrelated to abortion or reproductive health but was an example of the hospital considering the beliefs of the local Aboriginal population and taking steps to cleanse the hospital so that the community would be willing to continue to attend for medical treatment. See also Juli Coffin, 'Rising to the Challenge in Aboriginal Health by Creating Cultural Security' (2007) 31 (3) *Aboriginal and Islander Health Workers Journal* 23.

well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community.

16.3.2 Aboriginal health is a whole of life view and includes the cyclical concept of life-death-life.[1630]

16.3.3 One ACCHS worker advised SALRI that the impact of abortion in the Aboriginal community does not result in the loss of the fetus from the community and in fact it creates a child which, in spirit, remains with the mother and in the community going forward.

16.3.4 It was suggested to SALRI that where an abortion is performed, for any reason, an Aboriginal person should be provided the opportunity to have any products released from the women's body so that they can be returned to the land and, should the woman choose, an appropriate ceremony or acknowledgement performed.

16.3.5 All ACCHS staff who spoke with SALRI indicated that, due to the limited service provision in rural, remote and regional areas, Aboriginal women were travelling to a metropolitan area to access abortion services. By doing so the women did not have access to the support of their communities and as such it is important that any organisation providing abortion services should have culturally appropriate information to provide to Aboriginal women. It was noted to SALRI that any such material or resources should include the local Aboriginal language(s) of that area.

16.3.6 It was also noted by ACCHS staff that if their service was able to provide medical abortions, a proportion of women may still elect to travel to a metropolitan area instead so as to separate themselves from the community for privacy reasons. One reason for this is the stigma which is still attached to having an abortion.

16.3.7 ACCHS staff generally, however, did not want the women of their community to be further hindered from accessing a health service by imposing any additional requirements or considerations on Aboriginal women in accessing an abortion than for women generally. However, as noted above, culturally appropriate information, by way of a pamphlet or other information source (including in the local Aboriginal languages), should be made available to them.

16.4 Expanding the Role and Use of Data

16.4.1 While SA Health has been collecting data on the rate of abortions undertaken in South Australia since the original enabling legislation came into effect in 1969,[1631] this has not included whether the woman identified as Aboriginal.

16.4.2 All ACCHS staff who spoke to SALRI indicated that the collection of this data is vital to service planning and to ensure that the needs of the community are satisfied.

16.4.3 Aboriginal women have higher fertility rates than non-Aboriginal women and one of the queries raised in consultation was whether this was due to a decreased amount of reproductive health services available to them in regional and rural areas. Such reproductive health services are not limited to abortions services, but include contraception and sex education.

[1630] National Aboriginal Health Strategy Working Party, *National Aboriginal Health Strategy* (Report, 1989).

[1631] See below Part 20.

16.4.4 The collection of data as to the rates of abortions in the Aboriginal community would be able to be collated against other collected reproductive health data to allow for investigation as to the higher rates of fertility.

16.5 Submissions

16.5.1 More than one party highlighted to SALRI the disproportionate effect of present law and practice upon Aboriginal women.

16.5.2 Australian Lawyers for Human Rights commented:

> ALHR notes that Aboriginal women are disproportionately affected in accessing health services given the number of Aboriginal women that live in remote and very remote communities vis-à-vis non-Aboriginal women. When developing any new legislative framework and guidelines, such as that for practitioners, the Government must specifically consider the nature of the barriers that Aboriginal women face in accessing services, and work towards minimising the burden of those barriers to Aboriginal women.

16.5.3 SALRI notes that similar criticisms were expressed to the QLRC.[1632] The Institute for Urban Indigenous Health Ltd, for example, noted that criminal laws relating to abortion disproportionately impact on Aboriginal and Torres Strait Islander women.[1633]

16.5.4 As the South Australian Abortion Action Coalition noted in their submission to SALRI of the effects of present South Australian law and practice: 'Aboriginal women are disproportionately resident in rural and remote locations and so disproportionately affected.'[1634] It was noted to SALRI that travel to Adelaide for Aboriginal women, especially in a context of family violence, is 'an expensive and long process' and has the potential to lead to increased risk for the woman concerned.

16.5.5 The Family Violence Legal Service Aboriginal Corporation (SA) noted, in its submission to SALRI, the following issues regarding rural and regional access to abortion services for its clients:

> Currently access to termination services are inconsistent and unreliable in many parts of regional and remote South Australia. Termination procedures are not performed locally at many of the regional hospitals including in Ceduna and Whyalla.
>
> Women in Ceduna who wish to access a termination through the public health system are required to travel to Port Augusta (470km) or Adelaide (778km). The Patient Assistance Transport Scheme (PATS) will not cover the cost of airfares in most cases, and women are required to take the journey by bus, taking at least five hours each way to complete.
>
> Except in a very limited set of circumstances, PATS will not pay up front the women's expenses and most women are required to cover the costs of transport and accommodation themselves and seek reimbursement.
>
> We consider that access to termination services should be available at a majority of public hospitals in South Australia. If termination services are not available locally then PATS should, as a matter of course, pay up front the expenses for the women to travel to the closest available service.

[1632] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 56 [3.30].

[1633] Ibid 107 [3.152].

[1634] This theme was also emphasised to SALRI by health practitioners, especially those working with rural, remote and Aboriginal communities.

16.6 SALRI's Observations and Conclusions

16.6.1 Aboriginal women, by being disproportionality affected by regional and rural access issues, will receive a significant benefit from improvements to access and services recommended for regional and rural areas elsewhere in this Report.

16.6.2 It is not recommended that there be any additional requirements or restrictions on Aboriginal women accessing abortion services as to do so would create an added barrier to health services for a community who already experiences lower health outcomes.

16.6.3 It is, however, recommended that, to the greatest extent possible, culturally safe services be made available to Aboriginal women.

16.6.4 Recommendations

Recommendation 41

SALRI notes the particular issues in South Australia relating to Aboriginal communities and recommends that practitioners who prescribe MS-2 Step, or hospitals which undertake abortion procedures, should have access to pamphlets, literature or referral sources which can be supplied to Aboriginal women to ensure they have access to culturally appropriate information and support.

Recommendation 42

SALRI recommends that all health services, including hospitals and specialist clinics, ensure that staff have undertaken cultural awareness training to ensure a culturally safe environment for Aboriginal women attending the service.

Part 17 - Conscientious Objection and Referral

17.1 Rights and Duties of Medical Practitioners

17.1.1 Conscientious objection arises where there is a 'refusal to comply with an authoritative standard or rule … because doing so entails betraying one or more of [a person's] deepest commitments.' Fundamentally, therefore, it involves a process by which a person asserts reasons of conscience to avoid a compulsion.[1635]

17.1.2 The role of conscientious objection for health practitioners is an established feature of not only the present law in South Australia in relation to abortion, but also wider health law and practice and professional guidelines and protocols.[1636]

17.1.3 Peak bodies for health practitioners, including the Australian Medical Association,[1637] the Royal Australian and New Zealand College of Obstetricians and Gynaecologists,[1638] the Australian Nursing and Midwifery Federation,[1639] the Australian College of Nursing,[1640] the Australian College of Midwives,[1641] the Pharmacy Board of Australia, the Medical Board of Australia and the Royal

[1635] Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85, 89.

[1636] See Table 2 below.

[1637] Australian Medical Association, 'Position Statement: Conscientious Objection' (Media Release, 2019).

[1638] RANZCOG stated to SALRI: 'RANZCOG believes that health practitioners should not be required to perform abortion where it is in conflict with their personal convictions, except in cases of emergency. However, all health practitioners have a professional responsibility to inform patients where and how abortion services can be obtained and must be respectful of the woman's decision.'

[1639] The Australian Nursing and Midwifery Federation SA Branch told SALRI: 'The 2018 Code of Conduct for midwives and the 2018 Code of Conduct for nurses clearly states that when a nurse or midwife has a conscientious objection to a procedure they must responsibly use their right to not provide a treatment, however, they must inform the woman, their colleague and employer and ensure that the woman has alternative care options. The only caveat to conscientious objection is in the case where an emergency situation has or is imminent and failure to treat will adversely affect a person.'

[1640] The Australian College of Nursing stated to SALRI: 'ACN is aware that there will be health professionals strongly opposed to termination of pregnancy and they should not be expected to provide services against their personal beliefs (except in emergencies). However, ACN believes all health professionals have a moral and ethical obligation/duty to inform women seeking termination of where and how services can be accessed without fear of judgement.' Adjunct Professor Kylie Ward of the Australian College of Nursing similarly explained to the NSW Legislative Council Committee the position of nurses to conscientious objection and referral as follows: 'There are many areas where conscientious objection comes into place. The nursing code of conduct recognises individual nurses have their own personal beliefs and values but outlines specific standards which all nurses are expected to adopt in their practice. In particular, the nursing profession must avoid expressing personal beliefs to people in ways that exploit the person's vulnerability, are likely to cause unnecessary distress or may negatively influence their autonomy in decision-making. We would see that by not giving a referral could have an impact on somebody's ability to make a decision. I appreciate that there is the internet and there are other ways, but it is a very difficult time for women, making this decision, so we would see that it is a health professional's responsibility to refer': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 39 (Adjunct Prof Kylie Ward FACN, CEO, Australian College of Nursing).

[1641] The Australian College of Midwives reiterated to SALRI: 'the importance of women having access to registered health professionals that support their right to abortion services in a timely fashion and in appropriate environment. We understand that registered practitioners hold their own ethical and moral views with respect to abortion and that they are entitled to these opinions without consequence. However, in the event that a woman seeks abortion services from a health care practitioner who conscientiously objects to abortion, we hold that the health care practitioner be legally obliged to refer the woman to another registered health care practitioner that will support the woman's choice so as to not deny her right to bodily autonomy, or her human right to exercise informed decision making free from coercion or manipulation.'

Australasian College of Physicians[1642] all have policies and codes of conduct (or, at least, statements) relating to conscientious objection and referral.[1643] Their common feature is that the conscientious objection of health practitioners to decline to take part in a non-emergency medical procedure (it is not confined to abortion) is respected but so is the need for the practitioner to provide the patient with genuine referral to a willing practitioner or service.

17.1.4 Section 82A(5) of the *CLCA* provides that 'no person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this section to which he has a conscientious objection, but in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it'. It is significant that the categories of persons who can claim this objection are not defined.

17.1.5 However, the right of conscientious objection does not affect any duty to participate in treatment which is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman.[1644]

17.1.6 The VLRC considered at some length the questions of conscientious objection and referral.[1645] The VLRC recommended the legislative inclusion of a 'conscience clause' to make it clear that individual health professionals have no duty to provide or assist with an abortion procedure (except in an emergency situation), but they must inform the patient of the conscientious objection and make an 'effective referral' to another provider without such an objection.[1646] The QLRC also considered at some length the questions of conscientious objection and referral.[1647] The QLRC also recommended legislative recognition of conscientious objection for health practitioners but subject to the requirement 'to refer the woman, or transfer her care' to a practitioner without such an objection.[1648]

17.1.7 It is considered best practice under present health practices and professional protocols to include provisions for persons involved in decision making or treatment to be able to conscientiously object, and if they are such an objector, to be relieved of any duty to terminate or assist in an abortion. However, in Victoria, Queensland and Tasmania there is an additional requirement for a medical practitioner who conscientiously objects to performing an abortion to refer the woman to a medical practitioner who is known or believed not to hold such an objection. This provision aims to ensure that women are assured access to appropriately qualified medical practitioners who are willing to provide a comprehensive range of family planning advice and services.[1649] This referral requirement also reflects present health practice and professional protocol.

[1642] The RACP told SALRI: 'The RACP acknowledges that some medical practitioners have a conscientious objection to termination of pregnancy. In line with guidance from the Medical Board of Australia and the Australian Medical Association, the RACP agrees that personal beliefs should not impede patient access to treatments that are legal and referrals to alternative health professionals should be provided where required.'

[1643] See Appendix I for relevant excerpts of codes of conduct or policies of peak national health bodies and associations.

[1644] *CLCA* s 82A(6). See also Tom Gotsis and Laura Ismay, 'Abortion Law: A National Perspective' (Briefing Paper No 2/2017, NSW Parliamentary Research Service, Parliament of New South Wales, 2017) 47–49.

[1645] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 112–115 [8.1]–[8.38].

[1646] Ibid 7 and Rec 3, 115.

[1647] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 115–153.

[1648] Ibid Rec 4.1–4.3, 152–153. See also at 146–152 [4.139]–[4.176].

[1649] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016) 8.

17.1.8 The *Abortion Law Reform Act 2019* (NSW) contains a somewhat diluted requirement for referral or to provide certain information to a patient.[1650] The requirement for referral of a health practitioner who has a conscientious objection to performing or advising about a termination is limited to a requirement to 'give information to the person on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination'.[1651] Alternatively, the first practitioner may transfer the patient's care to another registered health practitioner or health service provider where, in the first practitioner's reasonable belief, the requested service can be provided by another health practitioner who does not have a conscientious objection.[1652]

17.1.9 The Abortion Legislation Bill 2019 (NZ) requires medical practitioners who have a conscientious objection to performing abortions to inform their patients at the earliest opportunity and to provide them with information on how to access abortion services.

17.1.10 A Summary of key conscientious objection and referral principles promoted in the policies of Australia's peak health bodies can be found below in **Table 2**.

[1650] This was a contentious issue in relation to the 2019 NSW Act. See New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 54–60.

[1651] *Abortion Law Reform Act 2019* (NSW) s 9(3)(a). Also see s 9(4): For the purposes of subsection (3)(a), the first practitioner is taken to have complied with the practitioner's obligations under that paragraph if the practitioner gives the person information approved by the Secretary of the Ministry of Health for the purposes of that paragraph. **Note.** The information to be approved by the Secretary is to consist of contact details for a NSW Government service that provides information about a range of health services and resources, including information about medical practitioners who do not have a conscientious objection to the performance of terminations.

[1652] *Abortion Law Reform Act 2019* (NSW) s 9(3)(b).

Table 2: Summary of key conscientious objection and referral principles promoted in the policies of Australia's peak health bodies

Name of body / *Name of Policy*	**Respect for objector's right to act on their conscience**	**Respect for patient's autonomy**	**Objector must not impede access to healthcare?**	**Requires some form of referral necessary following a conscientious objection?**	**Process of referral specified**
Medical Board of Australia (MBA) *Code of Conduct*	Yes	Yes	Yes	Not expressly, however, must generally facilitate continuity of care. Referral more broadly required when in patient's best interests.	**Take reasonable steps to ensure** that the person being referred to has the qualifications, experience, knowledge and skills to provide the care required. **Communicating sufficient information about the patient** and the treatment they need.
Australian Medical Association (AMA) *Position Statement: Conscientious Objection* (2019)	Yes	Yes	Yes	Yes	Ensure the **patient has sufficient information** to enable them to exercise their right to see another doctor. Continue to provide other care to the patient, if they wish. Refrain from expressing their own personal beliefs to the patient in a distressing manner.
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPB) *Code of Conduct*	Yes	Yes	Yes	Not expressly, however, must generally facilitate continuity of care.	No
Nursing and Midwifery Board of Australia (NMBA) *Code of Conduct for nurses* and *Code of Conduct for midwives*	Yes	Yes	Not expressly mentioned	Yes	Ensure the person has alternative care options.
Pharmacy Board of Australia (PBA) *Code of Conduct**	Yes	Yes	Yes	Not expressly, however, must generally facilitate continuity of care.	No

*Note these provisions are the same as the ATSIHPB's *Code of Conduct* above					
Australian Nursing and Midwifery Federation (ANMF) *Conscientious Objection Policy*	Yes	Yes	Yes	Not expressly, however, must general not impede access to care.	Generally, must take all reasonable steps to ensure that the person's preference, quality of care, safety, and advance care directives are not compromised.
Pharmaceutical Society of Australia (PSA) *Code of Ethics for Pharmacists*	Yes	Yes	Not expressly mentioned	Yes	Appropriately facilitates continuity of care.
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) *Position statement on the termination of pregnancy* AND *Code of ethical practice*	Yes	Yes	Yes	Yes	**Inform patients where and how termination of pregnancy services can be obtained.** Make appropriate referral and, with patient's consent, **communicate relevant information to new practitioner**.

17.1.11 There is a tension in the provision of abortion services between respecting a health practitioner's conscientious objection and ensuring a patient's unimpeded access to appropriate healthcare.[1653] This was a topic that often arose in SALRI's consultation with broad ranging views[1654] which can be summarised as follows:

a. Medical practitioners working in a public healthcare system should be unable to refuse service on anything other than medical grounds;

b. Medical practitioners have private and moral views. Their personal beliefs should be respected and they should not be forced to participate in a procedure they do not support;

c. Women should not have their access to healthcare impeded or limits placed on their personal decision-making, as a result of the private views of a medical practitioner;

d. Medical practitioners who elect to work in areas with limited health services, such as regional, rural or remote parts of South Australia, should not be able to further limit access to services by exercising a conscientious objection;

e. Conscientious objection should relate to all aspects of abortion including after care and referral; and

f. Conscientious objection should only relate to the performance of the procedure and not a requirement to refer or provide after care services if required.

17.1.12 Most Australian jurisdictions have taken a compromise approach by permitting conscientious objections by health practitioners, but compelling facilitation of access to alternative care through some form of referral.[1655] In doing so, they attempt to balance the health practitioner's rights with a countervailing obligation.[1656] The 2019 NSW Act partly takes this approach.[1657]

17.1.13 However, there are clear differences in referral requirements between jurisdictions, and limited research about the effectiveness of each approach.[1658]

17.1.14 There is a risk in leaving referral completely at the discretion of medical practitioners as it has been reported to SALRI that this has resulted in intentional delays, and even bullying and coercive tactics, which disrespect the patient's autonomy. Contrarily, a passive approach to referral would require patients to coordinate their own care whilst too stringent a referral requirement may prove

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[1653] Daniel Sulmasy, 'Tolerance, Professional Judgement, and the Discretionary Space of the Physician' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 18, 18–19; Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513, 514.

[1654] See also, for example, the differing views expressed in Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act* 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900; Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85.

[1655] Victoria, Queensland, Northern Territory and Tasmania all presently have referral requirements in their laws.

[1656] See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 114 [8.27]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 145 [4.140]–[4.141], 148 [4.154].

[1657] The Statutes Amendment (Abortion Law Reform) Bill 2018 (SA) implicitly takes this approach. It makes no provision for conscientious objection or referral and leaves this to professional guidelines.

[1658] See Appendix J for summary of laws regarding conscientious objection in Australian jurisdictions; Appendix K for state-based Australian health department policies/guidelines on conscientious objection and referral; Appendix L for key referral principles in the policies of international health bodies.

impracticable and be too onerous. A balance must be struck between these factors if referral requirements are to be effectively implemented in South Australia.

17.1.15 The present South Australian conscientious objection provisions allow any person to abstain from participation in abortion treatments, except in circumstances of an emergency.[1659] There is no definition of a 'conscientious objection' and there is ambiguity in its application.[1660] Some guidance can be obtained from the AMA's position statement[1661] (and other professional protocols)[1662] which view conscientious objection as encompassing any sincerely held beliefs not born out of self-interest or discrimination. Additionally, the AMA encourages its members to ensure access to care is unimpeded and equip women with sufficient information to see another medical practitioner.[1663] The Medical Board of Australia concurs with these principles, advocating for a patient-centred form of care and providing referrals where it is in the patient's best interests.[1664] SA Health has also encouraged prompt referrals to be provided when abortion services are unavailable.[1665] However, these clarifications from relevant health bodies merely represent best practice recommendations and, therefore, non-compliance with them has no express legal consequence, aside from the possibility of disciplinary action from an employer and/or AHPRA.[1666]

17.1.16 It is worth noting that a refusal by a medical practitioner to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the medical practitioner's skills or scope of practice, is illegal, or where the practitioner believes the patient has impaired decision-making capacity.[1667]

Arguments against a conscientious objection provision

17.1.17 Conscientious objections are said to delay women's access to healthcare and some commentators are opposed to the concept.[1668] Health practitioners owe a public duty to provide treatment to those who seek it and their personal beliefs should not override a patient's autonomy.[1669] To maintain employment, individuals are typically required to fulfil all their occupation's prescribed tasks, however, conscientious objections give practitioners discretion over the ambits of their own

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[1659] *CLCA* ss 82A(5)–(6). The conscience clause is unavailable where treatment 'is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman'.

[1660] Ibid. Section 82A(5) merely states that the conscientious objector has the burden of proof but does not provide any guidance as to how a conscientious objection is to be evidenced.

[1661] Australian Medical Association, 'Position Statement: Conscientious Objection' (Media Release, 2019) [1.2]–[1.3].

[1662] Ibid.

[1663] Ibid [1.5] and [2.3].

[1664] Medical Board of Australia, *Good Medical Practice: a Code of Conduct for Doctors in Australia* (Code of Conduct, 2014) [2.1], [2.4.6] and [2.4.7]. For extracts see Appendix I.

[1665] SA Health, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 11.

[1666] *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) Sch 2 s 41. This section states that a National Board's code is admissible in legal proceedings for what constitutes appropriate professional conduct.

[1667] Australian Medical Association, *Position Statement: Conscientious Objection* (Media Release, 2019).

[1668] Brooke Johnson Jnr et al, 'Conscientious Objection to Provision of Legal Abortion Care' (2013) 123 *International Journal of Gynecology and Obstetrics* 60, 61; Christian Fiala and Joyce Arthur, '"Dishonourable Disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 13–14.

[1669] These public duties have been historically recognised through the Hippocratic Oath and the Declaration of Geneva that represent universal ethical codes upholding the medical profession. See Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513, 517; Aurora Ciuca, 'The Right to Conscientious Objection' (2017) 5(1) *Logos Universality Mentality Education Novelty Section: Law* 17, 20.

roles.[1670] This discretion therefore promotes inequity and inefficiency in a patient's access to treatment.[1671] Furthermore, there is already an inherent power imbalance between health practitioners and patients.[1672] Since health professionals monopolise the provision of healthcare,[1673] there is a strong dependency on them by the public, making it important to enforce public duties upon them.[1674]

17.1.18 Some commentators also emphasise that, even in an international human rights context, freedom of conscience is not an absolute right and can be abrogated for other public-based interests.[1675]

17.1.19 There are also many issues with assessing the legitimacy of a conscientious objection as faith is often a personal and subjective experience that is immeasurable and difficult, if not impossible, to accurately verify.[1676] Most conscientious objections would have to be accepted on face value leaving patients unprotected from objections motivated by self-interest or discrimination.[1677]

17.1.20 It is also argued that conscientious objection may impede or undermine rural or remote access where there are already relatively few health practitioners.[1678] Indeed, its effect may be to literally close down an entire hospital or district.[1679] SALRI heard recurring concerns in its consultation (including from health practitioners) that the effect of conscientious objection is compounded in rural and remote areas and referral may prove otiose as there may literally be no willing practitioners available. For instance, during consultation in one regional area where there were limited medical

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[1670] Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513, 514–515; See also Adriana Lamackova, 'Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v France*' (2008) 15 *European Journal of Health* 7, 17 (where conscientious objection was permitted in the military for compulsory enlistment which is argued to be unlike the case of Australian medical practitioners who voluntarily choose to enter the medical field).

[1671] Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* 294, 295.

[1672] Adriana Lamackova, 'Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v France*' (2008) 15 *European Journal of Health* 7, 37–38.

[1673] Christian Fiala and Joyce Arthur, '"Dishonourable Disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 19.

[1674] It is argued that health professionals monopolise the provision of health care because they are the only members in society that are sufficiently qualified to provided it. See Daniel Sulmasy, 'Tolerance, Professional Judgement, and the Discretionary Space of the Physician' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 18, 23.

[1675] Lorenzo Zucca, 'Is There a Right to a Conscientious Objection?' in Susanna Mancini and Michel Rosenfeld (eds), *The Conscience Wars: Rethinking the Balance Between Religion, Identity, and Equality* (Cambridge University Press, 2018) 127, 128–129 and 136–138.

[1676] Christian Fiala and Joyce Arthur, 'There is No Defence for "Conscientious Objection" in Reproductive Health Care' (2017) 216 *European Journal of Obstetrics and Gynecology and Reproductive Biology* 254, 255–256.

[1677] For example, some practitioners object to avoid social stigma and minimise financial damage to their practice. See, for example, Christian Fiala and Joyce Arthur, '"Dishonourable disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 17; Brooke Johnson Jnr et al, 'Conscientious Objection to Provision of Legal Abortion Care' (2013) 123 *International Journal of Gynecology and Obstetrics* 60, 61.

[1678] This is compounded by the major problem of the 'crisis level' number of medical practitioners in rural, remote and regional areas. See Rural Doctors' Association of South Australia Inc, 'Country Patients Need More Rural Generalist Doctors …and Better Hospital Infrastructure Funding' (Media Release, 22 February 2018).

[1679] Kate Marchesi described the Queensland experience of conscientious objection to SALRI. 'The Queensland experience showed that some medical practitioners, nurses and midwives held very strong personal beliefs about abortion and objected to the procedure as a matter of conscience. Some practitioners stated that these beliefs meant that they would refuse to perform or provide advice on terminations in any circumstance. This was especially, but not exclusively, in regional and rural areas (excepting Cairns). Conscientious objection has a real effect in terms of access. It means that the ability to access abortion services for many people depends on where they live, and is effectively a "postcode lottery". This isn't limited to private facilities. It was reported that one particular public hospital near Brisbane had refused to provide abortion services, even in cases of sexual assault.' See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 47 [3.102]–[3.103], 114 [8.28].

practitioners, SALRI observed that the prevalence of conscientious objection effectively prevented any access to abortion services in that location, meaning the closest service was over 300 km away.[1680]

17.1.21 There are reports that women in rural areas often suspect their medical practitioners of deliberately delaying access to abortion so they could have more 'thinking time'[1681] by refusing to give information or referrals for religious or moral reasons. In extreme cases, misinformation concerning abortion services may even be provided.[1682] This is especially problematic as medical practitioners are, paradoxically, the sole gatekeepers of providing abortion services.[1683]

17.1.22 A further argument against allowing conscientious objection in relation to abortion is the simple premise that if a medical practitioner has a strong objection to abortion, he or she should not be involved in reproductive medicine. Such sentiments were expressed as early as 1938 in *Bourne*, where MacNaghten J, dismissed objections to performing an abortion based on religious grounds, stating that 'a person who holds such an opinion ought not to be a doctor practising in that branch of medicine'.[1684] Another modern reiteration of this view stated:

> Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely choose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women's health.[1685]

Arguments in favour of a conscientious objection provision[1686]

17.1.23 Every jurisdiction in Australia, and many national and international health bodies, have accommodated the use of conscientious objections by members of the health profession.[1687]

17.1.24 Some commentators argue that its availability in the law is fundamental to affording respect to the various belief systems present in a secular society and protecting the personal integrity

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[1680] During consultation, while some health practitioners were aware of this issue, others only identified the failure of service provision during the process of speaking with SALRI and other health practitioners in the area. While this caused them significant concern as to the disadvantage it was creating for patients they were unable to provide suggestions to resolve the issue. No practitioner wished to remove the availability of conscientious objection in these circumstances.

[1681] Julie Kruss and Heather Gridley, '"Country Women are Resilient but…": Family Planning Access in Rural Victoria' (2014) 22 *Australian Journal of Rural Health* 300, 303; Rebecca Heller et al, 'Barriers to Accessing Termination of Pregnancy in a Remote and Rural Setting: a Qualitative Study' (2016) 123 *BJOG An International Obstetrics and Gynaecology* 1684, 1688.

[1682] Frances Doran and Julie Hornibrook, 'Barriers around access to Abortion experienced by Rural Women in New South Wales, Australia' (2016) 15 *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 1, 4; Frances Doran and Susan Nancarrow, 'Barriers and Facilitators of Access to First-trimester Abortion Services for Women in the Developed World: a Systematic Eeview' (2015) 41 *Journal of Family Planning and Reproductive Health Care* 170, 172.

[1683] Rebecca Heller et al, 'Barriers to Accessing Termination of Pregnancy in a Remote and Rural Setting: a Qualitative Study' (2016) 123 *BJOG An International Obstetrics and Gynaecology* 1684, 1688.

[1684] *R v Bourne* [1939] 1 KB 687, 693.

[1685] Julie Cantor, 'Conscientious Objection Gone Awry: Restoring Selfless Professionalism in Medicine' (2009) 360(15) *New England Journal of Medicine* 1484.

[1686] See generally Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85.

[1687] See Appendix J for summary of laws regarding conscientious objection in Australian jurisdictions; Appendix I for summary of policies of Australia's peak health bodies and associations; Appendix L for key principles in policies of international health bodies.

of individuals.[1688] A number of medical practitioners view the referral procedure as inherently contradictory to the health profession's underlying principles of preserving life and reducing harm.[1689]

17.1.25 It has even been asserted that a state that compels medical personal to succumb to the collective conscience of the majority is a discriminatory regime, where persons are either forced to act against their will to maintain employment or penalised for their personal convictions.[1690] A suppression of personal moral views can set a concerning precedent in the medical profession that practitioners are expected to mechanistically provide procedures without concern for questions of ethics.[1691] Furthermore, there are concerns that the performance of a practitioner may be compromised if they are compelled to act against their conscience.[1692]

17.1.26 These reasons explain the present acceptance of conscientious objections in the medical community. However, it is clear that many health bodies are attempting to address its consequences through compulsory referral requirements.[1693]

17.2 Should a Conscientious Objector be Obliged to Provide a Referral?

Arguments against an obligation to refer

17.2.1 Individuals and groups that argue against a referral requirement often highlight the oxymoronic nature of respecting a medical practitioner's moral objection to abortions yet compelling them to facilitate one.[1694] Some medical practitioners state that providing a referral makes them feel 'complicit' in procuring the morally objectionable abortion.[1695] It is suggested that compelling a medical practitioner to refer a patient in respect of a potential abortion undermines freedom of conscience and

[1688] Armand Antommaria, 'Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment (2010) 9(1) *Ave Maria Law Review* 81, 83–84; Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 114.

[1689] David van Gend, 'Freedom of Conscience: Why the Right to Conscientious Objection Must be Restored' in Justin Healey (ed), *The Abortion Right Debate* (Spinney Press, 2016) 37; JW Gerrard, 'Is it Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?' (2009) 35 *Journal of Medical Ethics* 599, 600–601.

[1690] Erin Whitcomb, 'A Most Fundamental Freedom of Choice: An International Review of Conscientious Objection to Elective Abortion' (2010) 24(4) *St John's Journal of Legal Commentary* 771, 797–798; Roger Trigg, 'Conscientious Objection and "Effective Referral"' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 32, 41–42.

[1691] Anita Showalter, 'Conscientious Objection to Referral for Reproductive Services' (2017) 32(2) *Issues in Law & Medicine* 255, 256; Jeanette Kennett, 'The Cost of Conscience: Kant on Conscience and Conscientious Objection' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 69, 74.

[1692] It is noted that, since conscientious objection is often born out of deep-rooted personal convictions, compelling practitioners to act against these beliefs may result in an inadequate level of care being inadvertently provided. See Aaron Ancell and Walter Sinnott-Armstrong, 'How to Allow Conscientious Objection in Medicine While Protecting Patient Rights' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 120, 127–128; Mark Wicclair, 'Conscientious Objection in Healthcare and Moral Integrity' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 7, 11.

[1693] See Table 2 at [17.1.10] for summaries of key conscientious objection and referral principles promoted in Australian national health bodies' policies and see Appendix L for summaries of international health bodies' referral principles.

[1694] Daniel Hill, 'Abortion and Conscientious Objection' (2010) 16 *Journal of Evaluation in Clinical Practice* 344, 347–348.

[1695] Erin Whitcomb, 'A Most Fundamental Freedom of Choice: An International Review of Conscientious Objection to Elective Abortion' (2010) 24(4) *St John's Journal of Legal Commentary* 771, 793–795; Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22 *Journal of Law and Medicine* 900, 908–909.

the premise and rationale of conscientious objection, and is tantamount to making the medical practitioner complicit in a process they fundamentally oppose.[1696]

17.2.2 Associate Professor Joanna Howe and Professor Suzanne Le Mire of the University of Adelaide have described that it is legitimate to protect the freedom of conscience of health practitioners to not refer for abortions. Their argument is that the benefits to society of taking a pluralistic and pragmatic approach to freedom of conscience are significant enough to justify its legislative protection, and argue that such approaches fit within a secularised society.[1697]

17.2.3 Various parties, for example, argued to the NSW Legislative Council Committee that a requirement for health practitioners with a conscientious objection to abortion to provide a referral is 'gravely unjust'.[1698] 'A requirement of effective referral', Professor Somerville contended to the NSW Legislative Council Committee, 'is a breach of the doctor's right to freedom of conscience, and for some their freedom of religion. This is… 'ideological totalitarianism".[1699] Mr Mimmo of the Ambrose Centre for Religious Liberty noted that 'conscience to an individual, including a health professional, may be a very, very sacred and dear thing that goes to the very question of identity' and 'that person should not be made some sort of a link to the possibility where it results in a termination'.[1700]

17.2.4 Furthermore, the strong convictions of health practitioners may also affect the quality and timeliness of referrals provided with some practitioners actively delaying the process to encourage women to reconsider their decision.[1701] Some commentators also argue that it is the State's responsibility, not the medical practitioner, to ensure that women have access to their desired treatment and abortion access should be coordinated through a public authority instead.[1702]

[1696] See generally Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 134–137, [4.86]–[4.95]; Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85; Joanna Howe and Suzanne Le Mire, 'Doctors' rights to object to abortion should be protected', *Sydney Morning Herald* (online, 4 August 2019) <https://www.smh.com.au/lifestyle/health-and-wellness/doctors-rights-to-object-to-abortion-should-be-protected-20190802-p52dc9.html>.

[1697] Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85.

[1698] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 43 [3.89]. See also at 43–44 [3.90]–[3.92].

[1699] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 60 (Professor Margaret Somerville, School of Medicine, University of Notre Dame).

[1700] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 56 (Mr Rocky Mimmo, Chairman, Ambrose Centre for Religious Liberty). 'In short, to refer for abortion is not a passive step. It is to begin the process of procuring an abortion. Freedom of conscience demands that doctors who believe abortion ends the life of an unborn baby should not be compelled to begin the abortion process': Joanna Howe and Suzanne Le Mire, 'Doctors' Rights to Object to Abortion Should be Protected', *Sydney Morning Herald* (online, 4 August 2019) <https://www.smh.com.au/lifestyle/health-and-wellness/doctors-rights-to-object-to-abortion-should-be-protected-20190802-p52dc9.html>.

[1701] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1, 5–6; Nazeneen Homaifar, Lori Freedman and Valerie French, "She's On Her Own': a Thematic Analysis of Clinicians' Comments on Abortion Referral' (2017) 95 *Contraception* 470, 474.

[1702] Armand Antommaria, 'Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment (2010) 9(1) *Ave Maria Law Review* 81, 97.

17.2.5 It is also pointed out that any patient can readily find an abortion provider and referral is therefore unnecessary.[1703]

Arguments in favour of an obligation to refer

17.2.6 The argument that referral undermines conscientious objection and makes the health practitioner 'complicit' in any abortion has been widely dismissed. The QLRC, for example, dismissed such concerns, observing: 'A referral does not necessarily mean that a termination will take place, but enables a woman to access a practitioner who can offer her a range of options, including termination.'[1704]

17.2.7 Since conscientious objectors impede a patient's immediate access to abortion services, it has been argued that they should consequently facilitate the patient's continuance of care.[1705] This is the position taken by many Australian and international health bodies. However, only some have phrased their policies as requiring positive steps to be taken.[1706] Compelling a referral, or some other form of positive action, from a conscientious objector is instrumental in reinforcing that medical practitioners only dispense of their duties to patients when another practitioner has taken on this duty in their stead.[1707] Some commentators argue that a referral requirement takes a balanced approach to the tension between a medical practitioner's right to act on their conscience and a patient's right to access medical treatments.[1708] Furthermore, practitioners often have pre-established networks in the healthcare sector that allow them to arrange alternative care more efficiently than the patients themselves.[1709]

17.2.8 Abortion care, as Marie Stopes Australia asserted to SALRI, is an 'essential health service', and health practitioners should be required to provide an 'immediate referral' to a suitably qualified and willing health practitioner or provider.

[1703] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 137 [4.96]. This view was noted to SALRI by parties such as Dr Šeman and Dr Turnbull. Cherish Life Australia noted: 'In this day and age with the Internet, those who seek an abortion are easily able to locate an abortion clinic.'

[1704] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 149 [4.159]. Some health practitioners also made this point to SALRI. See also Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87, 107–108; Ronli Sifris, '*Tasmania's Reproductive Health (Access to Terminations) Act 2013*: An Analysis of the Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22 *Journal of Law and Medicine* 900, 908–909.

[1705] Eleanor Milligan, 'Doctors' Moral Objections don't Justify Denying Abortion Access' in Justin Healey (ed), *The Abortion Right Debate* (Spinney Press, 2016) 36.

[1706] The MBA, ATSIHPB and PBA policies are phrased in terms of preventing obstructive action from the practitioner as opposed to compelling positive action. Their policies do not expressly require referral following an objection but merely state that the objection cannot be used to impede access to care.

[1707] Aurora Ciuca, 'The Right to Conscientious Objection' (2017) 5(1) *Logos Universality Mentality Education Novelty Section: Law* 17, 24; Bernard Dickens, 'Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical' (2009) 28 *Medicine and Law* 337, 344.

[1708] Rebecca Dresser, 'Professionals, Conformity, and Conscience' (2005) 35(6) *Hastings Center Report* 9, 10; Aaron Ancell and Walter Sinnott-Armstrong, 'How to Allow Conscientious Objection in Medicine While Protecting Patient Rights' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 120, 129. See also Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 114 [8.27].

[1709] Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38 *Monash University Law Review* 87, 96–97.

17.2.9 It is significant that existing professional guidelines crucially recognises the role of conscientious objection in combination with effective referral. The Australian Nursing and Midwifery Federation SA Branch told SALRI:

> Conscientious objection is an important feature of any change to the legislation supporting a woman's choice to terminate her pregnancy. Termination is one of those issues which divides communities even in 2019. Whether on religious, moral or for any reason, a health practitioner must have the ability to conscientiously object to caring for a woman who has requested termination. If an objection is raised the health practitioner should be obliged to assist the woman to find another practitioner to assist.[1710]

17.2.10 It has been argued that as a democratic society it is important that both a woman's right to terminate a pregnancy and a health practitioner's right to freedom of conscience are respected. Where these rights conflict, as is the case when a health practitioner with a conscientious objection to abortion is confronted with a patient who seeks information about abortion, they must be balanced. The Victorian and Tasmanian Acts which recognise conscientious objection but also require effective referral are said to 'represent a considered and reasonable approach to balancing the rights at issue'.[1711] As the Legal Director of the Human Rights Law Centre stated in this context to the NSW Legislative Council Committee:

> … we hear a lot about the rights of the doctors for their right of freedom of conscience and religion, but we are also balancing that with the woman's right to life, health, autonomy and non-discrimination.[1712]

17.2.11 It has been noted that health practitioners cannot simply invoke conscientious objection and disregard their duty of care to a patient.[1713] It has been argued that a requirement for effective and timely referral benefits women from rural, remote, migrant and Aboriginal communities who already struggle to find a second willing medical practitioner and 'may not pursue a second practitioner if not provided with adequate referral information due to existing cultural and language barriers'.[1714]

17.2.12 This point was made clear by Professor Permezel of RANZCOG to the 2016 Queensland Parliamentary Committee:

[1710] The Australian Colleges of Midwives (see above n 1641) and Nurses (see above n 1640) also made this point.

[1711] Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900. See also Queensland Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 145 [4.140]–[4.141], 148 [4.154].

[1712] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 7 (Ms Edwina MacDonald, Legal Director, Human Rights Law Centre).

[1713] 'However, we chose to be doctors, we were not made to be doctors. We chose to be doctors. In choosing to be doctors we have a duty of care to the patient and if the patient seeks our care and we are unable to deliver that care, and there are other reasons why we cannot deliver it, we might not have experience in that area, we might not have a skill in that area. If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

[1714] NSW Council of Social Services, Submission No 44 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64880/0044%20NSW%20Council%20of%20Social%20Service.pdf>.

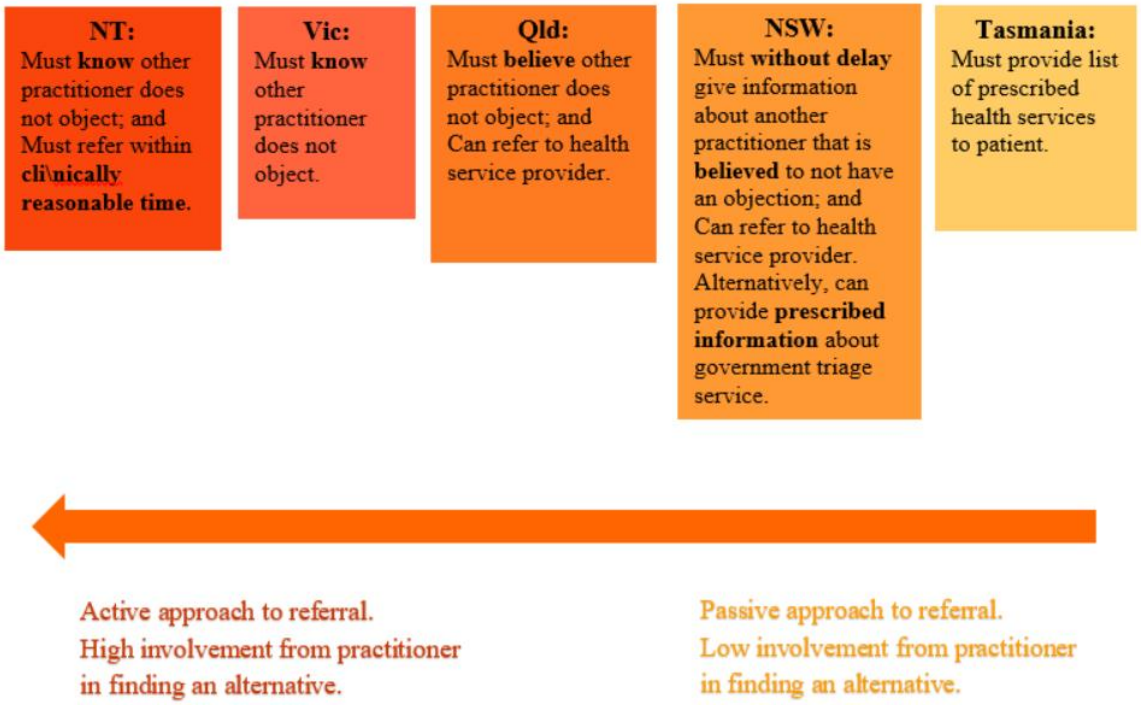
> Conscientious objection is something we feel strongly about. We absolutely respect the right of all practitioners to have a conscientious objection, but it is extremely unfair to women for them to be placed on a roulette wheel where they cruise around a circle of practitioners and cannot access the service, and by the time they find someone who can provide the service the gestation is advanced and the issue of termination becomes a lot more complex than it would have been had the first practitioner directed her to somebody without such a conscientious objection.[1715]

17.3 What Constitutes an Effective Referral?

The term 'referral' has special meaning in a health care context.[1716] Referral can take a variety of forms, as evident from the different referral requirements presently enforced in Australian jurisdictions.[1717] Types of referral vary, based on whether medical practitioners must take an active or passive approach to facilitating alternative care.[1718]

Table 3 below shows a spectrum distinguishing more active and passive referral approaches presently taken by Australian jurisdictions that compel referral.

Table 3: Spectrum of referral approaches in Australian jurisdictions



[1715] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016) 89 [16.5].

[1716] The QLRC commented: 'The Commission is aware that the term "refer" can have a particular meaning for health practitioners. For medical practitioners, "referral" generally involves the partial transfer of responsibility for a patient's care for a defined time and particular purpose. Good medical practice involves ensuring that the second practitioner is qualified, and communicating sufficient information about the patient and the necessary treatment to enable their continuing care': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 149 [4.160].

[1717] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, 2018) 119–120 [4.17]–[4.21]. Also see Appendix J for summary of laws regarding conscientious objection in Australian jurisdictions.

[1718] Nazeneen Homaifar, Lori Freedman and Valerie French, "She's On Her Own': a Thematic Analysis of Clinicians' Comments on Abortion Referral' (2017) 95 *Contraception* 470, 472.

17.3.1 Both Victoria and the Northern Territory require referral to another practitioner that is *known* to not possess an objection.[1719] Queensland adopts a similar although slightly lesser standard of *belief* that no objection is possessed.[1720] These more active forms of referral require the practitioner to locate an alternative and confirm that they can provide the desired procedure.[1721]

17.3.2 However, there are difficulties with a knowledge-based requirement, as shown in the case of Dr Hobart, who objected to a gender selective abortion and hence infringed Victoria's referral requirement because he was unaware of any non-objecting practitioners.[1722] Such requirements may inadequately accommodate practitioners that are so entrenched in communities with common moral principles, and result in delayed referrals as practitioners must go outside of their immediate networks.[1723]

17.3.3 Furthermore, the more involved an objecting medical practitioner may be in the referral process, the greater the opportunity they have to seek to frustrate the will of a patient and actively impede access to a lawful abortion.[1724] A case study in Victoria after the 2007 changes, for example, described numerous instances of medical practitioners with a conscientious objection to abortion providing ineffective referrals and even shaming women for their decision.[1725] This concern has also arisen in SALRI's consultation, especially in rural, regional and remote areas.[1726]

17.3.4 Contrastingly, Tasmania's more passive approach, of providing a prescribed list of health services to the patient, has the benefit of more objectivity for the woman and simplicity for the practitioner.[1727] However, this allows medical practitioners to dispense of their responsibility to patients with merely a piece of paper or direction to a website and without any confirmation required that the patient has located alternative care.[1728] This approach puts the responsibility of coordinating continued

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[1719] *Abortion Law Reform Act 2008* (Vic) s 8; *Termination of Pregnancy Law Reform Act* 2017 (NT) ss 11–12.

[1720] *Termination of Pregnancy Act 2018* (Qld) s 8.

[1721] See, for example, Nazeneen Homaifar, Lori Freedman and Valerie French, "She's On Her Own': a Thematic Analysis of Clinicians' Comments on Abortion Referral' (2017) 95 *Contraception* 470, 472 (where active referral includes phone calls to the alternate practitioner and a transfer of records. Although, these are not specifically required in Vic and NT, a knowledge requirement can encourage these forms of communication to be made).

[1722] Dr Hobart faced disciplinary action from the Medical Board despite stating that he could not refer the couple because 'the general response from my colleagues is disbelief and revulsion'. See Miranda Devine, 'Doctor Risks His Career After Refusing Abortion Referral', *Herald Sun* (online, 5 October 2013) <https://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5>.

[1723] See, for example, Christian Fiala and Joyce Arthur, "'Dishonourable disobedience": Why Refusal to Treat in Reproductive Healthcare is Not Conscientious Objection' (2014) 1 *Woman —Psychosomatic Gynaecology and Obstetrics* 12, 15 (where high proportions of conscientious objectors are described in Italy and Austria necessitating medical practitioners to travel from far regions to provide abortion care).

[1724] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1, 5–6. An extreme example of this is demonstrated in *P and S v Poland* [2012] EHHR 298 where the medical practitioners attempted to delay a 14 year old girl's abortion to allow for members of the Catholic Church to dissuade her. The girl was first forced to await a gynaecologist's return from holiday, then brought to a Roman Catholic priest by that gynaecologist to convince her to carry the pregnancy to term.

[1725] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1, 5–6.

[1726] See further below [17.5.1]–[17.5.15].

[1727] Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900, 905–906; *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6–7.

[1728] Ibid.

care on the patients themselves as they must independently investigate each of these health services and determine which is most appropriate.[1729]

17.3.5 The variations in the active and passive approaches can also be seen in the positions of national and international health bodies and professional protocol.[1730] Bodies that more strongly emphasise the rights to conscientious objections of medical practitioners merely require information about alternatives to be provided to patients.[1731] Contrastingly, other bodies with a stronger emphasis on patient autonomy tend to more actively require the objector to confirm a replacement and co-ordinate with the new practitioner as well.[1732]

17.3.6 Temporal and geographic factors are also relevant in determining the effectiveness of referral. Although many States' health departments have advocated for timely referrals, only the Northern Territory has a legislative basis and also sets a specific timeframe through their clinical guidelines.[1733] Stricter timeliness requirements, such as that in Western Australia, would ensure that patients' access to alternative care is expedited and minimise the effects of the conscientious objection.[1734] However, too stringent a timeliness requirement, especially if practitioners are expected to take a more active approach to referral, may overburden medical practitioners and prove too inflexible in practice.[1735]

17.3.7 Some commentators also advocate for consideration of the geographic proximity of alternate care and its accessibility for the patient.[1736] This is particularly pertinent in rural or regional areas where, as SALRI has heard in consultation, non-objecting medical practitioners may be largely unavailable, forcing a patient to expend considerable time and expense to obtain suitable treatment.[1737] This invites the question of whether limits should be set on the timing and proximity of referrals whereby a medical practitioner is forced to provide treatment if a sufficiently accessible alternative

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[1729] Ibid.

[1730] See Table 2 at [17.1.10] for summaries of key conscientious objection and referral principles promoted in Australian peak health bodies' policies and see Appendix L for key conscientious objection and referral principles in policies of international health bodies.

[1731] The AMA and ANMF require a broader facilitation of care where the patient can merely be given details of an alternative.

[1732] The MBA, NT Department of Health, RANZCOG and RCOG encourage transfer of information to the new practitioner. The NMBA, GMC, NMC, WMA, FIGO and WHO require the practitioner to co-ordinate the replacement and ensure that another practitioner is available. See Table 2 above and Appendices J and L for summaries of their policies.

[1733] NT's conscience clause states that referral must occur with a 'clinically reasonable time' and their clinical guidelines encourage referral within 2 working days. See *Termination of Pregnancy Law Reform Act 2017* (NT) s 11(2)(b); Department of Health (NT), *Clinical Guidelines for Termination of Pregnancy* (Policy Paper, 2017) 22. For extracts see Appendices I and J.

[1734] Department of Health (WA), *Termination of Pregnancy: Information and Legal Obligations for Medical Practitioners* (Policy Paper, 2007) 8 as noted in Appendix K.

[1735] See, for example, JW Gerrard, 'Is it Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?' (2009) 35 *Journal of Medical Ethics* 599, 602 (where it is argued that the referral process requires time to provide the patient with all the available option, and allow for more impartiality and informed decision-making).

[1736] Francesca Minerva, 'Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 109, 116–117; Meghan Fischer, 'The United Nations and The Right to Conscientious Objection in the Health-Care Field' (2016) 21 *Texas Review of Law and Politics* 201, 230–232.

[1737] Louise Keogh et al, Women's Health Grampians and The University of Melbourne, *Rural GPs and Unintended Pregnancy In The Grampians, Pyrenees and Wimmera Regions* (Research Report, 2017) 19; Christian Fiala and Joyce Arthur, '"Dishonourable Disobedience": Why Refusal to Treat in Reproductive Healthcare is Not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 16.

cannot be found.[1738] Although such a provision would guarantee access and continuity of care, such a legislative requirement would be novel on both a national and international scale. In most jurisdictions and within the health community there is a reluctance to compel objecting medical practitioners to provide treatment unless it is an 'emergency'.[1739]

17.3.8 Some jurisdictions have allowed their conscientious objection clauses to have a broad application to any individual that might participate in the provision of an abortion.[1740] This applies in South Australia. As raised to SALRI in consultation,[1741] this creates the possibility of conscientious objection being available not only to health professionals but, potentially, support staff, administration staff such as receptionists, orderlies, counsellors, paramedics or even the cleaners.[1742] For example, in the English case of *Janaway*, a clinic's receptionist sought to rely on a conscience clause by refusing to type a referral letter.[1743]

17.3.9 The more expansive the objection clause, the greater the impediment to a person's access to care, as not only will it minimise their access to the treatment itself, but also to preliminary services prior to treatment, such as counselling and advice.[1744] Furthermore, some commentators cogently argue that certain employees, especially administrative ones, possess such a large degree of separation from performing an abortion that a conscientious objection should be unavailable.[1745]

17.3.10 SALRI notes that referral has a specialised medical meaning.[1746] However, for the purposes of this Report, the specialised medical meaning of 'referral' has not been adopted. Rather what is meant by the use of the term 'referral' in the context of conscientious objection and abortion is designed to reflect the role and scope of referral in existing professional regulations and standards in relation to conscientious objection and abortion.[1747] The concept of referral in this context requires

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[1738] Both WHO and FIGO advocate for this. World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO Press, 2nd ed, 2016) [3.3.6] and [4.2.2.5]; International Federation of Gynecology & Obstetrics (FIGO), *Resolution on 'Conscientious Objection'* (Press Release, 2006). For extracts of policies see Appendix M.

[1739] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 121. See also *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6 (where emergency includes threat to life or risk of serious physical injury); *Abortion Law Reform Act 2008* (Vic) s 8 (where emergency refers to threat to life); *Termination of Pregnancy Law Reform Act 2017* (NT) s 10 (where emergency refers to threat to life); *Termination of Pregnancy Act 2018* (Qld) s 8.

[1740] South Australia, Western Australia and Tasmania have conscience clauses that are available to 'any person' or 'individual' that participates in the treatment. See also Rebecca Cook and Bernard Dickens, 'The Growing Abuse of Conscientious Objection' (2006) 8(5) *Ethics Journal of the American Medical Association* 337, 339.

[1741] This is not a fanciful prospect as SALRI was told such an expansive view of conscientious objection has been taken on occasion and has impacted the ability of organisations to provide services to women both for an abortion procedure and for aftercare. See also below [17.6.45].

[1742] Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513, 518, provides examples of some US States that have expanded their conscience clauses to even include therapy and pre-procedure testing.

[1743] *Janaway v Salford Health Authority* [1989] AC 537. The House of Lords ultimately rejected the claim as, in the UK Act, conscientious objection is only available to any person who 'participates' in the abortion and simply typing a referral letter was deemed by the court to not be 'participation'.

[1744] British Medical Association, *Conscientious Objection (Medical Activities) Bill* (Parliamentary Brief, 2018) 2–3 (where the BMA argues against an expansion of England's conscience clause).

[1745] Roger Trigg, 'Conscientious Objection and "Effective Referral"' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 32, 41.

[1746] See above n 1716.

[1747] As Dr Roach of RANZCOG stated to the NSW Legislative Council Committee of the professional requirements in relation to referral and abortion. 'Then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks.' See also Australian

that the health practitioner effectively transfers the care of the woman, or provides her information. This can be undertaken by either transferring her care to another health practitioner who, to the first practitioner's knowledge, can provide the requested service and does not hold a conscientious objection to the performance of the abortion; or providing information on a health service provider at which, to the first practitioner's knowledge, the requested service can be provided by another health practitioner who does not have a conscientious objection to the performance of the abortion.

17.3.11 Other jurisdictions have also permitted an institution-based conscientious objection where entire hospitals and health services can refuse to provide abortions.[1748] This could further limit access to care as individual medical practitioners willing to provide abortions may be prevented from doing so owing to the policies (or culture) at their institution.[1749] Therefore, if a State wishes to maintain fair and equitable access to abortion services, explicit limits will need to be placed on the use of the conscience clause and untenable uses of the objection prevented.[1750]

17.3.12 SALRI was provided with evidence from some medical practitioners, in areas where abortion, and particularly medical abortion, would otherwise be available but was not (due to conscientious objection), that they would be willing to provide this service, however, due to the directions of their employer, or due to an understanding that if they wished to take up further employment opportunities in the future at other medical services in the area, they could not.

17.4 Views of the VLRC and QLRC

17.4.1 The VLRC recognised and supported legislative recognition of conscientious objection, but subject to 'a requirement that the person inform the patient of his or her conscientious objection and make an effective referral to another provider.[1751] The VLRC explained:

> In framing a provision, it is important not to trivialise the important ethical consideration of the best interests of the patient. A well-drafted conscience provision should ensure that conscientious objection is based on adequate justification and not mere prejudice. It should operate in a transparent manner to minimise the risk of women being demeaned or poorly treated if they seek abortion.
>
> In particular, it should strike an appropriate balance between people within the therapeutic team complying with their personal moral values and those individual moral values not becoming institutional or geographic barriers to the timely provision of safe services.

Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019), <https://ama.com.au/position-statement/conscientious-objection-2019>.

[1748] *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(2). See also Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019) [3.1] <https://ama.com.au/position-statement/conscientious-objection-2019> (which broadly accepts the availability of institutional conscientious objections). See Appendix J for conscientious objection clauses in Australian jurisdictions and Appendix I for excerpts of policies of Australian peak health bodies and associations.

[1749] Christian Fiala and Joyce Arthur, '"Dishonourable disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 17–18; Ben Rich, 'Your Morality, My Mortality' (2015) 24 *Cambridge Quarterly of Healthcare Ethics* 214, 219.

[1750] See, for example, *Doogan & Anor v Greater Glasgow and Clyde Health Board* [2015] AC 640, 654 [34] (Baroness Hale) (where the English courts have expanded the interpretation of their conscience clause since *Janaway* to include medical and nursing care associated with the process of undergoing labour).

[1751] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) Rec 3, 115.

> As freedom of conscience is generally understood to be held by individuals, the conscience provision should not extend to corporations. This is consistent with existing conscience provisions in other Victorian laws.
>
> The danger in extending the provision to institutions is that it may establish a precedent of corporations holding interests that could be categorised as human rights. This could lead to perverse outcomes.
>
> A conscience provision should only cover the abortion procedure itself. It should not prevent the effective after-care of women who have had abortions. Nor should it encourage health providers to avoid giving women accurate information about abortion, including alternative providers. As a minimum standard of care, practitioners should refer the woman appropriately.[1752]

17.4.2 The QLRC also supported legislative recognition of conscientious objection,[1753] but that, to minimise potential barriers to access, any conscientious objection provision should be confined to health practitioners directly involved and not extend to administrative, managerial or other tasks ancillary to the provision of abortion related services.[1754] The QLRC accepted that conscientious objection should not apply in an 'emergency' situation.[1755] The QLRC was conscious of the implications of conscientious objection for rural and remote access but considered that any legal recognition of conscientious objection should not be qualified for rural or remote practitioners:

> In Queensland, the accessibility of practitioners and services is likely to be different in different areas of the State. Women in rural, regional or remote areas may experience particular difficulties in accessing a practitioner or termination service, and in accessing an alternative if the first is unable to provide assistance due to conscientious objection or for another reason. The lack of another practitioner or termination service within a reasonable geographic proximity is a service delivery and access issue, and a lack of alternatives where a practitioner has a conscientious objection represents only part of that issue. The draft legislation is not the most suitable means to deal with this matter. Other initiatives may assist in improving access to services.[1756]

17.4.3 The QLRC also supported legislative recognition of 'a requirement to inform and refer'.[1757] This means that, whilst conscientious objection should be recognised, it is qualified by a need for a practitioner to inform the patient of their conscientious objection and provide timely and effective referral. The QLRC noted that this approach is 'generally consistent' with clinical and professional guidelines.[1758] The QLRC observed that it was aware of 'significant concerns about the inclusion of a requirement to inform and refer',[1759] but its approach best balanced the conflicting interests:

> The Commission notes that health practitioners have the right to provide services according to their conscience and beliefs. Women also have the right to health and health care. There is a need to ensure that women's access to lawful termination services is not impeded. The inclusion of a

[1752] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) 114 [3.29]–[3.34].

[1753] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 146 [4.139]–[4.140], 147 [4.143]. See also at 117–118 [4.8]–[4.11], 122–126 [4.29]–[4.49].

[1754] Ibid 147 [4.143]–[4.1.149]. See also at 118–119 [4.12]–[4.16], 126–130 [4.50]–[4.64].

[1755] Ibid 150–151 [4.167]–[4.171]. See also at 121 [4.22]–[4.25], 138–141 [4.102]–[4.117].

[1756] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 151 [4.172]–[4.173]. See also at 141–145 [4.118]–[4.135].

[1757] Ibid 148 [4.150]. See also at 119–120 [4.17]–[4.21], 130–134 [4.66]–[4.85], 146 [4.141].

[1758] Ibid 148 [4.155]. See also at 146 [4.142].

[1759] Ibid 148 [4.154]. See also at 134–137 [4.86]–[4.95].

> requirement to inform and refer or transfer care represents an appropriate limitation on the rights of health practitioners, which is necessary to adequately protect the rights of women.[1760]

17.4.4 The QLRC noted that the term 'refer' can have a particular meaning for health practitioners.[1761] For medical practitioners, 'referral' generally involves the partial transfer of responsibility for a patient's care for a defined time and particular purpose. Good medical practice involves ensuring that the second practitioner is qualified, and communicating sufficient information about the patient and the necessary treatment to enable their continuing care.[1762]

17.4.5 The QLRC contemplated any legislative requirement should include two referral or transfer options. The first option should be referral or transfer of care to another health practitioner who, in the objecting practitioner's belief, can provide the requested service and does not have a conscientious objection to the performance of an abortion. If a woman requests that an abortion be performed, a referral or transfer would generally be to a suitable medical practitioner; in some situations, such as a request for a late term abortion, the referral may be to a specialist medical practitioner. A request for advice about the performance of an abortion might also be referred or transferred to another suitable practitioner.[1763] The second option should be referral or transfer of care to a health service provider at which, in the objecting practitioner's belief, the requested service can be provided by another health practitioner who does not have a conscientious objection to the performance of an abortion. For example, a woman who requests an abortion could be referred or transferred to a health service provider known to offer suitable abortion related services. A woman who requests advice about abortion could also be referred or transferred to a service relevant to women's reproductive health, or to appropriate counselling.[1764]

17.4.6 The QLRC concluded:

> The terms 'refer' and 'transfer of care' should not be defined. It will be for the objecting practitioner to determine how to appropriately refer a woman to another practitioner or service, and how and when to transfer a woman's care. An example of a referral could be giving a woman enough information to contact an alternative practitioner or health service provider about obtaining the requested service (for example, their name and contact details), or providing a written referral to another medical practitioner (for example, an obstetrician). Where it is not practicable for a woman to make the arrangements to see another medical practitioner, it might be appropriate for an objecting practitioner to make the necessary arrangements on her behalf. For example, in a hospital, the woman's care could be transferred to another equivalent practitioner.[1765]

17.4.7 The QLRC noted that there are a range of professional and legal consequences that apply in relation to inappropriate medical procedures or conduct. The QLRC considered, consistently with its (and the position of SALRI) position about compliance with the requirements for a lawful abortion, a specific offence or penalty for a health practitioner's failure to comply with any responsibilities to conscientious objection was inappropriate.[1766] However, the QLRC considered that a failure to comply

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[1760] Ibid 148 [4.154].

[1761] See above n 1716.

[1762] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Code of Conduct, March 2014) [4.3] in Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 149 [4.160].

[1763] Ibid 148–149 [4.156].

[1764] Ibid 149 [4.157].

[1765] Ibid 150 [4.163]–[4.165].

[1766] Ibid 151–152 [4.175]. See also at 122 [4.26], 145–146 [4.136]–[4.138], 147 [4.144].

with any laws relating to conscientious objection and referral should amount to possible behaviour for which action may be taken under the *Health Practitioner Regulation National Law (Queensland)* or the *Health Ombudsman Act 2013*. 'The Commission recommends that the draft legislation should provide that, in deciding an issue under those Acts about a registered health practitioner's professional conduct, regard may be had to whether the practitioner has complied with the conscientious objection provision.'[1767]

17.5 Possible Misuse of Conscientious Objection

17.5.1 There was considerable unease expressed in SALRI's consultation as to the possible misuse of conscientious objection by some medical practitioners and its implications for safe and affordable access to abortion related services or treatment. This proved a consistent theme. A number of medical and health practitioners described to SALRI examples of other medical practitioners seeking to influence or impede treatment and to dissuade a woman, sometimes in strong terms, from undertaking an abortion. This can have particular implications in a regional, rural or remote context.

17.5.2 The Central Adelaide Local Health Network (Pregnancy Advisory Centre) stated that it is aware of many circumstances over the last 25 years, where women have attended their GP or health practitioner and have not been provided with any referral information regarding access to abortion healthcare, or worse, are given inaccurate, false or misleading information about access to abortion. The Pregnancy Advisory Centre commented: 'This type of conduct is neither acceptable nor appropriate in modern healthcare and should no longer be tolerated.'

17.5.3 One leading health provider similarly told SALRI:

> Our concern is however, of instances where a medical practitioner has actively impeded access to abortion by failing to refer a person to an abortion service or referring them to a counselling service that is pro-life. Additionally, we are aware of gynaecologists who have actively refused to do a dilation and curettage (D&C) on a person with a failed EMA [early medical abortion]. In these examples, the doctors are in violation of the *Medical Board of Australia Code of Conduct* (2014) and should be reported to the Australian Health Practitioner Regulation Agency (AHPRA).

17.5.4 Family Planning Alliance Australia noted:

> Doctors who are conscientious objectors can delay a woman or person seeking help, and permeate a sense of judgement, often causing considerable psychological distress, as well as increasing risks as time progresses. FPAA advocates for the education of doctors about their duty of care in relation to a person seeking abortion to facilitate timely referral to an appropriate service without delay.

17.5.5 Noting this distinction, a number of respondents provided the following insights. One survey response commented: 'Doctors should not be allowed to provide counsel on matters that do not relate to objective medical facts about a potential termination'. Another remarked: 'Being a medical practitioner isn't about imposing your personal views, it's putting them aside to medically assist patients.' Yet another noted: 'Practitioners who do observe the conscientious objector rights should be liable if they threaten or cajole other practitioners to conform to their objections therefore limiting services and disabling women within their communities to be able to access services if they need.'

17.5.6 A specialist medical practitioner cited the duty of care of a medical practitioner to provide a patient with the health care they need and noted there have been medical practitioners demonstrating potential bullying behaviour, trying to stop referrals and contacting other medical practitioners to

[1767] Ibid 152 [4.176].

impede treatment. It was noted this behaviour goes far beyond proper conscientious objection and is trying to control the behaviour of patient. The specialist medical practitioner stated that: '[Our] own personal views should be kept to yourself, you're not making an ethical decision, it's the patient's job to make the ethical decision.' Other health practitioners shared accounts of practitioners seeking to impose their private views on patients and impede or influence a woman's recourse to an abortion. Dr Roach of RANZCOG confirmed to SALRI that he is aware of conscientious objection been used by some medical practitioners to undermine or impede a woman's access to abortion.

17.5.7 SALRI is not in a position to confirm whether or not the incidents described by respondents could or did amount to a breach of the relevant codes of conduct. What such submissions do readily indicate is that there is a distinction to be drawn between the exercise of a conscientious objection on the part of a medical professional on the one hand, and the preservation of that view to the patient in order to diminish or impede the patient's choice of health care option, on the other.

17.5.8 The impact of this bullying behaviour is not just limited to the patient, with one specialist medical practitioner describing to SALRI that they had observed persistent workplace bullying and harassment by colleagues opposed to abortion within public hospitals. Abortion providers consequently develop symptoms associated with PTSD.[1768]

17.5.9 The Human Rights Law Centre informed SALRI of been provided with examples of women in different parts of Australia being obstructed by medical practitioners who oppose abortion, for example by being told that 'abortion is illegal', that they were 'meant to be a mother', and that their baby would ask from heaven 'why did you kill me?' Addressing the operation of conscientious objection, the Human Rights Law Centre suggested that medical practitioners with a conscientious objection be mandated to refer their patient to a medical practitioner known not to have a conscientious objection. However, they noted that in regions where there are no medical practitioners willing to provide abortion related services or information, or to register (once legal) to prescribe early abortion medications, 'a duty to refer will do little to alleviate the financial and emotional damage incurred when women are forced to travel long distances to access a safe and legal health service'.

17.5.10 The Human Rights Law Centre further highlighted that law reform alone may not prove adequate, especially given the implications of conscientious objection, and raised possible additional measures:

> The South Australian Government needs to ensure that unbiased reproductive healthcare services are available to all women regardless of where they live. In regions where there are no doctors currently willing to provide abortion (and contraceptive) services, we **recommend** that the Government provide funding to establish accessible services. Section 9(1)(h) of the *Health and Community Services Complaints Act 2004* (SA) provides for the Health and Community Service Complaints Commissioner to inquire into and report on any matter relating to health and community services on the Commissioner's own motion or at the request of the Minister. We have already recommended… that the Commissioner be requested to inquire into health practitioner compliance with conscientious objection duties within two years… As an additional **recommendation**, we recommend that SA Health or the Commissioner undertake a survey of all medical practitioners operating in South Australia to ascertain those with a conscientious objection to abortion (and contraception) so as to determine where there are gaps in access to unbiased reproductive healthcare. This will then assist the Government to identify where it should invest funding to support access to comprehensive reproductive healthcare.

[1768] See also above [5.2.39]–[5.2.45].

17.5.11 Medical and other health practitioners, during consultation, presented SALRI with various examples of the apparent misuse of conscientious objection to abortion. More than one medical practitioner told SALRI of their practice to show an ultrasound to a woman contemplating an abortion in order to dissuade them from going ahead with the procedure. Others spoke of sharing the rationale of their conscientious objection with a patient. Of particular concern was the fact that SALRI heard of incidences where the interpretation of 'conscientious objection' extended to a refusal to provide after care, or treatment, to a woman who had already undertaken an abortion (with adverse implications in at least one incidence for the woman's health). Such conduct, especially a refusal to provide after care or treatment to a woman who had already undertaken an abortion, was widely perceived in SALRI's consultation (including by parties opposed to the decriminalisation of abortion) as being without any justification.

17.5.12 A similar view was expressed at the 16 May 2019 roundtable with faith groups. The situation was raised of a woman who has had an abortion and suffered complications and then presented at a hospital and whether there should be a conscientious objection at this point? Should there be any conscientious objection to aftercare such as not wanting to treat women who have had complications after an abortion. There was disapproval of any such practice. One attendee highlighted that the medical practitioner's vital professional role applied in the described situation and it is wrong to discriminate against a patient on this ground. The Lutheran Church also made this point clear. 'If a woman experiencing abortion-related complications (for example, persistent bleeding or infection after medical or surgical abortion) seeks help from a medical practitioner, the practitioner has a duty to help as best he or she can. There is no right to refuse to treat post-abortion.'

17.5.13 SALRI notes that concerns over the misuse of conscientious objection by medical practitioners have been expressed elsewhere,[1769] notably in Queensland[1770] and Victoria.[1771]

17.5.14 For completeness it should also be pointed out that concerns have also been expressed to SALRI (and in relation to the 2019 NSW Act) over pressure by medical practitioners upon women to undergo an abortion[1772] or performing an abortion despite knowing the woman was coerced.[1773]

[1769] See, for example, Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513; Christian Fiala and Joyce Arthur, '"Dishonourable Disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 13–14; Diya Uberoi and Beatriz Galli, 'Refusing Reproductive Health Services on Grounds of Conscience in Latin America' (2016) 13 *International Journal of Human Rights* 105; Arianne Shahvisi, 'Conscientious Objection: a Morally Insupportable Misuse of Authority' (2018) 13(2) *Clinical Ethics* 82.

[1770] Ben Smee, 'Queensland's Abortion Law Change Improved Access but "Postcode Lottery" Remains', *The Guardian* (online, 6 August 2019) <https://www.theguardian.com/australia-news/2019/aug/06/queenslands-abortion-law-change-improved-access-but-postcode-lottery-remains>. Ms Marchesi told SALRI that in Queensland, 'there have been problems of medical practitioners impeding or even bullying patients in relation to abortion who have refused to provide a referral for patients seeking a termination. Patients have been told: "Abortion is a crime, you can't get it, we won't provide it".'

[1771] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1.

[1772] Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) 6 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012%20Real%20Choices%20Australia.pdf >.

[1773] Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 13 [56], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

17.5.15 The AMA(SA) reiterated to SALRI that any conduct designed to intentionally impede a patient's access to abortion is inappropriate and would be in breach of professional standards. SALRI wishes to make clear that, despite any protections or recommendations in this report, the imposition of a health practitioner's personal views from whatever underlying belief should not diminish their professional obligation.

17.6 Submissions

17.6.1 The issues of conscientious objection and referral proved a prominent theme of SALRI's consultation and online survey responses.

17.6.2 There was a great diversity in views (although almost all parties agreed that conscientious objection should not arise in an emergency situation where the life of the mother is at risk).[1774]

17.6.3 Four broad views were expressed. The first view was that conscientious objection should **not** be recognised and it was inappropriate and operated to deny women access to abortion procedures. The second view was that conscientious objection should be explicitly recognised (a view widely expressed by parties both favouring and opposing abortion) but that it should **not** be combined with a requirement for effective referral. This view was especially expressed by faith groups and groups and individuals opposed to decriminalisation of abortion. The third view was that conscientious objection should be explicitly recognised but should be combined with a formal requirement for effective referral. The final view accepted, sometimes reluctantly, the role and place of conscientious objection but that it should be combined with a requirement for effective referral. However, this view did not support legislative provision on the basis that both conscientious objection and referral could be properly left to general health law and professional protocols and guidelines and indeed it is preferable to deal with conscientious objection and referral in that manner.

17.6.4 SALRI would preface discussion of the online responses by noting it is not an opinion poll. However, the answers to the online survey found considerable diversity in views:

a. The majority of respondents support conscientious objection in conjunction with a requirement to make an effective referral.

b. A significant portion, less than half of all respondents, opposed conscientious objection, many citing restrictions in relation to rural, regional and remote access in their reasoning.

c. Less than a quarter of respondents opposed referral requirements.

d. Many respondents consider professional protocols and codes of conduct sufficient to regulate conscientious objections and referral requirements and it was therefore unnecessary to make explicit legislative provision.

[1774] The rationale for this was cogently put by the South Australian Council for Civil Liberties: 'Medical practitioners in particular occupy a position of privilege and are paid to perform specialised services. Just as we would not tolerate, say a firefighter or a police officer who had a religious objection of attending at work on a particular day, or fighting a fire on a particular day, we should not provide an exemption for medical practitioners to object to assist a woman in an emergency or where there is no other reasonable alternative for her to obtain treatment.' Even groups adamantly opposed to the decriminalisation of abortion such as the Lutheran Church accepted this position. This view was sometimes qualified. For example, 40 Days for Life, argued: 'As laypersons, we believe that a conscientious objection to providing an abortion should be overridden ONLY in an emergency involving a HIGH PROBABILITY that the woman's life is in grave danger AND no other suitable medical practitioner is available within the timescale required to save the woman's life — an extremely rare occurrence one would expect.'

17.6.5 This disparity of views also emerged in the 340 odd written submissions provided to SALRI. Of these submissions, only seven were clearly against conscientious objection, 30 respondents were in favour of conscientious objection without an obligation of referral, while over 150 were in favour of conscientious objection with an obligation of referral in some capacity. The remainder did not address the issues of conscientious objection and/or referral. Of the 150 in favour of referral, 21 favoured explicit legislative provision, whilst 14 preferred leaving it to health practice and professional guidelines. The breakdown of submissions is detailed in **Table 4** below:

Table 4: Breakdown of Submissions on Conscientious Objection

Against	**For but Without Referral**	**For with Referral Generally**	**For (with Referral Expressly Provided for in Legislation)**	**For (with Referral, but Not Provided for in Legislation)**	**For (Generally, without mentioning referral)**	**No Comment**	**Other**
7 [1775]	30 [1776]	120	21 [1777]	14 [1778]	126	7	15

17.6.6 For the most part, the submissions on conscientious objection fitted neatly within the categories specified in **Table 4** above. However, several submissions were more nuanced, and were instead placed within a broader 'Other' category.

> For instance, one respondent was of the view that only clinicians in private practice should have conscientious objection available to them. The respondent considered that those employed by the government should have the option to informally request that they not be rostered to perform abortions, but should be obliged to perform an abortion should they be rostered to do so.

17.6.7 Further, two respondents expressed that practitioners should not be able to object on conscientious grounds, while also expressing that any such right should be accompanied by an obligation of referral.

17.6.8 The Coalition of Women's Domestic Violence Services SA, whilst opposing legislative provision for conscientious objection, was of the view that if such provision is made, the right to conscientious objection, along with particular exceptions to this right, should be provided for. Such

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[1775] Those against conscientious objection included Professor Margaret Davies of Flinders University; the Coalition of Women's Domestic Violence Services; the Pregnancy Advisory Service; and the Robinson Research Institute.

[1776] Respondents included the Concerned Woman's Collective; Adelaide Centre for Bioethics and Culture; Pregnancy Help Australia; Right to Life Association of SA; 40 Days for Life; Lutheran Church of Australia; Birthline Pregnancy Support Inc; Cherish Life Australia; the Canberra Declaration; Dr Šeman and Advocates International.

[1777] Respondents included a medical practitioner; a rural midwife; the Australian Medical Association; Reproductive Choice Australia; Australian Lawyers for Human Rights; Castan Centre for Human Rights Law; Professor Ben White of the Centre for Health Law Research; a retired specialist; Dr Sarah Moulds; Professor Caroline Da Costa; Dr Susie Allanson; International Planned Parenthood Federation; Australian Lawyers Alliance; Australian College of Midwives; Marie Stopes Australia; Professor Sally Sheldon; Fair Agenda; Children by Choice; Human Rights Law Centre; and Bernadette Richards of the University of Adelaide.

[1778] Respondents included the Southgate Research Institute; three rural GPs; the South Australian Abortion Action Coalition; Women's Lawyers Association of South Australia; the Greens; Australian Women's Health Network; the Honourable Tammy Franks; Dr Erica Miller of La Trobe University; and Barbara Baird of Flinders University.

exceptions included where it was necessary for medical emergencies where a woman's life is at immediate risk, and for where there is not another qualified health practitioner or abortion service within reasonable geographic proximity.[1779] The Coalition of Women's Domestic Violence Services SA was also of the view that practitioners should be obliged to publicly disclose their objections, both online and at the premises.

17.6.9 There was a view that conscientious objection by a health practitioner is inappropriate. This view was expressed by parties such as Dr Caroline De Moel at La Trobe University and Professor Margaret Davies. More than one party noted to SALRI that other professions do not get to exercise a conscientious objection in their choice of clients. It was noted, for example that barristers engaged in criminal practice are obliged by the cab rank rule to represent whoever presents as a client.[1780] It was also noted (and conceded by more than one medical practitioner) that conscientious objection may not be based on a genuine religious or moral objection to abortion as opposed to a pragmatic or expedient wish not to be involved with a contentious area of practice. As more than one practitioner commented: 'It is bad for your career to be known as an abortion doctor.'[1781]

17.6.10 The Coalition of Women's Domestic Violence Services SA saw no justification for conscientious objection:

> It is the view of this submission that there should not be provision for health practitioners in South Australia to decline to provide an abortion related service on the grounds of conscientious objection. The current Victorian model of abortion law reform allows for conscientious objection by health practitioners, on the proviso that they refer the patient on to another provider under s 8 of the *Abortion Law Reform Act*. However, a study on the views of abortion experts on the operation of Section 8 found that negative impacts were experienced by women, with some practitioners refusing to comply with the clause.[1782] We are particularly concerned by the implications for conscientious objection provisions for women whose access to abortion services may already be limited, including but not limited to: Aboriginal and Torres Strait Islander women, women with disabilities, women from culturally and linguistically diverse backgrounds and women in rural, regional or remote locations.[1783]

17.6.11 There was extensive support for conscientious objection, significantly from groups both opposed and supportive of the decriminalisation of abortion. One retired GP simply voiced support for conscientious objection by noting: 'Yes!!' The Catholic Archdiocese of Adelaide and Port Pirie 'believes that medical and/or health practitioners who have a conscientious objection to providing or referring for an abortion should be respected and protected from legal sanction'. Other parties such as Advocates International, Birthline Pregnancy Support Inc, Cherish Life Australia, Concerned Women's Collective, 40 Days for Life, Family Voice Australia and the Right to Life Association of South Australia expressed a similar view. The Australian Christian Lobby supported conscientious

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[1779] The South Australian Council for Civil Liberties also supported exceptions to the right to conscientious objection in these terms.

[1780] See, for example, Rule 21 of the *NSW Barristers' Rules 2014*.

[1781] See above [5.2.39]–[5.2.45].

[1782] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20 *BMC Medical Ethics* 11.

[1783] The Coalition of Women's Domestic Violence Services SA also noted the findings of a 2018 report by the International Women's Health Coalition which also argues that the denial of health care, including abortion services, based on personal belief is a violation of human rights. The report highlights that 'policies allowing health providers to deny care based [their personal] on belief put patients at risk of discrimination, physical and emotional harm, and financial stress', and recommends that 'policymakers should support women's access to health care and reject policies that allow providers to deny care to people in need'. See <https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/>.

objection, noting: 'Therefore freedom of conscience and the right of conscientious objection must be preserved… There should be consistency between SA and national standards in this regard.' One nurse shared her view that 'abortion is a most terrible blight on our society' and noted that she has looked after patients both before and after abortion and to her relief it was permissible to say 'no to assisting in the actual abortion theatre. I hope that this current situation is never reversed. I personally will never assist.'

17.6.12 One survey response noted:

> Ethically a person should never be forced to perform a task they do not wish to especially if it contradicts their religious beliefs. And for the safety of the patient having a doctor who is not confident performing a procedure can lead to more mistakes and possible fatalities.

17.6.13 All the professional associations that responded to SALRI supported conscientious objection, noting it is already an established feature of Australian health law and practice and professional protocols.[1784] There was extensive support for conscientious objection for health practitioners in all of SALRI's roundtables and amongst the medical and health practitioners SALRI spoke to. It was a particularly strong theme amongst the Port Augusta and Whyalla practitioners that SALRI spoke to (though less so amongst the Port Lincoln and Ceduna practitioners). SA Health also declared its support for conscientious objection. There was wide, though not universal, support for at least the premise of conscientious objection for health practitioners on the part of groups favouring the decriminalisation of abortion, including the South Australian Abortion Action Coalition (though this was generally qualified by a need for effective referral). The Castan Centre for Human Rights Law expressed this view, noting: 'It is clear that many doctors who conscientiously object to abortions possess a sincere, deeply held belief in the immorality of abortion.'

17.6.14 However, a qualification to allowing conscientious objection was raised in a regional, rural or remote context where there may simply be no other willing practitioners. This theme was expressed to SALRI, especially by some regional, rural and remote health practitioners. The size of South Australia and the sometimes vast distances between medical practitioners was highlighted.

17.6.15 Some rural GP's noted that if you can improve access at an early stage there will be less risks and complications and therefore we need more people prescribing making a conscientious

[1784] Supporters included Dr Niki Vincent (the Commissioner for Equal Opportunity), Dr Susie Allanson, Professor Emerita Margaret Allen at the University of Adelaide, Dr Jane Baird, Associate Professor Barbara Baird at Flinders University, Professor Caroline de Costa, Dr Caroline de Moel-Mandel at Deakin University, Professor Margaret Davies at Flinders University, Professor Heather Douglas of the University of Queensland, Associate Professor Catherine Kevin at Flinders University, Dr Erica Miller at La Trobe University, Mark Rankin at Flinders University, Dr Margie Ripper at Flinders University, Professor Sally Sheldon of the University of Kent, Professor Ben White and Professor Lindy Willmott of the Australian Health Law Research Centre, Beth Wilson AM, the Australian College of Midwives, the Australian College of Nursing, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian Nursing and Midwifery Federation (SA Branch), the Australian Lawyers' Alliance, Australian Lawyers for Human Rights, the Australian Medical Association (SA), the Australian Women's Health Network, the Castan Centre for Human Rights Law, Children by Choice, the Church of the Flying Spaghetti Monster Australia, Fair Agenda, Family Planning Alliance Australia, Family Planning Welfare Association of the Northern Territory, the Greens (SA), Human Rights Law Centre, International Planned Parenthood Federation, the Law Society of South Australia, Marie Stopes Australia, several senior clinicians, the Central Adelaide Local Health Network (Pregnancy Advisory Centre) (as an alternative to abolishing conscientious objection), Public Health Association of Australia, Queensland Advocacy Inc, Reproductive Choice Australia, Royal Australasian College of Physicians, Royal Australian and New Zealand College of Psychiatrists, the South Australian Abortion Action Coalition (itself consisting of various groups), the South Australian Council for Civil Liberties, the South Australian Rainbow Advocacy Alliance, the Southgate Institute for Health, Society and Equity at Flinders University, Women's Electoral Lobby Australia, Women Lawyers' Association of South Australia Inc, the Women's International League for Peace and Freedom, YWCA Australia and a leading health provider.

objection difficult however, if someone has an objection a women would not want them involved especially considering how vulnerable the woman is.

17.6.16 The Church of the Flying Spaghetti Monster Australia accepted conscientious objection, but the practitioner with the conscientious objection should be responsible for arranging and providing a prompt consultation for the pregnant person with a non-conscientious objector in the case of a non-emergency. However, in the case of an emergency, or the absence a qualified health professional or abortion service in close geographic proximity, there should be no conscientious objection allowed. The Coalition of Women's Domestic Violence Services SA made a similar point.[1785]

17.6.17 This concern was also raised by the Castan Centre for Human Rights Law:

> The question nevertheless arises, what should be the approach in areas where the doctor with a conscientious objection is the only doctor within a reasonable geographical proximity of the patient, rendering the obligation to refer of little practical utility should a woman not be in a position to travel. We strongly urge the Law Reform Institute to give serious thought to this issue and to the plight of women who may have no point of access to services.

17.6.18 Associate Professor Bernadette Richards powerfully outlined:

> I completely support a right to conscientiously object, however, I have concerns when a sole practitioner in an isolated setting chooses to object and denies access to treatment (or a group of providers in a town create a 'cartel' of denial as they all exercise their right to conscientiously object). In this instance the limited availability of care shifts the power dynamic, and as a sole practitioner (or member of a smaller group of providers) they have chosen to be settled in a particular area, and have set themselves up as a healthcare provider. In doing so, they create an expectation of appropriate care and a reliance and relationship of trust. If they then allow their personal value systems to interrupt the provision of care, they are failing a community that relies on them, this is unethical, contrary to professional standards and inappropriate. Often those who seek to have a pregnancy terminated belong to a vulnerable population and they did not choose to live in that environment, often they are young and have no other option. Thus whilst I support conscientious objection in principle, there needs to be some protection for those who do not live in a densely populated area with access to a wide range of care. The healthcare provider who chooses to move to an isolated setting are holding themselves out as providing comprehensive medical care and they need to work out a way that this can be achieved.

17.6.19 SALRI accepts these are valid concerns of the implication of conscientious objection in the South Australian rural and remote and even regional context. However, the practicality of such a 'rural' exemption seems difficult. SALRI notes the view of Professor De Costa that in practice it would be very difficult to define and enforce what is 'reasonable proximity'.[1786]

17.6.20 The second view was that conscientious objection should be explicitly recognised but that it should **not** be combined with a requirement for effective referral. It was noted that this would undermine the whole concept and rationale of conscientious objection and make the health practitioner complicit in a process he or she fundamentally opposed.[1787] Parties such as Anna Walsh, 40 Days for

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[1785] It said GPs with a conscientious objection should publicly disclose this position on their clinic website and premises, to allow them to practice as they choose while at the same time prioritising women's right to timely and supportive information and care.

[1786] Professor De Costa also noted that the provision of telemedicine or Skype abortion services across South Australia will be more likely to solve this problem. 'Such services are now well established in many parts of rural Australia and have proved to be safe, effective and very acceptable to women; telemedicine is now an important part of rural healthcare of many kinds in Australia.'

[1787] Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85, 107.

Life, Advocates International, the Australian Christian Lobby, the Canberra Declaration, Cherish Life Australia, Concerned Women's Collective, the Christian Legal Centre, Family Voice Australia, Pregnancy Help Australia, the Lutheran Church and the Right to Life Association of South Australia made this point. It was a point also strongly made to SALRI by Dr Šeman and Dr Turnbull. Most parties at SALRI's roundtables with faith groups and faith group NGO's shared this view.

17.6.21 Women's Forum stated a medical practitioner's freedom of conscience should be respected and 'they should not be required to refer as this contradicts the nature of conscientious objection'. One survey response noted: 'A requirement of health practitioners to refer practically removes the concept of this ability to object as they are required to take part in the process which to them is objectionable.'

17.6.22 The Lutheran Church argued that medical practitioners and other healthcare professionals 'must not be reduced to the status of slaves, compelled against their will and against their conscience to provide any service that their patients want, especially procedures they deem not to be in their patients' best interests' and they 'will feel that the act of referral makes them morally complicit in the abortion'.[1788] The Lutheran Church stated that a society that respects and understands conscience 'recognises the harm that can be done to individuals who are forced to act against their conscience, that it attacks their integrity'.[1789]

17.6.23 Cherish Life Australia disagreed with any suggestion that a health practitioner who has a conscientious objection should be obliged to refer a woman to another willing practitioner:

> No, because that is formal cooperation making them complicit in the moral evil to which they object. In this day and age with the Internet, those who seek an abortion are easily able to locate an abortion clinic. If a doctor believes abortion is not in the patient's best interests, he or she is actually under an ethical obligation not to refer.

17.6.24 One survey response noted:

> All health practitioners should be allowed a conscientious objection, no matter the circumstances. Being allowed to follow one's conscience is a human right. No health practitioner should be forced to provide a referral against his or her conscience. If the woman wishes to continue on with termination, she is free to obtain a referral for the service from another doctor.

17.6.25 Birthline Pregnancy Support Inc argued:

> It would be somewhat illogical to, on the one hand, permit conscientious objection, but on the other hand require the medical practitioner to refer the woman to a practitioner *who will* undertake the procedure. To amend the legislation in that fashion runs contrary to the idea of a person objecting to certain conduct on the basis of conscience, because the person would, in effect, be

[1788] The Lutheran Church noted that 'health care institutions, as corporations, are considered persons at law and are regarded as moral agents. Corporate bodies as well as individuals can therefore also hold a conscientious objection to abortion. Thus church-run hospitals or health centres should also be free to dissociate themselves from abortion'.

[1789] The Lutheran Church suggested that the South Australian Government should relieve medical practitioners of any obligation to refer and should take the responsibility itself for directing people to abortion services. 'It could do this by creating and maintaining a publicly accessible online register of doctors who are willing to be involved in abortion, and under what conditions they are prepared to be involved. Doctors should be able to change their willingness at any time.' SALRI notes this suggestion but it is impracticable. It was cogently pointed out to SALRI in consultation that a public register of medical practitioners willing to provide abortion services undermined considerations of privacy and risked harassment and intimidation.

compelled to do the *very thing* (by a referral) which could result in the harm to the woman and/or the baby.

17.6.26 Anna Walsh opposed mandatory referral and stated that such a law would destroy the notion of individual rights and beliefs and 'it is hard to escape the conclusion that doctors are reduced to mere technicians or service providers'.[1790] Ms Walsh told the NSW Legislative Council Committee that there is an assumption built into any provision that requires the provision of information to a patent seeking an abortion by a medical practitioner with a conscientious objection 'is a reasonable compromise and should not harm the doctor with the objection'. However, Ms Walsh stated this assumption is unfounded and is not supported by the evidence.[1791]

17.6.27 The roundtable discussion with faith groups on 16 May 2019 supported conscientious objection and some attendees opposed a referral requirement. There was support from the attendees for conscientious objection for health practitioners. Several parties suggested that requiring a health practitioner to undertake referral to a willing practitioner undermined the notion of conscientious objection. It was noted that there have been problems in Victoria where the law requires referral. One party said they did not support referral and though some practitioners may be willing to refer, at least some medical practitioners and nurses would not do it 'as this makes them complicit in the process'.[1792]

17.6.28 It was also suggested by several parties such as Dr Šeman and Dr Turnbull opposed to referral that it is unnecessary in any event. The Australian Christian Lobby, for example, argued:

> There is no need for there to be such an infringement of conscience in the world of the internet and Google. The SA Health website already lists providers and more detail may easily be added. Where the State can provide the information readily there is no reason a citizen's conscience should be infringed. All a practitioner would then be required to do is to refer a patient to the website.

17.6.29 A number of parties supported conscientious objection but with a requirement for effective referral and that both should not just be left to ethical and professional guidelines and protocols and should be confirmed or clarified in legislation. One survey response noted: 'It is appropriate the practitioners can conscientious object provided they provide patients with appropriate (non-judgemental) advice and refer appropriately.' Another survey response said: 'In the case of conscientious objection mandatory referral to another medical practitioner who does not hold a conscientious objection should be a legal duty.' Another accepted that all medical practitioners should be able to conscientiously object by not perform abortions but 'they do not have the right to impose

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[1790] Ms Walsh noted that there is an absence of research as to the impact of mandated referral on health practitioners but the preliminary findings of her research on 35 medical practitioners who have a conscientious objection to abortion found that the majority of respondents 'object to not just referral but other peripheral acts such as paperwork for abortion and medical tasks such as inserting a cannula to ensure venous access for fluids or medication to be used during the abortion'.

[1791] Anna Walsh, Submission No 21 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 6 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64858/0021%20School%20of%20Law,%20University%20of%20Notre%20Dame%20Australia.pdf>.

[1792] However, one attendee at the 16 May 2019 session emphasised that the medical practitioner must be careful to avoid conscientious objection allowing his other personal views to interfere with their professional role. 'You need to place the patient's view ahead of your own. You can have the conscientious objection that you won't do it but then you need to refer.' It was also noted that it needs be a proper referral not a perfunctory referral. This party elaborated: 'Within the healthcare frame that [referral] would be mandatory. You are not obliged to do it, but you are obliged to refer and if you don't that is a professional matter within the healthcare frame. Prior to 24 weeks there should be no issue around conscientious objection. The AMA, Royal College would take a very dim view of a practitioner that failed to advise of a procedure that was available.'

their beliefs on the patient and should assist the patient to identify a suitably trained practitioner to assist them with their health needs'.

17.6.30 Another survey response said:

> Doctors are people and entitled to conscientious objection in this matter, but their duty of care as a professional includes directly referring a woman to another practitioner and assisting her if this is not practical, not causing unnecessary delay in her pursuing an abortion.

17.6.31 This point emerged elsewhere. The Castan Centre for Human Rights Law, whilst noting its support for conscientious objection, saw the need for this to be combined with a requirement for timely and effective referral. It commented: 'Thus the imposition of an obligation to refer seems like a reasonable way to balance the rights of a doctor against the rights of a patient; it also seems to be an approach which is adopted by a number of key medical organisations both locally and globally'. The Human Rights Law Centre accepted conscientious objection but only with a legislative requirement of timely and effective referral without seeking to impede or influence a woman's choice.[1793]

17.6.32 Associate Professor Bernadette Richards highlighted the need for effective referral:

> I am also supportive of the requirement for meaningful referral, this needs to be clearly identified as something more than simply counselling against abortion and then handing over a pamphlet or card. Patients are vulnerable and general health law, codes of conduct and professional standards clearly prohibit value judgments of patients. Abortion should be not different, these patients generally do not come to this decision lightly and therefore need appropriate support and care, to judge them and discuss personal values is inappropriate. If a patient came in with an infected body piercing for example, it would be inappropriate for a doctor to give them a lecture on the evils of body piercing, the doctor patient relationship is one of trust and cannot involve the imposition of the doctor's value system on the patient.

17.6.33 Professors White and Wilmott highlighted the importance of effective referral:

> [any] conscientious objection clause should include a legal obligation of referral, whereby a health practitioner exercising a conscientious objection is required by law to refer the woman to a practitioner who does not have an objection. Referral in those circumstances is critical to ensure the patient is able to receive appropriate advice and information about termination, and to reduce delay in securing a termination. An obligation to refer exists in Tasmania, and in Victoria. The Victorian provision requires the doctor with the conscientious objection to refer the patient to a registered health practitioner in the same regulated health profession who the objecting doctor knows does not have a conscientious objection. The Tasmanian provision requires the objecting doctor to provide the woman with a list of prescribed health services from which she may seek advice, information or counselling on the full range of pregnancy options. We consider the Victorian provision a better model to ensure more timely and direct access to a qualified health practitioner who is known not to have a conscientious objection.

17.6.34 The Law Society also supported conscientious objection but only if combined with effective referral.[1794] Professor Heather Douglas expressed a similar view, noting there is a need for

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[1793] The Human Rights Law Centre also raised the need for patients to have access to complaint mechanisms. See above [17.5.10]. The Human Rights Law Centre also explained its preference for a State legislative requirement for timely referral owing to the potential effect of the recent draft Commonwealth Religious Discrimination Bill. See further below [17.7.7].

[1794] Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [18], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

clear limits to be placed on conscientious objection, because conscientious objection can be used to thwart women's legitimate access to abortion and it should be seen as a relative, rather than an absolute, right; it must yield to the requirement to protect public health and safety. Reproductive Choice Australia commended the 'responsible and professional advice' of the AMA but noted that membership of the AMA is optional and the code of conduct is voluntary. Reproductive Choice Australia favoured a legislative requirement for conscientious objection and genuine referral as in Victoria and Queensland, noting that 'failure to refer to an unbiased medical practitioner, or worse, referral to an anti-choice group, can delay access to abortion as well as add to cost and distress'. Women's Electoral Forum Australia expressed a similar view, noting the need for 'timely' referral.

17.6.35 It is significant that professional health associations supported the role of conscientious objection for health practitioners, but only if combined with effective referral.

17.6.36 The Australian College of Midwives favoured legislative provision as in Victoria and Queensland to cover conscientious objection but also effective referral. RANZCOG pointed out to SALRI its belief that health practitioners should not be required to perform an abortion where it is in conflict with their personal convictions, except in cases of emergency. 'However, all health practitioners have a professional responsibility to inform patients where and how abortion services can be obtained and must be respectful of the woman's decision'.[1795]

17.6.37 The Australian College of Nursing stated:

> ACN is aware that there will be health professionals strongly opposed to termination of pregnancy and they should not be expected to provide services against their personal beliefs (except in emergencies). However, ACN believes all health professionals have a moral and ethical obligation/duty to inform women seeking termination of where and how services can be accessed without fear of judgement.

17.6.38 The AMA(SA) supported legislative provision for conscientious objection and effective referral:

> … we recommend that any legislative reform should allow medical practitioners to refuse to provide or participate in medical or surgical termination based on a conscientious objection. In these situations, medical practitioners should be required to provide patients with information about medical practitioners or services which provide these services. A doctor with a conscientious objection to abortion must not intentionally impede an individual's access to such services.

17.6.39 The final view accepted, sometimes reluctantly by some consultees, the role and place of conscientious objection, but that it should be combined with a requirement for timely and effective referral. However, this view did not support legislative provision on the basis that both conscientious objection and referral could be properly left to general health law and professional protocols and guidelines and indeed it is preferable to deal with conscientious objection and referral in that manner. This view was expressed at the roundtable with parties in favour of the decriminalisation of abortion on 7 June and by some attendees at the 7 June session with the legal and medical sectors.

17.6.40 The South Australian Abortion Action Coalition submitted to SALRI that it did not support legislative provision for conscientious objection and referral and it was preferable to leave this

[1795] This was explained to the NSW Legislative Council Committee as follows: 'If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well': Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

to professional guidelines, notably the AMA's position statement: '[We do] support any new laws with reference to abortion and conscientious objection, but rather extensive efforts to ensure that both the community and health professionals are aware of these requirements'. This position was also expressed by the Australian Women's Health Network, the Women Lawyers' Association of South Australia Inc and Dr Erica Millar.

17.6.41 One leading health agency stated that 'we don't think conscientious objection is warranted in health law as it is covered in health regulations and professional guidelines'. One survey response noted that the AMA Code of Conduct already states that access to medical care must not be impeded based on conscientious objection, and that information must be provided so that care can be sought elsewhere. Another survey response noted that conscientious objection, effective referral and emergencies are all covered under professional guidelines and explicit laws are therefore unnecessary.

17.6.42 One survey response commented: 'Health care professionals are protected from being required to undertake health care to which they have a CO under health regulations. No special protections are required for abortion care. Similarly, the obligation to refer or provide information is already in place'.

17.6.43 Associate Professor Barbara Baird supported conscientious objection and effective referral but stated that no explicit provision is required:

> A health care practitioner with a conscientious objection to abortion should declare this to patients and immediately refer to a practitioner that they know does provide this care. But there does not need to be any specific legislation to this effect; current professional codes of ethics for doctors and others are adequate in this respect and should be promoted and respected. Abortion does not need to be made an exceptional case in this matter.

17.6.44 The Southgate Research Institute, whilst supportive of conscientious objection and referral, considered these are better left to health law and practice and professional guidelines and specific legislative provision is unnecessary and unhelpful:

> Protection for conscientious objection is encoded in mandatory national codes of conduct for all health professions under their national registration boards. No special provision is required, and if it were included in the law, it would cause unintended consequences, as has been the experience in other jurisdictions. The requirement for those with a conscientious objection to provide referral or information regarding alternatives is also encoded in national codes of conduct. No change is needed, or helpful.

17.6.45 One incidental issue concerns who should be able to claim conscientious objection. The present law in relation to abortion is unclear and refers to 'any person'. SALRI in consultation has heard accounts of employees beyond the health practitioners directly involved in an abortion claiming a conscientious objection such as secretarial and administrative support staff and even cleaners.[1796]

[1796] No party in SALRI's consultation went as far as the extreme view advanced by a radical American anti-abortion group. 'There is certainly a strong defence here for those who are opposed to abortion to refuse to service abortion facilities. Let this witness begin, from plumbers, electricians, office supply companies, delivery services, printing companies, lawn and garden companies, snow removal services, computer consultants, office machine repair services, sanitation workers, roofing companies, taxi drivers, security companies, lock and key companies, cleaning and maintenance services, sign and fence companies, food services, exterminators, and every other conceivable service': Christian Fiala and Joyce Arthur, '"Dishonourable Disobedience": Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman — Psychosomatic Gynaecology and Obstetrics* 12, 14.

There are suggestions that conscientious objection should be available for anyone and not confined to the staff directly involved in the procedure.[1797]

17.6.46 There was little support in SALRI's consultation for such an expanded notion of conscientious objection. The prevailing view from the parties who addressed the issue was that the entitlement to claim a conscientious objection should be confined to the health practitioners directly involved in the procedure (consistent with other health procedures) and it should not extend to other individuals such as secretarial or support staff or extend to the provision of after care.[1798] A Port Lincoln health practitioner highlighted the importance of patient care and that conscientious objection should not be about the wider community but rather about the women and her medical practitioner.

17.6.47 Fair Agenda contended:

> Fair Agenda would oppose any provision for conscientious objection that applied to administrative staff, services, facilities, organisations, or corporate entities. Or give a mandate to institutions to refuse this type of healthcare.

17.6.48 There was also reference as to whether a private hospital (run by a religious order, for example) should be able to claim a conscientious objection.[1799]

17.7 SALRI's Observations and Conclusions

17.7.1 It is useful to reiterate that a refusal by a medical practitioner to provide, or participate in, a treatment or procedure for legitimate medical or legal reasons, does not constitute a conscientious objection. For example, where a patient requests a treatment or procedure that is of no medical benefit, outside the medical practitioner's skills or scope of practice, illegal, or where the practitioner believes the patient has impaired decision-making capacity.[1800]

17.7.2 Conscientious objection must be genuine and not based on expediency, self-interest or discrimination.[1801]

17.7.3 SALRI suggests that the recent insightful comments to the NSW Legislative Council Committee of Dr Roach, the President of RANZCOG, should be adopted as a sound basis for the role and scope of both conscientious objection and referral:

[1797] The Christian Medical and Dental Fellowship of Australia, for example, submitted to the NSW Legislative Council that 'involvement in the abortion process will be distressing to healthcare providers. It is essential that the right of conscientious objection be protected and extended to everyone involved, from doctors and nurses, to students, to administrative staff and cleaners': Christian Medical and Dental Fellowship of Australia, Submission no 19 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64851/0017%20Christian%20Medical%20and%20Dental%20Fellowship%20of%20Australia.pdf>.

[1798] See above [17.5.1]–[17.5.14].

[1799] There was some support amongst parties opposed to the decriminalisation of abortion and amongst Port Augusta practitioners for such an entitlement. There were contrary views. Marie Stopes Australia, for example, commented: 'Public health services, such as hospitals that receive government funding regardless of their affiliation (religious or otherwise), should not be able to object to the provision of essential health services.' The issue of organisational conscientious objection raises involved issues, including the role of the Commonwealth as a main provider of funding, and it is beyond the remit of this reference.

[1800] Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019), <https://ama.com.au/position-statement/conscientious-objection-2019>.

[1801] See Ibid.

> The first place I would start is that there is an extraordinary irony in all of this which is that people who are talking about their own conscientious objection or their own conscience are actually making judgements on the conscience of others, particularly the women who are choosing to have an abortion or not. I do not think they recognise that or are aware of that. They sit back on their own morality while judging the morality of others. The statement that we made and we stand by is that we respect the conscience of our members, we respect the conscience of each person in society and that they should be aware of their own and they should live by that. However, we chose to be doctors, we were not made to be doctors. We chose to be doctors. In choosing to be doctors we have a duty of care to the patient and if the patient seeks our care and we are unable to deliver that care, and there are other reasons why we cannot deliver it, we might not have experience in that area, we might not have a skill in that area. If we are unable to provide that care, and it may be because of conscientious objection, then it is our duty, and I think a better term would be transferring the care or providing information to the patient so that she is then able to access the care that she seeks. The other part of that is that we have no right to impede that woman from receiving care as well.[1802]

17.7.4 SALRI accepts the role and rationale of conscientious objection, but notes that there are legitimate concerns over the role and rationale of conscientious objection. Other professional roles do not get to exercise a conscientious objection in their choice of work or client. SALRI especially accepts, as powerfully outlined by Associate Professor Richards, the Castan Centre for Human Rights Law and others, the real concern that the exercise of conscientious objection can effectively close down a hospital or area in relation to abortion and related services, and has significant implications for regional, rural and remote access.

17.7.5 SALRI also notes that conscientious objection, in relation to abortion, is not an all or nothing scenario. It was noted by various medical and health practitioners in consultation that a practitioner may be willing to perform an abortion in one situation, but not another. As Advocates International observed:

> Finally, even among medical practitioners who will perform an abortion, there is a spectrum with regards to conscientious objection. For example, some medical practitioners will only perform an abortion for fetal abnormality, and never for social reasons. Other medical practitioners will only perform an abortion in the first trimester, and most would refuse sex selective abortions at any stage of pregnancy. The vast majority of medical practitioners would refuse to perform a late term abortion for any reason.[1803]

17.7.6 Conscientious objection preserves the moral integrity of practitioners and respects their diverse beliefs and faith. Therefore, in accordance with the views of many national and international health bodies, these objections warrant protection and SALRI recommends that conscientious objection, on the part of a health practitioner in relation to performing an abortion or assisting in the performance of an abortion, should be respected and explicitly included in any new law. Therefore no medical or heath practitioner should be under a duty to perform or assist in performing an abortion, save for a medical emergency.

17.7.7 SALRI notes the view expressed in consultation that specific provision for conscientious objection and/or referral is unnecessary and it is better left to health law and professional protocol. SALRI respectfully disagrees with this view and concurs with the view of parties such as the South

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[1802] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, Uncorrected transcript, 29 (Dr Vijay Roach, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

[1803] This point was made by Dr Šeman and Dr Turnbull and various health practitioners that SALRI spoke to.

Australian Law Society,[1804] AMA(SA), Ms Marchesi and the Human Rights Law Centre that legislative clarification of such an important issue is preferable. Indeed, as more than one medical practitioner told SALRI, the law here plays an important role in informing, reinforcing, shaping and setting professional guidelines. It is inappropriate to simply leave something as important as conscientious objection and referral in the context of abortion to professional guidelines. SALRI considers that, in relation to abortion, explicit legislative provision is preferable to supplement and support the existing references to conscientious objection that already appears in health law and practice and professional protocols in relation to health procedures generally. Moreover, the express intention of the Commonwealth Attorney-General to bring forward new laws to protect aspects of religious belief may necessitate an interaction between Commonwealth and State Regulations. Assuming the draft Commonwealth Bill passes in its current form, including cl 8(5) in particular, then it is important to provide for conscientious objection and referral in State law. The intent of cl 8(5) appears to be to override health practitioner conduct rules, except to the extent that they are 'consistent' with a State or Territory law that allows a health practitioner to conscientiously object or, if there is no such State or Territory law, to override health practitioner conduct rules except as provided for in cl 8(6).[1805]

17.7.8 However, a person's access to healthcare must not be jeopardised and processes such as a referral requirement should be implemented to ensure their continuity of care. Furthermore, the possibility of referral coordination through a public authority should be explored, to combat issues of non-compliance with these referral requirements. There is an evident research gap in the desired and actual uses of conscientious objections by South Australian health practitioners. This should be investigated to determine an appropriate set of limits for a conscience clause that will ensure access to healthcare is protected, especially for women living in rural and regional areas where healthcare options are already inherently limited.[1806]

17.7.9 SALRI notes suggestions that conscientious objection should be available for anyone and not confined to the health practitioners directly involved in the procedure.[1807] However, SALRI does not agree with this position as it is too expansive and at odds with current clinical practice in relation to other medical procedures, including the position both interstate and in the UK.

17.7.10 The logistical implications of an open-ended entitlement to conscientious objection, especially for the smaller rural and regional hospitals, was pointed out to SALRI as likely being considerable, if not unworkable. Such an expansive concept of who can claim conscientious objection received little support in SALRI's consultation.

17.7.11 SALRI notes that neither the VLRC nor the QLRC supported extending conscientious objection beyond the health practitioners directly involved in the procedure. The VLRC recommended that 'the provision should be clearly drafted to only apply to individuals who are part of the clinical

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[1804] Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [18], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

[1805] Draft Religious Discrimination Bills <https://www.ag.gov.au/Consultations/Pages/religious-freedom-bills.aspx>. SALRI notes this is a potentially complex issue. It seems likely to depend upon the precise operation of the Commonwealth Act and any State Act (or for that matter the relevant professional or administrative guideline) with respect to a particular fact scenario.

[1806] Francesca Minerva, 'Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 109, 116–117 (where it is suggested to investigate the balance of objectors and non-objectors in any given region).

[1807] See above [17.6.45].

therapeutic team. It should not apply to administrators, corporate services staff or to organisations'.[1808] The QLRC similarly recommended that conscientious objection should only apply to health practitioners directly involved in assisting or performing an abortion or potential abortion (including advice in that context such as by a GP but not a counsellor).[1809]

17.7.12 SALRI suggests that conscientious objection should be restricted to individuals who are directly performing an abortion or assisting in the performance of an abortion, and it should not apply to other parties such as administrators, corporate services staff or to any provision of after care.

17.7.13 Virtually all parties agreed that conscientious objection should be qualified in the event of an emergency. Children by Choice noted: 'Conscientious objection should not apply in an emergency. One person's life should always take precedence over another's personal values or beliefs, no matter how firmly held.' Parties such as the Australian Christian Lobby opposed to the decriminalisation of abortion expressed a similar view. Dr Šeman, whilst opposing any requirement of referral, stated that no change to the law should affect 'any duty to participate in treatment which is necessary to save the life of the mother'. The Adelaide Centre for Bioethics and Culture accepted if 'there exists a threat to the life of a woman, or a direct and serious threat to her health, conscientious objection can be overridden'.

17.7.14 SALRI agrees with this position (which also reflects the present law in South Australia and professional guidelines) and that conscientious objection on the part of a health practitioner to abortion should not apply in an emergency. Whilst the precise scope of an emergency differed, SALRI adopts the existing definition in the *CLCA* in this context, namely 'treatment which is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman'.

17.7.15 SALRI accepts that the notion of effective referral can be contentious for those health practitioners who hold genuine moral or religious objections to abortion (or in at least the situation contemplated).[1810] A number of parties made this plain to SALRI, including health practitioners such as Dr Šeman and Dr Turnbull. SALRI does not doubt the sincerity of such objections, but does not support the view that providing a referral does, in fact, make a practitioner complicit in any procedure which may, or may not, subsequently take place.

17.7.16 Associate Professor Richards told SALRI that effective referral 'does not preclude conscientious objection, rather it precludes the sharing of the doctor's personal views and value system — it is open to a doctor to refuse to treat but not open to them to judge and impose their views on a patient who has come to them seeking help'. Professor De Costa similarly said:

> I think the CO has to be clear, any doctor who is a CO and is approached by a woman requesting abortion must declare his/her objection immediately and must not take any steps or provide any

[1808] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 7.

[1809] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 147 [4.143]–[147]. 'To minimise potential barriers to access, the conscientious objection provision should not extend to administrative, managerial or other tasks ancillary to the provision of termination services. It should only apply in relation to a registered health practitioner's objection to performing the termination that is contemplated by a woman… The conscientious objection provision should not apply to a counsellor who is not a registered health practitioner, or to others who are not directly involved in the provision of services; for example, administrative staff at a hospital… If the provision applied more broadly, it might increase the likelihood of conscientious objection becoming a barrier to accessing services. The provision also should not extend to hospitals, institutions or services, as the right to freedom of thought, conscience and religion is a personal and individual right': at 147 [4.147]–[4.149].

[1810] See also Joanna Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Cambridge Journal of Law and Religion* 85.

obstacle impeding the woman receiving timely correct information about abortion services, and accessing the abortion in a timely manner, if that is her choice.

17.7.17 SALRI agrees with this position. It notes the cogent concerns raised in its consultation (supported by research in Victoria)[1811] as to the misuse of conscientious objection by some medical practitioners as an opportunity to impede or obstruct treatment and/or for the practitioner to seek to impose their private views regarding abortion on the patient.[1812] SALRI reiterates that conscientious objection is not an opportunity to impede or obstruct treatment, or for the medical practitioner to impose or seek to impose their personal or moral views regarding abortion on the patient. This approach is consistent with professional guidelines.

17.7.18 SALRI acknowledges the concerns expressed to it (and also the NSW Legislative Council Committee)[1813] by Dr Šeman and Dr Turnbull and parties such as the Canberra Declaration, Family Voice Australia, 40 Days for Life, Family Voice Australia, the Australian Christian Lobby and Advocates International that requiring health practitioners to refer a woman contemplating an abortion elsewhere or transferring her care makes them 'complicit' in any subsequent abortion. The QLRC dismissed such concerns, observing: 'A referral does not necessarily mean that a termination will take place, but enables a woman to access a practitioner who can offer her a range of options, including termination'.[1814] SALRI concurs with this reasoning. The International Federation of Gynecology and Obstetrics has expressly stated that '[r]eferral for services does not constitute participation in any procedures agreed upon between patients and the practitioners to whom they are referred'.[1815]

17.7.19 SALRI also notes the argument of Dr Šeman and Dr Turnbull and others, that effective referral is practically unnecessary as any woman considering an abortion can readily find a willing medical practitioner themselves, such as the Pregnancy Advisory Centre in Woodville. It was pointed out that internet access is readily available. Dr Carol Portmann, the AMA(SA) and others pointed out to SALRI, however, that medical practitioners have a fundamental duty of care and professional responsibility to their patients. Health and medical practitioners cannot abdicate this responsibility by simply expecting the patient to find their own willing medical practitioner or service.[1816]

17.7.20 It should also be recognised that there are problems for women in rural, remote and Aboriginal communities in regard to locating alternate services including a lack of internet or mobile phone connection and these issues should not be discounted. SALRI was informed, for example, that

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[1811] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1; Melissa Davey, 'Victorian doctors Who Object to Abortion "Attempting to Delay or Deny Access"', *The Guardian* (online, 31 January 2019) <https://www.theguardian.com/world/2019/jan/31/victorian-doctors-who-object-to-abortion-attempting-to-delay-or-deny-access>.

[1812] See above [17.5.1]–[17.5.15].

[1813] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions): Report 55* (Report No 55, August 2019) 43-44 [3.89]–[3.92].

[1814] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 149 [4.159]. See also Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87, 107–108; Ronli Sifris, '*Tasmania's Reproductive Health (Access to Terminations) Act 2013*: An Analysis of the Conscientious Objection to Abortion and the "Obligation To Refer"' (2015) 22 *Journal of Law and Medicine* 900, 908–909.

[1815] FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (Report, October 2015) 39.

[1816] Medical practitioners are often better positioned than their patients to access information about alternate care options due to their pre-established networks in the medical community. See Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38 *Monash University Law Review* 87, 96-97.

are very limited AVL or Skype facilities in many Aboriginal communities. Patients may also be in a vulnerable state making it more difficult for them to identify and locate alternative support.

17.7.21 SALRI notes that both the VLRC[1817] and QLRC[1818] recommended legislative recognition of conscientious objection but only in the context of legislative provision for 'effective referral'.

17.7.22 SALRI is therefore of the view that any new law in South Australia should provide that a health practitioner who holds a conscientious objection to performing or assisting in the performance of an abortion, making a decision about whether an abortion should be performed on a woman, or offering advice in relation to the potential performance of an abortion, must provide timely and effective referral to a willing health practitioner or health service.

17.7.23 SALRI notes that referral has a specialised medical meaning. SALRI is of the view that any new law in South Australia should explicitly provide for referral. However, the specialised medical meaning of 'referral' should not be adopted. Rather SALRI suggests that the term 'referral' in the context of conscientious objection and abortion should reflect the role and scope of referral in existing professional regulations and standards in relation to conscientious objection and abortion.[1819] The concept of referral in this context should require that the health practitioner effectively transfers the care of the woman, or provides her information. This can be undertaken by the health practitioner either transferring her care to another health practitioner who, to the first practitioner's knowledge, can provide the requested service and does not hold a conscientious objection to the performance of the abortion; or providing information on a health service provider at which, to the first practitioner's knowledge, the requested service can be provided by another health practitioner who does not have a conscientious objection to the performance of the abortion.

17.7.24 SALRI further is of the view that any exercise of conscientious objection and/or referral to a woman in regards to an abortion (or potential abortion) must be conducted without seeking to impede or influence the woman's decision and/or expressing the rationale for their conscientious objection. The law should make it clear that a health practitioner's refusal to provide or participate in a treatment or procedure must be done in a way to minimise disruption to patient care and must never be used to intentionally impede a patient's access to an abortion.[1820]

17.7.25 SALRI, consistent with its reasoning as to not retaining any offence in relation to inappropriate conduct by a health practitioner pertaining to an abortion, does not support any specific offence or penalty in this context. Rather non-compliance by a health practitioner with their obligations as to conscientious objection and/or timely and effective referral is preferably dealt with under the regulatory framework for registered health practitioners.[1821] For example, any deliberate attempt to impede or influence the woman's decision may be a matter for the health practitioner's regulatory body. This is accords with the position in Victoria, Queensland and under the 2019 NSW Act.

17.7.26 Additionally, SALRI suggests that, in deciding any issue about a health practitioner's professional conduct, regard may be had as to whether the practitioner contravenes the provisions in

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[1817] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, March 2008) Rec 3, 115.

[1818] Ibid 148 [4.150]. See also at 119–120 [4.17]–[4.21], 130–134 [4.66]–[4.85], 146 [4.141].

[1819] See Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019) <https://ama.com.au/position-statement/conscientious-objection-2019>.

[1820] See also New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 67.

[1821] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 147 [4.144], 151–152, [4.174]–[4.176].

the recommendations in this Report relating to limitations on the application of conscientious objection, disclosure of a conscientious objection and requirements relating to referral.[1822]

17.7.27 SALRI notes that legislative provision for conscientious objection[1823] and referral will require careful drafting to ensure the rights of both the health practitioner and the woman are equally respected and, crucially, the woman's access to proper health care is maintained.[1824]

17.7.28 Recommendations

Recommendation 43

SALRI recommends that conscientious objection on the part of a health practitioner, in relation to performing an abortion or assisting in the performance of an abortion, should be respected and explicitly included in any new law and therefore no medical or heath practitioner should be under a duty to perform or assist in performing an abortion, save for a medical emergency.

Recommendation 44

SALRI recommends that conscientious objection should be restricted to individuals who are directly performing an abortion or assisting in the performance of an abortion, and it should not apply to other parties such as administrators, corporate services staff or to any provision of after care.

Recommendation 45

SALRI recommends that any new law in South Australia should provide that a health practitioner who holds a conscientious objection to performing or assisting in the performance of an abortion, making a decision about whether an abortion should be performed on a woman or offering advice in relation to the potential performance of an abortion, must provide timely transfer of care or provide information to the patient regarding a willing health practitioner or health service.

[1822] See below Recommendations 45–47. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 105 [3.236]–[3.230].

[1823] Professor Sally Sheldon of the University of Kent raised the following model to SALRI for reference based on a UK Private Members Bill.

> 'Subject to subsection (3), no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment for the termination of pregnancy to which that person has a conscientious objection; provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.
> (3) Nothing in subsection (2) affects any duty to participate in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health, of a pregnant woman.
> (4) The duty of—
> (a) the Secretary of State under section 1 of the *National Health Service Act 2006* (Secretary of State's duty to promote health service), and
> (b) the Welsh Ministers under section 1 of the *National Health Service (Wales) Act 2006* (Welsh Ministers' duty to promote health service) includes a duty to provide or secure services such that the timely access to treatment for the termination of pregnancy is not impeded by the operation of subsection (2).

[1824] See also below [18.6.1]–[18.6.28].

Recommendation 46

SALRI recommends that any new law in South Australia should make it clear that if a health practitioner has a conscientious objection in relation to an abortion (or potential abortion), then that health practitioner is required to:

a. disclose their conscientious objection to the person; and
b. if the request is made by the woman, effectively transfer the care of the woman, or provide her information by either:
    i. transferring care to another health practitioner who, to the first practitioner's knowledge, can provide the requested service and does not hold a conscientious objection to the performance of the abortion; or
    ii. providing information on a health service provider at which, to the first practitioner's knowledge, the requested service can be provided by another health practitioner who does not have a conscientious objection to the performance of the abortion.[1825]

Recommendation 47

SALRI recommends that a health practitioner's refusal to provide or participate in treatment or a procedure must be done in a way so as to minimise disruption to patient care and must never be used to intentionally impede a patient's access to an abortion.

Recommendation 48

SALRI recommends that any new law in South Australia should provide that, in deciding any issue about a health practitioner's professional conduct, regard may be had as to whether the practitioner contravenes the provisions in Recommendations 45, 46 and 47 above.

[1825] See also Australian Medical Association, *Position Statement: Conscientious Objection* (Web Page, 27 March 2019) <https://ama.com.au/position-statement/conscientious-objection-2019>.

Part 18 – Safe Access Zones

18.1 Current Law

18.1.1 There is no current provision in South Australia for safe access zones around premises that provide abortion services so as to prevent or restrict certain kinds of behaviour.

18.1.2 Freedom of expression is protected under international human rights law, but it can legitimately be limited by laws that are both necessary and proportionate to protect others' fundamental rights, including rights to privacy and health.[1826] Australia does not have a right to freedom of speech and the High Court has held that the rights of Australian's of political communication does not include a right to be heard.[1827]

18.2 Nature of the Behaviour Involved

18.2.1 The purpose of safe access zone legislation is to protect the safety and wellbeing, and respect the privacy and dignity, of people (who are often vulnerable) accessing premises at which abortion services are provided, as well as employees and others who need to access those premises in the course of their duties and responsibilities.[1828] A recurring issue in both SALRI's consultation and wider commentary is whether exclusion or safe access zones are necessary near abortion clinics.[1829] Such laws exist in the Northern Territory,[1830] the ACT,[1831] Tasmania,[1832] Victoria,[1833] Queensland[1834] and, most recently, New South Wales.[1835] They are under active consideration in Western Australia.[1836] This potentially leaves South Australia as the only jurisdiction without such laws. The Statutes Amendment (Abortion Law Reform) Bill 2018 (SA) has provision for safe access zones (and associated

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[1826] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 76 [2.67]. See also at: 122–125 [99]–[107].

[1827] See *Brown v Tasmania* (2017) 261 CLR 328; *Clubb v Edwards* [2019] HCA 11.

[1828] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 69 [2.50].

[1829] Safe access zone laws were first introduced in British Columbia in 1996 and has since been established in Newfoundland, Quebec, Ontario and, most recently, Alberta. See *Access to Abortion Services Act*, RSBC 1996, c 1; *Access to Abortion Services Act*, SNL 2016, c A–1.02; *An Act Respecting Health Services and Social Services*, CQLR c S–4.2, ss 9.2, 16.1 and 531.0.1; *Safe Access to Abortion Services Act*, SO 2017, c 19; *Protecting Choice for Women Accessing Health Care Act*, SA 2018, c P-26.83A. In the UK, the Home Office recently announced a review on harassment and intimidation near abortion clinics, including consideration of whether existing laws for protection against harassment or intimidation are sufficient, or whether new police and civil measures are necessary: Rt Hon Amber Rudd MP, Home Secretary, 'Review into harassment and intimidation near abortion clinics' (Media Release, 26 November 2017) <https://www.gov.uk/government/news/review-into-harassment-and-intimidation-near-abortion-clinics>.

[1830] *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3 (ss 14–16) (commenced on 1 July 2017).

[1831] *Health Act 1993* (ACT) pt 6, div 6.2 (ss 85–87), as inserted by the *Health (Patient Privacy) Amendment Act 2015* (ACT) (commenced on 22 March 2016).

[1832] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9 (commenced on 12 February 2014).

[1833] *Public Health and Wellbeing Act 2008* (Vic) pt 9A (ss 185A–185H), as inserted by the *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic).

[1834] Termination of Pregnancy Act 2018 (Qld) pt 4, div 2.

[1835] *Public Health Act 2010* (NSW) pt 6A (ss 98A–98F), as inserted by *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018* (NSW).

[1836] Government of Western Australia: Department of Health, *Safe Access Zones: Proposals for Reform in Western Australia* (Discussion Paper, April 2019).

new offences and police move on powers). The Health Care (Health Access Zones) Amendment Bill 2019 (SA) introduced to the South Australian Parliament on 26 September 2019 is to similar effect.[1837]

18.2.2 The QLRC observed:

> There is evidence that people who oppose termination of pregnancy sometimes engage in activities including protesting, holding prayer vigils, or providing 'footpath counselling',[1838] at or near premises at which a service of performing terminations on women is provided ('termination services premises'); and that such behaviour may impact on the safety, privacy and well-being of women who are accessing those premises and of service providers.[1839]

18.2.3 The Hon Tammy Franks noted that, consistent with much (though not necessarily all) of SALRI's consultation, these problems also exist in South Australia.[1840]

18.2.4 Although the provisions vary between jurisdictions, the laws commonly prohibits a range of behaviours such as threatening, harassing, intimidating, impeding or obstructing a person from obtaining or performing a termination of pregnancy in a safe access zone.

18.2.5 One concern that has also arisen is the video recording of staff or patients outside abortion clinics.

18.2.6 It is an offence interstate (notably in Queensland) to make, publish or distribute a 'restricted recording' without the other person's consent and without reasonable excuse.[1841] A 'restricted recording' is defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, termination services premises, and that contains information that identifies, or is likely to lead to the identification of, the person.[1842]

18.2.7 There are differing views as to the nature and effect of conduct outside abortion clinics.[1843]

[1837] See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478 (Hon Tammy Franks MLC); South Australia, *Parliamentary Debates*, House of Assembly, 26 September 2019, 7501–7504 (Ms Cook).

[1838] 'Footpath counselling' (also referred to as 'sidewalk counselling') may include conduct such as handing out information, telling women entering the clinic that there is an alternative to termination, praying or proselytising. Footpath counsellors view themselves as providing support, assistance or an alternative to women and are generally opposed to terminations': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws:* (Consultation Paper, WP No 76, December 2017) 155, n 1.

[1839] See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 38–39 [7.4.1]–[7.4.2].

[1840] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2427. See also South Australia, *Parliamentary Debates*, Legislative Council, 29 May 2018, 256–257; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2777.

[1841] *Termination of Pregnancy Act 2018* (Qld) pt 4, div 2, ss 16.

[1842] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) iv.

[1843] See, for example, Victorian Law Reform Commission, *Law of Abortion* (Report No 15, June 2008) 138–140 [8.253]–[8.273]. This is well summarised in the differing views before the NSW Parliament. 'Many of the arguments drew upon starkly different characteristics of 'sidewalk counsellors' who oppose abortion and are known to stand outside clinics with the intention of changing the minds of women entering the clinics. [NSW] Health Minister, Brad Hazzard… said that while he believed that abortion should be a 'last resort women should be able to access facilities 'without any concerns at all that others would seek to impose those views on you at your most vulnerable time'… Ms Davies, who is pro-life, defended 'sidewalk counsellors' as people who provided women entering clinics with information to make a 'truly informed decision'. 'They are providing the other pieces of information that some women choose to accept. They don't force their views onto these women. They are offering simply another choice,' she said. Labor MP Trish Doyle said she supported the Bill 'as someone who needed to visit a

18.2.8 One view may be that such laws are unnecessary as there are various existing crimes that could apply to abusive or threatening conduct.[1844] This view was also expressed at the 16 May 2019 roundtable with faith groups.

18.2.9 However, the QLRC disagreed. 'Existing laws also do not adequately address the full range of behaviours engaged in by people who oppose terminations at or near termination services premises.'[1845]

18.3 Recent High Court Decisions and Constitutional Implications

18.3.1 It was raised with the QLRC and SALRI that any safe access zone raises constitutional implications. Few aspects of the *Australian Constitution* ('the Constitution') take the courts as directly to the heart of social and political controversy as the freedom of political communication that is 'implied' in the Constitution.

18.3.2 There is no explicit constitutional right to 'freedom of speech' in Australia.[1846] However, the High Court has recognised an implied freedom of political communication as a necessary part of the system of representative and responsible government established by the Australian Constitution and that the freedom to discuss political matters is essential to these systems of government. [1847] This protection is limited in both its scope and its level of protection, operating as a limit on the exercise of legislative power.[1848] The freedom does not amount to a positive right to protest.[1849] It is not a personal right, but rather a right to freedom from government restraint on political communication. Thus, the constitutional protection for political communication provides some safeguards for protest except where the protest and the process of political communication are 'inextricably linked'.[1850]

18.3.3 Laws may place some restrictions on the implied freedom, provided they are reasonably appropriate and adapted to serve a legitimate purpose in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible

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reproductive health clinic at a very difficult time in my life and was harassed by these judgemental supposed sidewalk counsellors, shouting at me that I was a baby killer':

[1844] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, WP No 76, December 2017) 68 [2.48]; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 168 [5.47]–[5.48], 169–170 [5.59].

[1845] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 83 [5.130].

[1846] *Nationwide News Pty Ltd v Wills* (1992) 177 CLR 1; *Australian Capital Television v Commonwealth Pty Ltd* (1992) 177 CLR 106. Some States have introduced human rights legislation protecting, among other things, the freedom of expression: see *Human Rights Act 2004* (ACT) s 16; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 15. No such law has been introduced in South Australia. Whether such a law should be introduced in South Australia (see Sarah Moulds, 'It's Time to Talk About Rights Protection in South Australia', *In Daily* (online, 1 March 2019) <https://indaily.com.au/opinion/2019/03/01/its-time-to-talk-about-rights-protection-in-south-australia/>) is beyond the scope of this review.

[1847] See *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *Coleman v Power* (2004) 220 CLR 1; *McCloy v New South Wales* (2015) 257 CLR 178, *Brown v Tasmania* (2017) 261 CLR 328.

[1848] Adrienne Stone, '"Insult and Emotion, Calumny and Invective": Twenty Years of Freedom of Political Communication', (2011) 30(1) *University of Queensland Law Journal* 79, 80; *Brown v Tasmania* (2017) 261 CLR 328; *McCloy v New South Wales* (2015) 257 CLR 178; *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 165.

[1849] Daniel McGlone, 'The Right to Protest' (2005) 30(6) *Alternative Law Journal* 274, 276.

[1850] Aidan Ricketts, 'Freedom from Political Communication: The Rhetoric Behind Anti-Protest Laws', (2015) 40(4) *Alternative Law Journal* 234, 235.

government.[1851] A law may be invalid where it impermissibly burdens this freedom of political communication. To determine this question, an analysis must be made as to whether the law effectively burdens the implied freedom, whether the purpose of the law is legitimate, and whether the law is reasonably appropriate and adapted to advance that legitimate purpose.[1852] The High Court has indicated that there can be an effective burden on religiously motivated speech such as preaching.[1853] Where the communication is entirely religiously motivated, for example quoting a bible verse, it may not fall within the scope of the test, unless it also contains implications for government policy.[1854]

Clubb v Edwards & Anor; Preston v Avery & Anor[1855]

18.3.4 The precise limits of this implied right, in the context of safe access zones and abortion clinics, was unclear until the recent decision of the High Court[1856] in *Clubb v Edwards; Preston v Avery*.[1857] The reasoning and result of this case is crucial to this part of SALRI's reference.[1858] The facts of the case are described below (from [18.3.7]).

18.3.5 In the case, the High Court unanimously decided that safe access zones are constitutionally valid and do not infringe the implied right of political communication. The High Court applied the test from *Lange*.[1859] The effective burden on the implied freedom was found to be evident in the statutes. In addition, the purpose of protecting women was found to be a legitimate purpose as women accessing abortion 'are entitled to do so safely, privately and with dignity, without haranguing or molestation'.[1860] Demonstrations about abortions occurring at a clinic were a threat to the privacy and dignity of women seeking treatment.[1861] It was determined by members of the High Court that the prohibition was found to extend to silent prayer or other vigils,[1862] and, in support of safe access zone laws, the Court further held that 'silent but reproachful observance… may be as effective' in dissuading women from accessing abortion services as more boisterous demonstrations.[1863] The rational

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[1851] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws (Consultation Paper,* WP No 76, December 2017) 76 [278].

[1852] *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *McCloy v New South Wales* (2015) 257 CLR 178.

[1853] *Attorney-General (SA) v Adelaide City Corp* (2013) 249 CLR 1; Mitchell Landrigan, 'Protests Outside Abortion Clinics: Constitutionally Protected Speech?' (2016) 41(1) *Alternative Law Journal* 8, 10; Shireen Morris and Adrienne Stone, 'Before the High Court: Abortion Protests and the Limits of Freedom of Political Communication: *Clubb v Edwards; Preston v Avery*' (2018) 40 *Sydney Law Review* 395, 399.

[1854] *Catch the Fire Ministries Inc v Daniel Nalliah and Daniel Scot v Islamic Council of Victoria Inc and Attorney General for the State of Victoria* (2006) 206 FLR 56; Mitchell Landrigan, 'Protests Outside Abortion Clinics: Constitutionally Protected Speech?' (2016) 41(1) *Alternative Law Journal* 8, 10.

[1855] *Clubb v Edwards* [2019] HCA 11, (2019) 366 ALR 1.

[1856] See generally Shireen Morris and Adrienne Stone, 'Abortion Protests and the Limits of Freedom of Political Communication: *Clubb v Edwards; Preston v Avery*' (2018) 40(3) *Sydney Law Review* 395.

[1857] *Clubb v Edwards* [2019] HCA 11, (2019) 366 ALR 1.

[1858] 'I note… Tasmania, Victoria and the ACT have laws authorising safe access zones around abortion clinics and that similar laws are before the New South Wales Parliament. These laws recognise the right of people to access legally available services. However, they do raise issues in relation to freedom of speech. I notice that there are at least two legal challenges to the validity of the laws. The laws under challenge, I understand, are in Victoria and Tasmania, so I'm sure that the Attorney-General would be watching those cases, and this Parliament may choose to have the validity of such laws clarified before it considers legislating': South Australia, *Parliamentary Debates*, Legislative Council, 29 May 2018, 256 (Hon SG Wade).

[1859] *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.

[1860] *Clubb v Edwards* [2019] HCA 11, 84 [258],

[1861] Ibid 24 [126].

[1862] Ibid 47 [164].

[1863] Ibid 24 [89].

connection between the legislation and the purpose evident in both instances, satisfied the suitability requirement of the guarantee.[1864]

18.3.6 The High Court noted that the limited burden on the freedom of 150 metre safe access zones established in the Victorian and Tasmanian legislation were constitutionally valid.[1865] Although the legislation draws no distinction between pro and anti-abortion communications, it was acknowledged that anti-abortion activists are most likely to be affected by its operation.[1866] In his judgment, Gageler J stated that 150m would be close to the maximum justifiable reach and that he would consider the protest prohibition legislative overreach were it to prevent protest at a location 'meaningfully proximate' to an abortion facility. [1867]

18.3.7 In *Clubb*, the High Court held upheld the validity of certain provisions of Part 9A of the *Public Health and Wellbeing Act 2008* (Vic) ('the Victorian law').

18.3.8 The relevant facts are that on 4 August 2016, Mrs Kathleen Clubb approached a couple entering the East Melbourne Fertility Control Clinic. Mrs Clubb spoke to the couple and attempted to hand them a pamphlet. The content of her speech was unknown. Mrs Clubb was charged under s 185D *Public Health and Wellbeing Act* (Vic) which prohibits communication relating to abortion that is able to be seen or heard by someone access a premises where abortions are provided, that is likely to cause distress or anxiety.

18.3.9 The Victorian legislation is significant. Section 185D creates the offence of engaging in 'prohibited behaviour' within a 'safe access zone'.[1868] Section 185B(1) defines 'prohibited behaviour' as including:

> (b) communicating by any means in relation to abortions in a manner that is able to be seen or heard by a person accessing, attempting to access, or leaving premises at which abortions are provided and is reasonably likely to cause distress or anxiety.[1869]

18.3.10 *Clubb* upheld the validity of the prohibition of this conduct in a safe access zone. The Victorian legislation also prohibits other conduct within access zones, but the validity of those prohibitions was not in issue in *Clubb*. It is, however, relevant to consider paragraphs (a) and (c) of the definition of 'prohibited behaviour':

> in relation to a person accessing, attempting to access, or leaving premises at which abortions are provided, besetting, harassing, intimidating, interfering with, threatening, hindering, obstructing or impeding that person by any means;

[1864] Ibid 23 [84].

[1865] Ibid 27 [100]. The High Court rejected arguments regarding different ways in which the extent of the burden on the implied freedom might have been reduced, including by:

- requiring that an offending communication actually be heard or seen by any person: at [92] (Kiefel CJ, Bell and Keane JJ) and [287] (Nettle J).
- creating an exception for where the person consents to receiving an otherwise prohibited communication: at [93] (Kiefel CJ, Bell and Keane JJ) and [285]–[286] (Nettle J);
- providing for an exception to the prohibition during election campaigns: at [94] (Kiefel CJ, Bell and Keane JJ) and [288] (Nettle J).

[1866] Ibid 15 [56], 28 [102].

[1867] Ibid 62 [210], 63[213].

[1868] A 'safe access zone' means 'an area within a radius of 150 metres from premises at which abortions are provided': *Public Health and Wellbeing Act 2008* (Vic) s 185B(1).

[1869] Section 185B(2) exempts from this definition communications by an employee or other service provider at an abortion clinic.

…

(c) interfering with or impeding a footpath, road or vehicle, without reasonable excuse, in relation to premises at which abortions are provided.

18.3.11 Clearly, the behaviour prohibited by paragraph (b) (that is, the prohibition upheld by the High Court) is behaviour that would *not* be caught by paragraphs (a) or (c). In other words, *Clubb* establishes that a parliament can make a law prohibiting communication that would cause distress or anxiety, even if that communication does not involve the physical obstruction or aggression inherent in the behaviour described in paragraphs (a) and (c).

18.3.12 Three members of the High Court (Kiefel CJ, Bell and Keane JJ) dismissed the appeal, and the challenge to the Victorian law, on the grounds that the facts of this case did not raise the issue of freedom of political communication, as it was not demonstrated that Mrs Clubb's speech was political. As such, the matter did not need to be considered. However, due to a number of 'unusual features' in the case, the joint judgment proceeded to consider the application of the constitutional guarantee to the situation. The remaining four judges (Gageler, Nettle, Gordon and Edelman JJ) stated that the case did warrant consideration and the application of the *Lange* test. The majority held that there is a fine line between speech agitating for legislative change and speech directed at persons making personal moral choices where the issue is politically contentious, and that the question is likely to arise in the future.[1870]

18.3.13 It was accepted that the Victorian law burdens the implied freedom but that the purpose of the law, namely that of protecting the welfare and dignity of women seeking access to healthcare, was compatible with the maintenance of the constitutionally prescribed system of government.[1871] The Victorian legislation was suitable for that purpose.[1872] Determining whether a law is 'adequate in its balance' is to ask whether the law is 'manifestly excessive by comparison to the demands of the legitimate purpose'.[1873] Ms Clubb put forward a variety of less burdensome alternatives such as an exception during election campaigns, however, these were deemed to undermine the purpose of the Act.[1874] The majority noted that, in a point especially apt for the present context, freedom of political communication does not entitle speakers to address 'unwilling listeners'.[1875]

18.3.14 The majority observed:

> The burden on the implied freedom is slight in respect of both its subject matter and its geographical extent. Within the safe access zones, the only burden on the implied freedom is upon communications about abortions, and that burden is limited to preventing the capture of an audience.[1876]

18.3.15 In *Preston*, Mr Graham Preston regularly protested outside the Specialist Gynaecology Centre in Hobart. He held signs with images and statements stating that 'everyone has the right to life', quoting Article 3 of the *Universal Declaration of Human Rights*. Mr Preston was charged with three breaches of s 9(2) of the *Reproductive Health (Access to Terminations) Act* (Tas).

[1870] [2019] HCA 11, [36]–[38].

[1871] Ibid [258].

[1872] Ibid [276].

[1873] Ibid [69].

[1874] Ibid [92]–[95], [285]–[289].

[1875] Ibid [97].

[1876] Ibid [100].

18.3.16 The High Court applied the three part test from *Lange*. It was accepted that the Tasmanian law burdens the implied freedom. The purpose of the law was not expressly stated, so was inferred from the terms, subject matter and the relevant Second Reading Speech.[1877] It was determined that the purpose of the law to ensure women could access abortion services in an atmosphere of privacy and dignity was compatible with the maintenance of the constitutionally prescribed system of government and compelling.[1878] The Tasmanian prohibition on certain forms of protest was held to have had a rational connection to the purpose of limiting abortion demonstrations at, or outside, a clinic which constitute a threat to the privacy and dignity of women seeking treatment. In these circumstances, it is generally the case that a law will be inadequate in its balance if it involves gross or manifest lack of balance.[1879] It was not demonstrated that the law is not adequate in its balance.[1880]

18.3.17 The size of the zone was considered, with an acknowledgement that a larger size, or a zone of this size in different circumstances, may too significant a burden.[1881] In the *Preston* case, the burden of the freedom was held to be minimal and was justified in that the law was reasonably adapted to achieving a legislate purpose.[1882]

18.3.18 Any law (if there is to be a new law in this area) must strike a careful balance between considerations of free speech and freedom of religion on the one hand, and the need to protect both patients and staff from harassment and coercion in the sensitive context of access to lawful abortion services, on the other.

18.3.19 As the QLRC concluded:

> The draft legislation should include safe access zone provisions. Termination of pregnancy is an issue about which many people have strongly held views. There is a history of ongoing activities by people who are opposed to terminations at or near termination services premises in Queensland. This is likely to continue in future … Women are entitled to access health services for terminations without interference and with privacy and dignity. To the extent that safe access zone provisions prohibit certain conduct (such as protest or communications in relation to terminations) at or near termination services premises, they restrict the implied freedom of political communication and the right to peaceful assembly. However, neither the freedom of political communication nor the right of peaceful assembly is absolute. Legislation may place some restrictions on the free expression of political communication, including peaceful protest, provided they are reasonably appropriate and adapted to serve a legitimate purpose in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government … The right to protest must be balanced with other rights and freedoms. They include a right to sexual and reproductive health and rights to privacy and personal autonomy... the safe access zone provisions is to protect the safety and well-being and respect the privacy and dignity of persons accessing services provided at termination services premises and employees and others who need to access those premises in the course of their duties and responsibilities… Safe access zone provisions are intended to promote public safety and public order and will provide a simple and effective mechanism for the protection of women and service providers. Similar provisions appear to have been effective in curtailing harassing and intimidating conduct at or near termination services premises in other jurisdictions… The safe access zone provisions are tailored

[1877] Ibid [121], [500].

[1878] Ibid [197], [306].

[1879] Ibid [497].

[1880] Ibid [324].

[1881] Ibid [210].

[1882] Ibid [325].

> to prohibit conduct that infringes the rights of other individuals at the time and place they are seeking to access lawful health services. The provisions do not otherwise prohibit people from protesting or expressing their views about termination of pregnancy. The introduction of safe access zone provisions is consistent with other Australian jurisdictions that have recently reformed their termination of pregnancy laws.[1883]

18.3.20 Safe access zone provisions recognise that an abortion procedure can create a high level of emotion, stress and anguish for the woman, her family and the community and that sometimes these emotions are incompatible with each other and can cause a disturbance which is a risk to the personal safety of individuals and the wider community.

18.3.21 The *CEDAW*, as ratified by Australia, requires that parties take all appropriate measures to ensure access to health care services, 'including those related to family planning'.[1884] The United Nations Special Rapporteur of the Human Rights Council, has observed that, on the right to health, measures should be taken to protect abortion service providers from harassment and violence.[1885]

18.3.22 Several parties, including some who have participated in protests or 'sidewalk counselling', insisted to the QLRC that people at or near clinics do not engage in harassing, intimidating or obstructing behaviour. Rather, they are offering people who are seeking an abortion 'an alternative', or providing support or assistance that may be beneficial, in a non-harassing way.[1886] This concept of 'sidewalk counselling' was described to SALRI by Anna Walsh as follows:

> Sidewalk counselling is an activity which informs women of choices other than abortion, and offers practical help and assistance to woman who may feel that they have no choice other than to undergo abortion, and who are in great turmoil or distress when considering abortion as a viable choice for their personal circumstances.[1887]

18.3.23 One member of the public insisted to the QLRC of the benign nature of such conduct:

> My experience in being a footpath presence as a pro-lifer is that it has always been a peaceful and prayerful gathering, nothing else. The strategy of a footpath presence is that if a woman is seeking a termination of pregnancy … or her partner or support person approaches the footpath presence for support or opinion or advice, then it is provided respectfully and without judgement or prejudice. No attempt is made by the footpath presence to engage or offer advice without it being requested.[1888]

[1883] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 182–184 [5.122]–[5.133].

[1884] *Convention om the Elimination of All Forms of Discrimination against Women (CEDAW)*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) art 12; *Sex Discrimination Act 1984* (Cth), Sch 1.

[1885] Human Rights Council, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda item 69(b), UN Doc A/66/254 (3 August 2011) [28]. Explicit support for safe access zones has been provided by the Committee on the Elimination of Discrimination against Women in a 2017 review of Australia's implementation of the Convention: Committee on the Elimination of Discrimination against Women, *Concluding Observations on the Eighth Periodic Report of Australia,* 70th Session, UN Doc CEDAW/C/AUS/CO/8 (25 July 2018) 14.

[1886] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 169–170 [5.69].

[1887] Other groups such as Advocates International provided similar accounts.

[1888] Ibid 170 [5.61]. SALRI also heard from a number of groups such as Advocates International, Cherish Life Australia similar explanations of the role and nature of such conduct and 'counselling'. Such a categorisation was widely disputed by other parties.

18.3.24 There was wide disagreement noted to the QLRC with such assertions of the benign conduct of protestors or 'counsellors'. Marie Stopes Australia reported on 29 March 2018 to the QLRC that 'verbal abuse, mainly religious in nature' is commonly experienced by staff or patients at or near its Queensland clinics.[1889] Children by Choice similarly observed: 'Most providers of pregnancy termination services have extensive experience with opponents of abortion being obstructive, abusive and violent toward patients, their support people, staff and passers-by.'[1890] The Australian Lawyers for Human Rights told the QLRC that: 'Women seeking abortions and staff working at clinics providing reproductive services report routinely experience harassment and intimidation from anti-abortion protesters outside the clinics'.[1891]

18.3.25 Such a view has been expressed elsewhere. One commentator observes:

> The labelling of anti-abortionists unsolicited interventions as 'door-stop' counselling is misleading. It suggests a consensual conversation, when in reality many such conversations are designed to publicly intrude on a woman's personal choice and interfere with her ability to access reproductive healthcare. For many women these encounters are deeply traumatic and affect their ability to feel safe seeking medical support.[1892]

18.3.26 The Queensland Law Reform Commission heard differing views about the necessity or justification for an exclusion zone around clinics.

18.3.27 Many parties asserted to the QLRC that safe access zone provisions undermine freedom of speech.[1893] Women's Forum Australia, for example, stated:

> the ability for people to engage in peaceful protests or to freely engage in debate on political and moral issues is an intrinsic part of every Australian's implied right to freedom of political communication. In a democratic society, and on an issue like abortion which has such a profound impact on women, it is critical to uphold the rights of women to both express and have access to all views and perspectives on the perceived advantages or harms of abortion.[1894]

18.3.28 Some parties, including legal academics, submitted to the QLRC that safe access zone laws may be unconstitutional for unduly limiting the implied freedom of political communication.[1895] Some parties also suggested to the QLRC that safe access zone provisions could undermine freedom of religion, particularly if prayer is a prohibited behaviour.[1896] It should be noted that the QLRC reported prior to the High Court's decision in *Clubb*.

[1889] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 171, n 93.

[1890] Ibid 171, n 93. This view was endorsed and supported by a number of other parties to the QLRC, including Health Consumers Queensland Ltd, the National Foundation for Australian Women Ltd, White Ribbon Australia and a group of academics from Griffith Law School.

[1891] Ibid 171 [5.67].

[1892] Lou Dargan, 'High Court Decision Could Spell Trouble for the Right to Protest', *Sydney Morning Herald* (online, 11 April 2019) <https://www.smh.com.au/national/high-court-decision-could-spell-trouble-for-the-right-to-protest-20190410-p51cun.html>.

[1893] Ibid 175 [5.84]

[1894] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 175 [5.86].

[1895] Ibid 175 [5.187].

[1896] Ibid 175, n 114. In contrast to the freedom of political communication, freedom of religion is explicitly protected to a limited extent by s 116 of the *Constitution*. However, s 116 applies only to the Commonwealth Parliament. It does not impose any relevant limit on the power of the Parliament of South Australia. It is possible that a distinct issue might arise were the Commonwealth Parliament to enact laws directed to protecting religious freedom. Such a law could result in some State laws being invalid (in the sense of inoperative) to the extent of any inconsistency with the Commonwealth law, by reason of the operation of s 109 of the *Constitution*. The precise effect, if any,

18.3.29 There was wide support to the QLRC for exclusion zones.[1897] There is support elsewhere. One study of the Victorian experience of anti-abortion activity reported behaviour including chasing people, referring to staff and patients as murderers, and verbal abuse.[1898] A study of rural women identified protestors as one factor in women choosing a medical over surgical abortion, which would have required attendance at a facility.[1899]

18.3.30 Ronli Sifris, for example, argues:

> What is clear is that – for now at least – Victoria has had a huge victory for the rights of women to exercise their choice to access a legal medical service free of intimidation and harassment. This is not a law about preventing those who oppose abortion from holding such views. People remain free to express anti- abortion sentiments, just not in a place that prevents women from exercising their right to privacy and reproductive health care.[1900]

18.3.31 Jones notes that anecdotal evidence of intimidation and harassment was heard by the Tasmanian inquiry but 'abortion clinic protests are not an endemic feature of the Tasmanian, or Australian, political landscape.'[1901]

18.3.32 Women's Abortion Rights Campaign Brisbane noted to the QLRC that 'video and audio recordings as well as stills can and have been used for public harassment and intimidation campaigns.'[1902] The National Alliance of Abortion and Pregnancy Options Counsellors similarly observed that: 'Technology-facilitated abuse is increasingly common in our society and there is international evidence that this strategy is being adopted by anti-abortion opponents to harass patients and/or staff outside termination clinics.'[1903] Some parties argued that this type of conduct causes distress and anxiety to staff or patients, and may discourage or deter people from accessing or providing abortion services.[1904]

18.3.33 Several parties told the QLRC that the violation of privacy may particularly impact already vulnerable women, including women who are experiencing domestic and family violence, Aboriginal women, women in rural, regional and remote communities and women of culturally and linguistically diverse backgrounds.[1905] It is significant that very similar concerns were expressed to SALRI.[1906]

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upon State legislation prescribing safe access zones would depend upon the precise terms and operation of the Commonwealth law. See further below [18.6.1]–[18.6.28].

[1897] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 175–177 [5.89]–[5.85]

[1898] This point was made to SALRI by parties including the Castan Centre for Human Rights Law.

[1899] Alana Hulme-Chambers et al, 'Australian Women's Experiences of a Rural Medical Termination of Pregnancy Service: A Qualitative Study' (2018) 15 *Sexual AND Reproductive Healthcare* 23, 25.

[1900] Ronli Sifris, 'State by State, "Safe Access Zones" around Clinics are Shielding Women from Abortion Protesters', *The Conversation* (online, 30 November 2015) <http://theconversation.com/state-by-state-safe-access-zones-around-clinics-are-shielding-women-from-abortion-protesters-51407>.

[1901] By comparison, more than 70 000 anti-abortion protesters were reportedly arrested at American abortion clinics between 1987 and 1993. See Tara Kelly, 'Silencing the Lambs: Restricting the First Amendment Rights of Abortion Clinic Protestors in *Madsen v Women's Health Centre*' (1995) 68 *Southern California Law Review* 427, 429–430.

[1902] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 181 [5.118].

[1903] Ibid 181 [5.115].

[1904] Ibid 181 [5.116].

[1905] Ibid 181 [5.118].

[1906] See also below [18.5.10]–[18.5.11].

18.3.34 Some parties expressed concern to the QLRC that women may be pressured by their partners or parents to terminate a pregnancy.[1907]

> The Commission is conscious of the need for laws to keep up with the use of rapidly advancing technologies to engage in harassing behaviours. However, it is unable to determine the extent to which existing laws are able to be used effectively in the context of the harassment of women or service providers in relation to terminations. In the absence of evidence suggesting that addressing harassment in this context is a clear problem in practice (beyond that which can be addressed by safe access zone legislation), the introduction of a specific offence or civil regime is not warranted.[1908]

18.3.35 The Castan Centre for Human Rights Law was also unconvinced of assertions about the benign conduct of 'counsellors'. It gave some examples to the QLRC of the disturbing conduct of anti-abortion protestors, which included: approaching, following or walking alongside people approaching clinic premises; dispensing brochures or plastic fetal dolls; displaying posters with distressing words or images, such as photographs of dismembered fetuses; castigating patients and staff as murderers; chasing, photographing, heckling, threatening and verbally abusing patients and staff and preventing patients from exiting their cars or obstructing clinic entrances.[1909] The Castan Centre submitted to the QLRC, based on research it had undertaken in Victoria, that:

> Anti-abortion protesters frequently describe themselves as sidewalk counsellors seeking to render assistance to women. This characterisation differs markedly from what we heard from interviewees who spoke of the protesters' unwelcome intrusions into the personal space of patients and staff.[1910]

18.3.36 A similar view was expressed to the QLRC by the Queensland Synod of the Uniting Church:

> … women or staff of clinics have, in the past, been attacked verbally and even physically when entering or leaving the building. People who strongly oppose termination of pregnancy at times conduct intrusive campaigns targeting specific clinics. They stand on the footpath and demonstrate using protest signs which may contain graphic images, and/or speaking to or shouting at people entering and leaving the premises. This may be termed 'footpath counselling' by the protestors, but may be very confronting, frightening, intrusive and confusing for women who are entering or leaving the premises before or after termination of pregnancy.[1911]

18.3.37 It was noted to the QLRC, including by domestic and family violence and sexual assault support services, noted that such behaviours may have a particular impact upon already vulnerable women at a sensitive time.[1912] The family violence context is significant. The Women's Legal Service Queensland submitted to the QLRC:

> Women who have experienced domestic violence, reproductive coercion and sexual assault have often experienced significant trauma associated with the physical, emotional and psychological

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[1907] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 169 [5.55]. See also below [19.3.1]–[19.3.34].

[1908] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 182 [5.121].

[1909] Ibid 172, n 95.

[1910] Ibid 172 [5.69]. This theme also emerged in SALRI's consultation. See further above [12.5.50]–[12.5.51], below [18.5.15]–[18.5.16], [18.5.49]–[18.5.54].

[1911] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 171–172 [5.68].

[1912] Ibid 173 [5.73].

> abuse of the perpetrator. It is unacceptable that women and pregnant people should have to risk being further traumatised or made to feel unsafe by the actions of protestors whilst accessing health services for a termination, particularly when the choice to terminate a pregnancy was made due to ongoing safety concerns within the context of a violent relationship.[1913]

18.3.38 The particular impact of such conduct upon Aboriginal women was also highlighted to the QLRC. The Institute for Urban Indigenous Health Ltd submitted to the QLRC:

> Termination of pregnancy is a sensitive and highly personal subject, with issues of access and confidentiality particularly pronounced for [Aboriginal and Torres Strait Islander] women. In our experience, a patient's decision to access a termination service is difficult and considered. Anti-abortion behaviours in proximity to termination services compound the difficulty, angst and trauma for Aboriginal and Torres Strait Islander women and their partners or other support persons.[1914]

18.3.39 There have been similar concerns of harassment and obstruction of patients and staff in abortion clinics in Western Australia.[1915] A recent West Australian Discussion Paper noted that since abortion was legalised in Western Australia, 'there have been ongoing instances of individuals accessing abortion services and being approached by protestors outside the clinics.'[1916] It was noted that potentially thousands of women are impacted by the regular protests that take place outside the two main private West Australian clinics that provide abortions every year. The relevant behaviour[1917] was noted to affect both patients and those accompanying patients to the clinic. Staff working at these clinics, such as medical, legal and counselling staff, also report experiences of harassment and intimidation.[1918] The Paper observed:

> This constant stream of protests can cause anxiety and distress for staff at the clinics. For patients, the presence of these protestors, and their behaviour, can compound the emotional toll of deciding to have an abortion. It is widely acknowledged that the decision to have an abortion is already a difficult one, and the presence of demonstrators exacerbates the situation for patients, individuals accompanying the patients, and staff at the clinics.[1919]

[1913] Ibid 174 [5.73]

[1914] Ibid 173 [5.74].

[1915] See, for example, Melissa Davey, 'Protect Us From Anti-abortion Protesters, Say Women's Clinics in WA', *The Guardian* (online, 26 January 2018) <https://www.theguardian.com/world/2018/jan/26/protect-us-from-anti-abortion-protesters-say-womens-clinics-in-wa>; Cathy O'Leary, 'Midland Abortion Clinic Staff Want "Safe Zones"', *Perth Now* (online, 8 February 2019) <https://www.perthnow.com.au/news/wa/midland-abortion-clinic-staff-want-safe-zones-ng-b881098721z>; Rhiannon Shine, 'Abortion Clinic Safe Zones Months Away in WA as Government Criticised For Lagging Behind', ABC News (online, 26 March 2019) <https://www.abc.net.au/news/2019-03-26/abortion-clinic-safe-zones-considered-in-wa/10937920>.

[1916] Government of Western Australia: Department of Health, *Safe Access Zones: Proposals for Reform in Western Australia* (Discussion Paper, April 2019) 6.

[1917] The behaviour includes: 'Confronting verbal communications, and approaching patients to try and change the minds of women seeking abortions; Taking visual recordings of patients without their consent; Giving gift bags containing food (to precipitate cancelling procedures that require fasting), and information pamphlets with emotive and non-evidence based information about abortion and its health impacts; Visual communication through placards and posters set up at clinics with words to discourage the termination of pregnancies alongside emotional imagery of babies and fetuses; Assembling outside clinics for at least two hours at a time. Groups can range from three demonstrators to 30 demonstrators; Creating a physical barrier impeding a patient's free access to a clinic, or walking back and forth in front of the entry to the clinic and Singing outside clinics at a volume that can be heard within the clinic': Ibid 6–7.

[1918] Ibid 6.

[1919] Ibid 7.

18.3.40 The West Australian Discussion Paper stated:

> There must be clear reasons justifying the introduction of new legislation … the [Health] Department has gathered some evidence suggesting the need for Government intervention to better regulate and manage the behaviour of protestors and demonstrators outside clinics that provide abortion services.[1920]

18.3.41 The Abortion Legislation Bill 2019 (NZ) also proposes to establish safety zones around abortion providers and associated offences to prohibit intimidatory or obstructive behaviour that seeks to prevent people from seeking access to abortion.

18.3.42 The 2018 South Australian Bill also contains provision for safe access zones of 150 metres with associated new offences and police move on powers. The Hon Tammy Franks, drawing on the Woodville clinic and what she asserted is the 'ghoulish gauntlet' that patients are forced to endure, explained the rationale of this aspect of the Bill as follows:

> It is well known to many who work in the provision of abortion health care that protesters often frequent outside clinics. Indeed, the 40 Days for Life vigil outside the Pregnancy Advisory Centre is well known to patients and staff alike. They deal with protest outside their workplace and outside their place of health care far too often. Those protesters have even set up a shop across the road that sells recycled baby gear. That shop will not be criminalised by this bill. However, the actions of transgressing and invading the privacy and dignity of woman seeking health care, within 150 metres of that healthcare service, certainly will be. Patients deserve protection and healthcare workers deserve occupational health and safety. This Bill contains provisions for a safe access zone. It provides that protection for 150 metres around prescribed areas, including, of course, that Woodville clinic.[1921]

18.3.43 The Health Care (Health Access Zones) Amendment Bill 2019 (SA) was concurrently introduced to both Houses of the South Australian Parliament on 26 September 2019.[1922] This Bill also contains provision for safe access zones of 150 metres with associated new offences and police move on powers.[1923] The movers of the Bill, the Hon Tammy Franks and Ms Cook, spoke at length about their concerns over the intimidation, harassment and obstruction of both patients and staff that prompted this Bill.[1924]

[1920] Government of Western Australia: Department of Health, *Safe Access Zones: Proposals for Reform in Western Australia* (Discussion Paper, April 2019) 17.

[1921] South Australia, *Parliamentary Debates*, Legislative Council, 5 December 2018, 2427. See also South Australia, *Parliamentary Debates*, Legislative Council, 29 May 2018, 256–257; South Australia, *Parliamentary Debates*, Legislative Council, 27 February 2019, 2777.

[1922] See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478 (Hon Tammy Franks MLC); South Australia, *Parliamentary Debates*, House of Assembly, 26 September 2019, 7501–7504 (Ms Cook).

[1923] SALRI has not considered the issue of police move on powers in any detail. Such powers may be seen as problematic and, in any event, this may be an issue better left for operational police practice. The police already possess various statutory and common law powers.

[1924] See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478 (Hon Tammy Franks MLC); South Australia, *Parliamentary Debates*, House of Assembly, 26 September 2019, 7501–7504 (Ms Cook). See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4863–4870 (Hon Tammy Franks MLC).

18.4 Logistics Declaration or Defined in Law and Size and Operation

18.4.1 In every Australian jurisdiction, with the exception of the ACT, safe access zones are established by the relevant law.[1925] By contrast, in the ACT, safe access zones are created upon the declaration of a Minister.[1926] The ACT Act states that the Minister *must* declare a protected area around an approved medical facility which is not less than 50 metres, sufficient to ensure privacy and unimpeded access, and not bigger than necessary.[1927] An automatic perimeter around premises at which abortions are performed is the approach favoured in the majority of Australia States.

18.4.2 In Australia, safe access zones most commonly extend 150m from the premises at which abortions are performed.[1928] The sole exception is the ACT. Although the Queensland law dictates a 150m zone, it also provides for Ministerial discretion to increase or decrease the size of the zone as needed.[1929] An alternative approach is NSW, which stipulates two locations where the restrictions on behaviour within safe access zones do not apply. These are inside churches and places ordinarily used for religious worship, as well as outside Parliament House.[1930]

18.4.3 There appears to be broad consensus amongst Australian jurisdictions for a 150m perimeter. The distance of 150m was found to be valid by the High Court in *Clubb*.[1931]

18.4.4 If the 150m zone is, in general, an appropriate balance between freedom of speech and the right to access health services without being subjected to that communication, it is then necessary to determine from where this is measured. Most laws merely states that the zone is measured from the 'premises'. However, the term 'premises' is unclear. It may mean the building, a public entrance, some other perimeter such as a carpark or from the boundary of the land.[1932]

18.4.5 An Information Sheet created by the Victorian Government specifies that the 150m extends from 'the perimeter of the land where the premises providing abortions is situated'.[1933] The Northern Territory specifies the boundary of the premises, while Queensland specifies the zone is

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[1925] *Public Health and Wellbeing Act 2008* (Vic) s 185B; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9; *Termination of Pregnancy Act 2018* (Qld) ss 13–14; *Public Health Act 2010* (NSW) s 98A; *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definitions of 'premises for performing terminations' and 'safe access zone').

[1926] *Health Act 1993* (ACT) s 86.

[1927] Ibid.

[1928] *Public Health and Wellbeing Act 2008* (Vic) s 185B (definition of 'safe access zone'); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'access zone'*); Termination of Pregnancy Act 2018* (Qld) ss 13–14; *Public Health Act 2010* (NSW) s 98A (definition of 'safe access zone'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definitions of 'premises for performing terminations' and 'safe access zone').

[1929] *Termination of Pregnancy Act 2018* (Qld) s 14.

[1930] *Public Health Act 2010* (NSW) s 98F(1)(a)–(b).

[1931] Though Gageler J questioned a distance for a safe access zone of more than 150 meters as 'legislative over reach': *Clubb v Edwards* [2019] HCA 11, [210].

[1932] *Public Health and Wellbeing Act 2008* (Vic) s 185B (definition of 'safe access zone'); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'access zone'); *Termination of Pregnancy Act 2018* (Qld) s 14; *Public Health Act 2010* (NSW) s 98A (definition of 'safe access zone'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definitions of 'premises for performing terminations' and 'safe access zone').

[1933] Victoria State Government Health and Human Services, 'Safe Access Zones around Abortion Clinics: Information for Stakeholders' (Press Release, April 2016) 3.

from an entry to the premises.[1934] The ACT differs slightly, stating that the area should be no less than 50m at any point from the approved medical facility.[1935]

18.4.6 The ACT is the only jurisdiction to specify the hours of operation of the safe access zone, limiting the hours of operation to the period between 7am and 6pm on days the facility is open.[1936] A risk of the ACT approach is that is does not provide protection for staff (or patients) who may attend the facility after hours. Other jurisdictions do not specify set hours of operation. However, through the requirement in jurisdictions such as Victoria and Tasmania that the communication or protest be able to be seen or heard by a person attempting to access the facility, it is possible to infer an hours of operation.[1937] This approach, unlike the ACT, provides protection for both patients and staff who may be accessing the facility outside of normal business hours.

18.4.7 A summary of safe access zone legislation within Australia can be seen below in **Table 5**.

[1934] *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definitions of 'safe access zone'); *Termination of Pregnancy Act 2018* (Qld) s 14.

[1935] *Health Act 1993* (ACT) s 86(2)(a).

[1936] Ibid s 85 (definition of 'protected area' at sub-s (2)).

[1937] *Public Health and Wellbeing Act 2008* (Vic) s 185B (definition of 'prohibited behaviour); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'prohibited behaviour'); *Clubb v Edwards* [2019] HCA 11, [169].

Table 5: Summary of safe access zone legislation within Australia[1938]

	Victoria	Tasmania	NSW	Queensland	ACT	NT
Legislation	*Public Health and Wellbeing Act 2008*	*Reproductive Health (Access to Terminations) Act 2013*	*Public Health Act 2010*	*Termination of Pregnancy Act 2018*	*Health Act 1993*	*Termination of Pregnancy Law Reform Act 2017*
Creation	Act	Act	Act	Act	Minister	Act
Size	150m	150m	150m	150m unless otherwise prescribed	>50m	150m
Measured from…	'Premises'[1939]*	'Premises'	(i) Any part of the premises of clinic, or (ii) a pedestrian access point to a building that houses a clinic	Entrance to premises	'The approved medical facility'	Boundary of premises
Hours of effect	Implied: when patients/staff are present (except blocking road)	Implied: when patients/staff are present.	Implied: when patients/staff are present (except blocking road)	Implied: when patients/staff are present.	7am-6pm on days of operation	Implied: when patients/staff are present.
Prohibited Behaviours	Besetting, harassing, intimidating, interfering with, threatening, hindering, obstructing or impeding by any means a person accessing facility. Communication relating to abortion, able to be seen or heard by a person accessing facility, which is likely to cause distress or anxiety. Interfering with or impeding a footpath, road or vehicle in relation to premises of facility Recording a person accessing facility	Besetting, harassing, intimidating, interfering with, threatening, hindering, obstructing, impeding or recording a person Protest relating to terminations able to be seen or heard by a person accessing facility Footpath interference	Intimidating, besetting, threatening, hindering, obstructing or impeding a person accessing facility. Obstructing or blocking footpath or road leading to facility. Communication relating to abortion able to be seen or heard by a person accessing facility that is likely to cause distress or anxiety. Capturing visual data of a person, or publishing or distributing a recording of a person that is likely to identify them	Conduct relating to termination that would be visible/audible to a person at premises and likely to deter a person from entering or leaving the premises, undergoing a termination, or performing a termination. Making an audio or visual recording of a person that identifies them (without consent), or distributing or publishing this kind of recording.	Harassment, hindering, intimidation, interference with, threatening, obstruction, capturing visual data, or any act that can be seen or heard by a person, designed to stop a person from entering the facility or having or providing an abortion Protest relating to abortion	Harassing, hindering, intimidating, interfering with, threatening or obstructing a person, recording the person, or any act that could be seen/heard by a person in vicinity that may deter the person from entering or leaving premises or performing or receiving an abortion. Publishing recording of another person in safe access zone.

[1938] Western Australia does have safe access zones at this time but they are forthcoming.

[1939] Victoria State Government, Health and Human Services, 'Safe Access Zones around Abortion Clinics: Information for Stakeholders' (Press Release, April 2016): Perimeter of the land where the premises is situated.

18.5 **Submissions**

18.5.1 Many survey responses and submissions to SALRI powerfully highlighted concerns surrounding safe access to abortion services and protecting both patients and staff from harassment and obstruction and supported legislated safe access zones in South Australia. Of the 340 odd submissions provided to SALRI, about 180 supported safe access zones, about 25 were opposed and the remainder expressed no clear view on the issue.[1940]

18.5.2 The Central Adelaide Local Health Network's Pregnancy Advisory Centre (the Woodville clinic), which is the main site for anti-abortion activities outside and in the vicinity of the clinic, submitted:

> Safe access zones are essential in South Australia to protect clients, staff and visitors to the Pregnancy Advisory Centre and other health care settings that provide abortion health care … Placing personal values onto another person about the healthcare they choose has no place in modern healthcare. People are free to pray in their places of worship if they feel strongly about abortion and are free to protest politically in more appropriate space; outside healthcare facilities is not one of these places.

18.5.3 There was extensive support elsewhere in SALRI's consultation for safe access zones[1941] (though the need and rationale for such zones in South Australia was questioned by some parties and groups).[1942]

18.5.4 Over two-thirds of survey respondents supported the introduction of safe access zones in South Australia. It was noted that such zones 'provide women with privacy, respect and safety'. One response noted: 'Women should feel safe, secure, unquestioned and right in their decision to terminate a pregnancy. All actions against this should be unlawful.' Another response said there 'is no doubt that public, often vitriol-fuelled, demonstrations' in close proximity to abortion clinics are damaging to both patients and staff' and such zones provide a 'buffer zone' where staff can go about their daily

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[1940] It should be noted that many of the submissions opposed to the decriminalisation of abortion did not address this issue.

[1941] The individuals and groups advocating this approach included Dr Susie Allanson, Professor Emerita Margaret Allen at the University of Adelaide, Dr Jane Baird, Professor Caroline de Costa, Dr Caroline de Moel-Mandel at La Trobe University, Professor Margaret Davies at Flinders University, Professor Heather Douglas of the University of Queensland, Dr Erica Miller at La Trobe University, Dr Sarah Moulds at the University of South Australia, Professor Sally Sheldon of the University of Kent, Beth Wilson AM, Dr David MacFarlane, Rabbi Shoshana Kaminsky, the Australian Medical Association (SA), Maurice Blackburn Lawyers, the Public Health Association of Australia, the Robinson Research Institute, Royal Australian College of Physicians, the Australian Lawyers' Alliance, International Planned Parenthood Federation, the South Australian Abortion Action Coalition (itself consisting of various groups), the Southgate Institute for Health, Reproductive Choice Australia, the South Australian Council for Civil Liberties, the Women's International League for Peace and Freedom, Fair Agenda, the Church of the Flying Spaghetti Monster Australia, Law Society of South Australia, National Alliance of Abortion and Pregnancy Options Counsellors, Australian Lawyers for Human Rights, Central Adelaide Local Health Network, the Honourable Tammy Franks, Women Lawyers' Association of South Australia Inc, the Equal Opportunity Commissioner, Coalition of Women's Domestic Violence Services, Marie Stopes Australia, the Castan Centre for Human Rights Law, Women's Electoral Lobby Australia, YWCA Australia, a leading health provider, Public Health Association, Human Rights Law Centre, Children by Choice, the Australian Women's Health Network, Human Rights Law Centre, Australian Nursing and Midwifery Federation, the SA Health Department, QUT Australian Centre for Health Law Research.

[1942] These individuals and groups included Dr Elvis Šeman and Dr Turnbull, Anna Walsh at Notre Dame University Australia, the Adelaide Centre for Bioethics and Culture, 40 Days for Life, Advocates International, the Australian Christian Lobby, the Catholic Archdiocese of Adelaide, Birthline Pregnancy Support Inc, the Canberra Declaration, Cherish Life Australia, Family Voice Australia, Genesis Pregnancy Support Inc, the Lutheran Church, Pregnancy Help Australia Ltd, the Right to Life Association of South Australia.

work without the intrusion of protesters. 'And, more importantly, women can access a critical service without the intimidation and condemnation of total strangers.'

18.5.5 Of those survey responses who opposed safe access zones, the majority still agreed that it should be unlawful to harass, intimidate or obstruct any person around premises where abortion services are provided, but believe other behaviour should be permitted.

18.5.6 Rural, regional and remote medical and health practitioners almost universally supported safe access zones. One practitioner noted: 'I would hate it if my patients get to Adelaide and then are harassed at the door. People are entitled to their views but shouldn't deliberately hurt people who are making a personal decision'. It was noted that women from rural locations or small country towns often, for privacy and confidentiality, may prefer to travel to Adelaide (even if local services are available) and 'the last thing they would want' is to be challenged and their details made public.

18.5.7 The example of the anti-abortion activities at the Albury clinic was raised with SALRI.[1943]

18.5.8 One party said: 'Women's autonomy to make their own decisions about their bodies must be respected, supported and protected. I therefore fully support safe access zones to ensure the safety of people visiting and working at medical clinics providing abortions.' The RANZCP SA Branch supports such laws 'as directly protective of women's autonomy, mental health and right to private, dignified access to essential health care services and urges the SA legislature to adopt the same'. The Women's Electoral Lobby Australia similarly argued: 'Safe access zones should be legislated as soon as practicable. No one should be subjected to bullying, harassment or intimidation tactics when attempting to access abortion care. Staff at facilities that provide abortions should not be subjected to those same behaviours.' Dr Erica Miller also highlighted the value of safe access zones.[1944] The Department for Health and Wellbeing recommends that exclusion zones around abortion provider premises be introduced prohibiting threatening, intimidating or harassing behaviour within 150 metres.

18.5.9 The desirability of safe access zones was also the firm view expressed by professional medical and health associations and at SALRI's roundtable sessions with the disability sector on 20 May 2019, medical and legal sectors on 7 June 2019 and parties in favour of decriminalisation on 7 June 2019. This was also the almost universal view to emerge in SALRI's regional visits to Whyalla, Port Augusta, Ceduna, Port Lincoln and Murray Bridge and discussions with medical and other health practitioners and providers.

18.5.10 A theme often raised by rural and remote health practitioners and Aboriginal health workers was the particular need to protect the privacy and dignity of often vulnerable women from rural, remote and/or Aboriginal communities who may seek a lawful abortion. The consensus from health practitioners in Port Lincoln was that it is hard enough for women attending these locations without the added stress of being confronted by members of the public. Women (and staff) must be as safe as if they were undertaking any other form of medical procedure. The Aboriginal Health Service in Port Lincoln simply noted: 'Ban the lot of them!'

[1943] See also Melissa Davey, 'Albury's only Abortion Clinic: Protests "Push Women to Point of Self-Harm"', *The Guardian* (online, 9 December 2014) <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide>; Nick Fogarty and Suzi Taylor, 'Walking the Gauntlet of Protesters at Albury's Fertility Clinic', *ABC Goulburn Valley*, 21 March 2014, <http://www.abc.net.au/local/photos/2014/03/21/3968890.htm>.

[1944] Dr Miller also noted a recent survey showing strong community support for such laws. See Alexandra Barratt et al, 'Knowledge of Current Abortion Law and Views on Abortion Law Reform: a Community Survey of NSW Residents' (2019) 43(1) *Australian and New Zealand Journal of Public Health* 88.

18.5.11 Other parties such as the Castan Centre for Human Rights Law and health practitioners told SALRI that women attending premises providing abortions are likely to be in a vulnerable and emotional state and will include victims of domestic violence or sexual assault and/or women from migrant or Aboriginal communities. The effects of obstruction or harassment on such women who are particularly vulnerable should not be underestimated.

18.5.12 Maurice Blackburn Lawyers, drawing on their experience in Victoria,[1945] highlighted that, for more than 20 years, anti-abortion protestors outside the entrance to the Fertility Control Centre in East Melbourne were 'verbally and physically intimidating patients and staff members on a daily basis'.[1946] Maurice Blackburn strongly supported safe access zones as such laws 'ensure that women and staff employed by reproductive health and abortion services providers can access these services safely, privately and with dignity'. Maurice Blackburn made the valid point that, whilst patients are obviously important, it is equally important to consider the interests, safety and welfare of staff.[1947] Maurice Blackburn noted that, until safe access zones were established, the Melbourne City Council and police had proved unable or unwilling to take action against anti-abortion protests.

18.5.13 The Law Society similarly supported the legislative establishment of 'a safe access zone to protect a woman who is seeking or who has accessed terminations services from harassment and intimidation, or behaviour which attempts to obstruct a woman from accessing health care services related to terminating a pregnancy'.[1948] It argued that, in weighing up the competing rights, namely ensuring safe and dignified access to health care, while also respecting freedom of political of communication as they relate to premises which perform abortion services, 'the Society considers a fair balance exists with the introduction of a safe access zone'.[1949] The Law Society explained:

> The Society supports the general principle that a person ought to be able to access health care services privately and without fear or risk of ridicule, humiliation or publication. This principle is also recognised internationally, including by United Nations treaty bodies, including the Special Rapporteur, who recommended that States whose domestic law authorises abortions under

[1945] In 2015, Maurice Blackburn and the Human Rights Law Centre commenced proceedings in the Supreme Court of Victoria on behalf of the Fertility Control Clinic against the Melbourne City Council, seeking orders to compel the Council to stop the harassment of staff and patients entering the clinic. Maurice Blackburn represented the interests of the clinic as amicue curie in the recent High Court case of *Clubb v Edwards* [2019] HCA 11.

[1946] In the course of conducting this case, Maurice Blackburn noted to SALRI that 'it was contacted by dozens of women from diverse backgrounds, keen to share their experience of feeling threatened, followed and intimidated by protestors outside' the clinic.

[1947] Maurice Blackburn elaborated to SALRI: 'Safe access zones protect staff and employees. The right to a safe workplace is fundamental and enshrined in our occupational health and safety and industrial laws. Employers have a legal responsibility to provide a safe working environment. Notwithstanding this, premises offering termination services often struggle to protect staff from the actions of protesters, which at the very least, regularly cause staff to experience feelings of fear, intimidation, anxiety and anger…This impact on staff safety and security and mental health can be extreme… safe access zones have the potential to significantly improve the safety, wellbeing and freedom of movement of staff.'

[1948] Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [25], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.The Law Society also considered that the same protection should also apply to a health care practitioner who performs or assists in the lawful termination of pregnancy.

[1949] Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [26], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

> various circumstances should ensure that services are effectively available without adverse consequences to the woman or the health professional.[1950]

18.5.14 Some parties supporting safe access zones drew on their own personal experiences.[1951] One experienced health care provider described:

> Abuse of abortion providers takes many forms and safe access zones are an important and positive legislative response that constrains those who exert their views on others in offensive and threatening ways. This positive approach supports everyone and reflects community expectation. For all of us who have been accused of being murderers as we provide abortions for women… safe access zone legislation provides both a practical response and validates and respects abortion care as health care.

18.5.15 Kate Marchesi, drawing on the Queensland experience, submitted to SALRI:

> There is a clear need for safe access zones. I do not accept for a moment the argument that freedom of speech, freedom of political communication or freedom of protest should outweigh a patient's right to access healthcare safely. Those who are opposed to abortion are free to pray, protest and offer their advice anywhere outside the 150m protection zone. The activities of anti-abortion protesters, including 'sidewalk counsellors' and those participating in silent prayer outside clinics are directed towards threatening and coercing women… the purpose of those types of activities is not to influence policy or inform public debate, but to seek to influence an individuals' choice about their healthcare.

18.5.16 The Castan Centre for Human Rights Law supported safe access zones, noting the effect of the Victorian model.[1952] They outlined to SALRI that the activities of anti-abortion protestors (including 'sidewalk counsellors') frequently has a negative impact on both staff and patients entering and leaving clinics which provide abortion services. 'Such activities not only invade the privacy of women who are already in a vulnerable situation, they also undermine their health and well-being.' The Centre noted that anti-abortionists frequently describe themselves as 'sidewalk counsellors seeking to render assistance to women' but the Castan Centre for Human Rights Law disagreed with this characterisation and highlighted that it differed markedly from what they had heard from the interviewees who spoke of the unwelcome intrusions of 'sidewalk counsellors' into the personal space of patients and staff. The examples of inappropriate conduct provided included:

a. Approaching, following or walking alongside people approaching clinic premises;
b. Dispensing brochures or plastic foetal dolls;

[1950] Ibid 5 [31]. See also J Méndez and JE Mendez, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* UN DOC A/HRC/22/53 (2013) 23 [90].

[1951] One party submitted: 'I write to express my strong support for reform that provides for safe and legal access to abortion; and protects patients from harassment and intimidation at clinics. I had an abortion before exclusion zones and my anxiety about whether I'd have to run a gauntlet of anti-choicers added a great deal extra stress and dread to what was otherwise a straightforward medical procedure. I was lucky, thankfully, but I want to ensure that no person has to feel nauseous and unsafe at the idea of accessing medical care because of other peoples' self-righteous aggression.'

[1952] 'The general consensus among our interviewees is that the activities of anti-abortionists outside clinics is harmful to both patients and staff who work at clinics and that safe access zones go a long way towards helping combat this problem… Of the thirteen health professionals we spoke to in Victoria, all took the view that the zones were operating to distance anti-abortionists from clinics and prevent them from targeting individuals. The activities of anti-abortionists have accordingly been de-individualised; sending 'a wonderful positive message … that society won't condone that sort of behaviour' targeted at women accessing health services (quoting an interview with a social worker, Melbourne, 20 March 2017).' See also above [18.3.29]–[18.3.31], below [18.6.8].

c. Displaying posters with distressing words or images, such as photographs of dismembered fetuses;
d. Castigating patients and staff as murderers;
e. Chasing, photographing, heckling, threatening and verbally abusing patients and staff; and
f. Preventing patients from exiting their cars or obstructing clinic entrances.

18.5.17 One view opposed such zones as unnecessary and inappropriate.[1953] One survey response said that every person has the right to express their concerns, as 'the well-being of women and children (including unborn children) are an issue for the whole community'. Another survey response asserted that 'protection zones are a breach of human rights and the freedom of speech and expression'.

18.5.18 One party objected to safe access zones as an effort 'to deliberately demonize volunteers providing counselling outside abortion clinics is an agenda to boost the need to facilitate abortion no matter what. This is not what a civil society should be having to suppress freedom of speech and genuine free choice from alternatives'. Anna Walsh described safe access zones carrying up to a year imprisonment for contravention as 'an extreme and unjustified violation of freedom of speech'. Cherish Life Australia asserted: 'Human rights activists should be able to protest peacefully at abortion clinics especially when not hindering anyone. It is a basic human right to act according to your conscience.' Another party told SALRI: 'Having an exclusion zone around an abortion clinic stops people offering support when the mother does not really want one or is unsure. Often women are uneducated as to what the risks and after affects really are.' Safe access zones were opposed by 40 Days for Life as 'restrictive of free speech, deny support for women, are unnecessary and should not be contemplated'.

18.5.19 Women's Forum disagreed with safe access zones and said such zones deny support and informed choice to vulnerable women when they need it most by cutting them off from family, friends, or 'sidewalk counsellors' who may seek to offer them information or support. 'Such support is crucial in a situation in which many women feel as if abortion is their only choice, and are often driven to make a decision to abort for the very reason that they are lacking in financial, emotional, physical or psychological support.' Dr Šeman and Dr Turnbull expressed a similar view to SALRI.

18.5.20 The Canberra Declaration opposed safe access zones:

> We are not in favour of so-called 'safe access zones'. They not only contravene the democratic rights of citizens, but they deprive vulnerable women who may have been coerced into abortion or know little about their options the support and services they might otherwise choose. In addition to this, they provide an unfair business advantage to abortion providers, and they also deny protection to those who are most often victimised near abortion clinics, which is those who are there to peacefully protest or pray.

18.5.21 A linked view was advanced, arguing why conduct outside abortion clinics should be singled out, and why not extend such safe access zones to protests in relation to other health facilities or treatment.[1954] One party, for example, at the 16 May roundtable stated specific issue laws directed

[1953] See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4853–4858 (Hon Dennis Hood MLC).

[1954] SALRI notes this suggestion but there are constitutional doubts over the validity of a law of more general application creating safe access zones for any premises providing medical services. SALRI draws on the comments of Dr Anna Olijnyk in this regard. There is a sound argument that such a law would breach the implied freedom of political communication. Such a law would be *more likely* to breach the implied freedom than a safe access zone law limited to abortion clinics or sites where abortion related services are provided. On the one hand, it would prohibit a wider range of political communication than a law that only protected access to abortion services. On the other hand, the justification for the law may be less compelling than the justification for safe access zones

to abortion protests are misplaced. 'There should be prohibitions of a generic nature that protect people when they are having lawful healthcare related activity'. Other attendees shared this view.

18.5.22 It was argued by some parties, such as Advocates International, that the existing criminal laws in South Australia are adequate to cover any misconduct. This view was also expressed by some attendees at the 16 May 2019 roundtable with faith groups and at the roundtable with faith groups and NGOs on 12 June 2019. One attendee at the 16 May 2019 roundtable stated that specific laws are unnecessary and there are existing laws for intimidation and protection. Another party agreed: 'If there is a problem, there is no need for issue specific legislation like this. This is pejorative. The regulation of civil behaviour should be banished.' A few survey responses also contended that the present law adequately covers any misconduct and safe access zones are unnecessary in South Australia.

18.5.23 Other parties disagreed that the present criminal law adequately covered such conduct.

18.5.24 The Law Society noted that s 7 of the *Summary Offences Act 1953* (SA) covers a person whose conduct is of a disorderly or offensive manner in a public place but that 'while this provision may address some of the unwanted behaviours exhibited in the vicinity of termination facilities, it is unlikely to provide complete and adequate protection'.[1955] The Law Society 'supports the establishment of a safe access zone to protect a woman who is seeking or who has accessed terminations services from harassment and intimidation, or behaviour which attempts to obstruct a woman from accessing health care services related to terminating a pregnancy'.[1956] The Law Society also considered that the same protection should also apply to a health care practitioner who performs or assists in a lawful abortion.

18.5.25 Several parties, including at the 12 June 2019 roundtable, accepted that intimidation and harassment are unacceptable but any law establishing a safe access zone needed careful drafting and that 'counselling' is beneficial (even necessary) and should not be covered. One submission outlined:

> I believe it should be unlawful to harass, or intimidate women regarding abortion, however care should be taken in the definition of harassment and intimidation. One of the major failings of the current system is that appropriate information is just not being provided. Many women do not get the facts about developmental stages, the nature of the procedure etc during referral. This is an unusual situation, as in any other procedure, the tendency is toward giving more information, not less. With termination, it is clearly the other way. There is this unspoken sense, that giving information is likely to create guilt and harm the mother in some way. Thus, it's a short step to calling this intimidation and harassment. The provision of information without physical obstruction should not be an offence.[1957]

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around abortion services. Accessing abortion services is, as was noted by the High Court in *Clubb*, a very personal and private matter for a woman, and may well be an occasion of considerable emotional distress and vulnerability. For these reasons, as the High Court accepted in *Clubb,* there was a compelling justification for laws creating safe access zones around (in that case) abortion clinics. Victoria and Tasmania were able to point to ample historical and contemporary evidence supporting the need for safe access zones. It is possible that a similarly compelling set of circumstances may exist in relation to some other health services or premises (the example of anti-child vaccine protests was raised in consultation), but these would be rare. *Clubb* does not suggest that a law of more general application would be valid (although it does not rule out that possibility).

[1955] Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [24], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

[1956] Ibid 4 [25].

[1957] Cherish Life Australia expressed a similar view. 'Lovingly and calmly presenting alternatives to abortion and offering support, or simply praying silently or singing hymns, is not harassment, intimidation or obstruction. It is

18.5.26 It was said by parties such as 40 Days for Life, Advocates International and the Australian Christian Lobby that such laws are unnecessary. It was asserted that South Australia is different to interstate and the issues and problems that had happened in Victoria did not happen in South Australia.[1958]

18.5.27 It was accepted by all attendees at the roundtable discussion on 16 May 2019 that behaviour that amounted to intimidation, harassment, obstruction or included taking photographs of staff or patients was unacceptable.[1959] However, it was raised that the situation in South Australia is different to Victoria and in Adelaide there has not been a prosecution of an individual for activities outside the Woodville clinic since 2012 and that charge was eventually dropped.[1960] It was suggested that safe access zones are unnecessary in South Australia 'because we don't have the problems they have had in Victoria'. Imposing a safe access zone in South Australia was seen by attendees as unjustified and unnecessary and serving as an unwelcome precedent in limiting free speech.

18.5.28 The procedure for what happens in Woodville and why South Australia is said to be different to Victoria was elaborated:

> … 40 Days for Life obtain a permit from the Charles Sturt Council that puts us 30–40m from the clinic and 150m in reality to the door of the clinic. We are allowed to counsel anyone who approaches us, but we are not allowed to approach them. Since they pushed us further away very few clients do actually approach us. We are very mindful of remaining within the law, we advise the police of our campaign, we endeavour to be polite at all times, our volunteers sign a peace statement and pledge that they will not harass anyone. Where Tammy Franks gets the notion that we harass, I really don't know where she gets that from. We are there from 8am to 6pm seven days a week for 40 days. There can be between two and six or seven at any point in time and we are behind these barriers that they use for roadworks. It is difficult to move so we are there behind them supposedly for our safety.[1961]

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presenting true choice to women in desperate circumstance.' The High Court did not necessarily agree with this proposition. See *Clubb v Edwards* [2019] HCA 11, [89]. See also below n 1984.

[1958] The Lutheran Church, for example, observed: 'We know of no inappropriate instances of protest. In South Australia opposition to abortion has been expressed in peaceful ways. For example, the pro-life group 40 Days for Life have peacefully coexisted with the Woodville Pregnancy Advisory Clinic for many years. We accept that protests and prayer vigils in the vicinity of abortion facilities, although well intentioned, have been conducted in ethically questionable ways in some places outside South Australia, such as in the United States. However, banning them here seems unnecessary and sets a dangerous precedent. "Safe access zones" will potentially deprive women and couples of what may be their only exposure to people offering them support to continue their pregnancy and parent their child.'

[1959] A similar point was made by the Lutheran Church. 'It should be lawful to draw attention to the truth, including unpleasant truths about abortion … However, we also recognise that it is best to exercise these freedoms responsibly. It should be possible to publicly express concerns about morally questionable activities like abortion … but do it in ways that do not involve harassment, intimidation or obstruction (let alone abuse, vilification or violence). As a Church, we would encourage our members to avoid harassment, intimidation and obstruction of people with whom we disagree, or of people engaging in activities that while morally questionable are not illegal. Such aggressive tactics, even if well intentioned, put Christians in a bad light and in any case are at odds with the example Jesus set for us.'

[1960] The 2012 case was a man and a woman holding a model of a fetus.

[1961] This was reiterated by 40 Days for Life in its submission to SALRI. A Mr Doecke similarly argued to SALRI: 'The real reason behind this proposal is to prevent any form of opposition no matter how peaceful, or offer of alternatives to abortion. At the Woodville facility, the only thing I've seen is a peaceful quiet prayer vigil well away from the main entrance, which I understand is on the opposite side of the block. There is also a coffee shop nearby which also sells baby clothes. Again, this is well away from the main entrance, again on the opposite side of the block… As you are aware, there are already laws in place to protect people from harassment etc.' See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4854–4857 (Hon Dennis Hood MLC).

18.5.29 It was noted that persons from this group don't approach staff or patients or obstruct or harass and do not take pictures or hand out unsolicited brochures. 'If they approach us, we will hand out flyers. The situation has changed in recent years. Some years ago, people may have approached them, not anymore. We have posters on the barricades … some say we value both mother and baby. We do have posters, a variety of sentiments expressed there.' However, it was acknowledged that 'there are other people who go along as individuals who go along and pray outside the abortion clinics. That will probably always be the case.' It was made clear that these persons are not members of 40 Days for Life.

18.5.30 The Australian Christian Lobby also submitted that South Australia is different to Victoria and safe access zones are unnecessary and misplaced in South Australia:

> … there is no evidence of any breach of the law or harassment in South Australia. The only case of a prosecution was about 2012 and the charge was dropped and the prosecution paid costs … South Australia should not infringe the freedom of speech of its citizens where there is no demonstrable harm being caused. The position in South Australia is quite different to that in Victoria, where there was evidence of a long running conflict between the staff at the East Melbourne clinic and pro-life activists and between those activists and anti-life activists … In South Australia, the predominant activity is in the 40 days for Life campaigns, which are carried out under council supervision, located at least 40 metres from the driveway entrance to the Woodville clinic and at least 100 metres from the actual entrance to the clinic. Members of the 40 days team do not approach people and only hand out information, if requested. Safe access or censorship zones are therefore not needed in South Australia.

18.5.31 Advocates International similarly argued:

> However, there is no evidence of entrenched conflict around abortion clinics in South Australia. Rather, the main example of a presence which might be considered 'protesting' is the *40 Days for Life* campaign, whose members do not approach women entering the clinic and only provide material upon request. However, peaceful prayer is not 'protesting' for it does not involve the characteristics of political action. Rather, those offering peaceful prayers are most frequently harassed and threatened near abortion clinics, despite participants in the 40 Days for Life prayer vigil being required to sign a peace pledge.[1962] Far from a problem which needs to be managed by the enactment of law, this type of activity upholds the freedom of individuals to take a reasonable non-threatening action against a practice they consider to be wrongful (despite the practice being lawful in some circumstances). Further, such practice also supports the principle of fully informed and voluntary consent by making available to women, should they wish it, information regarding alternatives to abortion. In the absence of a requirement for non-directive independent counselling, this might be the only chance that women have to receive information from someone who does not have a pecuniary interest in an abortion clinic.[1963] Finally, there are already laws in South Australia which address harassment.[1964]

[1962] 40 Days for Life in its submission to SALRI confirmed that: 'All volunteers on 40 day prayer vigils must sign a Peace Statement'. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 170 n 89; See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4854–4857 (Hon Dennis Hood MLC). For a contrary view, see South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4864–4865, 4867 (Hon Tammy Franks MLC).

[1963] It should be emphasised, to dispel one point that was sometimes raised in SALRI's consultation by groups opposed to decriminalisation of abortion, that the Woodville Clinic is a publicly funded service and the suggestion of a vested or financial motive makes no sense.

[1964] Advocates International and several other parties opposed to exclusion zones also asserted that safe access zones 'denies protection to the persons who are most frequently harassed and threatened near abortion clinics, who are people peacefully offering counsel and prayer for the women entering an abortion clinic'.

18.5.32 One party argued:

> This submission also opposes any exclusion zones around abortion clinics. Such move is nothing but blatant censorship. Abortion is a moral, religious and political issue. Any one of these is a valid reason for non-violent assembly. Pro-lifers outside abortion are not just there to express opposition to abortion. They are also there to offer practical assistance to pregnant women and to pray for pre-born babies and their parents. The desire to speak on behalf of the voiceless and accompany the dying with prayer is perfectly natural and honourable. To want to ban this shows utter contempt for the humanity of pre-born babies and also for free speech and religious freedom. It is also unnecessary as there are already laws in place to govern behaviour during assemblies. Pro-assemblies are far, far milder than most others particularly those of the radical far left. Why then are they alone being singled out for criminalisation?

18.5.33 Another party argued:

> In a truly free society, we are against the idea of establishing so-called '**safe access zone**' near abortion clinics. It is because it takes away the last chance of counselling for vulnerable women who need it the most. Women often feel rushed and pressured into having an abortion assuming that is the only quick fix of the situation. It is during this difficult moment they need good counselling with sincere support for possible alternative. Women should not be left with no options to go. Do we know how many unspoken cases of mothers regretting their decision to abort their babies? To deliberately demonise volunteers providing counselling outside abortion clinics is an agenda to boost the need to facilitate abortion no matter what. This is not what a civil society should be having to suppress freedom of speech and genuine free choice from alternatives.

18.5.34 The benign categorisation of the situation in South Australia was challenged in SALRI's consultation[1965] and the query was raised that if South Australia became the only State or Territory without a safe access zone, would it place South Australia at risk of becoming a 'protest tourism' destination, similar to the 1969 concern of 'abortion tourism' which led to the implementation of the two month residency requirement.[1966]

18.5.35 The Central Adelaide Local Health Network (Pregnancy Advisory Centre) commented:

> Safe access zones are essential in South Australia to protect clients, staff and visitors ... Currently regular groups of protesters gather outside the Pregnancy Advisory Centre every week with their aim being to stop women from attending the service and making an alternate decision to abortion. These groups suggest that what they are doing is 'providing support' for women to consider alternatives to abortion … The Pregnancy Advisory Centre already offers women access to support and decision making regarding all their reproductive options. This type of public and unsolicited harassment outside of any health care facility is not wanted by women who are entering the service. Women who have been exposed to this activity outside the Pregnancy Advisory Centre report how uncomfortable, threatened, harassed and unsafe they feel having to walk past these groups. These groups have attempted to video staff and clients in the past. They have tried to approach and stop women to give them graphic material depicting false imagery and information about abortion. Placing personal values onto another person about the healthcare they choose has no place in modern healthcare. People are free to pray in their places of worship if they feel strongly

[1965] The husband of a former member of staff at the Woodville clinic told SALRI: 'The issue of violence was of constant concern. It was not the protestors who were out the front of the PAC that were the real concern. The real concern was the risk that there would be a physical attack on the premises and or staff, by a misguided person who may be encouraged by such protest as has happened in Victoria. There were many nights when she was working late that she would ring me as she walked to her car so that at least someone would know if she was attacked.'

[1966] See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4866, 4869 (Hon Tammy Franks MLC).

about abortion and are free to protest politically in more appropriate space; outside healthcare facilities is not one of these places.

18.5.36 This account was repeated elsewhere to SALRI. Ms Franks referred SALRI to 'the horrifying gauntlet that people are forced to run — whether they are seeking an abortion or seeking to provide abortion care, or in fact other health care — around places that provide abortion care in our state'.[1967] The South Australian Abortion Action Coalition and the Women Lawyers' Association of South Australia Inc noted that 'anti-abortion protests at the entrance and adjacent to the Pregnancy Advisory Centre in Woodville are commonplace and cause concern and distress to clients and staff'.

18.5.37 Dr Jane Baird, the Director of the Pregnancy Advisory Centre, argued:

> As far as Safe Access Zones go, the current groups are reasonably tame but the law is being made for the future and it may well need to last us for another 50 years so I don't think that the current practice of these groups is really relevant. I think civil liberties of people accessing health care trumps people praying loudly out the front of health care facilities. They can pray in their churches but we can't practice health care outside their churches. We are concerned with the emotional as well as physical safety of our patients and our staff. This is our one opportunity to give South Australian women the same safe access as women interstate. We should be trying to make laws as close to being consistent across our nation rather than making it more different.

18.5.38 A specialist medical practitioner with experience at the Woodville site told SALRI that the general situation in South Australia is better than interstate and 'protesters' are restricted by the local council and policing. She strongly supported safe access zones as necessary to protect both staff and patients. She noted that the conduct extends beyond 40 Days for Life and spoke of others involved and 'Street-side counsellors' and 'silent prayer' and 'waving posters'. She noted persons outside and opposite the front entrance. 'Patients come in affronted and offended and feel threatened by their presence.' She noted 'spasms of action — sometimes experts from USA come and campaign'.

18.5.39 In particular, there was emphasis that the activities outside the Woodville Clinic extend beyond the group described. One employee at the clinic described regular harassment of staff and patients. She noted one occasion of an individual on the premises videoing her wheeling a client out of the back door in a wheelchair because she was unwell, unrelated to her abortion and was admitted to hospital via ambulance. 'When I asked him to stop filming he accused me of murdering babies.' She also described:

> … the mostly middle aged men who stand at the entrance gate with signs of fetuses and the fact that they DO approach women on their way into the premises of Pregnancy Advisory Centre. The protestors attend PAC most days in the mornings and twice a year for 40 day vigils, all day, every day. The café at the corner of Belmore Terrace and Park Street North is run by the protesters.[1968] When I have been informed by women and their support person(s) that the protestors had caused them distress I have tried to talk to the protestors and ask them not to approach women and to please stay across the road at all times, they often deny ever approaching women and state they have every right to be there. The constant presence of the protestors is distressing to staff, clients and visitors. A 150 metre access zone would be of great benefit to women, staff and visitors to clinics who provide abortion care. Actually to anywhere where privacy is of uppermost importance.

[1967] Ms Franks also recently provided various accounts of obstruction and harassment directed at both patients and staff. See South Australia, *Parliamentary Debates*, Legislative Council, 26 September 2019, 4474–4478. See also South Australia, *Parliamentary Debates*, Legislative Council, 31 October 2019, 4863–4870 (Hon Tammy Franks MLC).

[1968] SALRI also heard reference in consultation to a baby clothes shop and the cafe/coffee shop located in close proximity to the Woodville clinic and opposite the local train station. SALRI heard accounts in its consultation about the coffee shop and of alleged intrusive and unsolicited offers to patrons of 'counselling'. It should be noted that other parties insisted to SALRI that the role and operation of the coffee shop is helpful and constructive.

18.5.40 There was emphasis that the activities of concern extend well beyond 40 Days for Life and safe access zones are necessary. One current employee at the clinic described that since 2016 other groups, or at least individuals (not part of 40 Days for Life), wait opposite the clinic generally every Tuesday across the road and are in plain sight of the front gate and door. It was noted:

> Generally, this specific group pray, there have been members on occasions that will attempt to approach a client. Many clients and their support persons have noted that this caused increased anxiety by the presence in such an obvious and unavoidable position. I have counselled many clients about how this makes them feel and staff have reported the same to me.

18.5.41 The employee noted the problem of random individuals who 'lurk' by the front entrance to the clinic. This happens at least once per week and there has been some instance of individuals or groups attempting some sort of protest. The employee clarified that over the last two years:

> One man will stand at the gate wearing an anti-abortion T-shirt facing the incoming traffic – this has usually occurred once per week, often on a Monday. The graphics on the T-shirt are very obviously anti-abortion. At least once per fortnight there have been additional random groups that have been extremely visible in groups of up to ten.

18.5.42 The employee described the effect of all this on both staff and patients causes 'severe distress' and 'significant time' is spent dealing with police and distressed clients to address the issue. She complained of regular obstruction and harassment:

> Many [protestors] have approached clients and staff, have attempted to hinder access by way of sitting in chairs at the gate, cars at the entrance. Many have harassed staff and patients, including myself. I have been approached, banners with offensive material have been waved in my face. Some staff have reported scratches to their car on a day that the protestors had been present.

18.5.43 The employee described she had been video recorded and some patients' support persons had also reported being video recorded by protestors.[1969] She noted a recent incident when anti-abortion protestors entered the premises. 'I believe this has occurred on other occasions as well where the protestors stand in the onsite car park trying to impede carparks and harass patients.'

18.5.44 Individuals opposed to abortion also noted to SALRI that they are also photographed outside the clinic.

18.5.45 Survey responses also highlighted the inappropriate nature of at least some of the activity in the vicinity of the Woodville clinic. One response noted that 'anti-abortion protests at the entrance and adjacent to the Pregnancy Advisory Centre in Woodville are commonplace and cause concern and distress to clients and staff'.

18.5.46 Another survey respondent commented:

> I live near the Woodville clinic and have witnessed protesters following women with signs stating 'do not be as bad as your rapist', even when they weren't attending the clinic. On one occasion I was walking past the clinic to get to the Woodville Park train station and was heckled as a 'baby killer'. Protest of laws should occur at a place related to law — Parliament House. The actions of these 'protesters' is not protest of a law, it is harassment of women.

[1969] See also below [18.6.25]–[18.6.27].

18.5.47 Recent media reports have also reported on the inappropriate conduct said to occur outside and in the vicinity of the Woodville clinic.[1970] One article dated 3 October 2019 stated:

> ANTI-ABORTION campaigners have begun 40 days of continuous prayer outside South Australia's largest abortion clinic as pressure mounts to force them to move 150m away through draft laws now before State Parliament. Documents released under Freedom of Information show a growing list of complaints to Charles Sturt Council over a group of weekly protesters and the biannual 40 Days for Life Prayer Campaign, now outside the Pregnancy Advisory Centre, in Woodville. Complaints include protesters intimidating and harassing visitors and staff, handing out 'misleading' anti-abortion material, blocking pedestrian access into the centre, displaying 'offensive' and 'unnecessarily cruel' images, including fetuses and placing signs along private property. The objections were made from 2014 to last month by staff, clients, clients' families and friends, and nearby residents, who have repeatedly asked for the council to move the protesters. … Council staff and police have visited the site several times this year. The complaints were rejected by 40 Days for Life campaigners, who have been running a 40-day prayer vigil outside the clinic before Easter and around September each year since about 2010. They say they had themselves been the target of false accusations and abuse, and were operating in accordance with a council permit which expires after November 2. The council has issued 18 operating permits to the group over the past nine years to limit signage, protest activity and distribution of literature to a designated area behind a bollard opposite the driveway entrance to the clinic.[1971]

18.5.48 SALRI also heard accounts, including from some of the groups and participants, of so called 'sidewalk counselling' outside or in the vicinity of the Woodville clinic. These groups and individuals were adamant that their conduct is beneficial and is neither threatening nor obstructive. Several parties at the 12 June 2019 roundtable spoke of what they viewed as the valuable role of 'street counselling', in that often women attending a clinic are not aware of alternatives to abortion and where they can access help and alternative services, and this was seen as 'the last opportunity' to be able to offer such support. It was said 'we are not there to shame women, but to help them'.

18.5.49 However, such benign categorisation was not shared. Another attendee at the 12 June 2019 roundtable strongly supported for harassment and intimidation to be assessed from the perspective of the often highly vulnerable woman attending the clinic and not from the perspective of

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[1970] Angela Skujins, 'Adelaide Abortion Clinic Calls for Safe Access from Protesters', *In Daily* (online, 31 May 2019) <https://indaily.com.au/news/2019/05/31/adelaide-abortion-clinic-calls-for-safe-access-from-protesters/>. This recent article highlighted: 'Staff at an Adelaide abortion clinic have called for safe access zone laws due to pro-life supporters they claim stand near the centre, holding placards and photographing and filming people entering and leaving. "Cecilia" is an employee of the western suburbs centre… She said pro-life religious groups and protesters congregate outside the centre up to three days a week, sometimes with banners and shouting phrases such as "save the unborn". "There's one group that are here for 40 days — they're called 40 Days for Life — and they have posters and are sometimes reading the Bible, but it can be quite distressing for women," she said. "Some of the religious groups have pictures of a fully-formed baby on their placards, and would say "save the baby" or "save the unborn" to women driving into the clinic. I know there have been some men that just stand right outside the gate or just outside the premises, and one time one of them took my photo. That's how they became a bit more menacing. Safe access zones would be really beneficial." This view was disputed. The leader of pro-life group 40 Days For Life Adelaide, which regularly gathers near the clinic, denied that any members filmed or photographed individuals, while vowing to fight safe access laws if passed by Parliament. "The clinic maintains that some of their clients and staff are being harassed but I've not seen that, and I've spoken to people on occasion who were supposedly the subject of this complaint and they emphatically denied it," Alan Tyson said… He denied centre staff claims that members photographed or filmed people leaving entering or leaving the centre. "40 Days for Life is a peaceful group and outside 40 Days for Life there are various individuals who do go and pray", he said. "We don't do harassment or do anything like that.'"

[1971] Rebecca Digirolamo, 'Protesters Begin 40-day Prayer Event Outside Abortion Clinic', *The Advertiser* (online, 4 October 2019) <https://www.adelaidenow.com.au/news/south-australia/protesters-begin-40day-prayer-event-outside-abortion-clinic/news-story/10a0286c6e7ce49cea87d0de75871e28>.

the persons praying outside or handing out leaflets about alternatives to abortion. The circumstance of a woman attending an abortion clinic can be distinguished from other circumstances because of how vulnerable and fraught a woman might be feeling. When a woman is being handed flyers or offered advice while making their emotionally taxing walk to an abortion clinic, this behaviour, although intended as a form of support, may actually feel like harassment or intimidation to the patient. This party supported safe access zones in South Australia.

18.5.50 Kate Marchesi was unimpressed with assertions of the 'benign' categorisation of 'sidewalk counselling', noting her criticism of the 'disingenuous' role and partiality of such counselling.[1972]

18.5.51 It was further pointed out to SALRI that both patients and staff do not welcome such unsolicited 'sidewalk counselling'. The National Alliance of Pregnancy Options Counsellors observed that some anti-abortion individuals and groups state that when they approach women outside abortion clinics, they provide 'counselling'. However, this term is misleading as their 'counselling' can:

> … include shoving a bundle of baby clothing or second hand baby products at the woman. These claims of 'counselling' provision are inconsistent with the reports of clinic patients and staff, who frequently report experiencing abuse, both physical and emotional, from protestors, for example, women being told they are 'selfish' for not considering adoption.

18.5.52 The Castan Centre for Human Rights Law noted their discussions with health professionals stated that the 'picketing' of the Woodville Clinics, which intensifies in the lead-up to Easter and Christmas, 'is an ongoing problem for staff, patients and others seeking access to premises in which abortions are provided'. They noted that, as in other States, 'these activities have caused significant anxiety and distress and have stigmatised and shamed women seeking abortions.' The Human Rights Law Centre noted that anti-abortion activities had taken place every week for some 25 years outside the Pregnancy Advisory Centre in Woodville. They commented:

> One group of up to 12 people stands outside the clinic every Tuesday and Wednesday morning. Another group attends on a weekly or fortnightly basis. In the 40 days leading up to Lent and Christmas each year, anti-abortion activities intensify. An on-site carpark creates a small buffer zone between the gate (at which anti-choice activists can gather) and the entrance to the clinic. Despite this buffer, people still have to pass anti-choice activists to drive or walk into the clinic and can hear them as they get in or out of their cars. South Australia should introduce safe access zones around clinics and hospitals that provide abortion services, modelled on safe access zone laws in Victoria.

18.5.53 The National Alliance of Abortion and Pregnancy Options Counsellors pointed out to SALRI that patients, supporters and staff attending premises providing abortions in South Australia and Western Australia are exposed to harassment and abuse by abortion opponents, causing distress to patients, their supporters and staff.[1973] They noted that the experience of their professional counsellors includes bearing witness to client fears of being accosted by anti-abortion abortion protestors prior to attending an appointment, 'and the psychological distress clients have experienced after being subjected to abuse when attempting to access healthcare at hospitals and abortion clinics'.

18.5.54 Australian Lawyers for Human Rights argued that that 'silent' protests, for example prayer outside abortion clinics 'are just as harmful to patients seeking termination services as other types of

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[1972] See above [12.5.51].

[1973] The National Alliance of Abortion and Pregnancy Options Counsellors noted that not all patients who attend a clinic providing abortion procedures are attending the clinic for that purpose; many attend the clinic to obtain contraception 'and in so doing experience harassment and intimidation unrelated to the purpose of their visit to the clinic'.

protests and it is important that any legislation captures this behaviour as well as more vocal types of behaviour'. They noted that s 15(2) of the *Termination of Pregnancy Act 2018* (Qld) provides that a person's conduct may be prohibited conduct whether or not another person sees or hears the conduct or is deterred from taking an action mentioned in s 15(1)(c)(i)-(iii). ALHR submits a similar provision should be included in South Australia to ensure a breach of the offence can be proved without the need to call a person protected by the legislation to give evidence. On this issue, the plurality in *Clubb* said that 'that can readily be understood as an aspect of the protection of the privacy of women seeking access to abortion services'.[1974]

18.5.55 During consultation, there was some reference to what the scope of safe access zones should be. Some parties such as Advocates International opposed safe access zones but, whilst not accepting the need for such zones in South Australia, noted that any such zones and the prohibited behaviour must be strictly limited and carefully defined to not capture conduct such as 'silent prayer'. It was especially contended by parties such as Dr Šeman and Advocates International that 'polite and respectful' 'sidewalk counselling' should be permitted under any safe access zone.[1975] The Lutheran Church contended:

> We urge lawmakers not to prohibit pregnancy support and parental support groups from advertising their services in the vicinity of abortion facilities. Many women considering abortion are unaware of them and frequently hear nothing of them in the minimal pre-abortion counselling they currently receive … It should be lawful to draw attention to the truth, including unpleasant truths about abortion … we view with concern the fact that courts in other states have interpreted behaviour that most reasonable people would consider benign as 'harassment' or 'intimidation'.

18.5.56 Advocates International argued that safe access zones should only apply to public places and not private premises and six metres is appropriate[1976] and 150 meters is excessive:

> … the range of 150 metres does not consider what else might be located within that range. It is conceivable that a 150 metre zone, which imposes broad prohibitions on the distribution of information or publications about abortion, would restrict what a person could do and say within their own home if that home happened to be located near an abortion clinic ... The enactment of a more limited zone preserves the rights of both sides.[1977]

18.5.57 The risk of unintended consequences was also raised. The practical difficulty in defining and enforcing safe access zones in a rural or regional locality were also noted to SALRI.

18.5.58 Many parties such as the Department of Health and Wellbeing, the Castan Centre for Human Rights Law, Children by Choice, the National Alliance of Pregnancy Options Counsellors, the Human Rights Law Centre, the Women's Electoral Lobby, Maurice Blackburn, the Women Lawyers' Association of South Australia Inc, the Law Society, Dr Susie Allanson and Associate Professor Baird urged SALRI to adopt the Victorian model for a safe access zone. A representative submission expressed this view. The Coalition of Women's Domestic Violence Services SA supported the

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[1974] *Clubb v Edwards* [2019] HCA 11, [92].

[1975] 'It should not be a crime for otherwise law-abiding citizens to offer information to people if it is done in a polite and respectful manner. Women and couples who are supported after contact with volunteers near clinics, say this was the only time they were offered a real option to continue their pregnancy.'

[1976] Advocates International raised by way of analogy, s 340 of the *Commonwealth Electoral Act 1918* (Cth) which provides a limitation on certain behaviour within six metres of a polling booth. This distance prohibits interference with the lawful activity of entering a polling booth with a limited restriction upon where a person is able to express their views on a subject.

[1977] The example of a church within 150 metres of an abortion clinic was also raised to SALRI.

Victorian model and suggested covering any behaviour or conduct that may be reasonably viewed as, and/or is experienced as harassment, stalking, violent, threatening, defamatory, intimidating or obstructing.[1978]

18.5.59 The South Australian Abortion Action Coalition also supported the Victorian model, suggesting:

> We submit that in the zone around such premises it should be an offence to conduct these behaviours in relation to patients and/or staff who are entering or leaving such premises:
>
> • beset, harass, intimidate, interfere with, threaten, hinder, obstruct or impede;
>
> • communicate in relation to abortion in a manner that is able to be seen or heard by a person accessing, or attempting to access, premises at which reproductive health services are provided, and is likely to cause distress or anxiety (this prohibition does not apply to those who work at the abortion clinic);
>
> • impede access to a footpath, road or vehicle without a reasonable excuse within the zone; and
>
> • make or publish a recording of another person entering or leaving such premises without their consent.

18.5.60 International Planned Parenthood submitted:

> The implementation of safe access zones around all healthcare facilities that provide comprehensive sexual and reproductive health services. This includes healthcare facilities that offer counselling, information and support services, the provision of abortion care, and referral to abortion providers. General practitioner clinics, public hospitals, pharmacy and radiology services, and specialist sexual and reproductive health clinics should all be included, in recognition that sexual and reproductive health is an inalienable aspect of healthcare. The implementation of safe access zones of a minimum of 150 metres effective 24 hours a day, every day, with no exemptions.

18.5.61 Amongst the parties supporting safe access zones,[1979] there was very wide support for the 150 metre zone.[1980] The only concern which was raised by health practitioners in rural areas was that such zones would draw attention to the services offering the procedures.

[1978] This was suggested to include, but not be limited to: handing out anti-abortion pamphlets or other materials; holding anti-abortion petitions; filming, photographing or otherwise recording people entering, leaving or trying to enter or leave the premises where termination of pregnancy services are performed, without consent of the person being recorded; displaying anti-abortion placards or any other materials; following, blocking or obstructing any person entering, leaving, or trying to enter or leave the premises within the safe access zone, without that person's consent; yelling, swearing, or otherwise verbally threatening or harassing people within the safe access zone and the use of drones, or any other remotely controlled or other surveillance device over or near the safe access zone.

[1979] See above n 1941.

[1980] Maurice Blackburn suggested that the relevant law should specify that the safe access zone should extend a minimum of 150m of any part of the premises; and/or any pedestrian access point to a building that houses the premises. The Australian Lawyers Alliance noted that the safe access zone radius 'should also factor in potential attempts by protestors to stop women entering clinics by accosting them at pedestrian access points. To this end, we suggest that the legislation, or associated regulation, should specify that the safe access zone should extend a minimum of 150m from: any part of the premises; and/or any pedestrian access point to a building that houses the premises. SALRI considers this a sensible formulation.

18.5.62 There was extensive support[1981] for the notion that such zones should be legislatively established rather than relying on Ministerial Decree or delegation. It was also noted this is preferable for clarity and certainty. The suggestion of a ministerial declaration was seen by some parties as subjecting the intent of any possible legislation to the particular views of individual ministers, over time. Women's Electoral Lobby Australia, for example, stated that any safe access zone law should automatically mandate a minimum of a 150m zone around premises providing abortion services where certain conduct is prohibited as 'empowering a Minister to make declarations about the establishment of each safe access zone may result in seeing the intent of the law subverted, or even disregarded'.[1982]

18.5.63 There was extensive (though not universal)[1983] support for the notion that such zones should operate automatically and on a 24 hour basis. The Coalition of Women's Domestic Violence Services SA stated any prohibition on misconduct 'must apply around-the-clock for the protection of out-of-hours staff, patients and their support people'. Maurice Blackburn said safe access zones 'should apply 24 hours a day, 7 days a week' and favoured the automatic establishment of a relevant area as a safe access zone and that it should not depend on a Ministerial declaration. The laws should operate by virtue of a premises meeting the applicable statutory definition. The automatic establishment of safe access zones in South Australia 'would ensure the strongest possible protection for service providers, employees and patients and enshrine these laws in a manner that is less susceptible to delay, error or changes in political will'. Australian Lawyers for Human Rights took a similar view.

18.5.64 The Public Health Association of Australia argued:

> Protections should apply at all times. Protection should not be inapplicable due merely to factors such as clinics not yet being opened for the day, or just after closing time, or for other periods of closure during the day. The concept of 'periods of operation' is unnecessary and might potentially be misused to evade the intended application of protective safe access laws.

18.5.65 Fair Agenda similarly argued:

> We believe that safe zone protections should apply at all times, for the sake of simplicity and certainty. We would be worried that given the sensitive and highly politicised nature of abortion, an approach that left the creation of safe access zones to Ministerial declaration or prescribed on a case by case basis could see the intent of such protections undermined. We note our concern that a prohibition designed to apply only during clinic opening hours might also lead to staff who arrive early for work or who depart after closing hours to still be subjected to the kinds of behaviours which should be protected against.

18.6 SALRI's Observations and Conclusions

18.6.1 SALRI is grateful for the various submissions it received on the issue of safe access zones and the often involved constitutional implications. SALRI is especially grateful for the insightful comments on the constitutional questions by Dr Anna Olijnyk of the University of Adelaide.

[1981] Parties opposed to safe access zones such as Advocates International preferred not leaving the establishment of zones to a Minister.

[1982] The Human Rights Law Centre also stated that SALRI has safe zones should be established in law similar to the approach in Tasmania, Victoria, New South Wales, Queensland and the Northern Territory rather than by Ministerial declaration. 'The law should provide certainty by enacting zones around all premises that provide abortion services, rather than listing the specific addresses of services that may change over time. Given the sensitive and highly politicised nature of abortion, leaving the creation of safe access zones to Ministerial declaration could see the intent of the law undermined.'

[1983] 40 Days for Life and Cherish Life Australia favoured such zones only applying during hours of business.

18.6.2 SALRI notes that there are various and competing considerations. However, considerations of freedom of expression and political communication, as the High Court has recognised, are not absolute considerations. The High Court, as the Hon Tammy Franks MLC noted, 'also reminds us that the implied freedom of speech in Australia does not include a right to a captive audience'. The Human Rights Law Centre made a similar point to SALRI, noting that when the intended audience, such as patients seeking health services that they may not be able to access elsewhere and cannot simply walk away, 'there is a greater imperative for protecting their rights'. This is especially in relation to abortion 'given the intensely private and personal nature of these services and the stigma that has long been attached to abortion'.

18.6.3 SALRI acknowledges that the situation in South Australia may not be as extreme as previously existed in Victoria. SALRI also acknowledges from the material presented to it that certain groups and individuals, notably 40 Days for Life, conducts itself with relative restraint. However, as was accepted by the group in question, there are clearly other individuals and groups that are opposed to abortion and are not part of 40 Days for Life that are also involved in the vicinity of the Woodville clinic and do not appear to share their restraint. SALRI has heard accounts of inappropriate conduct, including harassment, videotaping and obstruction. SALRI accepts that 'silent prayer' and 'sidewalk counselling' may well be sincerely motivated on the part of those engaging in such conduct, but the effect of such conduct outside or in the vicinity of an abortion clinic, especially on women in an often vulnerable condition, is inappropriate and undesirable. SALRI notes this point strongly emerged in consultation and before the QLRC. SALRI also notes that the High Court in *Clubb* appears to have contemplated 'silent prayer' falling within the permitted scope of safe access laws.[1984]

18.6.4 Absent any prohibition or limitation, there is a real possibility that South Australian clinics will become the focus for protest or national campaigns. All Australian jurisdictions bar South Australia already either have safe access zones or, in the case of Western Australia, are in the process of introducing safe access zones. The absence of safe access zones South Australia allows, and almost invites, anti-abortion campaigns.

18.6.5 SALRI accepts the sincerity of those individuals, including those who took part in SALRI's consultation, who view their role as providing counselling and assistance to women,[1985] and as 'presenting true choice to women in desperate circumstances'.[1986] However, such interventions should not be forced on individuals seeking medical services. It is also significant that this characterisation has not been echoed by patients and staff in both interstate studies and SALRI's consultation. The unwelcome nature of such conduct and its adverse effect has been widely noted.

18.6.6 SALRI notes that there are various civil and criminal remedies in relation to inappropriate or unacceptable conduct by groups or individuals adjacent to clinics. However, these are an incomplete

[1984] The High Court did not expressly address whether the Victorian law extended to silent vigil. However, when discussing the need for the communication prohibition, the plurality noted that 'silent but reproachful observance of persons accessing a clinic for the purpose of terminating a pregnancy may be as effective, as a means of deterring them from doing so, as more boisterous demonstrations' [2019] HCA 11, [89]. This suggests that the definition of the prohibited behaviour can extend to silent activities such as prayer. The Tasmanian law was discussed more explicitly. Edelman J stated that 'silent or quiet action can be a powerful form of protest and political communication': at [164]. Gageler J simply stated that the law can extend to peaceful demonstrations and silent vigil: at [475].

[1985] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 170.

[1986] This point was made to SALRI by parties such as the Castan Centre for Human Rights Law and Children by Choice.

and ineffectual remedy.[1987] There are also issues in enforcement[1988] (including the willingness of women to testify).[1989] The West Australian Discussion Paper notes the inadequacy of the present civil and criminal remedies. It explained:

> these options are only available after the offending conduct has already taken place. Further, successfully arguing and winning the action will depend upon the availability of relevant evidence, which is an ongoing practical issue experienced by both clinics. Often, patients do not want to pursue further action due to the associated stress and hassle.[1990]

18.6.7 Safe access zones play an important role in women's rights to privacy and health, as decriminalisation itself does not necessarily provide sufficient access to services.[1991]

18.6.8 It is significant that such laws have worked elsewhere as was raised in consultation by parties such as Fair Agenda, Marie Stopes Australia[1992] and Maurice Blackburn. Incidents of violence and intimidation have significantly decreased in America following the implementation of protest free zones around clinics.[1993] There are also indications that the safe access zone law in Victoria is achieving its objectives.[1994] Dr Susie Allanson, drawing on her experience in Victoria told SALRI: 'After decades of harassment of patients and staff by anti-abortion extremists, the Safe Access Zone legislation immediately and effectively provided women and staff with privacy, dignity and safety.'

18.6.9 SALRI concludes that in relation to abortion, the privacy, welfare and dignity of both women seeking abortions and staff are compelling and there is a need for appropriate safe access zones to protect the privacy, welfare and dignity of both women seeking abortions and staff. Such zones, as the High Court accepted, are justified for the 'the preservation and protection of the privacy and dignity

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[1987] See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 183 [5.129]–[5.130]; Law Society of South Australia, Submission on South Australian Abortion Law Reform Reference dated 31 May 2019, 4 [24], <https://www.lawsocietysa.asn.au/pdf/submissions/L%20310519%20to%20SALRI%20re%20Abortion%20Law%20Reform%20Reference.pdf>.

[1988] It was observed by Australian Lawyers for Human Rights and Maurice Blackburn that the police and Melbourne City Council proved unable or unwilling to take effective action against anti-abortion protestors in East Melbourne. See also *Clubb v Edwards* [2019] HCA 11, [86].

[1989] As Australian Lawyers for Human Rights noted: 'While some of these behaviours may already be captured by [the existing] criminal law, incidents rarely result in criminal prosecution. This is likely due to privacy concerns, the controversial and sensitive nature of abortion, and the particular vulnerability of victims.'

[1990] Government of Western Australia: Department of Health, *Safe Access Zones: Proposals for Reform in Western Australia* (Discussion Paper, April 2019) 10. See also Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 183 [5.129]–[5.130].

[1991] Ronli Sifris and Suzanne Belton, 'Australia: Abortion and Human Rights' (2017) 19(1) *Health and Human Rights Journal,* 209, 215; Katherine Galloway and Jemima McGrath, 'Reproductive Justice: A Framework for Abortion Law Reform' (2018) 43(4) *Alternative Law Journal* 295, 300.

[1992] They told SALRI that the previously routine abuse and harassment at their Melbourne premises stopped after the Victorian safe access zones were introduced.

[1993] William Pridemore and Joshua Freilich, 'The Impact of State Laws Protecting Abortion Clinics and Reproductive Rights on Crimes Against Abortion Providers: Deterrence, Backlash or Neither?' (2007) 31 *Law and Human Behaviour* 611, 624; Joshua Wilson, *Street Politics of Abortion: Speech, Violence and America's Culture Wars* (Stanford University Press, 2013) 180.

[1994] See, for example, Philip Goldstone, 'I've Seen First Hand Why We need Safe Access Zones Around Abortion Clinics', *Sydney Morning Herald* (online, 25 May 2017) <https://www.smh.com.au/opinion/ive-seen-first-hand-why-we-need-safe-access-zones-around-abortion-clinics-20170525-gwcwyx.html>; Ronli Sifris and Tania Penovic, 'Expanding the Feminisation Dimension of International Law: Targeted Anti-Abortion Protest as Violence against Women' (2018) 7(2) *Cambridge International Law Journal* 241; Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317.

of women accessing abortion services'.[1995] As one judge noted: 'Women seeking an abortion and those involved in assisting or supporting them are entitled to do so safely, privately and with dignity, without haranguing'.[1996] SALRI also notes, as aptly reminded by Maurice Blackburn, of the need for the interests and welfare of staff to be protected.[1997]

18.6.10 SALRI accepts that any safe access zone raises constitutional implications, but an appropriate and adapted law is both necessary and proportionate and in light of *Preston* does not infringe any right to free political communication. SALRI concurs with the view of the Human Rights Law Centre presented to the QLRC.

> Sensible and proportionate safe access zones, enacted for a legitimate purpose of protecting women from violence, harassment, surveillance and obstruction when trying to access a health service, do not unreasonably restrict freedom of expression. Overseas courts have noted that free speech rights do not extend to entitling people to a captive audience. When people cannot simply walk away, there is a greater imperative for protection of the rights of the audience. There is also a greater imperative in relation to abortion and other reproductive health care, given the intensely private and personal nature of the services for women.[1998]

18.6.11 SALRI also agrees with the conclusion of the Castan Centre for Human Rights Law that safe access zones don't prevent anti-abortionist protestors from expressing their views. Rather such laws:

> …impose limitations within a tailored geographic space, operating to ensure that anti-abortionists do not engage in targeted harassment and abuse. Safe access zones protect human rights. They protect the privacy, safety and dignity of women seeking health care services and staff requiring access to their workplace. They prevent human rights abuses, including acts of gender-based violence.[1999]

18.6.12 The scope of any offence requires careful consideration. Parties such as 40 Days for Life have argued to SALRI that silent prayer outside the Woodville clinic is legitimate and should be protected by freedom of religion and outside the scope of prohibited behaviour. However, SALRI has heard, reflecting interstate experience, of the adverse effects of silent prayer vigils. It is notable that the regular prayer vigil (which does not involve 40 Days for Life) is held each Tuesday and is held directly opposite both the main public entrance to the clinic and public carpark. It is within the sight and earshot of everyone entering and leaving the premises. Ms Marchesi and others contended to SALRI that these parties are free to pray elsewhere and questioned why they purposefully choose a location so close to the clinic (literally a matter of metres) from where they will be seen and heard by anyone entering or leaving the premises by the public front entrance.

18.6.13 It should be noted that, in terms of the Woodville clinic, the proximity of public transport is a significant factor in the design of a safe access zone. The ability, and direction of progress by individuals to access the clinic is largely dictated by the location of public transport. The local train

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[1995] [2019] HCA 11.

[1996] Ibid [84].

[1997] See also above [18.5.12].

[1998] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 176 [5.90].

[1999] See also Tania Penovic and Ronli Sifris, 'Expanding the Feminisation Dimension of International Law: Targeted Anti-Abortion Protest as Violence against Women' (2018) 7(2) *Cambridge International Law Journal* 241.

station is very close to the clinic and within a 150 metres radius.[2000] Similar circumstances are evident in other clinics in South Australia where proximity to public transport is a relevant consideration.

18.6.14 SALRI is of the view that certain conduct (including silent prayer) can be distressing to patients and is therefore inappropriate either outside or in the immediate vicinity of an abortion clinic and should be included within any South Australian safe access law. SALRI notes the comments in *Clubb* of Kiefel CJ, Bell and Keane JJ who observed:

> Silent but reproachful observance of persons accessing a clinic for the purpose of terminating a pregnancy may be as effective, as a means of deterring them from doing so, as more boisterous demonstrations.[2001]

18.6.15 It is not entirely clear whether such conduct would be caught within the Victorian and Tasmanian offences.[2002]

18.6.16 It would be possible for a South Australian law to make it clear that prayer vigils were prohibited behaviour within a safe access zone. Because this would be different from the precise laws upheld in *Clubb*, the validity of such a law may be uncertain. However, the judgments in *Clubb* provide strong arguments that such a law would be valid. Such a view is based on the following observations.

18.6.17 First, the High Court accepted that the Tasmanian and Victorian laws served the very important purpose of protecting the privacy and dignity of patients. Gageler J said this purpose was, 'by any objective measure, of such obvious importance as to be characterised as compelling'.[2003] Kiefel CJ, Bell and Keane JJ quoted Barak CJ's powerful description of dignity as the 'most central of all human rights'.[2004] Edelman J said the purpose of the Tasmanian law was 'of extreme importance'.[2005] These remarks are relevant to the validity of any South Australian law because the more important the purpose of a law, the greater the burden on political communication that can be justified.[2006]

18.6.18 Secondly, the High Court acknowledged that it is legitimate for Parliaments to prohibit behaviour that fell short of threats, intimidation or physical obstruction, but that nonetheless deterred

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[2000] Indeed, patients attending the clinic from the local train station also have to pass both the baby clothes shop and the coffee shop. See also above n 1968.

[2001] *Clubb v Edwards* [2019] HCA 11, [89].

[2002] Three interpretive questions would need to be answered to determine whether silent prayer would offend the provision upheld in *Clubb*:

(1) Does a prayer vigil amount to 'communicating', so as to be prohibited by a law identical to the Victorian law?
(2) Is a prayer vigil 'reasonably likely to cause distress or anxiety', so as to be prohibited by a law identical to the Victorian law?
(3) Is a prayer vigil a 'protest' within the meaning of a law identical to the Tasmanian legislation?

There is a clear argument that a silent prayer vigil *would* fall within the definition of 'prohibited behaviour' in the Victorian law. There is a sound argument that silent prayer is 'communication'; the point of conducting a vigil near an abortion clinic is that it be seen and heard by those accessing the clinic. It is also likely that, as SALRI has heard, prayer vigils are likely to cause distress or anxiety to people entering a clinic in an already vulnerable state.

There is also the argument that a silent prayer vigil would be a 'protest', and therefore prohibited under the Tasmanian legislation. Edelman J in *Clubb* expressly said (in obiter) that such a vigil would contravene the prohibition on protest in the Tasmanian law, although the Magistrate who decided the case at first instance rejected that construction of the provision. See [2019] HCA 11, [475]. Edelman J referred to the Second Reading Speech for the Tasmanian legislation to support this interpretation. See also Tasmania, *Parliamentary Debates*,

[2003] *Clubb v Edwards* [2019] HCA 11 [197].

[2004] Ibid [50].

[2005] Ibid [500].

[2006] See *Clubb v Edwards* [2019] HCA 11 [197].

women from accessing abortion services. Both the Tasmanian and Victorian laws upheld in *Clubb* prohibited non-violent, non-aggressive behaviour. Gageler J articulated the need for abortion services to be available 'in an atmosphere of privacy and dignity'.[2007] Nettle J described the purpose of the Tasmanian legislation as 'improving the health and wellbeing of women by enabling their access to a lawful termination service, privately, with dignity and without harassment, stigma or shame'.[2008] Kiefel CJ, Bell and Keane JJ described how the Victorian law achieved its purpose of promoting public health:

> Unimpeded access to clinics by those seeking to use their services and those engaged in the business of providing those services is apt to promote public health. A measure that seeks to ensure that women seeking a safe termination are not driven to less safe procedures by being subjected to shaming behaviour or by the fear of the loss of privacy is a rational response to a serious public health issue. The issue has particular significance in the case of those who, by reason of the condition that gives rise to their need for healthcare, are vulnerable to attempts to hinder their free exercise of choice in that respect.[2009]

18.6.19 A prohibition on silent prayer would arguably have the same purpose as, and seek to achieve that purpose in a similar way to, the laws upheld in *Clubb*. It would be relevantly similar to the Victorian prohibition on communications that are likely to cause distress or anxiety. SALRI considers that both 'silent prayer' as discussed by the High Court in *Clubb* as well as unsolicited 'sidewalk' counselling in a public place should fall with the prohibited conduct in a safe access zone.

18.6.20 The scope of safe access zones requires careful drafting to not be overexpansive.[2010] Parties also need to be clear where safe access zones are and are not, and what conduct is captured or not captured. As Advocates International suggested:

> … it is fundamental to a fair and just society that the laws should be easy to determine, so that people can comply with them. Therefore, if safe access zone laws are enacted, it must be obvious when they are in operation, just as traffic signs make it clear to motorists when particular behaviours will be penalised.

18.6.21 SALRI notes from Maurice Blackburn that the 150 metres was adapted for the particular Victorian situation but it appears a sensible approach.[2011]

18.6.22 SALRI agrees with parties such as Advocates International and Australian Lawyers for Human Rights that safe access zones should be automatic and not left to Ministerial decree.[2012] SALRI

[2007] Ibid [197].

[2008] Ibid [307].

[2009] Ibid [84].

[2010] A number of parties, both supportive and opposed to the decriminalisation of abortion told SALRI that the model in the 2018 South Australian Bill is too broad. The Human Rights Law Centre, for example, noted: 'The safe access zone provisions proposed in the Statute Amendment (Abortion Law Reform) Bill 2018 are not supported because they impose too great a burden on the implied freedom of political communication. In particular, we are concerned that the combination of a prohibition on communications or attempts to communicate about abortion, together with the powers given to the police and a maximum penalty of two years imprisonment, go too far.' The Australian Christian lobby also thought the Bill went too far.

[2011] Gageler J in *Clubb* has observed: 'The 150m reach of the protest prohibition around premises at which abortion services are provided must be close to the maximum reach that could be justified as appropriate and adapted to achieve the protective purpose of facilitating access to those premises': [2019] HCA 11, [213].

[2012] SALRI notes the comments of the Human Rights Law Centre: 'We repeat the concerns raised in our submission that, given the sensitive and highly politicised nature of abortion, leaving the creation of safe access zones to Ministerial declaration could see the intent of the law undermined. Any discretion in relation to the size of the zones should be additional to the legislative requirement for safe access zones to be automatically created, and should only be exercisable if consistent with the purposes of safe access zones. This would be in line with the

is of the view that for clarity and consistency there should not be provision for such zones to be reduced by Ministerial order as such an approach invites uncertainty.

18.6.23 The situation of regional or rural premises providing abortion services should not be overlooked. There was strong support, notably by rural and regional medical and health practitioners, that safe access zones should also apply to rural and regional premises providing abortion services. This would include doctors' surgeries, as well as local hospitals or clinics. It was often pointed out to SALRI that there is a particular need to protect the privacy and dignity of women and staff in country towns. SALRI was told by the Castan Centre for Human Rights Law and others of their concerns over the harassment and intimidation that was directed by anti-abortion protestors at women and patients outside an abortion clinic in Albury.[2013] It was noted that, should the law be amended to allow greater flexibility in South Australia, rural and regional providers wanted the same protection as the Woodville clinic.

18.6.24 SALRI agrees that rural and regional providers should be covered by any safe access zone.

18.6.25 There is no excuse or justification for filming women and staff going to and from abortion clinics.[2014] There was almost universal support to SALRI for such a prohibition. It is significant that parties such as the Australian Christian Lobby, 40 Days for Life, Cherish Life Australia and the Lutheran Church, whilst opposing safe access zones, favoured crimes relating to the videoing of patients or staff. It was accepted such conduct is 'a wrongful breach of privacy'. Cherish Life Australia noted: 'Yes. Abortion is a painful choice and we should not further victimise those who choose it.' This position was also accepted by all attendees at the 16 May 2019 roundtable with faith groups.

18.6.26 SALRI agrees that any offence should preclude the recording or photography of patients or staff going to or from clinics or any other place where abortion services are provided. SALRI notes the view of Women's Electoral Lobby Australia that 'recording a person entering or leaving a reproductive and sexual health clinic is a serious invasion of privacy and presents a clear danger of further harassment and intimidation of women and workers who are captured in this way' and all States and Territories that have legislated exclusion zones include an offence under the category of 'photography'. SALRI agrees with the suggestion of Women's Electoral Lobby Australia that 'this should be enlarged to that of publication, including publication on social media'.[2015]

18.6.27 SALRI supports the introduction of a new offence to support and complement safe access zones in South Australia to provide that it should be an offence for a person to make, publish or distribute a restricted recording of another person without the other person's consent and without

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discretion granted in subsection 14(4) of the *Termination of Pregnancy Act 2018* (Qld), which is additional to the legislative requirement in subsection 14(2).'

[2013] See, for example, Melissa Davey, 'Albury's Only Abortion Clinic: Protests "Push Women to Point of Self-Harm"', *The Guardian* (online, 9 December 2014) <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide>; Nick Fogarty and Suzi Taylor, 'Walking the Gauntlet of Protesters at Albury's Fertility Clinic', *ABC Goulburn Valley* (online, 21 March 2014) <http://www.abc.net.au/local/photos/2014/03/21/3968890.html>.

[2014] A member of the public told the QLRC that conduct such as filming or photographing 'is part of efforts to intimidate and harass women seeking an abortion and the employees of the abortion provider': Another party similarly stated that 'conduct of this kind is an invasion of the person's privacy, usually aimed at embarrassing, shaming or intimidating them': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, June 2018) 180, n 148.

[2015] The Australian Psychological Society Limited suggested to the QLRC that the inclusion of such conduct within any offence 'will prevent individuals or groups from seeking to shame, stigmatise, humiliate or cause distress to women by publishing images of them accessing premises providing abortions online': at 181 [5.117].

reasonable excuse. A 'restricted recording' should be defined to mean an audio or visual recording of a person while the person is in, or entering or leaving, an abortion services premises, and that contains information that identifies, or is likely to lead to the identification of, the person.[2016]

18.6.28 The QLRC recommended that the penalty in relation to the new offences relating to safe access should be a fine of 20 penalty units or one year's imprisonment. This penalty the QLRC said is appropriate 'because of the targeted nature of the offence and the harm that may be caused [and] is also consistent with the penalty prescribed in other jurisdictions that have enacted safe access zone provisions'.[2017] SALRI concurs with this reasoning.

18.6.29 Recommendations

Recommendation 49

SALRI recommends that any new law in South Australia should include safe access zone provisions around premises where abortion services are provided and that the purpose of these provisions is to protect the safety and welfare, and respect the privacy and dignity, of people accessing the services and employees or other persons who need to access those premises in the course of their duties or responsibilities.

Recommendation 50

SALRI recommends that any new law in South Australia should provide that a place will be within the safe access zone of premises at which the service of providing an abortion is ordinarily undertaken if it is in the premises or not more than the prescribed distance from an entrance to the premises.

Recommendation 51

SALRI recommends that any new law in South Australia should provide that the prescribed distance is 150 metres.

Recommendation 52

SALRI recommends that any new law in South Australia should provide that the operation of the safe access zone is not limited to the hours of operation of the premises and should be 24 hours a day and seven days a week, with no exceptions.

Recommendation 53

SALRI recommends that safe access zones should be automatically established by legislation and not by Ministerial decree.

[2016] See, for example, *Termination of Pregnancy Act 2018* (Qld) s 16.

[2017] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 86 [5.145].

Recommendation 54

SALRI recommends that a new offence be established in South Australia to provide that it is an offence to engage in prohibited conduct in the safe access zone for an abortion services premises and 'prohibited conduct' should be defined to mean intimidation, obstruction, impeding access, harassment or other conduct that relates to abortions or could reasonably be perceived as relating to abortions and would be visible or audible to another person entering, leaving or in the premises; and would be reasonably likely to deter a person from entering or leaving, or from requesting, undergoing, performing or assisting in the performance of, an abortion.

Recommendation 55

SALRI recommends that a new offence should be established in South Australia to provide that it is an offence for a person to make, publish or distribute a restricted recording of another person without the other person's consent and without reasonable excuse. A 'restricted recording' should be defined to mean an audio or visual recording of a person while the person is entering, leaving or in an abortion services premises, and which contains information that identifies, or is likely to lead to the identification of, the person being recorded.[2018]

Recommendation 56

SALRI recommends that there should be a maximum penalty of one year's imprisonment and/or an appropriate fine for each of the offences in Recommendations 54 and 55 above.

[2018] See, for example, *Termination of Pregnancy Act 2018* (Qld) s 16.

Part 19 - Consent, Capacity and Coercion

19.1 Informed Consent

19.1.1 As with all forms of medical treatment, informed consent is legally required before an abortion is performed. In South Australia, health practitioners have both common law and statutory legal obligations to obtain a patient's consent prior to performing any medical treatment.[2019] Consent will only be valid if it is free and voluntary.[2020] Consent is not free if it is obtained fraudulently or with reckless indifference.[2021]

19.1.2 The common law and statutory requirements for informed consent apply to all health practitioners in public and private health settings in relation to all medical treatment. They are also explicitly referred to in clinical guidelines and mandatory standards for termination of pregnancy in South Australia.[2022]

19.1.3 It is a requirement that the woman must be provided with sufficient information to make an informed decision about whether to consent to an abortion, including advice about the material risks or possible complications associated with the procedure, the likelihood of complications occurring, and alternative treatment options.[2023]

19.1.4 The standard of information that must be provided to a patient is what a reasonable person in the patient's position would want to be told, or what the health practitioner should reasonably know that a particular patient would want to be told.[2024] This legal standard recognises that it is the patient's decision to undergo a medical procedure and it is the patient who ultimately bears the burden of any material risks.

19.1.5 Professional guidelines are also material. Specific to obstetric and gynaecological treatment in Australia, the RANZCOG Statement concerning consent and the provision of information to patients in Australia regarding proposed treatment sets out the applicable legal principles and guidelines for informed consent. The statement addresses competence to consent and the duty to inform patients of risks, stating:

> The law requires that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment. A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, OR if the medical doctor is aware, or should be reasonably be aware, that the particular patient, if warned of the risk, would be likely to attach significance to it.[2025]

[2019] *Rogers v Whitaker* (1992) 175 CLR 479; See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

[2020] *Norberg v Wynrib* (1992) 2 SCR 226.

[2021] *Dean v Phung* [2012] NSWCA 223.

[2022] See SA Health, *Standards for the Management of Termination of Pregnancy in South Australia* (Policy, 2014) 10; SA Health, *South Australian Perinatal Practice Guidelines: First Trimester Medical and Surgical Termination of Pregnancy* (Clinical Guidelines, June 2014) 3–6.

[2023] *F v R* (1983) 33 SASR 189, 192; *Rogers v Whitaker* (1992) 175 CLR 479, 490.

[2024] *Rogers v Whitaker* (1992) 175 CLR 479.

[2025] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Consent and Provision of Information to Patients in Australia Regarding Proposed Treatment*, (Guideline, July 2016) 3. See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health (Abortion Law Reform) Amendment Bill 2016* (Report No 33a, 2017) 14 [2.52].

19.1.6 The South Australian Abortion Action Coalition has noted that informed consent is different to counselling and is already a standard required for medical care in Australia. They remarked:

> Informed consent supports people to understand health care procedures and any risks or side effects related to the procedure.[2026]

19.1.7 A failure to obtain the patient's consent, or to provide sufficient information, particularly about the material risks of the treatment, may form the basis of civil or even criminal liability, and professional disciplinary action. However, a person will not be criminally or civilly liable for providing medical treatment to a person who is unable to give their consent and immediate treatment is reasonable and necessary to save the person's life or to prevent serious injury to a person's health.[2027]

19.1.8 The importance of free and informed consent to a decision to undertake or not undertake an abortion is obvious, and was highlighted by many parties both supportive and opposed to the decriminalisation of abortion throughout SALRI's consultation.[2028] Some parties highlighted the concern of 'abortion coercion' and argued that the need for informed consent on the part of a woman to an abortion should be made explicit. One nurse for example argued that legislators have the responsibility to ensure both 'the mother and the child she carries' are safe and it 'is time to ensure informed consent will truly be enshrined in any change to the legislation. All life is precious.'

19.1.9 Other parties such as the South Australian Abortion Action Coalition and the Human Rights Law Centre submitted that any specific provision for informed consent in relation to abortion is unnecessary and counter-productive and that the existing common law and statutory obligations are sufficient to ensure that abortions are only performed by where free and informed consent has been obtained. It was also noted to SALRI this is an integral aspect of the role of a medical practitioner.

19.1.10 In the context of women with disabilities, access to reproductive health information and services is paramount, to ensure an autonomous choice is made to pursue or not pursue an abortion.[2029] The Victorian Women with Disabilities Network noted in its submission to the VLRC that pregnant women with a disability should be able to readily access information about available options.[2030] This should include information about either continuing a pregnancy or undergoing an abortion.[2031] The

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[2026] See also, Rachel Gold and Elizabeth Nash, 'State Abortion Counselling Policies and the Fundamental Principles of Informed Consent' (2007) 10(40) *Guttmacher Policy Review* 6 <https://www.guttmacher.org/about/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent>. Gold and Nash noted, '…patients should have access to the information they need to make the decisions that are theirs to make…[this] is also fundamental to the ethical practice of medicine'.

[2027] *Rogers v Whitaker* (1992) 175 CLR 479. See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13.

[2028] This accords with a central premise of health law and practice. As the Australian Lawyers Alliance noted to SALRI: 'Health care in Australia has been strongly influenced by the principle of patient autonomy, ie a patient's right to direct their own healthcare. This principle is a fundamental part of Australia's common law.' See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA) which deals with the need for consent to medical treatment. One of the objects of the Act under s 3 is 'to allow persons of or over the age of 16 years to decide freely for themselves on an informed basis whether or not to undergo medical treatment'. Section 15 requires 'that a medical practitioner explain to a patient (or a patient's representative), so far as may be practicable and reasonable in the circumstances — the nature, consequences and risks of proposed medical treatment; and the likely consequences of not undertaking the treatment; and any alternative treatment or courses of action that might be reasonably considered in the circumstances of the particular case.' This statutory duty, as Advocates International noted to SALRI, reflects the common law duty.

[2029] Centre for Reproductive Rights, Submission to the Committee on the Rights of Persons with Disabilities, *Half Day of General Discussion on Women with Disabilities* (March 2013) 10.

[2030] Victorian Women with Disabilities Network, Submission to Victorian Law Reform Commission, *Law of Abortion Final Report* (2008) 7.

[2031] Ibid.

Network emphasised that a pregnant woman should have the means and authority to make an informed decision about abortion.[2032]

19.1.11 Most Australian jurisdictions do not have specific legislative requirements relating to informed consent for the performance of an abortion. The VLRC[2033] and QLRC[2034] saw no need for any specific requirement given that informed consent is already an integral aspect of health law and practice for any health procedure and they saw no valid reason to treat abortion any differently.

19.1.12 The 2019 NSW Act contains a requirement for informed consent.[2035] The Act includes a requirement for 'informed consent' that applies to all abortions other than in the case of an emergency, and defines 'informed consent' as consent given 'freely and voluntarily' and 'in accordance with any guidelines applicable to a medical practitioner in relation to the performance of the termination'.[2036]

19.1.13 The NSW Attorney-General in moving the amendment to include 'informed consent' explained:

> I suggest that it should be made absolutely clear in this legislation, as an important statement of principle, that given that a decision to have a termination is a serious decision with an untold number of potential consequences that flow from whatever choice is made, there should be an expressed recognition of that in the legislation. None of this seeks to impede free choice or to suggest in any way that medical practitioners are not fulfilling their professional obligations at the moment.[2037]

19.1.14 The amendment was opposed. The Minister for Health commented 'there is no logical reason to put the proposed provisions in the Bill, the requirement of informed consent is already there. It underpins everything a doctor does'.[2038] Ms Leong elaborated:

> It is important to realise that we are talking about putting in place an extra barrier when we should be trying to remove any barriers. It is important to recognise that by seeking to codify informed consent in legislation we are, in a sense, setting up, yet again, another unequal scenario. In most cases, pregnant women will be attending upon a medical practitioner and requiring the procedure. Putting additional barriers in place may suggest or imply that pregnant women require additional safeguards compared with other people because they are somehow less capable of engaging with a medical procedure… I put on the record that I think it is offensive to suggest that a pregnant person who requires a termination should have a safeguard of an additional type of informed consent than exists within regular clinical practices and guidelines.[2039]

19.1.15 Various parties argued to the NSW Legislative Council Committee in favour of a legislative requirement for informed consent for abortion (and complained of the perceived inadequacy

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[2032] Ibid 8.

[2033] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 117 [8.53]–[8.59].

[2034] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 93 [3.176].

[2035] See New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 13–18.

[2036] See Reproductive Health Care Reform Bill 2019 (NSW), cl 5(2), 6(1)(c), sch 1.

[2037] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 14. Mr Henskens also commented: 'Informed consent is a fundamental concept to the law and the legal relationship around medical practice… Given that the law of informed consent applies to the Bill anyway, I see no harm in making that express within the bill. I expect practitioners who perform terminations will actually have a copy of the resulting legislation because, in some respects, they will refer to it from time to time. As everybody seems to agree that informed consent is a desirable aspect of good professional medical practice, I believe it is desirable to have it spelt out in the Bill': at 16.

[2038] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 15.

[2039] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 16.

of the provision to emerge from the Legislative Assembly).[2040] Anna Walsh noted that guidelines exist regarding the technical aspects of performing an abortion, but there is less clarity around the content of any warning the medical practitioner 'must give that goes beyond the physical risks of termination, and extends to the psychological and mental health risks that termination may have on the particular patient. This is worthy of debate and discussion'.[2041] Women's Forum Australia argued:

> Informed consent is a legal and ethical right for anyone who undergoes a medical procedure. Given the pressures and lack of support that often drive women to seek an abortion, as well as the physical and psychological risks inherent in abortion,[2042] robust safeguards to ensure women are giving fully informed consent, freely and voluntarily are required. Women seeking to end their pregnancy often experience a sense of desperation and a lack of real choice. This is a situation that is unique to abortion as compared with other procedures. As women in these circumstances are often at their most vulnerable, it is of the utmost importance that they are provided with as much information as possible about the termination before choosing to consider it.[2043]

19.1.16 However, this amendment, though ultimately included in the 2019 NSW Act, was contentious. Dr Philip Goldstone of Marie Stopes Australia observed to the NSW Legislative Council Committee:

> There has been considerable commentary on informed consent. Any doctor will tell you is that any medical treatment already requires informed consent. It is enshrined in clinical guidelines and it is standard practice for medical professionals and it is unfortunate that it has been found necessary to be legislated in this particular Bill.[2044]

19.1.17 The NSW Women's Legal Service stated that, as medical practitioners are already required to obtain a patient's informed consent for a medical procedure, the provision is 'unnecessary' and 'may provide uncertainty and confusion' and abortion should be treated like any other medical procedure.[2045]

[2040] See, for example, Australian Family Association, Submission No 35 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64871/0035%20The%20Australian%20Family%20Association.pdf;> Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 25 (Ms Terri Kelleher, National Vice President, Australian Family Association); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 60 (Professor Margaret Somerville, School of Medicine, University of Notre Dame); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 49 (Ms Rachel Wong, Managing Director, Women's Forum Australia).

[2041] Anna Walsh, Submission No 21 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 2, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64858/0021%20School%20of%20Law,%20University%20of%20Notre%20Dame%20Australia.pdf>.

[2042] This proposition is contentious as the research disagrees as to the effects, if any. See also above [2.1.42]–[2.1.52].

[2043] Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 30 [7]–[8], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[2044] Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 49 (Dr Philip Goldstone, Marie Stopes Australia).

[2045] Women's Legal Service NSW, Submission No 32 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64868/0032%20Womens%20Legal%20Service%20NSW.pdf>.

The NSW Bar Association similarly saw the explicit informed consent provision as 'unnecessary and may create confusion'.[2046]

19.1.18 In their submission to the NSW Legislative Council Committee, the Human Rights Law Centre expressed its concern as to the 'informed consent' provision.[2047] The Human Rights Law Centre considered this amendment was unnecessary, given the existing legal requirements for medical practitioners which are also reiterated in the NSW Health Policy Directive.[2048] They submitted:

> More alarmingly, the amendment creates legal uncertainties about the obligations of doctors towards their patients in relation to abortion. It is not clear how the definition inserted into the Bill should operate alongside the existing common law, and what this means in practice for doctors who are seeking to obtain informed consent.[2049]

19.1.19 The Human Rights Law Centre raised particular concerns that the 'informed consent' provision may be used to create a barrier to quality reproductive health care.[2050] It was noted:

> In the United States, the concept of informed consent has been manipulated by anti-choice politicians in some states in ways that are harmful to women, for example, forcing patients to look at materials with graphic images of fetuses in order to give informed consent. We are concerned that there is potential for guidelines around informed consent to be used in similar ways in NSW in the future — bypassing the Parliament to fundamentally change the intent of this Bill and the foundations of informed consent.[2051]

19.1.20 The AMA (NSW) raised similar concerns regarding the statutory requirement to gain informed consent before performing an abortion. In its submission to the NSW Legislative Council Committee, the AMA (NSW) stated that the amendment is unnecessary and 'does not serve the interests of doctors, patients or the community'.[2052] The provision was further described by the NSW(AMA) as 'insulting' and as confusing for both patients and practitioners.[2053] It was reported:

[2046] NSW Bar Association, Legal Service NSW, Submission No 19 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64845/0019%20New%20South%20Wales%20Bar%20Associations.pdf>.

[2047] Human Rights Law Centre, Submission on the Reproductive Health Care Reform Bill 2019 to the NSW Parliament Standing Committee on Social Issues, *Modernising NSW's Archaic Abortion Laws* (13 August 2019) 7–8 [26]–[35].

[2048] Human Rights Law Centre, Submission on the Reproductive Health Care Reform Bill 2019 to the NSW Parliament Standing Committee on Social Issues, *Modernising NSW's Archaic Abortion Laws* (13 August 2019) 7 [29]; see NSW Health, *Policy Directive: Consent to Medical Treatment — Patient Information* (Policy Paper, June 2017) 9–10, <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_406.pdf>.

[2049] Human Rights Law Centre, Submission on the Reproductive Health Care Reform Bill 2019 to the NSW Parliament Standing Committee on Social Issues, *Modernising NSW's Archaic Abortion Laws* (13 August 2019) 8 [30].

[2050] Ibid 8 [31]–[33].

[2051] Ibid 8 [32]. See, for example, Jessica Mason Pieklo, 'The slippery slope of "informed consent" abortion laws', *Rewire News* (online, 30 August 2012) <https://rewire.news/article/2012/08/30/informed-consent-salute-in-gop-platform-is-more-than-just-political-theater/>.

[2052] Australian Medical Association (NSW), Submission No 45 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (14 August 2019) 2, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64882/0045%20Australian%20Medical%20Association%20(NSW)%20Ltd.pdf>.

[2053] Michael McGowan, 'NSW Abortion Law: Informed Consent Requirement Confusing, says AMA', *The Guardian* (online, 8 August 2019) <https://www.theguardian.com/australia-news/2019/aug/08/nsw-abortion-law-plan-to-increase-restrictions-on-terminations-after-22-weeks-scrapped>.

> The [AMA(NSW)] Vice President in NSW, Danielle McMullen, said the passing of the amendment risked creating confusion for doctors and patients. 'Our concern with having it as a separate, statutory requirement within legislation is that it implies there is some extra hurdle when really there shouldn't be, it should be the status quo for doctors who already receive informed consent in any medical interaction and particularly medical procedure,' she said. 'Informed consent is a standard part of clinical practice and the concern with it being [in] the Bill is that it adds confusion, and an extra layer to the process, so that termination of pregnancy is different to every other procedure we perform. We would strongly refute that and say a termination is a medical procedure like any other.'[2054]

19.1.21 RANZCOG also was of the view that the amendment is unnecessary, 'because the requirement to obtain informed consent is inherent in every medical encounter and is a fundamental element of the doctor/patient relationship'.[2055]

19.1.22 Associate Professor Bernadette Richards of the University of Adelaide described a legislative requirement for informed consent for abortion as 'unnecessary and ridiculous'.

19.1.23 SALRI agrees with the view that any further legal requirement for informed consent by a woman to have an abortion is unnecessary, if not unhelpful, as this is already an integral aspect of present health law and practice to any medical procedure. There is no convincing reason to single out abortion for such specific legislative reference. SALRI finds the reasoning of the Human Rights Law Centre convincing. SALRI does not dispute the importance of informed consent, but it is of the view that it is unnecessary and otiose to make any such specific legislative provision. There is also a concern such a requirement could allow some practitioners 'to frighten patients with anti-abortion rhetoric'.[2056]

19.2 **Capacity**

19.2.1 The current test in South Australia as whether or not a person has the capacity to consent to an abortion is determined by the same principles that apply to all medical treatment. Informed consent will only be deemed valid where the person consenting to medical treatment is considered competent to consent to the treatment.

19.2.2 A person aged 18 or over is presumed to be competent to consent to medical treatment unless evidence indicates that they do not understand the nature of their condition or the medical treatment.[2057]

19.2.3 Where a person aged 18 or over does not have sufficient understanding of the condition or treatment as the result of impaired cognitive capacity, an intellectual disability or a health condition, the person cannot lawfully consent to the medical treatment.[2058]

[2054] Ibid.

[2055] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Submission No 39 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 2, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64875/0039%20The%20Royal%20Australian%20and%20New%20Zealand%20College%20of%20Obstetricians%20and%20Gynaecologists.pdf>.

[2056] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019 (Mr Speakman, Attorney-General).

[2057] *Re C (adult: refusal of medical treatment)* (1994) 2 FCR 151. See *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

[2058] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4(2). See also *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 237–238; applying the test in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC 112.

19.2.4 The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) states that a person will be taken to have impaired decision-making capacity if they are not capable of understanding any information that may be relevant to the decision, retaining such information, using such information in the course of making the decision, or communicating the decision, or the person is, by reason of being comatose or otherwise unconscious, unable to make the decision.[2059]

19.2.5 A person under the age of 18 can also validly consent to medical treatment if they are considered competent to do so. There is no need to gain parental consent. At common law, there is no fixed age at which a minor is considered competent to consent to medical treatment. Instead, this will be determined on a case-by-case basis by applying the test laid down in *Gillick*[2060] and upheld by the High Court in *Marion's Case*.[2061] In *Marion's Case*, McHugh J stated:

> Until recently, it was doubtful whether at common law a minor could validly consent to the carrying out of a medical procedure. It is now established that if a minor has the requisite capacity, he or she may do so. A minor has that capacity where he or she possesses sufficient intellectual capacity and emotional maturity to understand the nature and consequences of the procedure to be performed. Consequently, if a minor lacks the intellectual capacity and emotional maturity required to understand the nature and consequences of a medical procedure, his or her agreement to the carrying out of that procedure will be of no effect.[2062]

19.2.6 The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) further provides that a child will be considered competent to consent to medical treatment if the medical practitioner is of the opinion that the child can understand the nature, consequences and risks of the proposed treatment and that the treatment is in the best interests of the child's health and well-being, and that opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.[2063]

19.2.7 Where a person does not have the capacity to consent to medical treatment, some circumstances allow a substitute decision-maker or the parent of a minor to consent to the medical treatment on their behalf.[2064]

19.2.8 In South Australia, abortion is listed as a prescribed medical treatment under the *Guardianship and Administration Act 1993* (SA). This means that if a person is not able to consent to the procedure, consent must be obtained from the South Australian Civil and Administrative Tribunal (SACAT)[2065] and not through any other alternate decision maker or guardian.

19.2.9 RANZCOG instructs its members that:

> If the doctor is unsure whether or not a patient is competent to consent to treatment, the doctor should seek a second opinion from a medical professional qualified to make a capacity assessment

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[2059] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4(2).

[2060] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

[2061] *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

[2062] Ibid 311.

[2063] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12. See also LexisNexis, *Halsbury's Laws of Australia* (online, 22 June 2015) 205 Family Law, 'F. Medical Treatment of Children' [2130].

[2064] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

[2065] *Guardianship and Administration Act 1993* (SA) s 61(1). SACAT will only consent to a termination of pregnancy if satisfied that it would not constitute a criminal offence to do so, there is no likelihood the woman would acquire the capacity to give effective consent within the period where it is safe to carry out the termination, and SACAT has no knowledge of the woman communicating any refusal to consent to a medical practitioner while the woman was able to consent: s 61(3).

(for example, a neuropsychologist or psychiatrist) or seek legal advice (eg from his or her medical defence organisation).[2066]

19.2.10 Several parties to SALRI's consultation held the view that abortion should not be available to a girl under the age of 16 years without parental consent or notification.[2067] 40 Days for Life, for example, submitted: 'It should be illegal for a minor to have an abortion without parental consent.'

19.2.11 However, the majority view held by parties who responded to this issue was that the current principles (both common law and statutory) that apply in South Australia to govern the capacity of minors and adults with impaired decision-making capacity should continue to apply to obtaining consent for abortions. Associate Professor Bernadette Richards, for example, noted that the law is settled in South Australia and it is unnecessary and counter-productive to interfere with this area.

19.2.12 In relation to minors, Australian Lawyers for Human Rights submitted to SALRI:

> As a matter of law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed. If this principle is not applied, girls will have to seek consent from their parents or legal guardians to have an abortion. This undermines their ability to make decisions about their own health, and can also put both their mental and physical health at risk.

19.2.13 The VLRC was unconvinced that any change to the law was necessary to deal with capacity and consent, including by children:

> The law governing consent to medical treatment by adults, children, young people, and people who do not have the capacity to provide their own consent because of disability is clear and appears to operate well in practice. The Commission believes there is no demonstrated need to consider any changes to this body of law in the context of abortion law reform.[2068]

19.2.14 The QLRC reached a similar conclusion and found that no change to the law was necessary.[2069] It explained that its draft Bill was not intended to affect the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity, consent to medical treatment for minors or the regulation of health practitioners, public hospitals and health services and licensed private health facilities and the relevant general laws should continue to apply.[2070]

19.2.15 SALRI agrees with the reasoning of the VLRC and QLRC and considers that no changes are necessary to the existing laws in South Australia that govern consent to medical treatment for minors and adults with impaired decision-making capacity.

[2066] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Consent and Provision of Information to Patients in Australia Regarding Proposed Treatment* (Guideline, July 2016) 2.

[2067] This view was also relayed to the NSW Legislative Council Committee. See, for example, Australian Christian Lobby, Submission No 33 to the Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 15 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64869/0033%20Australian%20Christian%20Lobby.pdf>, Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 18–21 [78]–[90], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[2068] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 29 [2.90]. See also at 134–135 [8.214]–[8.216], 137 [8.230]–[8.236], Recs 14–15, 136.

[2069] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) iv [11].

[2070] Ibid 6 [1.33].

19.3 Reproductive Coercion

19.3.1 A number of parties in SALRI's consultation, both supportive and opposed to the decriminalisation of abortion, highlighted to SALRI the concern of 'reproductive coercion'.[2071] This has been defined as 'a behaviour that interferes with the autonomous decision-making of a woman, with regard to reproductive health'.[2072]

19.3.2 There was universal agreement in SALRI's consultation with the fundamental importance of reproductive autonomy for the woman involved, including women with disabilities, and the need for women to make any decision relating to abortion voluntarily and without coercion. As the VLRC also found: 'There was consensus throughout the consultations that coercion should not be tolerated. 'Coercion either to have the child, or not have the child is contrary to what the community wants or expects in terms of women's free choices.'[2073]

19.3.3 This premise was widely shared by parties both supporting and opposed to the decriminalisation of abortion, though there were differences to the precise definition of 'coercion' and its implications.[2074]

19.3.4 Advocates International, for example, emphasised the importance of informed and voluntary consent. The Greens (SA) submitted 'any law reform should also ensure that women seeking an abortion can make decisions regarding their reproductive health freely and without undue influence or pressure'. A leading health provider spoke of 'the right to make decisions concerning reproduction that are free of discrimination, coercion and violence'.

19.3.5 The Coalition of Women's Domestic Violence Services of SA Inc submitted:

[2071] See also Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341.

[2072] Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371. 'Reproductive coercion is defined as behavior that interferes with the autonomous decision-making of a woman, with regard to reproductive health… Specifically, this may take the form of birth control sabotage (such as removing a condom, damaging a condom, removing a contraceptive patch, or throwing away oral contraceptives), coercion or pressure to get pregnant, or controlling the outcome of a pregnancy (such as pressure to continue a pregnancy or pressure to terminate a pregnancy': at 371. Another definition is: 'Reproductive coercion is any interference with a person's reproductive autonomy that seeks to control if and when they become pregnant, and whether the pregnancy is maintained or terminated. It includes sabotage of contraceptive methods and intervention in a woman's access to health care': Elizabeth Price et al, 'Experiences of Reproductive Coercion in Queensland Women' (2019) *Journal of Interpersonal Violence* 1.

[2073] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 137 [8.237], quoting John Fleming and Nicholas Tonti-Filippini (eds), *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (St Pauls, 2007) 132.

[2074] There were differing assertions of what amounted and did not amount to 'coercion' and the implications for law reform. There were also conflicting claims of who may be responsible for 'coercion'. Whilst several parties opposed to abortion asserted that some medical practitioners 'coerce' women into seeking an abortion, pro-choice and health groups highlighted what they categorised as intimidation and harassment by anti-abortion groups. See also QLRC at 171–174 [5.64]–[5.82]. This includes so called 'sidewalk counselling'. As the QLRC explained: 'Although "sidewalk counsellors" may view their behaviours as harmless, their presence at or near termination services premises interferes with the privacy and dignity of individuals who are accessing lawful terminations': Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 183 [5.130]. As the Castan Centre for Human Rights noted to SALRI (and the QLRC): 'Anti abortionists frequently describe themselves as sidewalk counsellors seeking to render assistance to women. This characterisation differs markedly from what we heard from interviewees who spoke of their unwelcome intrusions into the personal space of patients and staff.' See also above [12.5.51], [18.3.24]–[18.3.25], [18.3.35]–[18.3.37], [18.5.15]–[18.5.16], [18.5.49]–[18.5.54].

> We advocate for maintaining a regulatory framework regarding abortion services, which supports women's health, safety and right of access to abortion services, and ensures that patents' informed consent to the procedure is assured without fear of coercion by any other person.

19.3.6 Attendees at the roundtable with faith groups and NGOs on 12 June 2019 expressed some concern that removing abortion from the criminal law[2075] without introducing anti-coercion laws and/or alternative safeguards may leave women more vulnerable to coercion. This concern has been expressed elsewhere.[2076] Support to SALRI for strengthening the law against coercion overlapped with suggestions to strengthen procedures and provisions around counselling[2077] and informed consent.[2078]

19.3.7 Various sources of reproductive coercion and external pressure were raised to SALRI, including partners, parents, friends and even medical practitioners and abortion service providers.[2079] Groups opposed to abortion typically raised coercion to undertake an abortion or, as the Australian Christian Lobby and others noted, 'Abortion Coercion'.

19.3.8 The Right to Life Association of South Australia noted 'research that shows not only that women have been pressured, coerced and sometimes forced to have an abortion, but that there is a strong link between abortion and intimate partner violence'.[2080] Cherish Life, for example, described: 'Abortion is a serious procedure and is often undertaken by women who are coerced by their partners, parents, employers or other parties (even doctors) who have a vested interest in the termination of the pregnancy, even though it be against the woman's own will.' Concerned Women's Collective described situations where 'parents and partners use violence, intimidation, and emotional exploitation to compel mothers to abort against their wishes'.

19.3.9 Concerned Women's Collective stated that coercion extends to economic coercion, 'where partners threaten to withdraw support on the one hand or promising greater support when the act is done'. Concerned Women's Collective also noted that pregnant minors who do not have independent income to support themselves may be especially vulnerable to economic coercion by their parents. The emotional control to compel abortion was also raised: 'Husbands and partners threaten to break up or they treat the woman coldly to convince them to abort their children'.

19.3.10 However, it was emphasised to SALRI by a number of parties from health, legal and women's rights sectors that this is only part of the picture and 'reproductive coercion' includes coercion

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[2075] See further above Part 5.

[2076] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 26 [3.212]–[3.33].

[2077] See further above Part 12.

[2078] See also above [19.1.1]–[19.1.23].

[2079] See also Real Choices Australia, Submission No 12 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (12 August 2019) 6–7 <https://www.parliament.nsw.gov.au/lcdocs/submissions/64837/0012%20Real%20Choices%20Australia.pdf>.

[2080] See also Christina Pallitto et al, 'Intimate Partner Violence, Abortion, and Unintended Pregnancy: Results from the WHO Multi-Country Study on Women's Health and Domestic Violence' (2013) 120(3) *International Journal of Gynaecology Obstetrics* 3; T Wokoma et al, 'A Comparative Study of the Prevalence of Domestic Violence in Women Requesting a Termination of Pregnancy and Those Attending an Antenatal Clinic' (2014) 121 *British Journal of Obstetrics and Gynecology* 627. This should be read subject to one study which reported that when violence is present in the lives of women seeking abortion, it was not often used to coerce abortions or pregnancy continuation, but rather more often was part of the woman's reason for seeking an abortion in an effort to end the relationship or to prevent a continuing connection to an abusive partner. See Karuna Chibber et al, 'The Role of Intimate Partners in Women's Reasons for Seeking Abortion' (2014) 24 *Women's Health Issues* 131.

to both terminate and continue a pregnancy.[2081] This is an emerging and relatively recent area of research.[2082] However, the research to date has highlighted the experiences of women who have been coerced into continuing a pregnancy through threats of harm, refusal to financially contribute to the cost of an abortion or transport to an appointment, and public shaming for a decision to terminate a pregnancy.[2083]

19.3.11 As one review notes:

> The prospect of women being coerced into having abortions has been the subject of much politicisation in the public arena of the abortion debate. Findings in this area do not support the assertion that women are frequently coerced into abortions, but rather, that they are more often coerced into continuing a pregnancy. Findings are limited, however, and in need of further investigation.[2084]

19.3.12 This review, while acknowledging that there have been few studies that have specifically identified partner coercion or pressure in the decision to have an abortion, notes the studies that have identified such behaviour reported low prevalence ranging from 0.1% to 4%. The review refers to one study that reports findings about male partners coercing women to continue a pregnancy or preventing them from accessing abortion services at 8% prevalence. Two studies reported the experiences of women whose partners threatened to harm or kill them if they had abortions.[2085]

19.3.13 Particular concerns were expressed to SALRI by a number of diverse parties such as Professor Heather Douglas, Dr Šeman and Dr Turnbull, Advocates International, the Australian Women's Health Network, the Coalition of Women's Domestic Violence Services of SA Inc, Reproductive Choice Australia, the Human Rights Law Centre, the Women Lawyers' Association of South Australia Inc and several city, regional and rural health practitioners about reproductive coercion in the context of domestic and family violence and the fact that reproductive coercion is 'a recognised

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[2081] 'Qualitative findings described male behaviours of pressuring women to have abortions… as well as preventing women from having abortions or accessing abortion services': Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 383. See also Jeanne Hathaway et al, 'Impact of Partner Abuse on Women's Reproductive Lives' (2005) 60 *Journal of the American Medical Women's Association* 42, 45; Ann Moore, Lori Frohwirtha and Elizabeth Miller, 'Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States' (2010) 70 *Social Science and Medicine* 1737.

[2082] As Women's Forum Australia notes: 'Reproductive research is a growing area of research in Australia. There is a significant unresolved and unregulated area concerning reproductive coercion in Australia that has received little attention from the national politics and other investigative other than [some] preliminary observation or commentary': Women's Forum, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 15 [66], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[2083] See Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371; Kathryn Fay and Lynn Yee, 'Reproductive Coercion and Women's Heath' (2018) 63(5) *Journal of Midwifery and Women's Health* 518; Cara Nikolajski et al, 'Race and Reproductive Coercion: A Qualitative Assessment' (2015) 25 *Women's Health Issues* 216; Ann Moore et al, 'Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States' (2010) 70 *Social Science and Medicine* 1737; American College of Obstetricians and Gynecologists, *Reproductive and Sexual Coercion* (Committee Opinion No 554, February 2013); Jeanna Park et al, 'Reproductive Coercion: Uncloaking an Imbalance of Social Power' (2016) 214 *American Journal of Obstetrics and Gynecology* 74; Linda Chamberlain and Rebecca Levenson, 'Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings', *American College of Obstetricians and Gynecologists* (Policy, 2nd ed, 2012) 7.

[2084] Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 386. See also at 382–383.

[2085] Ibid 382–383.

form of domestic violence'.[2086] The link between domestic violence and reproductive coercion is well established by research.[2087] 'There is a strong relationship between reproductive coercion and IPV.'[2088]

19.3.14 The Coalition of Women's Domestic Violence Services of SA Inc explained:

> This submission is particularly concerned for the rights of women to access required healthcare relating to abortion in cases of reproductive coercion and other forms of domestic and family violence, which may significantly contribute to women finding it extremely difficult and dangerous to access abortion services, causing significant delays in presentation. Particularly as pregnancy is associated with increased risk for women experiencing assault from a partner for the first time, or an increase in the form or intensity of violence,[2089] it is necessary for legislation and regulatory frameworks to support and enable women's independence and autonomy in relation to pregnancy at every stage.

19.3.15 The Family Violence Legal Service Aboriginal Corporation (SA) reported to SALRI:

> Our clients relate to us experiences of pregnancy and termination being used as a means to exert coercive control by perpetrators of family violence. Clients have related stories of trying to end relationships when pregnant and being told by the perpetrator that if they choose to end the relationship they will also need to end the pregnancy. Other clients have been forced to book appointments for terminations and have had their perpetrator attend at all appointments to ensure that no opportunity to disclose the family violence is provided. Clients who have wanted to terminate have been prevented from taking this action and forced to maintain a pregnancy. We know that having children with a perpetrator can be a further barrier to leaving an abusive relationship.

19.3.16 Professor Heather Douglas and Katherine Kerr also discuss the nature of reproductive coercion and its link with domestic violence:

> Like sexual violence in the domestic context, reproductive coercion is pervasive and hidden and has far-reaching consequences. The consequences of reproductive coercion often manifest in poor sexual and reproductive health outcomes and may also result in pregnancy and parenting in a violent relationship. Research has shown that pregnancy and having a child within a relationship where there is DFV (domestic and family violence) increases the likelihood that the woman will stay in the violent relationship.[2090]

19.3.17 Another concern expressed to SALRI in the context of reproductive coercion related to women with disability. Attendees at the roundtable session with the disability sector and several other

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[2086] See also Committee on the Elimination of Discrimination against Women, *General Recommendation No 35 on Gender-Based Violence Against Women,* UN Doc CEDAW/C/GC/35 (26 July 2017).

[2087] See, for example, Lindsay Clark et al, 'Reproductive Coercion and Co-occurring Intimate Partner Violence in Obstetrics and Gynecology Patients' (2014) 210 *American Journal of Obstetrics and Gynecology* 42; Ann Moore, Lori Frohwirtha and Elizabeth Miller, 'Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States' (2010) 70 *Social Science and Medicine* 1737; Melissa Sutherland, Heidi Fantasia and Holly Fontenot, 'Reproductive Coercion and Partner Violence Among College Women' (2015) 44(2) *Journal of Obstetric, Gynecologic and Neonatal Nursing* 218; Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341; Elizabeth Price et al, 'Experiences of Reproductive Coercion in Queensland Women' (2019) *Journal of Interpersonal Violence* 1.

[2088] Karen Grace and Jocelyn Anderson, 'Reproductive Coercion: A Systematic Review' (2018) 19(4) *Trauma, Violence and Abuse* 371, 372. 'All studies with findings in this area found associations between reporting reproductive coercion and reporting IPV': at 383.

[2089] See also Australian Institute of Family Studies, *Domestic and Family Violence in Pregnancy and Early Pregnancy* (Practitioner Resource, 2015).

[2090] Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341, 341–342.

parties expressed their concern that women with a disability may be compelled by family members and health practitioners to undertake an abortion. Australian Lawyers for Human Rights, for example, noted that, although it is unclear to what extent this happened in practice, it quoted one disability advocacy group. 'It is recognised that women with disability experience forced abortions, a form of sexual violence.'[2091] Australian Lawyers for Human Rights expressed its concern over the risk of women with disability encountering outdated attitudes and facing undue pressure to undergo an abortion. It commented:

> Women with disability may be forced to have an abortion by having her legal capacity removed, or as a result of stigma associated with the perceived capacity of people with disability to be parents... Forcing a woman with disability to have an abortion on the basis that she does not have legal capacity, because she has a disability, is discriminatory.

19.3.18 This concern was also raised to the VLRC:

> There was specific concern that the decision-making capacity of women with a disability be respected. Negative stereotypes about the parenting abilities of people with a disability, together with attitudes that question the capacity of women with a disability to make reproductive decisions, were identified. The Victorian Women with Disabilities Network also expressed concern that there may be coercion to continue with a pregnancy from groups opposed to abortion.[2092]

19.3.19 The Centre for Disability Law and Policy has previously raised the additional difficulties experienced by women with disability accessing abortion services, and highlighted that a lack of relevant information in accessible formats may create barriers to access.[2093] The Centre for Disability Law and Policy proposed developing a legislative framework for abortion 'that respects a woman's right to choose while simultaneously valuing the lives of persons with disabilities and providing support for people with disabilities to live full lives in their communities'.[2094]

19.3.20 SALRI, reflecting the strong theme expressed in consultation, reiterates that it is unacceptable for women with disability to encounter coercion in relation to reproductive decisions.[2095]

19.3.21 The *CRPD* reaffirms the importance of the reproductive autonomy of women with disabilities. Under Article 23 'Respect for home and the family', persons with a disability are to exercise autonomy in determining the 'number and spacing of their children'.[2096] This recognises autonomy as integral to decision-making in pregnancy. The *CRPD* also recognises a right to access reproductive health care and a right to privacy in the context of medical decision-making.[2097] The CRPD Committee has noted that 'it is particularly important to reaffirm that the legal capacity of women with disabilities

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[2091] Women with Disabilities Australia, *Sexual and Reproductive Rights* (Position Statement No 4, September 2016) 4.

[2092] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 137 [8.238]. The VLRC noted: 'Some people suggested that partners, parents, and doctors regularly coerce women into abortion… No firm evidence of coercion was provided to the Commission': at 137 [8.239].

[2093] Centre for Disability Law and Policy, *Submission to the Citizens' Assembly on Repeal of the Eighth Amendment to the Constitution* (December 2016) 3.

[2094] Ibid 6.

[2095] See also above [13.3.4], [13.4.10]–[13.4.15].

[2096] Centre for Disability Law and Policy, Submission to Committee on the Rights of Persons with Disabilities, *General Comment on Article 6: Right to Life* (June 2015) 6; *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, [2008] ATS 12 (entered into force 3 May 2008) art 23(b).

[2097] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 16 August 2008) art 22, 25.

should be recognised on an equal basis with that of others and that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children.'[2098]

19.3.22 It has been suggested to SALRI by a number of parties, especially from the disability sector, that these rights should be considered and safeguarded in the context of women with disability in any recommendations for law reform.

19.3.23 Australian Lawyers for Human Rights provided comment to SALRI on the issue of coerced abortions and possible means to address this issue, noting a comment of the United Nations Committee on the Rights of Persons with Disabilities, which concluded that under Art 16 of the *CRPD,* forced abortions are forms of violence, exploitation and abuse.[2099] Women with disabilities experience coerced abortions through the removal of capacity or the stigma attached to capacity and disability. A coerced abortion on the basis of capacity, due to the existence of a disability, is discriminatory. In light of this, ALHR recommended that SALRI consider ways to safeguard the right of women with disabilities to prevent coerced abortions. ALHR noted methods to address this 'may look like the criminalisation of forced abortions against women with disability, replacing existing laws which criminalise a woman's choice to terminate her pregnancy'.

19.3.24 A number of parties suggested to SALRI that a specific offence relating to coercion to undertake an abortion should be considered. This was most notably raised by parties opposed to the decriminalisation of abortion who highlighted 'abortion coercion'. This was also raised in relation to the 2019 NSW Act.[2100]

19.3.25 Some attendees at the roundtable session with the disability sector also supported an offence of coercion to undertake an abortion in relation to women with disability. Australian Lawyers for Human Rights suggested:

> A woman with disability may be forced to have an abortion by having her legal capacity removed, or as a result of stigma associated with the perceived capacity of people with disability to be parents… consideration should be given to the safeguarding [of] the right of women with disability to be free from violence, abuse and exploitation … Criminalising medical intervention by way of abortion where a woman does not choose to terminate the pregnancy and where the woman has a physical, intellectual or cognitive disability is a way to safeguard against continued rights violations for women with disability when forced to terminate their pregnancies. In other states and territories, there is not specific legislative safeguarding provisions by way of criminalising the acts of medical professionals who may be responsible for the forced abortion of a woman with disability.

[2098] Committee on the Rights of Persons with Disabilities, *General Comment No 3 (2016) On Women and Girls With Disabilities*, UN Doc CRPD/C/GC/3 (2 September 2016) [40].

[2099] *Convention on the Rights of Persons with Disabilities,* opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) Art 16 provides the right for a person with disability to be free from exploitation, violence and abuse.

[2100] See, for example, Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 25–26 [3.29]–[3.33]; Right to Life NSW, Submission No 13 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) 17, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64847/0013%20Right%20to%20Life.pdf>; Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 17–18 [75]–[77], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

19.3.26 Australian Lawyers for Human Rights submitted that women with disability may 'face undue pressure to terminate their pregnancies on the basis of their parenting capacity because they have a disability'. Recognising that it can be difficult to properly deal with these 'attitude barriers' in legislation and that 'there may not be an effective way to regulate such practices, ALHR suggested that SALRI put forward an education program for medical practitioners to better inform them on the right of women with disability to have a family and the need to acknowledge, protect and promote this right.

19.3.27 However, there was relatively little support in SALRI's consultation for introducing a specific anti-coercion offence (whether of general application or confined to a disability context). Such an offence was widely seen as unnecessary and unhelpful. While there was consensus that reproductive coercion is unacceptable and safeguards should be in place, parties generally referred to the need for health practitioners to be adequately trained in domestic violence, and for all service providers to carry out effective domestic violence screening and offer proper counselling.[2101]

19.3.28 Based on the experiences of their clients, Family Violence Legal Service Aboriginal Corporation submitted to SALRI that training and screening needs should be reinforced as legislative requirements.

19.3.29 The VLRC did not support an anti-coercion offence. Rather this is an issue better left to clinical practice as practitioners are already alive to the issue. As the VLRC observed:

> Abortion providers said they are mindful of the risk of coercion, and will not proceed with an abortion if the woman appears to be ambivalent or under pressure. This is consistent with the practitioner's existing ethical duty to gain valid consent.[2102]

19.3.30 Noting that anti-coercion laws does not exist in any Australian jurisdiction (except now in the 2019 NSW Act), nor in the United Kingdom or New Zealand, the VLRC was of the view that the current law governing all medication procedures deals appropriately with issues of consent, and no further legislative requirement was necessary.[2103]

19.3.31 These views are shared by the New Zealand Law Commission, who reported: 'Health practitioners the Commission spoke to emphasised that issues of potential coercion arise in a range of health care contexts and health practitioners are experienced in dealing with them.'[2104] The New Zealand Law Commission concluded that abortion practice and its regulation through professional standards and the law regarding informed consent are sufficient to manage issues of coercion.[2105]

19.3.32 The QLRC, whilst supporting safe access zones, also did not endorse general anti-coercion or harassment offences to make 'it unlawful to harass a woman who is considering, or who has undergone, a termination; or a person who performs or assists, or who has performed or assisted in performing, a termination'.[2106] The QLRC noted that there were already various civil and State and Commonwealth criminal laws and remedies in place.[2107]

[2101] See further above Part 12.

[2102] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 137 [8.240].

[2103] Ibid 137 [8.242].

[2104] New Zealand Law Commission, *Alternative Approaches to Abortion Law* (Ministerial Briefing Paper, October 2018) 145 [9.18].

[2105] Ibid 145 [9.21].

[2106] 182 [5.119].

[2107] Ibid 182 [5.120].

19.3.33 An amendment was moved to the NSW Bill in the Legislative Assembly to introduce a new offence of coercing someone to undergo an abortion. The amendment was not accepted.[2108] Suggestions for a specific offence to address 'abortion coercion' were also raised to the NSW Legislative Council Committee.[2109] The NSW Legislative Council eventually accepted an amendment to introduce a new offence of coercion to both undergo and not undergo an abortion.[2110]

19.3.34 SALRI shares the concerns expressed as to reproductive coercion, especially in the contexts of domestic violence and/or disability, but at this stage does not support the establishment of a specific offence to address 'abortion coercion'. It agrees with the conclusions and reasoning of the VLRC, the New Zealand Law Commission and the QLRC that such an offence is unnecessary. The new offence in the NSW Act of coercion to both undergo and not undergo an abortion is an improvement on the original suggestion of an offence confined to coercion to undergo an abortion as reproductive coercion is clearly not confined to undue pressure to undergo an abortion. However, SALRI remains unconvinced of the rationale or utility of any new offence in this context and does not support the introduction in South Australia of a new offence as in the 2019 NSW Act. The issue of coercion is better addressed by clinical and operational practice and enhanced training and awareness.

19.4 Definition of 'Domestic Abuse'

19.4.1 Parties such as Advocates International, the Christian Legal Centre and Dr Šeman and Dr Turnbull proposed to SALRI that the laws on domestic violence should be amended to recognise that a woman who consents to an abortion under duress due to coercion from her partner, or another person, is not providing valid consent and this should be recognised as a form of domestic or family violence.[2111] Advocates International submitted: 'The definition of domestic violence should be amended to include coercing a woman to have an abortion.'

19.4.2 SALRI accepts the strength of this suggestion, subject to the crucial qualification that reproductive coercion is not confined to undue pressure to undergo an abortion but is wider in scope and includes undue pressure to continue with a pregnancy and **not** undergo an abortion.[2112] There was wide recognition by parties both supportive and opposed to the decriminalisation of abortion that reproductive coercion is a form of family or domestic violence.

19.4.3 Section 8 of the *Intervention Orders (Prevention of Abuse) Act 2009* (SA) provides an expansive definition of 'domestic abuse' including physical, sexual, emotional, psychological and economic abuse, but does not explicitly include 'reproductive coercion'. The definition also includes numerous examples

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[2108] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 79–81.

[2109] See, for example, Right to Life NSW, Submission No 13 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (13 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64847/0013%20Right%20to%20Life.pdf>; Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 17–18 [75]–[77], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64873/0036%20Women%20and%20Babies%20Support%20(WOMBS).pdf>;

[2110] See below Part 22.

[2111] This point was also made to the NSW Legislative Council Committee. See, for example, Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 13–18, <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[2112] See also above [19.3.1]–[19.3.34].

of unreasonable and non-consensual denial of financial, social or personal autonomy amounting to domestic abuse, but makes no reference to 'reproductive autonomy'.[2113]

19.4.4 Professor Heather Douglas and Katherine Kerr, leading authorities in this area, argue 'while sexual abuse is increasingly well recognised as a form of domestic and family violence in Australian legal responses, the recognition and response to reproductive coercion is understudied and under-recognised'.[2114]

19.4.5 Douglas and Kerr note that most of the behaviours associated with reproductive coercion could fall within the South Australian definition of 'domestic abuse' as 'an unreasonable and non-consensual denial of financial, social or personal autonomy'.[2115] However, it is suggested that civil protection orders and Australian family law does not effectively respond to this form of abuse 'because of a lack of knowledge about reproductive coercion among police, lawyers and judicial officers'.[2116] Douglas and Kerr attribute the lack of judicial comment about reproductive coercion to the rarity of occasions where it has been raised.[2117]

19.4.6 Professor Douglas suggested to SALRI that the definition of 'domestic abuse' in South Australia's *Intervention Orders (Prevention of Abuse) Act 2009* should be brought into closer alignment with the Commonwealth *Family Law Act 1975*[2118] and Queensland's *Domestic and Family Violence Protection Act*.[2119] These definitions reflect recommendations of the ALRC.

19.4.7 In their joint report on Legal Responses to Domestic and Family Violence, the ALRC and the NSW Law Reform Commission recommended that a common definition of domestic abuse should be established in Australia that recognises examples of the coercive and controlling behaviour that are integral to DFV.[2120] Specifically, Recommendation 5–1 states:

> State and Territory family violence legislation should provide that family violence is violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes that family member to be fearful.[2121]

[2113] *Intervention Orders (Prevention of Abuse) Act 2009* (SA) s 8(5).

[2114] Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341, 341.

[2115] Ibid 346: See *Intervention Orders (Prevention of Abuse) Act 2009* (SA) s 8(2)(c).

[2116] Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341, 345.

[2117] However, see *Ahmed v Jeret* [2016] FamCA 442, where Rees J accepted that the behaviour of a man attending his wife's property and demanding that she have an abortion while calling her a 'bitch' and a 'slut' constituted family violence. See also *Lee v Hutton* [2013] FamCA 745 where, although the judge accepted there was pressure placed on the female partner to have an abortion, there was no allegation of family violence.

[2118] See *Family Law Act 1975* (Cth) s 4AB(1). For the purposes of this Act, *family violence* means violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the *family member*), or causes the family member to be fearful.

[2119] See *Domestic and Family Violence Protection Act 2012* (Qld) s 8(1):

> *Domestic violence* means behaviour by a person (the *first person*) towards another person (the *second person*) with whom the first person is in a relevant relationship that—
>
> (e) is coercive; or
>
> (f) in any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

[2120] Australian Law Reform Commission and New South Wales Law Reform Commission, *Family Violence: A National Legal Response* (Final Report No 114, 2010) 17, 19, 234.

[2121] Ibid 246.

19.4.8 Recognising that in most cases, reproductive coercion may be part of a broader pattern of coercive control, Douglas and Kerr argue that recognition of reproductive coercion in the context of civil protection orders and family law applications may have important ramifications for abused women and may help to contribute to their safety.[2122] They state:

> Experiences of reproductive coercion should not be treated as an indirect consequence of other forms of DFV. Rather it should be clearly identified and recognised as a specific behaviour associated with the coercive control that underpins DFV. The recognition of reproductive coercion in DFV screening tools used in health settings and DFV system responses, including by police, prosecutors and lawyers, is important so that this form of DFV is recognised and responded to.[2123]

19.4.9 It is also suggested that 'explicit recognition of reproductive coercion by police, prosecutors, lawyers and judicial officers as DFV may also have an important educative function for abusers'.[2124]

19.4.10 SALRI supports amending the definition of 'domestic abuse' to include coercive and controlling behaviour, bringing it into closer alignment with the recommendations of the ALRC. SALRI, in particular, accepts the premise advanced by parties such as Advocates International and Professor Douglas and acknowledges that reproductive coercion is a form of family violence and recommends that 'reproductive coercion' should be identified as an example of coercive and controlling behaviour, or otherwise explicitly included in the definition of family violence in s 8 of the *Intervention Orders (Prevention of Abuse) Act 2009* (SA).

19.5 SALRI's Observations and Conclusions

19.5.1 SALRI reiterates its view that a specific legislative provision to incorporate the need for informed consent to an abortion is unnecessary given this is already an integral aspect of health law and practice to any medical procedure in South Australia under both statute and the common law. SALRI also agrees with the VLRC and QLRC and considers that no incidental changes are necessary in South Australia to the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity or consent to medical treatment for minors.[2125]

19.5.2 SALRI also reiterates its view that any new law in South Australia relating to abortion should not include a new specific anti-coercion offence. Such an offence is not warranted at this stage.

19.5.3 SALRI notes the emerging research and the premise raised by parties both supportive and opposed to the decriminalisation of abortion and acknowledges that reproductive coercion (emphasising that this include both coercion to undergo and not undergo an abortion) is a form of domestic or family violence. SALRI therefore suggests that 'reproductive coercion' should be added to the definition of family violence in s 8 of the *Intervention Orders (Prevention of Abuse) Act 2009* (SA).

19.5.4 SALRI is of the view that no incidental changes are necessary in South Australia to the regulation of health practitioners, public hospitals and health services and licensed private health facilities.

[2122] Heather Douglas and Katherine Kerr, 'Domestic and Family Violence, Reproductive Coercion and the Role for Law' (2018) 26 *Journal of Law and Medicine* 341, 348.

[2123] Ibid 354.

[2124] Ibid 348.

[2125] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

19.5.5 Recommendations

Recommendation 57

SALRI recommends that any new law in South Australia relating to abortion should not include a new specific anti-coercion offence.

Recommendations 58

SALRI acknowledges that reproductive coercion is a form of family violence and recommends that 'reproductive coercion' should be added to the definition of family violence in s 8 of the *Intervention Orders (Prevention of Abuse) Act 2009* (SA) and/or elsewhere.

Recommendation 59

SALRI recommends that no incidental changes are necessary in South Australia to the laws that govern consent to medical treatment, substitute decision-making for adults with impaired capacity, consent to medical treatment for minors or the regulation of health practitioners, public hospitals and health services and licensed private health facilities.

Part 20 - Data Collection and Use

20.1 Data Collection in South Australia

20.1.1 Present law and practice in South Australia requires abortion notifications to be reported to the Department for Health and Wellbeing. Where a medical or surgical procedure is performed, the medical practitioner must provide a certificate and notice in the prescribed form[2126] to the Chief Executive of the Department.[2127]

20.1.2 Through this process, a significant amount of data concerning abortions in South Australia is collected. Indeed, this source dates back to 1969. The information to be reported includes where and when the abortion occurred, the reason for the procedure, the gestation of the pregnancy, the method of abortion and general patient characteristics, including the patient's name, date of birth and place of residence.[2128]

20.1.3 Data regarding Aboriginal and Torres Strait Islander identification is not currently collected. SALRI notes that members of Aboriginal communities and Aboriginal health providers it consulted support this data being collected if other changes were made to the scope of the requirements.

20.1.4 In addition, the Chief Executive Officer of a prescribed hospital at which abortions are performed must notify the Chief Executive of the Department of the number of abortions undertaken at the hospital and by each medical practitioner during each calendar month.[2129]

20.1.5 In South Australia, failure to comply with these notification requirements is an offence and is punishable by a penalty of up to $200.[2130] SALRI is unaware of any prosecution for such an offence.

20.1.6 The South Australian Abortion Registry was established along with the introduction of abortion legislation in 1969, and has been continuously collecting information since then. This dataset is widely considered to be unique to South Australia both within Australia and internationally. The data on the incidence of abortions is published online annually by SA Health and accessible to the general public along with other pregnancy outcome statistics.[2131] This data is widely (though not universally) seen to be of considerable benefit for research and health planning.

20.1.7 The Department of Health and Wellbeing in their submission to SALRI advocated for the retention of the Abortion Registry as it collects a range of data not ascertainable from other systems and is used to monitor trends and complications, provide insight into reducing teen abortions and assess equitable access.

[2126] See below Appendix N.

[2127] *CLCA* s 82A(4)(b)*; Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 4, sch 1.

[2128] Ibid.

[2129] *CLCA* s 82A(4)(b); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 5, sch 2.

[2130] *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) reg 8.

[2131] See Pregnancy Outcome (Statistics) Unit, 'Pregnancy Outcome Statistics', *SA Health* (Web Page, 21 July 2019) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public%20content/sa%20health%20internet/about%20us/health%20statistics/pregnancy%20outcome%20statistics/pregnancy%20outcome%20statistics>.

20.1.8 South Australia remains one of two Australian States that collects and publishes abortion data, the other being Western Australia.[2132] While a requirement to collect abortion data was introduced in the Northern Territory in 2017, this data has not been made available to the public.[2133]

20.1.9 The abortion notifications received in South Australia also inform the South Australian Birth Defects Register. It is estimated that Birth Defects Registers which do not include data related to abortions currently underestimate ascertainment by up to 20%. It is anticipated that, with more accurate and accessible prenatal screening for genetic disorders at an early stage, intervention at an earlier stage of gestation is likely to result in an associated increase in abortions (which may otherwise have occurred late term). Additionally, if this data is not accurately recorded, ascertainment of birth defects in South Australia may further decrease.[2134]

20.2 Expanding the Role and Use of Data

20.2.1 Data collection is provided for under the *CLCA*,[2135] and as such the current use of the data is limited. It has been raised in SALRI's consultation that moving the regulation of abortion to the *Health Care Act 2008* (SA) or equivalent may provide an opportunity to expand the permitted uses of the dataset, for example to inform and improve service planning and contribute to research.[2136] It has also been raised whether there could be some form of retrospective use, to allow SA Health to use the data collected since 1969 for these purposes.

20.2.2 Parties in favour of expanding the role and use of the data referred to the dataset's value for capturing and assessing teenage pregnancy rates, demographic trends, congenital anomaly rates and epidemiological data. One respondent to SALRI's online consultation commented:

> The main purpose of data collection must be to identify gaps in education on sexual and reproductive issues. Data must be able to capture geographic and ethnographic issues. Doing this can seem intrusive so the purpose must be clear.

20.2.3 Attendees at the 7 June 2019 roundtable with the medical and legal sectors also highlighted the dataset's potential value in informing health policy, service planning, and resource allocation. The benefits of reporting data to support family planning and determine service needs was also raised. One party emphasised that 'the data currently captured is crucial for planning for the next 20 years and to anticipate where the services are successful and where they are not'.

[2132] *Health (Miscellaneous Provisions) Act 1911* (WA) s 335. See also Department of Health, 'Reports on Induced Abortions in Western Australia', *Government of Western Australia* (Web Page, 2018) <http://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia>.

[2133] *Termination of Pregnancy Law Reform Act 2017* (NT) s 17; *Termination of Pregnancy Law Reform Regulations 2017* (NT) regs 8, 10. The information must be provided in the approved form within the prescribed time, namely: for a termination by surgical procedure or by a combination of both a surgical procedure and use of a termination drug, within 28 days after the termination is performed; for a termination by the use of a termination drug or by a means other than a surgical procedure or the use of a termination drug, within 28 days after the practitioner's last consultation with the woman in relation to the termination: *Termination of Pregnancy Law Reform Regulations 2017* (NT) reg 9.

[2134] The Department of Health and Wellbeing raised this point.

[2135] See *CLCA* s 81A(4); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA).

[2136] The Department of Health and Wellbeing Submission notably raised this point.

20.2.4 It was also noted to SALRI that the notification form provided to the Department for Health and Wellbeing is drafted to comply with legislative requirements,[2137] and not all the information is required or sought by SA Health for planning and data analysis.

20.3 Submissions

20.3.1 The value of the data collected by SA Health relating to abortions in South Australia was recognised by a number of parties in SALRI's consultation both supportive and opposed to the decriminalisation of abortion. Parties such as the Australian College of Midwives, RANZCOG, the Right to Life Association of South Australia and Cherish Life Australia highlighted the value of the data. There was broad agreement in favour of data collection continuing.

20.3.2 The Department for Health and Wellbeing submitted that the Abortion Registry provides the important function of collecting a range of data that is not ascertained from any other system.[2138] It was explained that Abortion Registry data is used to monitor trends and complications and assess equitable access, for example for rural women.[2139] The benefit of having a comparable historic dataset and a dataset following any legislative reform to monitor trends and access has also been highlighted to SALRI. It was noted as useful to capture demographic trends and epidemiological data. One party said: 'Hard data is important for analysis and progress.' A survey respondent noted: 'Without data, appropriate service provision and funding allocation cannot happen.' Another response noted it may provide insight into risks and prevention of unwanted pregnancies and can also provide information on areas of need and resource allocation.

20.3.3 The Northern Territory Family Planning Welfare Association noted that South Australian de-identified data has proved 'extremely helpful to health policy, researchers, advocates and managers of health systems' and without this data 'we would not understand how access to services is working'.

20.3.4 The Port Lincoln health practitioners strongly supported the ongoing collection of data and the expansion of its use for planning purposes, as with data about any other procedure. They did, however, object to the onerous monthly reporting requirements of the current reporting forms and encouraged a streamlined approach to reporting in accordance with other procedures undertaken.

20.3.5 Groups opposed to the decriminalisation of abortion also supported the collection of data. Genesis Pregnancy Support Inc, for example, stated that as a 'pregnancy support service we have found the data … invaluable' and it is informative about the reasons for abortions and age-related statistics. The data 'is particularly valuable in relation to teens. It provides essential information about methods and risk factors and we have often used the figures provided for research purposes.'

20.3.6 The Lutheran Church also supported the comprehensive collection of data as a matter of good governance and ensures best practice. 'Significant complications should be reported to all women's healthcare practitioners to improve the accuracy of advice in pre-abortion counselling and consent taking.' It suggested the following data be reported to an official registry: the annual number of abortions; the type of procedure used; complications that arise (both early and late); the clinicians overseeing and performing abortions; the locations or facilities at which abortions take place; the age and ethnic group of the women undergoing abortions; the residential region of the women undergoing

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[2137] *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) sch 1.

[2138] The submission from the Department for Health and Wellbeing provides a unique perspective as both the legislated governing body that collects and analyses abortion statistics through the South Australian Abortion Registry, and as the data custodian for the South Australian Abortion statistics collection.

[2139] Ibid.

abortions; each woman's number of previous live births and previous abortions; the gestation at which women are undergoing abortions and (contentiously) the reported reason for choosing abortion over parenting or adoption and whether contraception was being used at the time.

20.3.7 The importance of maintaining abortion notification for the purpose of informing South Australia's Birth Defects Register was also raised. One party submitted:

> Birth Defect Registers that do not include abortion data underestimate ascertainment by up to 20% and this would affect South Australia's capability to assess teratogenic exposures. Further, given the increasing availability of more accurate prenatal screening for genetic disorders (Harmony test in first trimester), early term abortions for genetic disorders may increase. This will further reduce ascertainment of birth defects in South Australia.[2140]

20.3.8 The Australian Christian Lobby expressed its support with the position held by RANZCOG:

> In order to better understand the individual and public health impacts of termination of pregnancy, the College supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.[2141]

20.3.9 Over two-thirds of respondents to SALRI's YourSAy survey supported data about abortions in South Australia continuing to be collected and reportable. However, many of these respondents indicated that data should only be reportable if de-identified or collected with the consent of the patient. SALRI's various roundtables also expressed namely broad support for the value of data but also concerns over privacy and treating abortion related data any differently to any other health data. It was also advanced that any data should only be reportable if de-identified or collected with the consent of the patient.

20.3.10 There were similar misgivings elsewhere. Concerns about data collection and access to private information was raised by some parties in SALRI's consultation. The Australian Women's Health Network described the current collection of abortion related data in South Australia as 'a gross invasion of women's privacy and should cease'. One respondent to SALRI's online survey commented 'people have a right to privacy around their reproduction'. Another respondent suggested 'as this is a stigmatised choice, there should be an option, not a requirement to have the procedure reportable'. Another response noted: 'Data should be gathered and used only with the consent of the individual accessing the service and anonymity must be guaranteed.' The Coalition of Women's Domestic Violence Services SA agreed with the collection and use of data 'but only if the data is de-identified and preserves the privacy and human rights of people whose data is being reported'. This view was repeated at SALRI's roundtable with the disability sector. The South Australian Council for Civil Liberties accepted the collection of data but only to accord with other medical procedures and depersonalised data gathered in such a manner as would be appropriate and necessary for the planning of services and stated that there are no grounds for any special laws requiring additional data as presently exist.

20.3.11 The Southgate Institute noted that current regulations governing the mandatory data collection in South Australia include very tight restrictions on the use of the data 'that render it

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[2140] Ibid.

[2141] Australian Christian Lobby, Submission to the South Australian Law Reform Institute, *The ACL's Submission to SALRI's Review of South Australian Abortion Law* (31 May 2019); Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Abortion' (RANZCOG Statements and Guidelines, March 2019) 4 [4.5] <https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Abortion-(C-Gyn-17)Review-March-2019.pdf?ext=.pdf>.

practically inaccessible to all but the reporting committee'. They commented that the present collection of the data compromises privacy rights normally enjoyed by health care recipients; and collection is burdensome for providers of care. They considered that the introduction of particular requirements into Regulations 'is not advisable and may encumber useful future developments'.

20.3.12 Similar concerns regarding privacy were raised to suggestions to allow the retrospective use of data already collected. One party noted: 'The reason why we shouldn't make some special provision for this dataset to be retrospectively used is that it wasn't collected with the woman's consent.'

20.3.13 However, it has been raised in SALRI's consultation with SA Health that patient names do not need to be collected, and consideration could be given to a de-identified Abortion Registry. SA Health are interested in collecting and reporting on age, postcodes, practitioners, and congenital anomalies. It was also explained that SA Health have limited allowance for using the data collected, and sufficient safeguards are in place to ensure identified information cannot be released under the *Health Care Act* unless there is a strong reason to do so.

20.3.14 It addition, it was noted by a number of parties to SALRI's consultation that data is currently collected on all medical procedures and medication dispensing on both a national and state level. Collection and reporting does not require patient consent. One respondent commented: 'Data on all medical procedures performed under Medicare funding is already collected. This does not change with the altered legal status of abortion.'

20.3.15 Another survey respondent suggested that data collection and reporting is also useful to refute misinformation.

20.3.16 A number of parties held the position that abortion data should not be treated any differently to other health data. A leading health provider was 'clear that we don't wish for abortion data to be handled any differently to other health data and certainly not reported on specifically in parliament, but that data collection is important for service planning'.

20.4 SALRI's Observations and Conclusions

20.4.1 SALRI appreciates the concerns that have been raised but acknowledges the value of the data previously collected by SA Health relating to abortions in South Australia and recommends that the collection of data should continue, with a number of changes implemented, including:

- names and addresses of patients should not be collected;
- Identification of Aboriginality should be collected;

20.4.2 Data collection should be permitted in either hard copy or electronic form (as directed by SA Health) and should not require signatures of health practitioners involved in the procedure (this will allow the data to be reported to SA Health by administration staff where appropriate); and

- Use of data should follow the same manner, and the same ethical and legal approval, as all other data sets collected by SA Health (and any other relevant agency).

20.4.3 In addition, SALRI notes the value of the historical data collected by SA Health and recommends that any historical data prior to any legislative changes should be de-identified and thereby

permitted to be used[2142] in the same manner, and with the same ethical and legal approval, as other data sets held by SA Health.

20.4.4 SALRI notes that with any repeal or reconsideration of the current data provision, the existing requirement of an annual Report to Parliament is now otiose. However, such data is widely perceived to be of value and therefore should continue to be made publicly available in a suitable manner through SA Health or the appropriate agency.

20.4.5 Recommendations

Recommendation 60

SALRI acknowledges the value of the data previously collected by SA Health relating to abortions in South Australia and recommends the collection of data continue with the following changes:

a. Data collected must not include names and addresses of patients;
b. Identification of Aboriginality should be collected;
c. Collection of data should be permitted to occur in either hard copy or electronic form as directed by SA Health and should not require signatures of health practitioners involved in the procedure, so as to allow the data to be reported to SA Health by administration staff where appropriate; and
d. Data should be able to be utilised in the same manner, and with the same ethical and legal approval, as all other data sets collected by SA Health or other relevant agency.

Recommendation 61

SALRI recommends that historical data collected by SA Health prior to any legislative changes be de-identified and permitted to be used in the same manner, and with the same ethical and legal approval, as other data sets held by SA Health. SALRI further recommends that the Annual Report to Parliament should be discontinued and replaced with such annual data to be made public in an appropriate manner.

[2142] SALRI acknowledges the concerns raised by some parties in its consultation in relation to the use of historical data collected without a patient's explicit consent. However, the benefit of the comparison over time, with regard to the prevalence of abortion procedures and reasons for the procedures (including identified fetal abnormalities), is considered by SALRI to be sufficient to outweigh this concern.

Part 21 - Incidental

21.1 Use of Gendered Terms

21.1.1 The Department of Health and Wellbeing in its submission to SALRI pointed out the need to update the terminology in the law to accord with contemporary values and practice. It noted that the language used throughout the *CLCA* and the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* is 'outdated and requires amendment'. The Department of Health and Wellbeing noted such examples as references to medical practitioners being male (use of 'he'); use of 'with child' instead of 'pregnant', the use of 'physical or mental abnormalities as to be seriously handicapped' instead of 'seriously disabled' (if such descriptions remain in any new law)[2143] and the use of 'Medical Board of South Australia' instead of 'Australian Health Practitioner Regulation Agency'.

21.1.2 SALRI agrees that any new law presents a timely opportunity to make such amendments as well any other incidental or consequential amendments.

21.1.3 A particular point raised in consultation concerned the use of 'woman' in the law in relation to abortion. SALRI, as part of its reference into discrimination on the grounds of sexual orientation, gender, gender identity and intersex status, recommended the removal or replacement of unnecessarily gendered terms in Acts or Regulations.[2144] This included removal of the following provision:

> *Criminal Law Consolidation Act 1935* (SA), Part 3, Division 17 (abortion - remove reference to 'females' who are pregnant).[2145]

21.1.4 The removal of this provision was initially included in the Statutes Amendment (Gender Identity and Equity) Bill 2016 but objections were raised during debate in State Parliament[2146] and this provision was ultimately defeated and removed from the Bill.[2147]

21.1.5 During consultation on this abortion reference, a number of submissions from parties such as Dr Damien Riggs at Flinders University and the Equal Opportunity Commissioner, raised concerns regarding the use of gendered terms and the need to ensure that any person who can become pregnant is covered within the law relating to abortion. Dr Riggs also raised various practical issues regarding inclusive practices for transgender people.[2148] Dr Sarah Moulds also made these points.

[2143] See also above [13.2.3].

[2144] South Australian Law Reform Institute, *Discrimination on the Grounds of Sexual Orientation, Gender, Gender Identity and Intersex Status in South Australian Legislation* (Audit Paper, September 2015).

[2145] Ibid 40 [1.4].

[2146] South Australia, *Parliamentary Debates*, 24 February 2016, House of Assembly, 4432 (Ms V Chapman); South Australia, *Parliamentary Debates*, House of Assembly, 9 March 2016, 4627–4628; 4660–4668.

[2147] South Australia, *Parliamentary Debates*, House of Assembly, 9 March 2016, 4667–4668. The provision was described as 'completely absurd', at 4661 (Mr Pengilly) and 'political correctness gone mad' and 'more useless crap we don't need', at 4662 (Mr Pederick). One MP explained: 'it is an objective truth that only women can give birth, and that is just how it is. I am no more erudite than that: that it is, and that is the case... The reason I will be opposing this clause is that I think they are so closely intertwined and it is not possible for a man to give birth. Given that it is not possible for a man to give birth, there is no point in changing it' at 4661 (Mr Kenyon).

[2148] SALRI notes its previous definition of trans as '**Trans**: is a general term for a person whose gender identity is different to their sex at birth': South Australian Law Reform Institute, *LGBTIQ Discrimination in Legislation: Legal Registration of Sex and Gender and Laws Relating to Sex and Gender Reassignment* (Report No 5, February 2016) 16 [30]. See further Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation Gender Identity and Intersex*

21.1.6 The South Australian Rainbow Advocacy Alliance highlighted that trans-men, gender queer and other gender diverse people who do not identify as women can become pregnant. 'From SARAA's perspective, it is important that if any legislative reforms occur they must acknowledge this and they need to be inclusive in their language.'

21.1.7 Associate Professor Barbara Baird at Flinders University noted: 'People who do not identify as women may also need access to abortion care and they may face discrimination and compromised access to health care across many domains.'

21.1.8 A sexual health counsellor also pointed out to SALRI the needs of gender diverse persons, commenting: 'Transgender men, trans masculine people and non-binary people can also be pregnant and need vital health services. Leaving these group out of the conversation and without acknowledgement is not OK.'

21.1.9 A considerable number of survey respondents also raised the need for more inclusive language to ensure the inclusion of transgender men and non-binary and gender diverse people. One response noted that the relevant laws 'should be changed to gender neutral pronouns as to not exclude transgender people'. Another said: 'Laws protecting cisgender women should also protect transgender and gender diverse people seeking abortions.'

21.1.10 One survey response commented:

> As many transgender men have uteruses and retain the ability to become pregnant, laws relating to pregnancy and abortion should endeavour to use gender neutral language when referring to the pregnant party to ensure the inclusivity of all rights and protections.

21.1.11 Some misgivings were expressed as to changing the terminology. It was said that only a woman can have a child. These misgivings were also expressed in relation to the 2019 NSW Act (though the 2019 NSW Act refers to a 'person'). Women's Forum Australia, for example, told the NSW Legislative Council Committee:

> It is deeply concerning that… the term 'woman' has been erased and replaced with the term 'person', denying that it is women who are uniquely impacted by pregnancy and abortion and absurdly suggesting that men could be pregnant. Tran-men of course can access abortion but they remain biologically female.[2149]

21.1.12 Women's Bioethics Alliance similarly objected to the NSW Legislative Council Committee to discarding the term 'woman':

> We object to the use of the term 'person' rather than 'woman' throughout the Bill. While trans-men may also access abortion, they remain biologically female. This Bill is meant to be about women's health, so it must refer to women otherwise it contributes to women erasure.[2150]

Rights (National Consultation Report, 2015) <http://www.humanrights.gov.au/sites/default/files/document/publication/SOGII%20Rights%20Report%202015_Web_Version.pdf >.

[2149] Women's Forum Australia, Submission No 46 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (15 August 2019) 33 [152], <https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf>.

[2150] Women's Bioethics Alliance, Submission No 49 to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Inquiry into the Reproductive Health Care Reform Bill 2019* (19 August 2019) <https://www.parliament.nsw.gov.au/lcdocs/submissions/64931/0049%20Women%27s%20Bioethics%20Alliance%20ORIGINAL.pdf>.

21.1.13 SALRI, consistent with its previous reasoning, recommends that gendered terms such as 'woman' in the present law should be replaced.[2151] This recommendation is not based on any ideal of political correctness but rather reflects sound modern drafting principles and provides recognition of diverse situations which can arise. SALRI notes that the 2019 NSW Act uses the term 'person' rather than woman'.[2152] SALRI agrees with this approach.

21.2 Child Concealment

21.2.1 The offence in South Australia of concealment of birth prohibits the secret disposal of the dead body of a child in order to conceal knowledge of that child's birth.[2153] The offence carries a maximum penalty of three years imprisonment. Similar offences exist in other Australian jurisdictions[2154] and England.[2155]

21.2.2 The gist of the offence requires a 'secret disposition' of a child's body and some form of concealment.[2156] It would be an offence to leave a child's body in a secluded place such as 'on the top of a mountain' but not in a street.[2157] The disposition must be of a dead body[2158] (though it is irrelevant if the child was born dead or alive).[2159] The offence does not extend to any case of concealment of the body of a child born or aborted in the early stages of pregnancy. The child must have 'a fair chance of life when born'.[2160]

21.2.3 The offence dates back to a 1624 English statute, *An Act to Prevent the Destroying and Murthering* [sic] *of Bastard Children*. The present offence is said to be closely connected to newborn infant homicide and defendants are often suspected of being responsible for a child's death.[2161] While the offence can be committed by anyone, the defendant is most often the birth mother. The offence of concealment of birth 'has been used as a means to prosecute women when homicide is suspected, but cannot be proven'.[2162] The Model Criminal Code Officers Committee noted that in its modern form, 'the primary purpose of the offence is to enable conviction of a lesser offence in circumstances where murder, manslaughter or infanticide are suspected but impossible of proof.'[2163]

[2151] See also South Australian Law Reform Institute, *Discrimination on the Grounds of Sexual Orientation, Gender, Gender Identity and Intersex Status in South Australian Legislation* (Audit Paper, September 2015) 40 [1.4]. See further above i.

[2152] An effort to amend the Bill in the Legislative Council to change 'person' to 'woman' was unsuccessful. See New South Wales, *Parliamentary Debates*, 17 September 2019, Legislative Council, 37–42.

[2153] 'Any person who, by any secret disposition of the dead body of a child, whether the child died before, at or after its birth, endeavours to conceal the birth of the child shall be guilty of an offence and liable to be imprisoned for a term not exceeding three years': *CLCA* s 83.

[2154] *Crimes Act 1900* (ACT) s 47, *Crimes Act 1900* (NSW) s 85(1), *Criminal Code Act 1983* (NT) s 171, *Criminal Code Act 1913* (WA) s 291, *Criminal Code Act* (Qld) s 314, *Criminal Code Act* (Tas) s166(1), *Crimes Act 1958* (Vic) s 67.

[2155] *Offences Against the Person Act 1861* (UK) s 60.

[2156] *R v Denham* (1843) 1 Cox CC 56; *R v Rosenberg* (1906) 70 JP 264.

[2157] *R v Clark* (1983) 15 Cox CC 171; *R v Narden* (1873) 12 SCR (NSW) 160.

[2158] *R v Turner* (1846) 173 ER 704.

[2159] *R v Donoghue* [1914] VLR 195.

[2160] *R v Berriman* (1854) 6 Cox CC 388. This expression is supplemented in some jurisdictions. Section 85(2) of the *Crimes Act 1900* (NSW) and s 47(2) of the *Crimes Act 1900* (ACT) provide that it is a defence if the child was born before the 28 week stage of the pregnancy.

[2161] Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Lawbook Co, 2nd ed, 2005) 499 [7.3].

[2162] Analysis of contemporary use of the offence would suggest that prosecutors continue to use concealment for this purpose,

[2163] Model Criminal Code Officers Committee, *Chapter 5: Fatal Offences against the Person* (Discussion Paper, 1998) 195.

21.2.4 The offence was a staple of the 19th century and juries proved reluctant to convict mothers of the murder of their new born (often illegitimate) children but more willing to return a guilty verdict on the lesser alternative offence[2164] of concealment of birth.[2165] The offence is now rarely prosecuted[2166] with only four convictions in England between 2010 and 2014,[2167] and since 2002 only one offender in England received an immediate custodial sentence.[2168]

21.2.5 The offence of child concealment was raised in SALRI's consultation. There was criticism of this offence. Dr Barbara Baird stated it 'is the time to remove this archaic law from the *CLCA*'. This offence has been criticised.[2169] There have been calls for its abolition.[2170]

21.2.6 Professor Sheldon of the University of Kent cogently argued to SALRI that the offence is outdated and should be discarded.

> Something I will mention is the offence of concealment of birth. It's not something that anyone ever thinks of and I honestly don't know if it's still prosecuted in South Australia, but it is prosecuted here [in the UK] occasionally… It is an offence which is solely about policing women's extra-marital activity, and policing extra-marital sex, and it has been prosecuted where prosecutors think a woman has either self-terminated a late pregnancy or killed a newborn child and they can't prove that, so they get to prosecute her because of concealment of birth instead. From a criminal law perspective, I don't think that is very good, because it's like, we think this woman has done something really bad but we can't prove it so let's just prosecute her for this lesser thing. The idea is that there is an independent moral wrong in concealing your birth is ludicrous, and there are public health arguments to say that, someone has tried to dispose of the body of this neo-nate fetus, there might be public health arguments about, you want to be able to prosecute that, but we can already do that under [inaudible] law, so there is no real independent point in having that offence. But it's an offence… it's a really horrible, messy, archaic, anachronistic piece of legislation — the language is archaic, there's overlapping offences, the sentencing is inconsistent — all the things we think is wrong with abortion offences — If it is actually getting prosecuted in South Australia, it would be a missed opportunity in this reform process to not look at it, because I don't see where the impetus for reform will come about otherwise.

21.2.7 One recent commentator concludes:

[2164] Concealment of birth remains an alternative verdict to both murder and manslaughter in South Australia. See *CLCA* s 83 (2).

[2165] See, for example, Constance Backhouse, 'Desperate Women and Compassionate Courts: Infanticide in 19th Century Canada' (1984) 34 *University of Toronto Law Journal* 447, Mary Emmerichs, 'Trials of Women for Homicide in 19th Century England' (1993) 5 *Women and Criminal Justice* 99, 99–109; Martin Wiener, *Reconstructing the Criminal: Culture, Law and Policy in England* (Cambridge University Press, 1990) 81.

[2166] *R v Jacobs* [1932] SASR 456. SALRI has been unable to find any recent cases of its use but such a case may be heard in the Magistrates Court and therefore not publicly available.

[2167] Emma Milne, 'Suspicious Perinatal Death and the Law: Criminalising Mothers Who Do Not Conform' (PhD Thesis, University of Essex, 2017) Emma Milne, 'Concealment of Birth: Time to Repeal a 200 Year Old "Convenient Stop Gap"?' (2019) 27(2) Feminist Legal Studies 139, 140.

[2168] Emma Milne, 'Concealment of Birth: Time to Repeal a 200 Year Old "Convenient Stop Gap"?' (2019) 27(2) *Feminist Legal Studies* 139, 140.

[2169] See, for example, Emma Milne, 'Concealment of Birth: Time to Repeal a 200 Year Old "Convenient Stop Gap"?' (2019) 27(2) *Feminist Legal Studies* 139; Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation (2016) 36 *Oxford Journal of Legal Studies* 334–365.

[2170] Model Criminal Code Officers Committee, *Chapter 5: Fatal Offences against the Person* (Discussion Paper, 1998) 196; Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Lawbook Co, 2nd ed, 2005) 500 [7.3]; Emma Milne, 'Concealment of Birth: Time to Repeal a 200 Year Old "Convenient Stop Gap"?' (2019) 27(2) *Feminist Legal Studies* 139, 158–159.

> Considering the gendered injustice of concealment… and that other offences exist to capture the wrongs of the behaviour, I conclude that there is no place for the offence of concealment, and it should be removed from criminal law. The statute is an archaic provision; a product of the nineteenth century, reflecting the values of that time in relation to women's sexuality and their positions as mothers and wives, specifically as pregnant single women. Analysis of recent cases illustrates that the offence continues to be used in line with misogynistic expectations of women's behaviours in relation to motherhood and pregnancy.[2171]

21.2.8 The 2018 South Australian Bill proposes to repeal this offence.

21.2.9 SALRI accepts the apparent cogency of the criticisms expressed of the offence of child concealment but notes that it has not had the benefit of detailed submissions on the rationale of any continued role or retention of this offence such as from the Director of Public Prosecutions, the police or the child protection sector. The offence is rarely charged but its prosecution is far from unknown.[2172] Any decision to discard this offence is beyond the scope of this reference and requires detailed input to take into consideration whether the offence has any continued public benefit.[2173]

21.3 Consequential Amendment to 'Harm and Serious Harm'?

21.3.1 One issue raised to SALRI was in relation to the criminal law and the situation where a woman is assaulted or subject to another offence that results in harm or even the loss of a fetus.

21.3.2 The VLRC recommended that s 5 of the *Crimes Act 1958* (Vic) should be amended to make the following addition to the definition of 'serious injury': 'Serious injury includes: the destruction (other than in the course of a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers any other harm.'[2174] The VLRC explained that it is also likely that a Victorian court would take a similar approach to that in *King*,[2175] and find that the fetus was part of the mother, allowing a serious injury or harm charge in relation to the mother to be preferred. The VLRC believed that, rather than await judicial clarification, 'the clearest and safest way forward is to amend the statutory definition of "serious injury" in the *Crimes Act*'.[2176]

21.3.3 One view presented to SALRI was that no change to the law in this context was necessary. One submission commented: 'A fetus does not have rights. A pregnant woman has rights. If her pregnancy is ended via assault, there are already offences in place that the perpetrator can be charged

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[2171] Emma Milne, 'Concealment of Birth: Time to Repeal a 200 Year Old "Convenient Stop Gap"?' (2019) 27(2) *Feminist Legal Studies* 139, 159.

[2172] Amanda Gardiner, 'What is the Charge of Concealment of Birth and why is it still happening in Australia?', *The Conversation* (online, 20 September 2019) <https://theconversation.com/what-is-the-charge-of-concealment-of-birth-and-why-is-it-still-happening-in-australia-122876>.

[2173] SALRI also notes that the expert Model Criminal Code Officers Committee only recommended the abolition of this offence by a 'narrow majority': Model Criminal Code Officers Committee, *Chapter 5: Fatal Offences against the Person* (Discussion Paper, 1998) 196.

[2174] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 109.

[2175] *R v King* (2003) 59 NSWLR 472. In this case an unplanned pregnancy resulted in a dispute between the man and the woman concerning an abortion. The woman decided against an abortion but, when 24 weeks pregnant, she was attacked by the man. He kicked and stomped on her stomach, killing the fetus, which was subsequently stillborn. The trial judge granted a permanent stay of proceedings on the charge of grievous bodily harm of the woman on the basis that the fetus was an organism separate to the woman and therefore the charge was 'doomed to failure'. The NSW DPP appealed the decision to stay proceedings. The Court of Criminal Appeal ruled that a violent act inflicted on a pregnant woman causing the stillbirth of the fetus constituted grievous bodily harm to the mother.

[2176] Ibid 107 [7.79].

with.' It was noted that assault causing harm, intentionally or recklessly causing harm and especially intentionally or recklessly causing serious harm would already apply in the situation of an assault on a pregnant woman that resulted in injury or the loss of the fetus (though crucially in the context of harm or serious harm to the pregnant woman). It was further noted that this is already the law.[2177] One lawyer said to SALRI that such a provision could serve as an unnecessary and unhelpful distraction.

21.3.4 A contrary view raised[2178] or urged the adoption in South Australia of an approach such as in New South Wales[2179] or Western Australia[2180] which recognises that 'harm' or 'grievous bodily harm' to a pregnant woman includes bodily harm to an unborn child, grievous bodily harm to the woman's unborn child and causing the loss of the woman's pregnancy. The Human Rights Law Centre suggested South Australia adopt this approach, but in the context of the 'law recognises that loss as a harm *to the woman* … so as to avoid creating any personhood rights in a fetus that could conflict with the rights of women'.

21.3.5 One party argued:

> This is a significant step forward in recognising in the criminal law of Western Australia that an assault on a pregnant woman that causes the death of an unborn child, or other bodily harm to the child, regardless of any other harm occasioned to the woman herself should be punishable by law … It is somewhat unsatisfactory to treat these offences, by a kind of legal fiction, as a species of bodily harm or grievous bodily harm to the mother of the unborn child rather than as, what they are in reality, direct harms to the unborn child as a separate individual human being… Nonetheless these new provisions are to be welcomed … the provisions go some way towards a just recognition of the real harm done when the life of an unborn child is taken by an unlawful act, such as an assault on a pregnant woman.

21.3.6 One submission argued (from a somewhat different perspective):

> I recognise that there might be circumstances in which a pregnant person loses a pregnancy due to a criminal act against her. In these cases, I believe any criminal provisions should recognise the harm caused to the woman, and not to the fetus — to avoid creating a situation where the rights of the fetus conflict with the rights of the woman. I'm aware that this has been achieved in NSW and Victoria by including the destruction of a fetus in the definition "grievous bodily harm" and "serious harm" in their respective criminal laws. I would strongly oppose any reform that gives rights to a fetus.[2181]

21.3.7 SALRI accepts that loss or injury to a fetus is not explicitly covered within s 21 of the *CLCA* as to either 'harm' or 'serious harm', but it is plain that such a situation would be covered within the existing South Australian provision. The loss or injury to a fetus would be likely to fall within either 'serious harm' or at least 'harm' to the mother. SALRI on this point disagrees with the approach of the VLRC. It appears unnecessary to clarify or amend the present law in this context.

[2177] *R v King* (2003) 59 NSWLR 472.

[2178] Mark Rankin of Flinders University, the Australian Women's Health Network and the South Australian Abortion Action Coalition raised this issue. Mr Rankin noted 'this may be viewed as a separate issue' to abortion.

[2179] Advocates International noted s 4 of the *Crimes Act 1900* (NSW) which defines 'grievous bodily harm' as including 'the destruction (other than in the course of a medical procedure) of the pre-born baby of a pregnant woman, whether or not the woman suffers any other harm'.

[2180] *Restraining Orders and Related Legislation Amendment (Family Violence) Act 2016* (WA).

[2181] Fair Agenda expressed a similar view but said 'it is critical that any harm attach to the offence against the pregnant person, not to the fetus, to avoid creating any personhood in a fetus that could conflict with the rights of a woman'.

21.3.8 Another incidental issue concerns the application or otherwise of the common law relating to abortion (including any lingering common law offences) in South Australia after the 1969 Act. Section 82A(9) states that all abortions are unlawful unless performed within the requirements of s 82A, even if the abortion would have been lawful at common law. This attempts to supersede and displace the common law. However, it is uncertain whether it has produced this effect.[2182]

21.3.9 One may assume that the 1969 Act repealed any common law offence but this may not be clear. The VLRC favoured the explicit repeal of any common law offences.[2183] It observed:

> It is strongly arguable that any common law offences in Victoria have been swept aside by the enactment of sections 10, 65 and 66 of the *Crimes Act*; however, it may be open to a judge to find that the common law offence was revived by the repeal of the *Crimes Act* provisions unless legislation made it clear that this was not the intention of Parliament. As there is so much uncertainty surrounding the scope of the old common law offence of procuring an abortion, it would be prudent to stipulate that it has been abolished and cannot be revived. The Commission has therefore included such a provision in each of its models for reform.[2184]

21.3.10 SALRI also notes the lingering doubts and uncertainty as to the continued operation of the common law, including any common law offences after the 1969 South Australian Act. SALRI agrees with the VLRC that, for the avoidance of any doubt, any lingering common law offences relating to abortion should be abolished.

21.4 SALRI's Observations and Conclusions

21.4.1 SALRI, consistent with its previous reasoning, recommends that gendered terms such as 'woman' in the present law should be replaced. This recommendation is not based on any ideal of political correctness but rather reflects sound modern drafting principles and provides recognition of diverse situations which can arise.

21.4.2 SALRI notes that the offence of child concealment in s 82 of the *CLCA* falls outside SALRI's terms of reference and suggests that this offence should be separately considered by the Attorney-General's Department in consultation with interested parties to examine whether the offence retains any continued public benefit or should be abolished.

21.4.3 SALRI recommends that no change is necessary to s 21 of the *CLCA* to cover the situation of the loss (other than in the course of a medical procedure) of the fetus of a pregnant woman,

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[2182] It is unclear whether the 1969 Act has displaced the common law. The South Australian Supreme Court has implied that the common law still applies in South Australia; see *R v Anderson* [l9731 5 SASR 256. Indeed, Bray CJ made the point that a jury should always be directed that the defence (as outlined in *R v Davidson* [1969] VR 667) had to be rebutted, whether or not the defence raised it, provided that there was an evidential basis for such a defence: See *R v Anderson* (l973) 5 SASR 256, 270. Bray CJ's comments should be contrasted with those of the English Court of Appeal in *R v Smith* [l973] 1 WLR 1510. In this case, the court held that s 5(2) of the *Abortion Act 1967* (UK) (the equivalent of s 82A(9) of the *Criminal Law Consolidation Act 1935* (SA)) meant that s l(1) 'supersedes and displaces the common law': [l973] 1 WLR 1510, 1512. See also Mark Rankin, 'Contemporary Australian Abortion Law: The Description of a Crime and the Negation of a Woman's Right to Abortion' (2001) 27 *Monash University Law Review* 229, 244 n 99.

[2183] Victorian Law Reform Commission, *Law of Abortion* (Report No 15, 2008) 7.

[2184] Ibid 25 [2.64].

whether or not the woman suffers any other harm, as the existing concepts and definitions of 'harm' or 'serious harm'[2185] to the woman would cover this situation.[2186]

21.4.4 Recommendations

Recommendation 62

SALRI recommends that gendered terms such as 'woman' in the present law should be replaced

Recommendation 63

SALRI notes that the offence of child concealment falls outside SALRI's terms of reference and recommends that the offence of child concealment in s 82 of the *Criminal Law Consolidation Act 1936* (SA) should be separately considered by the Attorney-General's Department in consultation with interested parties.

Recommendation 64

SALRI recommends that no change to the law in South Australia is necessary to the definition of 'harm' or 'serious harm' in s 21 of the *Criminal Law Consolidation Act 1936* (SA) to cover the situation of harm or the loss (other than in the course of a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers any other harm.

Recommendation 65

SALRI recommends that consequential amendments to other South Australian laws should be made where necessary and desirable in light of the repeal of ss 81, 82 and 82A of the *Criminal Law Consolidation Act 1936* and the potential introduction of the new offence in Recommendation 10 relating to the performance of an abortion by an unqualified person.

Recommendation 66

SALRI recommends that, for the avoidance of any doubt, any common law offence relating to abortion should be abolished.

[2185] 'Serious harm' means — (a) harm that endangers a person's life; or (b) harm that consists of, or results in, serious and protracted impairment of a physical or mental function; or (c) harm that consists of, or results in, serious disfigurement.

[2186] See also *R v King* (2003) 59 NSWLR 472.

Part 22 – *Abortion Law Reform Act 2019* (NSW)

22.1 Recent Developments

22.1.1 The Reproductive Health Care Reform Bill 2019 was introduced as a Private Member's Bill in the NSW Legislative Assembly on 1 August 2019 by Alex Greenwich MP, the Member for Sydney.[2187] Given its timing and that SALRI is required by both its usual premise[2188] and the Attorney-General's specific Term of Reference to look at interstate law and developments,[2189] the NSW Bill was of particular interest to SALRI.

22.1.2 Mr Greenwich explained that the Bill's rationale is 'that the best outcomes in women's reproductive health care are achieved when abortion is treated as a health matter, not a criminal matter, and a woman's right to privacy and autonomy in decisions about their care is protected'.[2190] He noted that the criminal law surrounding abortion is an unsatisfactory 'grey area' and is 'no longer fit for purpose and needs to be modernised'.[2191] Mr Greenwich elaborated:

> … it stigmatises women and it reduces their healthcare options, with the biggest impact being on women in rural and regional areas and women affected by physical or sexual violence. The law does not treat women with dignity or trust them to make decisions about their bodies, their life and their health care. This reform is long overdue; now is the time to decriminalise abortion in our law and give clarity to the medical profession, women and the wider community.[2192]

22.1.3 The explanatory memorandum to the Bill cited its objects as follows:

> (a) to enable a termination of a pregnancy to be performed by a medical practitioner on a person who is not more than 22 weeks pregnant,
>
> (b) to enable a termination of a pregnancy to be performed by a medical practitioner on a person who is more than 22 weeks pregnant in certain circumstances,
>
> (c) to identify certain registered health practitioners who may assist in the performance of a termination,
>
> (d) to require a registered health practitioner who has a conscientious objection to the performance of a termination on a person to disclose the objection and refer the person to another practitioner who does not have a conscientious objection,
>
> (e) to repeal offences relating to abortion in the *Crimes Act 1900* and abolish any common law rules relating to abortion,

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[2187] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3–6. Unusually, the Bill was co-sponsored by 15 members from across both Houses of the Parliament: in the Legislative Assembly the Hon Shelley Hancock MP, Trish Doyle MP, the Hon Brad Hazzard MP, Ryan Park MP, Jenny Leong MP, the Hon Leslie Williams MP, Alex Greenwich MP, Jenny Aitchison MP, Felicity Wilson MP, Greg Piper MP and Jo Haylen MP; in the Legislative Council the Hon Penny Sharpe MLC, the Hon Trevor Khan MLC, the Hon Abigail Boyd MLC and the Hon Emma Hurst MLC.

[2188] See above [1.1.2].

[2189] See above [1.2.5].

[2190] New South Wales, *Parliamentary Debates*, Legislative Assembly, 1 August 2019, 3.

[2191] Ibid 4.

[2192] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 3.

(f) to amend the *Crimes Act 1900* to make it an offence for a person who is not a medical practitioner otherwise authorised under the Act to terminate a pregnancy.[2193]

22.1.4 Mr Greenwich noted that the NSW Bill was based on the 2008 Victorian[2194] and 2018 Queensland reforms[2195] which came out of Law Reform Commission inquiries with extensive consultation. Mr Greenwich said, perhaps optimistically, 'there is no need to duplicate this process given that all the relevant issues have been canvased.'[2196]

22.1.5 The NSW Bill included the following items:

1. Abortions up to 22 weeks gestation are lawful on request if performed by a registered medical practitioner.
2. Abortions after 22 weeks gestation are only lawful (except in an emergency) if two medical practitioners consider that the procedure should be performed after considering all the relevant medical circumstances and the woman's current and future physical, psychological and social circumstances.[2197]
3. Abortions can be performed only by qualified medical practitioners regardless of whether the procedure is surgical or medical, but other health practitioners — namely, nurses, midwives, pharmacists and Aboriginal health practitioners — can assist an abortion, which includes dispensing, supplying or administering an abortion drug.
4. A woman cannot commit an offence for consenting to, assisting in or performing an abortion on herself.
5. Medical and health practitioners performing or assisting an abortion cannot commit an offence (although it may be material in a disciplinary context).
6. Any common law rules relating to offences for procuring an abortion are expressly abolished.
7. There is a new offence for a person who is not a medical practitioner to perform an abortion or for a person to assist in an abortion not performed by a medical practitioner. The Director of Public Prosecutions has to institute or approve any proceedings for this offence.
8. Health practitioners will not be forced to perform or participate in abortions if doing so would conflict with their values or personal beliefs, except in life-threatening emergencies.
9. If a medical practitioner has a conscientious objection when a woman seeks an abortion or advice about an abortion, that medical practitioner is obliged to refer the woman or transfer her care to another medical practitioner or healthcare provider, which the medical practitioner believes can provide the service and advice about it.[2198]

22.1.6 A number of amendments to the Bill were moved in committee stage in the Legislative Assembly.[2199]

[2193] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 1 [1.2].

[2194] *Abortion Law Reform Act 2008* (Vic).

[2195] *Termination of Pregnancy Act 2018* (Qld).

[2196] New South Wales, *Parliamentary Debates,* Legislative Assembly, 1 August 2019, 5.

[2197] Mr Greenwich noted that 22 weeks was chosen with the advice of the AMA and RANZCOG and follows the QLRC's recommendations.

[2198] New South Wales, *Parliamentary Debates,* Legislative Assembly, 1 August 2019, 4–5.

[2199] Other issues were raised such as the need for an Advisory Committee to approve late term abortions (New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 18–19, 20) or a waiting period or a panel (see Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 40 [3.82]) The proposal of a waiting period attracted particular criticism. See further Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 14 August 2019, 52 (Ms Janet Loughmann, Women's Legal Service NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 8 (Ms Melanie Fernandez, Co-convener, Pro-Choice NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Ann Brassil, CEO, Family Planning NSW).

22.1.7 Amendments were unsuccessful in relation to:

Lowering the requirement for the approval of two medical practitioners (and the at request stage) from 22 weeks to 20 weeks;[2200]

Explicitly requiring a medical practitioner to comply with any applicable professional standards or guidelines in performing an abortion;[2201]

Confining abortions after 22 weeks to where the medical practitioner reasonably considers an abortion is necessary to save the woman's life or the life of another fetus;[2202]

Mandatory reporting to the Secretary of the Department of Communities and Justice if a medical practitioner is asked to perform an abortion on a child under 16 years of age;[2203]

A requirement for a medical practitioner to provide information about counselling before any abortion;[2204]

Removing any requirement for referral if a medical practitioner has a conscientious objection;[2205]

Removing the requirement for referral at under 22 weeks gestation when the medical practitioner reasonably believes it would not be difficult for the patient to find a willing health practitioner;[2206]

Extending the new unqualified person offence to a medical practitioner who performs an abortion other than in accordance with the *Reproductive Health Care Reform Act 2019*;[2207]

A new offence to intimidate or annoy a woman to have an abortion, or intimidation or annoyance as a consequence of a woman abstaining from having an abortion performed;[2208]

more stringent data reporting restrictions;[2209] and

See also Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Adjunct Prof Deborah Bateson, Medical Director, Family Planning NSW); Evidence to Standing Committee on Social Issues, NSW Legislative Council, Sydney, 15 August 2019, 19 (Ms Karen Willis OAM, Executive Office, Rape and Domestic Violence Services Australia). See also above Rec 28, [12.5.10]–[12.5.19].

[2200] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 6–11. See also New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 42–56.

[2201] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 11–13, 77.

[2202] Ibid 21–25. The amendment would have only allowed an abortion after 22 weeks if:
(a) the medical practitioner considers, in accordance with reasonable medical judgment, the termination is necessary to save the person's life or the life of another foetus, and
(b) the termination is performed in a hospital with a neonatal intensive care unit, and
(c) so far as is compatible with saving the person's life or the life of the other foetus, every effort is made to deliver the foetus alive, and
(d) if a live child is born, the child must be given the same neonatal care as would be given to any other child born at the same stage of pregnancy and in the same medical condition.

See also New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 59–68.

[2203] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 27–31.

[2204] Ibid 45–47, 50–54. 'A medical practitioner must, before performing a termination on a person, ensure that the person has been offered the opportunity to receive counselling.'

[2205] Ibid 60–71.

[2206] Ibid 72–77.

[2207] Ibid 77–79. The amendment was opposed. It was noted that such conduct by a health practitioner could result in professional or disciplinary sanctions. 'If a doctor did something so extreme that it would clearly offend all of us and constituted a serious assault on a patient, then the doctor would be charged, and can be charged, and has been charged, under the *Crimes Act*': at 78 (Mr Brad Hazzard, Minister for Health). See also Recommendations 8, 9 and 11.

[2208] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 79–81.

[2209] Ibid 81–87.

prohibiting a medical practitioner from performing an abortion for the purpose of gender selection.[2210]

22.1.8 An amendment was also raised, but not pursued, to make it clear that 'a registered medical practitioner's refusal to provide or participate in a treatment or procedure must be done in a way to minimise disruption to patient care and must never be used to intentionally impede a patient's access to a termination'.[2211]

22.1.9 In summary, the NSW Legislative Assembly accepted amendments to the Bill to:

1. Specify the need for informed consent from a woman to undergo an abortion.[2212]
2. Abortions after 22 weeks being performed only by 'specialist' medical practitioners.[2213]
3. Abortions after 22 weeks being performed only at approved public health facilities.[2214]
4. The provision of information to a patient about counselling if a medical practitioner considers it would be 'beneficial'.[2215]
5. Clarifying the obligation on medical practitioners with a conscientious objection to abortions in respect of referral to allow this to include providing information about a willing provider.[2216]

[2210] Ibid 87–95. The proposed amendment read: 'Despite anything else in this Act or any other law, a medical practitioner may not perform a termination on a person—

(a) for the purpose of gender selection, or

(b) if the medical practitioner reasonably believes the termination is being performed for the purpose of gender selection.'

See also above Part 14.

[2211] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 67. SALRI has recommended that such a provision along with the requirement for timely and effective referral be added in South Australia to clarify the scope of conscientious objection and address the concerns raised in SALRI's consultation. See also above Rec 47, [17.7.1]–[17.7.27].

[2212] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 13–18. 'Informed consent, in relation to a termination performed by a medical practitioner, means consent to the termination given—

(a) freely and voluntarily, and

(b) in accordance with any guidelines applicable to the medical practitioner in relation to the performance of the termination.'

[2213] Ibid 18–21. This amendment was not opposed. 'Specialist medical practitioner, in relation to the performance of a termination, means—

(a) a medical practitioner who, under the Health Practitioner Regulation National Law, holds specialist registration in obstetrics and gynaecology, or

(b) a medical practitioner who has other expertise that is relevant to the performance of the termination, including, for example, a general practitioner who has additional experience or qualifications in obstetrics.'

[2214] Ibid 25–27. The amendment was not opposed.

[2215] Ibid 54–60. 'This amendment places an obligation on the medical practitioner who is to provide a termination to consider the provision of information about counselling after an assessment by the medical practitioner that such a discussion would be a benefit, not a detriment, to the patient and their partner… The counselling is not mandatory, it is simply a requirement on a medical practitioner to turn their mind to the issue of counselling and to provide information to the patient as to its availability': at 54 (Mr Alistair Hensken).

[2216] Ibid 71–72, 77. Referral will include giving 'information to the person on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination'. This amendment was explained by its mover as follows: 'For example, the requirement to give information to the person about how to locate or contact a medical practitioner who does not have a contentious objection will be satisfied if a health practitioner provides information on how to contact Family Planning NSW, another health practitioner or service provider. This clarified requirement places a limited burden on contentious objectors and appropriately balances their interests with the interests of a pregnant woman who may wish to have a termination': at 71 (Mrs Leslie Williams). This amendment was not opposed. SALRI does not support this approach. See above [17.7.1]–[17.7.27].

6. A review by the NSW Department of Health after 12 months of whether abortions are being used for the purposes of gender selection[2217] (including a legislative declaration 'that this House opposes terminations being performed for the sole purpose of gender selection').

22.1.10 At the conclusion of the sitting day on 8 August 2019, the Legislative Assembly agreed to the third reading of the Bill, as amended, on division, 59 votes to 31.[2218] The Bill moved to the Legislative Council.

22.1.11 The Bill had been referred, on 6 August 2019, to the Standing Committee on Social Issues by the Legislative Council on the recommendation of the Selection of Bills Committee. The Committee was due to report by Tuesday 20 August 2019. It released its Report on 27 August 2019.[2219]

22.1.12 The Bill attracted intense interest.[2220] The Legislative Council Committee[2221] heard from religious leaders, ethicists, right to life and right to choose advocates, academics, women's organisations, the legal sector and medical and health practitioners and associations. During the inquiry, the Committee considered a number of concerns that were raised by interested parties, including gestation periods, conscientious objection, counselling and gender selection, amongst others.

22.1.13 The Committee acknowledged these concerns and ultimately recommended that the Legislative Council proceed to consider the Bill and consider any amendments in the committee stage that could address the concerns of interested parties raised in the inquiry.[2222]

22.1.14 The Committee's Report did not seek to take a position on the Bill or to judge the competing positions expressed on abortion but rather simply acknowledged the full range of positions that were put to it during its inquiry and present the evidence and diverse opinions provided to it for the Legislative Council to consider in debating the Bill.[2223] The Committee also recognised and endorsed the evidence from all parties to its inquiry 'that the decision to have an abortion is often a heart-rending and agonising decision that women and their families take, often in extremely difficult circumstances'.[2224]

22.1.15 The Committee reiterated it had sought in its Report to set out the background and key provisions of the Bill and 'to note the wide-range of evidence from a representative group of parties on those provisions that it received during this inquiry'.[2225] However, the Committee noted that there was no consensus amongst either interested parties to the inquiry or the Committee 'as to the overall merits of the Reproductive Health Care Reform Bill 2019'.[2226] In those circumstances, the Committee decided to refer the Bill back to the

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[2217] New South Wales, *Parliamentary Debates,* Legislative Assembly, 8 August 2019, 88–95.

[2218] Ibid 96–97.

[2219] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019).

[2220] The input to the Committee amounted to over 13,000 submissions via the website portal or email, 15 hours of hearings over three days, 15 panels of witnesses grouped into areas of interest, 44 witnesses including ten senior religious figures, approximately 300 questions asked by committee members and 174 pages of Hansard transcript: at vii. See also at Ibid 3–4 [1.9]–[1.11].

[2221] The Committee consisted of the Hon Shayne Mallard MLC (Liberal Party), Ms Abigail Boyd MLC (The Greens), the Hon Niall Blair MLC (The Nationals), the Hon Greg Donnelly MLC (Australian Labor Party), the Hon Rose Jackson MLC (Australian Labor Party), the Hon Trevor Khan MLC (The Nationals), the Hon Natasha Maclaren-Jones MLC (Liberal Party) and the Rev the Hon Fred Nile MLC (Christian Democratic Party).

[2222] Ibid 56 Rec 1.

[2223] Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, August 2019) 17 [2.44].

[2224] Ibid 17 [2.45].

[2225] Ibid 56 [3.145].

[2226] Ibid 56 [3.146].

Legislative Council for further consideration, 'including consideration of any amendments in the committee stage that address stakeholder concerns raised in this inquiry'.[2227]

22.1.16 The Hon Greg Donnelly MLC unsuccessfully proposed the following amendment: 'That the Legislative Council seek the concurrence of the Legislative Assembly in the appointment of a joint committee of the two Houses to consider further the Reproductive Health Care Reform Bill 2019 in detail and that the committee report no later than the last sitting day in 2020.'[2228]

22.1.17 The majority of the Committee resolved 'that the Legislative Council proceed to consider the Reproductive Health Care Reform Bill 2019, including any amendments in the committee stage that address stakeholder concerns raised during this inquiry'.[2229]

22.1.18 The Hon Greg Donnelly MLC issued a dissenting opinion in which he complained at the very short time given to the Committee to investigate the Bill and release its Report and stated he stood by his unsuccessful amendment.[2230] This view was supported by the Hon Fred Nile MLC.[2231]

22.1.19 The Legislative Council considered the Bill in great detail over a number of days and it passed the Bill on 25 September 2019.[2232] This was only after 102 amendments were moved at committee stage (of which 25 were accepted).[2233] The Legislative Assembly accepted the 25 amendments added to the Bill from the Legislative Council (though some MPs expressed the view that a number of these amendments were unnecessary).[2234]

22.1.20 A summary of the proposed amendments to the Bill are detailed in **Table 6** below.

22.1.21 Considerations of space preclude SALRI considering each proposed amendment in the Legislative Council to the Bill. However, the main amendments added to the Bill by the Legislative Council and accepted by the Legislative Assembly[2235] are set out below:

1. Changing the name of the Bill to the *Abortion Law Reform Act 2019*.[2236]
2. Clarification of the informed consent provisions to ensure authorised persons can make decisions about abortions on behalf of a woman with an impairment;[2237]

[2227] Ibid 56 [3.147].

[2228] Ibid 76.

[2229] Ibid 56 Rec 1.

[2230] Ibid 78–79.

[2231] Ibid 80.

[2232] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 74.

[2233] Calla Wahlquist, 'NSW Abortion Law: Doctors Say Last-minute Changes "Unnecessary" but Manageable', *The Guardian* (online, 27 September 2019) <https://www.theguardian.com/australia-news/2019/sep/27/nsw-abortion-law-doctors-say-last-minute-changes-unnecessary-but-manageable>.

[2234] New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 4–8.

[2235] The 25 amendments are set out at: New South Wales, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 1–4. See also <https://www.parliament.nsw.gov.au/bill/files/3654/Schedule%20of%20Amdts%20-%20Reproductive%20Health%20Care%20Reform%20Bill%202019.pdf>.

[2236] New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 8–10.

[2237] New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 57–59. The rationale of this amendment was described: '… clarity is needed around doctors' obligations in cases where a woman lacks capacity to give informed consent. In most situations, women can make informed decisions about their life and their body but sometimes a woman lacks capacity to consent. That could occur if a woman is unconscious, is too young or has an intellectual disability, although not all women with an intellectual disability will lack capacity. Doctors are well trained to determine patients'

3. Mandate medical care for a child born alive during an abortion or 'clarifies that a person born after a termination who shows signs of life has the full protection of the law and must receive appropriate treatment';[2238]

4. Requiring a specialist medical practitioner for an abortion after 22 weeks to 'provide all necessary information to the person about access to counselling, including publicly-funded counselling'.[2239]

5. To provide that a medical practitioner with a conscientious objection to abortion can satisfy the requirement of referral by providing the patient with a pamphlet approved by NSW Health about contacting the Department of Health who will provide details of willing practitioners.[2240]

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capacity to make free and informed decisions. The amendments I move recognise the regime set out in the *Guardianship Act 1987* for obtaining consent when a person lacks capacity. Under the amendment, if a woman lacks capacity, her substituted decision-maker will be required to give informed consent. The change will ensure that if a woman cannot give informed consent, a person who is lawfully authorised to give consent on her behalf for medical treatment can give consent to a termination': at 57 (Hon Niall Blair).

[2238] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 4 (Hon Niall Blair). See also at 4–10, 26–31; New South Wales, *Parliamentary Debates*, Legislative Council, 17 September 2019, 68–80. This amendment was in response to emotive claims in the debate surrounding the 2019 NSW Act of 'children left to die'. See, for example, at: 76–78 (Hon Damien Tudehope). Mr Blair examined the rationale of this amendment: 'Some concerns have been raised that the Bill somehow or other changes a health practitioner's obligation to treat a child born alive following a termination. But existing legal and professional obligations unquestionably require health practitioners to provide any child born, regardless of the circumstances, appropriate clinical care and treatment unless the treatment is futile. If treatment is futile, palliative care is given… Current New South Wales guidelines relating to terminations reflect the existing law and require that any child born with signs of life as result of termination of pregnancy be afforded the right of dignity, maintenance of privacy and physical comfort whilst signs of life exist and to work with families to make compassionate decisions…The Bill expressly states that a health practitioner's duty to provide medical care and treatment to a child born as a result of a termination is no different to the duty owed to any child born in other circumstances.' See also Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry Into Laws Governing Termination of Pregnancy in Queensland* (Report No 24, 2016) 69; Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill (Provisions)* (Report No 55, (2019) 35 [3.64]–[3.66]. Dr Roach of RANZCOG explained to SALRI that a child 'born alive' during a late term abortion procedure is extremely rare, if not non-existent, and this situation is already fully covered by existing clinical practice. Dr Roach emphasised to SALRI that the claim of children 'left to die' is unfounded and offensive to the health practitioners involved and the parents. Any legislative provision (as in the 2019 NSW Act) seeking to regulate what happens is simply unnecessary and unhelpful as this situation, if it ever arises, is preferably left to clinical practice as to what is appropriate in the circumstances and to reflect the choice of the parties involved in careful consultation with their medical practitioners. SALRI reiterates that it concurs with the views and reasoning of Dr Roach on this point. See further above [7.2.7].

[2239] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 34–43. The rationale of this amendment was explained as follows: '… the vast majority of terminations after 22 weeks involve a devastating fetal diagnosis and women will have been preparing to have a child in these circumstances. It is important that women in this difficult situation are able to get counselling if they feel they need it. I must reiterate that last point: if they feel they need it. The amendment recognises that not all women will want counselling, with some preferring to rely on their personal support networks, and it will not force them to accept or undergo counselling if they do not want it': at 33 (Hon Niall Blair). Another amendment requiring counselling to be offered in any situation (see: at 31-32 (Hon Courtney Houssos)) was not accepted. Both amendments were opposed by some MPs. 'I will not support the legislative imposition of offering counselling. In some circumstances, the abortion may not be a difficult decision for a woman and counselling may only further delay a procedure that is inevitable, causing further stress and cost to the person involved — by cost I also include things like travel and accessibility to these counselling services. While I understand the idea is that the counselling is voluntarily taken up by the woman, the forced offer implies the decision is in some way ill thought out or is the wrong decision — adding more stress to a difficult situation. It also neglects to recognise most abortion decisions are made together with the man partly responsible for the pregnancy. Yet the man is not being offered mandatory counselling… This is not a pro-woman amendment. It is anti-choice': at 34 (Hon Emma Hurst). SALRI does not support any requirement for mandated counselling or offering of counselling and considers these are issues better left to clinical practice. See further above [12.3.14]–[12.3.15], [12.4.53]–[12.4.55], [12.6.1]–[12.6.3].

[2240] New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 78–87; New South Wales, *Parliamentary Debates*, Legislative Council, 19 September 2019, 4–18, 38–58. The object of this amendment was explained as follows:

6. The review by the NSW Department of Health into the issue of abortions on the ground of gender selection should also include suggested new professional guidelines to prevent abortions being performed for the purpose of gender selection and authorises the Secretary of the NSW Ministry of Health to issue such guidelines.[2241]

7. Requiring that non-identifying data be collected about abortions performed in New South Wales.[2242]

8. Provide that the domestic violence offence of intimidation extends to coercing a person to receive or not receive an abortion, with a maximum penalty of two years imprisonment.[2243]

9. Recognise that medical practitioners considering the performance of an abortion after 22 weeks 'may' seek advice from a multi-disciplinary team or hospital advisory committee.[2244]

22.1.22 The NSW Act received Royal Assent and came into operation on 2 October 2019.

22.1.23 The 2019 NSW Act is a significant improvement on the common law position and largely removes abortion from the criminal law. However, SALRI considers that some of the amendments to the 2019 NSW Act are unnecessary, even unhelpful, and the cumulative effect of the amendments has undermined the cohesion of the Act. The 2019 NSW Act creates an involved regime to regulate abortion alone amongst health procedures. SALRI considers that the 2019 NSW Act is not a suitable model to be adopted in South Australia.

'Rather than asking the doctor to refer the patient to another doctor who they know will not have a conscientious objection and will be able to assist the patient, the amendment puts in another step by enabling the doctor to refer the patient back to NSW Health. NSW Health will then identify someone who does not have a conscientious objection. Let NSW Health pick up the ball and do the matching between the patient who requires the health services and a doctor who can assist them. That will guarantee that the first doctor to whom the woman presents has met duty of care requirements by simply referring the woman back to NSW Health. The sort of information that the secretary could approve is information about an NSW Health managed phone or website service that would provide information about other service providers in the patient's area. The note to the amendment allows for NSW Health and the Secretary of the Ministry of Health to come up with that type of information and determine its form': New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 83 (Hon Niall Blair). An amendment moved by the Hon Mark Latham, at 78–82, to remove any requirement of referral (except in an emergency) for a health practitioner with a conscientious objection was rejected.

[2241] New South Wales, *Parliamentary Debates*, Legislative Council, 19 September 2019, 73–81. A renewed amendment to prohibit gender selective abortions was rejected: at New South Wales, *Parliamentary Debates*, Legislative Council, 18 September 2019, 44–53, 55–78. See also above Part 14 for SALRI's discussion of the issue of gender selective abortions (including the lack of any evidence that this is a real issue in Australia).

[2242] New South Wales, *Parliamentary Debates*, Legislative Council, 24 September 2019, 3–13, 24–28. The amendment was designed to improve access to services: at 4 (Hon Niall Blair). See also above Part 20. A more onerous reporting restriction was rejected.

[2243] New South Wales, *Parliamentary Debates*, Legislative Council, 24 September 2019, 47–64. This amendment was originally confined to coercion to undergo an abortion but was extended to apply both to coercion to have or not have an abortion. See at: 50–51 (Hon Penny Sharpe). SALRI, whilst sharing the concern over reproductive coercion (which is plainly wider than coercion to have an abortion) as a form of domestic violence, considers any such offence is unnecessary in South Australia. See also above [19.3.1]–[19.3.34].

[2244] New South Wales, *Parliamentary Debates*, Legislative Council, 25 September 2019, 59–65. It was explained that this amendment sought to merely codify existing clinical practice and provide additional advice in complex situations: at 59–60 (Hon Damian Tudehope). SALRI would not suggest the adoption of this provision in South Australia. See also above [11.4.1]–[11.4.15], [11.6.14]–[11.6.16], especially [11.6.17].

Table 6 – Summary of proposed amendments to the Reproductive Health Care Reform Bill 2019 (NSW)

For consideration	Proposed amendment	Agreed to
Name of Act	**c2019-124C – Legislative Council** 'This Act is the *Abortion Law Reform Act 2019*.'	✓
Commencement	**c2019-104A – Legislative Council** 'This Act commences on the date of assent to this Act' amended to 'This Act commences on a day or days to be appointed by proclamation.'	
Termination at not more than 22 weeks	**c2019-136A – Legislative Council** A medical practitioner may perform the termination if the medical practitioner: (a) is satisfied there is a serious danger to the life, physical health or mental health of the person in accordance with section 7, and (b) has ensured that, if the person is interested in accessing counselling, the person has had the opportunity to access the counselling, and (c) has obtained informed consent, and (d) the termination is performed at a hospital controlled by a statutory health organisation within the meaning of the *Health Services Act 1997*, or at an approved health facility. Compliance is not required if the termination is considered necessary to save the person's life or save another foetus.	
Termination after 22 weeks	**c2019-031-HE – Speakman – Legislative Assembly** Both medical practitioners involved in a termination on a person who is more than 22 weeks pregnant must be 'specialist' medical practitioners. A *specialist medical practitioner* means a medical practitioner who holds specialist registration in obstetrics and gynaecology, or who has other expertise that is relevant to the performance of the termination, for example, a general practitioner who has additional experience or qualifications in obstetrics.	✓
	c2019-175B – Legislative Council 'Note. This section is intended to reflect the common law position on terminations at the time this Act was enacted, subject to the purposes and requirements of this Act.'	✓
	c2019-160 – Legislative Council A specialist medical practitioner may perform the termination if the specialist medical practitioner: (a) is satisfied there is a serious danger to the life, physical health or mental health of the person, and	

	(b) has ensured that, if the person is interested in accessing counselling, the person has had the opportunity to access the counselling, and (c) has obtained informed consent, and (d) the termination is performed at a hospital controlled by a statutory health organisation within the meaning of the *Health Services Act 1997*, or at an approved health facility. These requirements will not need to be complied with if the termination is considered necessary to save the person's life or save another foetus. For the purposes of subsection (a), a specialist medical practitioner may be satisfied there is a serious danger to the life, physical health or mental health of the pregnant person if they: (a) honestly and on reasonable ground believe it is necessary to save the person from serious danger 'and not merely the normal dangers of pregnancy and childbirth', and (b) honestly and on reasonable grounds believe that, in all circumstances, the danger of the termination is not out of proportion to the serious danger. In considering whether there is a serious danger to the person's mental health, the specialist medication practitioner must consider an independent assessment of the person's mental health by a medical practitioner who holds specialist registration in psychiatry, or a person registered to practice in the psychology profession.	
	c2019-130D/c2019-129D/c2019-136A – Legislative Council As above, with the additional requirement that 'The specialist medical practitioner has consulted with another specialist medical practitioner and the other specialist medical practitioner is also satisfied there is a serious danger to the life, physical health, or mental health of the person.'	
	c2019-078C – Legislative Council A termination may be performed after 22 weeks only where the specialist medical practitioner considers that the person or the foetus has a severe medical condition that, in the clinical judgment of the specialist medical practitioner, justifies the termination. Furthermore, the specialist medical practitioner must consult with at least 2 members of a 'termination advisory panel' established by the Minister. In considering whether termination is justified, the specialist medical practitioners will no longer consider the person's current and future physical, psychological and social circumstances. In an emergency, only a specialist medical practitioner, and not a medical practitioner, is able to perform a termination without complying with the above requirements.	
	c2019-088B/c2019-092A – Legislative Council A termination may be performed after 22 weeks only where the specialist medical practitioner considers that the termination is necessary to save the person's life or the life of another foetus, and the specialist medical practitioner has consulted with another specialist medical practitioners who also agrees it is necessary for this reason, and so far as is	

	compatible with saving the persons' life or the life of another foetus, the specialist medical practitioner makes every effort to deliver the foetus alive.	
	c2019-175B – Legislative Council A specialist medical practitioner may perform a termination after 22 weeks if the specialist medical practitioner after considering the matters mentioned in subsection (3) and any advice received by a hospital advisory committee under subsection (4), considers that, in all the circumstances, there are sufficient grounds for the termination to be performed. The specialist medical practitioner must consult with another specialist medical practitioner who, after considering the matters mentioned in subsection (3) also consider that in all circumstances, there are sufficient grounds for the termination to be performed.	✓
Hospital advisory committees and multi-disciplinary teams	**c2019-175B – Legislative Council** After 22 weeks, the specialist medical practitioner may ask for advice about the proposed termination from a multi-disciplinary team or hospital advisory committee. 'Multi-disciplinary team' means a group of registered health practitioners and other health professionals, from diverse fields of practice, who work together in a coordinated way to deliver comprehensive care to a patient in a way that addresses as many of the patient's needs as practicable. 'Hospital advisory committee' means a committee established by a statutory health organisation, within the meaning of the *Health Services Act 1997*, or an approved health facility. The Secretary of the Ministry of Health may issues guidelines about matters relevant to the role of multi-disciplinary teams and hospital advisory committees, including their operation and the assistance they may provide to the specialist medical practitioner.	✓
Gestational limits	**c2019-042 – Davies – Legislative Assembly** Reduce the gestational limit for terminations at 'not more than 22 weeks' to 'less than 20 weeks'. Amending the requirements for performing a termination at '20 or more weeks': (a) the medical practitioner considers, in accordance with reasonable medical judgment, the termination is necessary to save the person's life or the life of another fetus, and (b) the termination is performed in a hospital with a neonatal intensive care unit (unless in the case of an emergency), and (c) so far as is compatible with saving the person's life or the life of the other fetus, every effort is made to deliver the fetus alive, and (d) if a live child is born, the child must be given the same neonatal care as would be given to any other child born at the same stage of pregnancy and in the same medical condition.	

	c2019-134C – Legislative Council Reduce the gestational limit for terminations at 'not more than 22 weeks' to 'not more than 20 weeks'. Whether before or after 20 weeks, a medical practitioner may perform the termination if the medical practitioner: (a) is satisfied there is a serious danger to the life, physical health or mental health of the person in accordance with section 7, and (b) has ensured that, if the person is interested in accessing counselling, the person has had the opportunity to access the counselling, and (c) has obtained informed consent, and (d) the termination is performed at a hospital controlled by a statutory health organisation within the meaning of the *Health Services Act 1997*, or at an approved health facility. After 20 weeks, a termination may only be performed if performed by a specialist medical practitioner who has consulted with another specialist medical practitioner.	
	c2019-091D – Legislative Council Reduce the gestational limit for terminations at 'not more than 22 weeks' to 'less than 20 weeks'.	
Informed consent	**c2019-031-FA – Speakman/c2019-042 – Davies – Legislative Assembly** A medical practitioner may perform a termination only if they have obtained the person's informed consent before performing the termination unless, in an emergency, it is not practicable to obtain the person's informed consent.	✓
	c2019-099 – Legislative Council A medical practitioner, or a specialist medical practitioner, may perform the termination only if they have obtained informed consent 'from the person, or if the person lacks the capacity to give informed consent to the termination, a person lawfully authorised to give consent on the person's behalf'.	✓
	c2019-141 – Legislative Council Changing the definition of 'informed consent' from consent to a termination given 'in accordance with any guidelines applicable to the medical practitioner in relation to the performance of the termination' to 'in accordance with the law'.	
	c2019-137B – Legislative Council Where a termination follows a prenatal diagnosis of a suspected or confirmed disability, informed consent can only be given after the person consenting to the termination has been given information about the support offered under the National Disability Insurance Scheme to children with that disability, and after being referred to representatives of the peak body, non-government organisation or peer network which represents children living with that disability.	

	For the purposes of these requirements, the Secretary of the Ministry of Health may keep a register of the bodies, organisations and networks referred to. 'Disability' means – (a) a condition that meets, or is likely to meet, the disability requirements or the early intervention requirements under the *National Disability Insurance Scheme Act 2013* (Cth), and (b) another condition that is a disability within the meaning of the *Disability Inclusion Act 2014*, and (c) another condition prescribed by the regulations for this definition.	
Meaning of emergency	**c2019-119 – Legislative Council** An 'emergency', in relation to performing a termination on a person, means the termination is, according to reasonable medical judgment, necessary to prevent an imminent threat of the person's death, or the death of another foetus.	
Counselling requirements	**c2019-042 – Davies – Legislative Assembly** A medical practitioner must, before performing a termination, ensure that the person has been offered the opportunity to receive counselling. Compliance is not necessary in an emergency when is not practicable to comply with this requirement.	
	c2019-040F – Henskens – Legislative Assembly A medical practitioner must assess whether or not it would be beneficial to discuss with the person and the person's partner accessing counselling about a proposed termination. If, in the medical practitioner's assessment, it would be beneficial and the person or the person's partner is interested in accessing counselling, they must provide all necessary information to the person or the person's partner about accessing counselling. This requirement will not apply in the case of an emergency.	✓ Agreed to following removal of references to the person's partner.
	c2019-107C – Legislative Council Before performing a termination on a person after 22 weeks' gestation, a specialist medical practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling.	✓

	c2019-094B – Legislative Council A medical practitioner must, before performing a termination, ensure the person has been offered counselling, and has been given information about non-directive pregnancy support counselling services provided under Medicare. This requirement does not apply in an emergency where it is not practical to comply with the requirement.	
Conscientious objection	**c2019-043D – McGirr – Legislative Assembly** Remove the provision 'this section does not limit any duty owed by a registered health practitioner to provide a service in an emergency' and instead provide 'A registered health practitioner who refuses to perform a termination, or to assist in or otherwise facilitate the performance of a termination, because of a conscientious objection is not, because of the refusal (a) in breach of any duty, however imposed, or (b) otherwise in contravention of any law of the State'. Registered health practitioners with a conscientious objection are not under any obligation to make a referral.	
	c2019-031-LA – Speakman – Legislative Assembly Referral obligations do not apply if the request is by a person who is not more than 22 weeks pregnant, and the first practitioner reasonably believes it would not be difficult for the patient to find another registered health practitioner, who does not have a conscientious objection to the termination, to perform the termination or to advise the person about the performance of a termination.	
	c2019-036-EE-5 – Williams – Legislative Assembly Replace the duty to refer with a duty to provide information on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection, or transfer the person's care to another registered health practitioner or health service provider at which, in the first practitioner's reasonable belief, the requested service can be provided.	✓
	c2019-103D/c2019-152A – Legislative Council A practitioner is taken to have complied with their obligations to give information to a person requesting an abortion on how to locate or contact an alternative medical practitioner if the first practitioner gives the person information approved by the Secretary of the Ministry of Health for the purposes of this obligation. The information to be approved by the Secretary is to consist of contact details for a NSW Government service that provides information about a range of health services and resources, including information about medical practitioners who do not have a conscientious objection to the performance of terminations.	✓
	c2019-056C – Legislative Council A health worker may refuse to perform, assist, or facilitate a termination if the health worker has a conscientious objection. The obligation to inform the person who requested the termination of the conscientious objection as soon as practicable only extends to medical practitioners who are involved in consultations or have contact with the person about the termination.	

	There are no obligations to provide a referral or information under this amendment.	
Compliance with professional standards and guidelines	**c2019-042 – Davies – Legislative Assembly** In performing a termination at not more than 22 weeks, a medical practitioner must comply with any applicable professional standards or guidelines.	
	c2019-040F – Henskens – Legislative Assembly In performing a termination, a medical practitioner must comply with any professional standards or guidelines that apply to medical practitioners in relation to the performance of terminations.	
	c2019-036-EF-2 – Williams – Legislative Assembly 'This Act does not limit any duty a registered health practitioner has to comply with professional standards or guidelines that apply to health practitioners.'	✓
Care of person born after termination	**c2019-155/c2019-106E/c2019-154 – Legislative Council** Where a termination results in a person being born, nothing in this Act prevents the medical practitioner who performed the termination, or any other registered health practitioner present at the time, from exercising any duty to provide the person with medical treatment that is clinically safe and appropriate to the person's medical condition. To avoid any doubt, the duty owed by a registered health practitioner to provide medical treatment to a person born as a result of a termination is no different than the duty owed to provide medical treatment to any person born.	✓
	c2019-089A – Legislative Council Where a termination results in a child being born alive, the medical practitioner who performed the termination, and any other registered health practitioner present at the time, must take all necessary steps to ensure the child receives the same neonatal care that would be given to any other child born at the same stage of pregnancy and in the same medical condition. If the child is born in a hospital that does not have a neonatal intensive care unit, the medical practitioner must arrange for a transfer. If a child is born alive following a termination, the child is taken to be at risk of significant harm for the purposes of Parts 2 and 3 of Chapter 3 of the *Children and Younger Persons (Care and Protections) Act 1998*. If a child is born alive following a termination but dies within 28 days after birth, the child's death is taken to be a reportable death for the purposes of the *Coroners Act 2009*.	

Approved health facilities	**c2019-036J – Williams – Legislative Assembly** A termination after 22 weeks is to be performed only at an approved health facility. The Secretary of the Ministry of Health may approve a hospital, or other facility the Secretary considers appropriate, as a facility at which terminations may be performed on persons who are more than 22 weeks pregnant.	✓
Guidelines about performance of terminations	**c2019-159 – Legislative Council** Omit 'at approved health facilities' from 'The Secretary of the Ministry of Health may issue guidelines about the performance of terminations at approved health facilities.'	✓
Data collection and reporting	**c2019-123 – Legislative Council** A medical practitioner who performs a termination must, within 28 days, give the Secretary of the Ministry of Health the information about the termination decided by the Secretary. Information must not include particulars which would allow a person on whom a termination was performed to be identified.	✓
	c2019-065D – Legislative Council Include 'Termination' as a Category 1 Scheduled medical conditions in the *Public Health Act 2010* for the purpose of collecting data about terminations.	
Reporting statistical information about terminations	**c2019-144J/c2019-064C – Legislative Council** The Secretary of the Ministry of Health must, by 30 June in a year, publish a report about terminations performed in the previous year. The report must include only statistical information and must not include information that identifies the person on whom a termination was performed or the person who performs or assists in the performance of a termination. The information to be reported includes the woman's date of birth, locality or postcode, weeks of gestation, number of previous terminations, locality of the place at which the termination was performed and whether a public or private hospital or clinic, date of the termination, reasons for the termination, category of medical practitioner who performed the termination, method of termination, whether or not the person experienced any medical complications, and any other relevant health characteristics of the person.	
Gender/sex selection	**c2019-046A – Davies – Legislative Assembly** A medical practitioner must not perform a termination on a person for the purpose of gender selection, or where the medical practitioner reasonably believes the termination is being performed for the purpose of gender selection.	
	c2019-048C – Williams – Legislative Assembly The Secretary of the Ministry of Health must, within 12 months, conduct a review of the issue of whether or not terminations are being performed for the purposes of gender selection, and prepare and provide to the Minister a report. The Minister must provide the report to the Presiding Officer of each House of Parliament.	✓

	c2019-159 – Legislative Council Change the terminology used from 'gender selection' to 'sex selection'.	✓
	c2019-159 – Legislative Council 'This Parliament opposes the performance of termination for the purpose of sex selection.'	✓
	c2019-159/c2019-157C – Legislative Council The report prepared by the Secretary of the Ministry of Health must include recommendations about how to prevent terminations being performed for the purpose of sex selection. The Secretary of the Ministry of Health may issue guidelines, about the performance of terminations, that prevent terminations being performed for the purpose of sex selection.	✓
	c2019-156B – Legislative Council Terminations must not be performed for the sole purpose of sex selection. However, a termination is not performed for the purpose of sex selection if it is performed because the foetus is confirmed or suspected to have a sex-linked genetic disorder. Nothing in this section imposes any additional duty on a medical practitioner to investigate the purpose for which a termination is requested.	
	c2019-057F – Legislative Council A medical practitioner must not perform a termination on a person if the medical practitioner reasonably believes the termination is being performed for the purposes of sex selection. A termination is performed for the purposes of sex selection if it is performed because the foetus is confirmed or suspected to be female, male, or intersex.	
	c2019-057H – Legislative Council Impose a maximum penalty of 40 penalty units or imprisonment for 6 months or both for medical and health practitioners who perform or assist in the performance of a termination that they know, or ought reasonably to know, is being performed for the purposes of sex selection. A termination is performed for the purposes of sex selection if it is performed because the foetus is confirmed or suspected to be female, male, or intersex. A termination is not performed for the purpose of sex selection if it is performed because the foetus is confirmed or suspected to have a sex-linked genetic disorder.	

Review of Act	**c2019-086B – Legislative Council** Reduce the number years in which the Minister must conduct a review of the operation of the Act from 5 years to 2 years.	
Criminal offences under the *Crimes Act 1900* (NSW)	**c2019-042 – Davies – Legislative Assembly** A medical practitioner who performs a termination other than in accordance with the *Reproductive Health Care Reform Act 2019* commits an offence. Maximum penalty – 7 years imprisonment.	
	c2019-138 – Legislative Council A medical practitioner who performs a termination on a person other than in accordance with the *Reproductive Health Care Reform Act 2019* commits an offence. A registered health practitioner who assists in the performance of a termination on a person that the registered health practitioner knows, or ought reasonably to know, is being performed other in accordance with the *Reproductive Health Care Reform Act 2019* commits an offence. Maximum penalty – 7 years imprisonment.	
'Intimidation or annoyance by violence or otherwise' under section 545B of the *Crimes Act 1900* (NSW)	**c2019-042 – Davies – Legislative Assembly/ c2019-095 – Legislative Council** If a person is convicted of this offence as a result of using intimidation or annoyance to compel a person to have a termination performed, or using intimidation or annoyance as a consequence of a person abstaining from having a termination performed, a maximum penalty of 7 years imprisonment applies.	
	c2019-111A – Legislative Council Provide that a person who coerces a person to have a termination performed, including for the purposes of sex selection, is taken to have used intimidation to compel the person to have the termination.	✓
	c2019-147 – Legislative Council As above, with the additional stipulation that a person who coerces a person to not have a termination performed is taken to have used intimidation to prevent the person from having the termination.	✓

Terminations on children under 16 years of age	**c2019-042 – Davies – Legislative Assembly** Where a medical practitioner is asked to perform a termination on a child under 16 years of age, the medical practitioner must report the name of the child and the request to the Secretary of the Department of Communities and Justice, whether or not the termination is performed.	
Sale of human tissue	**c2019-049 – Davies – Legislative Assembly** Prohibit the sale of tissue removed from a person in the course of the performance of a termination.	
	c2019-059B – Legislative Council A person must not enter into, or offer to enter into, a contract under which a person agrees to the sale or supply of tissue from the body a foetus that is removed or expelled from the body of a pregnant person because of a termination. Maximum penalty – 40 penalty units or imprisonment for 6 months, or both.	
Public Health Act 2010	**c2019-042 – Davies – Legislative Assembly** '***Termination*** has the meaning given in the *Reproductive Health Care Reform Act 2019*.'	
Pain relief for foetus	**c2019-166A – Legislative Council** Where a termination is performed on a person who is 20 weeks pregnant or more, the medical practitioner must ensure analgesia is administered to ensure the foetus does not experience pain. The stage of pregnancy at which this requirement will apply can be reduced to a number of weeks prescribed by the regulations.	
References to woman who is pregnant	**c2019-061C – Legislative Council** Change the terminology used from a 'person' to a 'woman' when referring to the person who is pregnant.	

Appendix A – Consultation Questions

We welcome your views on the topics raised by this reference and we especially welcome input on any, or all, of the questions to consider, as set out below. The questions should be read in conjunction with the Fact Sheets (as indicated) which provide background information and context.

Role of the Criminal Law [refer to Fact Sheets 4, 5 and 8]

1. Should there be offences relating to qualified health practitioners performing abortions in the *Criminal Law Consolidation Act 1935* (SA)?
2. Should there be offences relating to the woman procuring an abortion in the *Criminal Law Consolidation Act 1935* (SA)?
3. Should a woman ever be criminally responsible for the termination of her own pregnancy?
4. Should South Australia have criminal offences for abortions not performed by an appropriate health practitioner?

Who should be permitted to perform or assist in performing terminations [refer to Fact Sheets 4, 7 and 8]

5. Should health practitioners (other than medical practitioners) be permitted to authorise or perform, or assist in performing, lawful terminations of pregnancy in South Australia?

Gestational Limits and Grounds for Termination of Pregnancy [refer to Fact Sheets 4, 6 and 8]

6. Should a woman be allowed to access lawful abortion on request at any stage of a pregnancy?
7. Should there be a gestational limit or limits for a lawful termination of pregnancy in South Australia?
8. If there is a gestational limit for a lawful termination should it be related to:

   (a) the first trimester of pregnancy;

   (b) viability of the foetus (approximately 22 – 24 weeks);

   (c) other?
9. Should there be a specific ground or grounds for a lawful termination of pregnancy?
10. If there is a specific ground or grounds for a lawful termination should they include:

    (a) all relevant medical circumstances;

    (b) professional standards and guidelines;

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(c) that it is necessary to preserve the life of the woman;

(d) that it is necessary to protect the physical or mental health of the woman;

(e) that it is necessary or appropriate having regard to the woman's social or economic circumstances;

(f) that the pregnancy is the result of rape or another coerced or unlawful act;

(g) that there is a risk of serious or fatal foetal abnormality (drawing on the terminology from the present law).

11. Should different considerations apply at different stages of pregnancy?

Consultation by the medical practitioner [refer to Fact Sheets 4, 6 and 8]

12. Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), before performing a termination of pregnancy?

13. If a consultation is required, should it include:

(a) another medical practitioner; or

(b) a specialist obstetrician or gynaecologist; or

(c) a health practitioner whose specialty is relevant to the circumstances of the case; or

(d) referral to an appropriate counsellor; or

(e) referral to a specialist committee?

14. If there was a referral requirement should it apply:

(a) for all terminations, except in an emergency;

(b) for terminations to be performed after a relevant gestational limit or on specific grounds?

Conscientious objection [refer to Fact Sheets 4, 6 and 8]

15. Should there be provision for health practitioners in South Australia to decline to provide an abortion related service for conscientious objection?

16. If a medical practitioner had a conscientious objection are there circumstances where this objection should be overridden, such as:

(a) in an emergency;

(b) the absence of another health practitioner or termination of pregnancy service within a reasonable geographic proximity.

17. Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?

Counselling [refer to Fact Sheets 7, 8 and 9]

18. Should there be any requirements in relation to offering counselling for the woman?

Protection of women and service providers and safe access zones [refer to Fact Sheets 5, 6 and 10]

19. Should South Australia provide for safe access zones in the area around premises where termination of pregnancy services are provided?

20. If a safe access zone was established should it:

    (a) automatically establish an area around the premises as a safe access zone?; or

    (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone?

21. What types of behaviour or conduct should be prohibited in a safe access zone?

22. Should the prohibition on behaviours in a safe access zone apply only during periods of operation?

23. Should it be an offence in South Australia to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

24. Should it be unlawful to harass, intimidate or obstruct:

    (a) a woman who is considering, or who has undergone, a termination of pregnancy;

    (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Collection of data about terminations of pregnancy [refer to Fact Sheets 4, 6 and 7]

25. Should data about terminations of pregnancy in South Australia be reportable?

Rural and Regional Access [refer to Fact Sheets 4, 6 and 7]

26. Given the difficulties of access to medical services in rural areas of South Australia should there be different laws to facilitate access in rural and regional areas?

27. Should women be permitted to use telehealth or other electronic services to consult with medical and/or health practitioners?

28. Where a woman would otherwise be able to have a termination but does not have local access to clinics able to do so (such as in rural South Australia), should another qualified health practitioner (such as a registered nurse or pharmacist) be permitted to undertake this procedure.

Incidental

29. Should there be a residency requirement to access a lawful abortion in South Australia? [refer to Fact Sheets 6 and 7]

30. Do you have any suggestions for incidental law changes to present law and/or practice in South Australia in relation to abortion? [refer to Fact Sheets 4, 6 and 8]

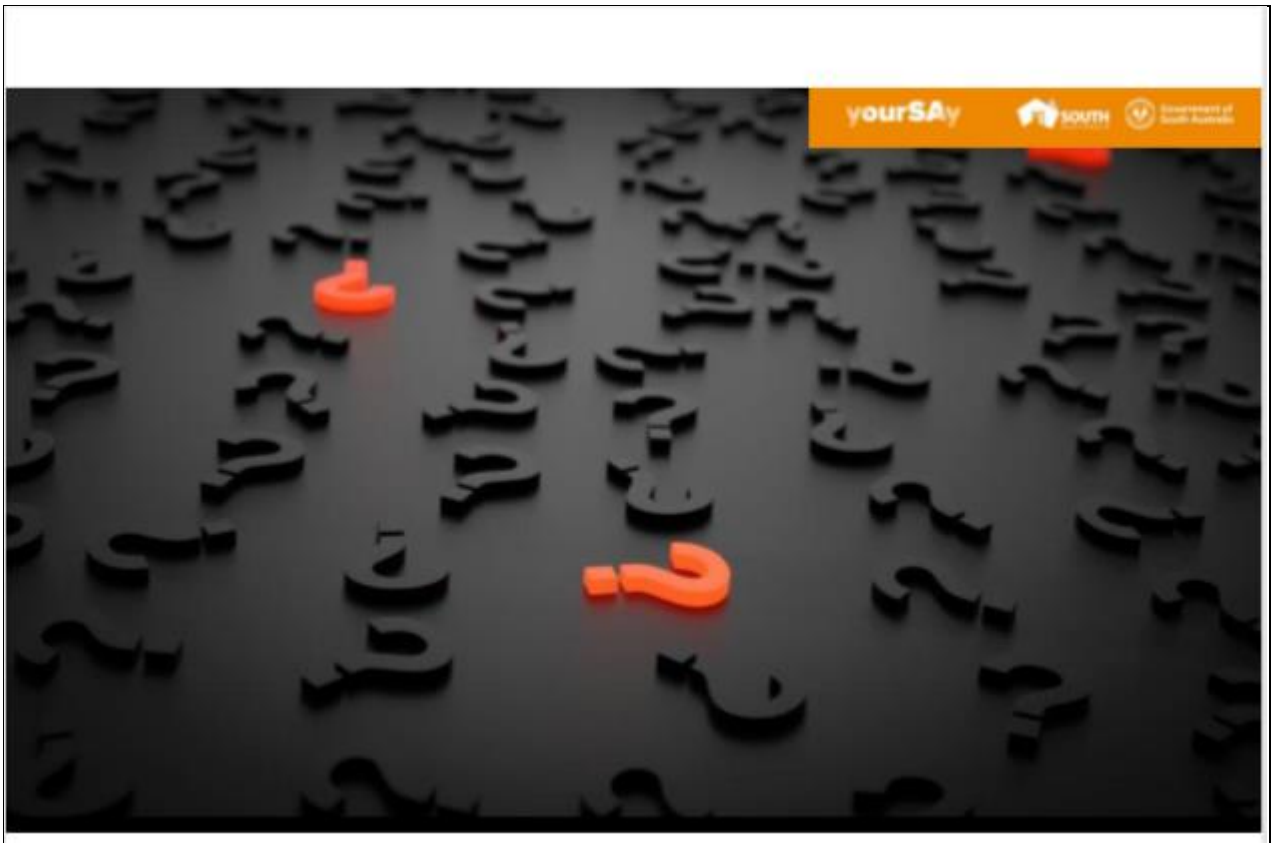
31. Are there any other comments you would like to make in relation to this reference?

***Please note*: SALRI does not, and cannot, provide legal advice to individuals. If you are in need of legal advice we encourage you to speak to a lawyer and/or contact a community legal service.**

SALRI acknowledges the assistance of the SA Attorney-General's Department in providing grant funding for this project.

2 April 2019

Appendix B – YourSAy Online Engagement Report



ONLINE ENGAGEMENT REPORT

Abortion: A Review of South Australian Law and Practice
15 April 2019 - 31 May 2019

Abortion: A Review of South Australian Law and Practice

yourSAy

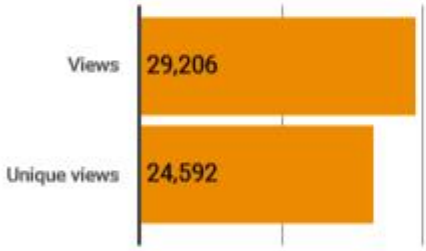
Overview

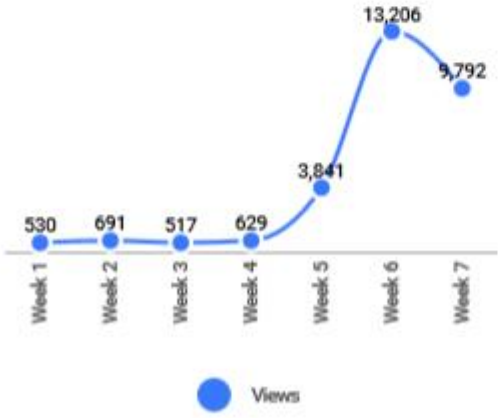
Your consultation was promoted by YourSAy from 15 April 2019 to 31 May 2019. It included an online engagement on YourSAy.sa.gov.au with a survey. Social media promotion was not undertaken at the agency's request.

Overall, this campaign achieved a cumulative reach of 49,720 and generated 29,206 visits to the website to learn more.

Website analytics

These charts provide an overview of the activity on the website during the open consultation period.





PDF

1,116

Fact sheet link clicks

2,383

Survey link clicks

infogram

YourSAy Channels

Your engagement was sent to 33,290 registered YourSAy users on 27 May 2019.
The email was opened a total of 20,514 times giving a large number of people the opportunity to see your engagement at least once. Your engagement attracted the highest number of clicks of all engagements featured in the email (around one third of all clicks).

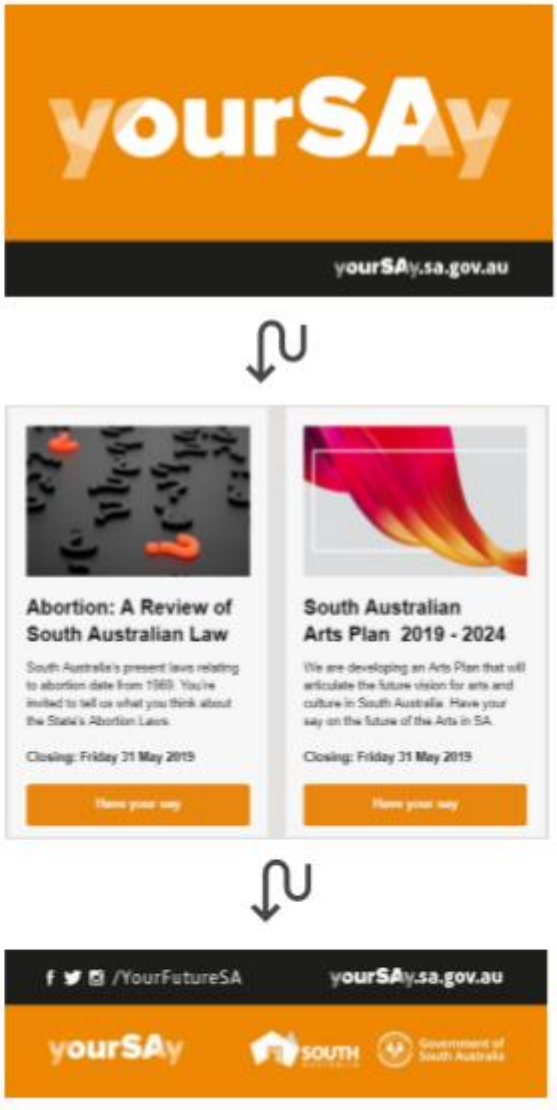
By email

33,290
Recipients

20,514
Email opens

32.27%
Opens

1,124
Your link clicks



Appendix C – *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA), Section 116

116—Claims by persons as to registration as health practitioner

(1) A person who is not a registered health practitioner must not knowingly or recklessly—

(a) take or use the title of "registered health practitioner", whether with or without any other words; or

(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) the person is a health practitioner; or

(ii) the person is authorised or qualified to practise in a health profession; or

(c) claim to be registered under this Law or hold himself or herself out as being registered under this Law; or

(d) claim to be qualified to practise as a health practitioner.

Maximum penalty:

(a) in the case of an individual—$60 000 or 3 years imprisonment or both; or

(b) in the case of a body corporate—$120 000.

(2) A person must not knowingly or recklessly—

(a) take or use the title of "registered health practitioner", whether with or without any other words, in relation to another person who is not a registered health practitioner; or

(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) another person is a health practitioner if the other person is not a health practitioner; or

(ii) another person is authorised or qualified to practise in a health profession if the other person is not a registered health practitioner in that health profession; or

(c) claim another person is registered under this Law, or hold the other person out as being registered under this Law, if the other person is not registered under this Law; or

(d) claim another person is qualified to practise as a health practitioner if the other person is not a registered health practitioner.

Maximum penalty:

(a) in the case of an individual—$60 000 or 3 years imprisonment or both; or

(b) in the case of a body corporate—$120 000.

Appendix D – *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA), Schedule 3

under the Criminal Law Consolidation Act 1935 (SA)

Schedule 3—Prescribed hospitals

Ashford Hospital

The Burnside War Memorial Hospital Incorporated

The following hospital facilities of the Central Adelaide Local Health Network Incorporated:

- The Queen Elizabeth Hospital
- Royal Adelaide Hospital

Central Districts Private Hospital Incorporated

The following hospital facilities of the Barossa Hills Fleurieu Local Health Network Incorporated:

- Angaston District Hospital
- Eudunda Hospital
- Gawler Health Service
- Gumeracha District Soldiers' Memorial Hospital
- Kangaroo Island Health Service
- Kapunda Hospital
- Mount Barker District Soldiers' Memorial Hospital
- Mount Pleasant District Hospital
- Southern Fleurieu Health Service
- Strathalbyn and District Health Service
- Tanunda War Memorial Hospital

The following hospital facilities of the Eyre and Far North Local Health Network Incorporated:

- Ceduna District Health Service
- Cleve District Hospital and Aged Care
- Coober Pedy Hospital and Health Service
- Cowell District Hospital and Aged Care
- Cummins and District Memorial Hospital
- Elliston District Hospital
- Kimba District Hospital and Aged Care
- Oodnadatta Health Service
- Port Lincoln Health Service
- Streaky Bay District Hospital
- Tumby Bay Hospital and Health Service
- Wudinna Hospital

The following hospital facilities of the Flinders and Upper North Local Health Network Incorporated:

- Hawker Memorial Hospital
- Leigh Creek Health Service
- Port Augusta Hospital and Regional Health Service
- Quorn Health Service
- Roxby Downs Health Service
- The Whyalla Hospital and Health Service

The following hospital facilities of the Riverland Mallee Coorong Local Health Network Incorporated:

- Barmera Hospital
- Karoonda and Districts Soldiers' Memorial Hospital
- Lameroo District Health Service
- Loxton Hospital Complex
- Mannum District Hospital
- Meningie and Districts Memorial Hospital and Health Service
- Murray Bridge Soldiers' Memorial Hospital
- Pinnaroo Soldiers' Memorial Hospital
- Renmark Paringa District Hospital
- Riverland General Hospital
- Tailem Bend District Hospital
- Waikerie Health Services

The following hospital facilities of the Limestone Coast Local Health Network Incorporated:

- Bordertown Memorial Hospital
- Kingston Soldiers' Memorial Hospital
- Millicent and District Hospital and Health Service
- Mount Gambier and Districts Health Service
- Naracoorte Health Service
- Penola War Memorial Hospital

The following hospital facilities of the Yorke and Northern Local Health Network Incorporated:

- Balaklava Soldiers' Memorial District Hospital
- Booleroo Centre District Hospital and Health Service
- Burra Hospital
- Central Yorke Peninsula Hospital (Maitland)
- Clare Hospital
- Crystal Brook and District Hospital
- Gladstone Community Health Centre
- Jamestown Hospital and Health Service

- Laura and District Hospital
- Minlaton Medical Centre
- Orrorroo and District Health Service
- Peterborough Soldiers' Memorial Hospital and Health Service
- Port Broughton District Hospital and Health Service
- Port Pirie Regional Health Service
- Riverton District Soldiers' Memorial Hospital
- Snowtown Hospital
- Southern Yorke Peninsula Hospital (Yorketown)
- Wallaroo Hospital and Health Service (also known as Northern Yorke Peninsula Health Service)

Flinders Private Hospital

Glenelg Community Hospital Incorporated

The Memorial Hospital

North Eastern Community Hospital Incorporated

The following hospital facilities of the Northern Adelaide Local Health Network Incorporated:

- Lyell McEwin Hospital
- Modbury Hospital

Saint Andrews Hospital Incorporated

The following hospital facilities of the Southern Adelaide Local Health Network Incorporated:

- Flinders Medical Centre
- Noarlunga Hospital
- Repatriation General Hospital

Southern Districts War Memorial Hospital Incorporated

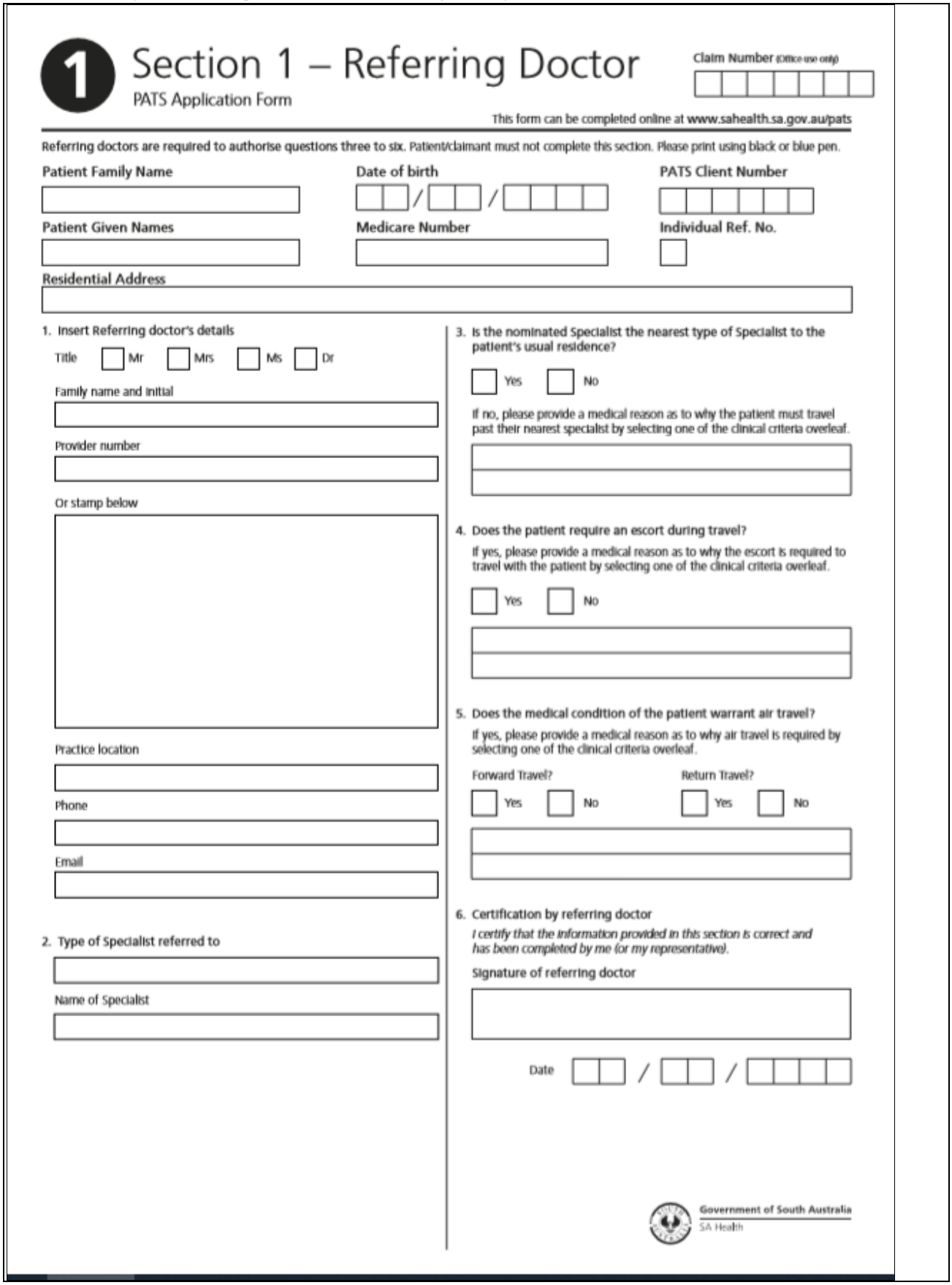
Stirling and Districts Hospital Incorporated

Wakefield Hospital Incorporated

Western Hospital

The Women's and Children's Hospital facility of the Women's and Children's Health Network Incorporated

Appendix E – Patient Assistance Transport Scheme - Application Form: Section 1 (Referring doctor to complete)



1 Section 1 – Referring Doctor

PATS Application Form

Claim Number (Office use only)

This form can be completed online at www.sahealth.sa.gov.au/pats

Referring doctors are required to authorise questions three to six. Patient/claimant must not complete this section. Please print using black or blue pen.

Patient Family Name

Date of birth

PATS Client Number

Patient Given Names

Medicare Number

Individual Ref. No.

Residential Address

1. Insert Referring doctor's details

Title Mr Mrs Ms Dr

Family name and initial

Provider number

Or stamp below

Practice location

Phone

Email

2. Type of Specialist referred to

Name of Specialist

3. Is the nominated Specialist the nearest type of Specialist to the patient's usual residence?

Yes No

If no, please provide a medical reason as to why the patient must travel past their nearest specialist by selecting one of the clinical criteria overleaf.

4. Does the patient require an escort during travel?

If yes, please provide a medical reason as to why the escort is required to travel with the patient by selecting one of the clinical criteria overleaf.

Yes No

5. Does the medical condition of the patient warrant air travel?

If yes, please provide a medical reason as to why air travel is required by selecting one of the clinical criteria overleaf.

Forward Travel? Yes No

Return Travel? Yes No

6. Certification by referring doctor

I certify that the information provided in this section is correct and has been completed by me (or my representative).

Signature of referring doctor

Date / /

Government of South Australia

SA Health

Appendix F – Patient Assistance Transport Scheme - Application Form: Section 2 (Specialist to complete)

2 Section 2 – Specialist

PATS Application Form

Claim Number (Office use only)

This form can be completed online at www.sahealth.sa.gov.au/pats

Specialistsor or authorised officers are required to authorise and complete questions two to nine to confirm that PATS eligibility requirements are met. Patient/claimant must not complete this section. Please print using black or blue pen.

Patient Family Name

Date of birth / /

PATS Client Number

Patient Given Names

Medicare Number

Individual Ref. No.

Residential Address

1. Treating Specialist's details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Family name and initial

Specialty area

Provider number

Or stamp below

Practice location

Phone

Email

2. Is this an initial assessment or visit?

☐ Yes ☐ No

3. Dates of this treatment episode or consultation

From / /

To / /

4. Name of hospital

Length of stay in hospital?

From / /

To / /

5. Does the patient require an escort during travel?

☐ Yes ☐ No

If yes, please provide a medical reason as to why the escort is required to travel with the patient by selecting one of the clinical criteria overleaf.

6. Does the patient require accommodation nearer the treatment location during or after treatment? Please note PATS provides an automatic two nights per trip - if the patient requires more, please note the number of nights beyond the first two.

☐ Yes ☐☐ How many night? ☐ No

7. Does the patient require an escort to be accommodated with them?

☐ Yes ☐☐ How many night? ☐ No

If yes, please provide a medical reason as to why the escort is required to be accommodated with or near the patient by selecting one of the clinical criteria overleaf.

8. Does the medical condition of the patient warrant air travel?

Forward Travel? ☐ Yes ☐ No

Return Travel? ☐ Yes ☐ No

If yes please provide a medical reason as to why the why air travel is required by selecting one of the clinical criteria overleaf.

9. Certification by treating Specialist

I certify that the information provided in this section is correct and has been completed by me (or my representative).

Signature of treating Specialist or Registrar

Date / /

Government of South Australia
SA Health

Appendix G – Patient Assistance Transport Scheme - Application Form: Section 3 (Patient details)

3 Section 3 – Patient and Payment Details

PATS Application Form

Claim Number (Office use only)

PATS Client Number

This form can be completed online at www.sahealth.sa.gov.au/pats

Patient is required to complete. Please print using black or blue pen.

1. Patient details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Patient Family Name

Patient Given name

Date of birth / /

Medicare Number – Individual Ref. No.

Residential Address

P/code

Postal Address *(if different from above)*

P/code

Preferred Phone

Email

2. Are you a Pensioner or Health Care Card holder requesting an accommodation subsidy?

☐ Yes ☐ No

If Yes, please attach a copy of both sides of your card to qualify for the accommodation subsidy for the first night. EXP

3. Are you a veteran or a war widow?

☐ Yes ☐ No ☐ White ☐ Gold EXP

4. Are you an Australian Citizen, or Permanent Resident?

☐ Yes ☐ No

5. Payment details: Please complete upon first PATS claim or when bank details change.

Account Name

BSB

Account

Payment confirmation to be sent to (please tick one)

☐ Mobile phone

☐ Email

6. Do you identify as Aboriginal or Torres Strait Islander

☐ Yes ☐ No

7. Have you claimed, or are you entitled to claim travel and/or accommodation benefits relating to this treatment from:

Any other Australian, State or Territory government scheme?	☐ Yes	☐ No
As part of Workers Compensation Claim?	☐ Yes	☐ No
As part of a third party insurance claim or any other insurance claim?	☐ Yes	☐ No

8. Mode of travel: Please attach mode of travel receipt for reimbursement (excludes fuel receipt for private travel).

	Forward		Return	
	Patient	Escort		
Private car	☐	☐	☐	☐
Bus/coach/rail	☐	☐	☐	☐
Ferry	☐	☐	☐	☐
Authorised Air	☐	☐	☐	☐
Community bus	☐	☐	☐	☐
Community car	☐	☐	☐	☐
Emergency	☐	☐	☐	☐

Dates of travel?

Forward / / Return / /

Total amount paid for travel: $

9. What town/city did you travel to for your specialist appointment?

If you live on a rural property or outside of recognised town boundaries, what was the first town on your journey to the specialist appointment?

What is the distance one way from the property to that town? kms

10. If an escort accompanied you, provide name of escort.

11. Are you entitled to claim travel and accommodation expenses through a private health fund?

☐ Yes ☐ No If yes, attach evidence that you have reached your maximum claimable amount.

12. Accommodation: Please attach your accommodation receipt for reimbursement

Number of nights: Patient ☐☐ Escort ☐☐

Number of nights: Patient ☐☐ Escort ☐☐

Total amount paid for accommodation (or owing): $

Dates - Patient

From / / To / /

Dates - Escort

From / / To / /

13. Accommodation Provider: Please complete for the accommodation subsidy to be provided directly to the accommodation provider.

Accommodation provider name:

PATS Claim Number:

14. Certification by Patient

This form must be signed and submitted by the patient and/or their guardian. I certify that the information in this form is true and correct and that the expenditure shown was actually incurred. I hereby consent to Country Health SA Local Health Network (CHSALHN) obtaining further information from referring medical practitioners, treating specialists, other health professionals and travel accommodation providers where further information may be required to process or audit this application.

Signature of Applicant

/ /

Government of South Australia
SA Health

Appendix H - Patient Assistance Transport Scheme - Application Form: Section 4 (Block Treatment – Specialist and patient to complete)

4 Section 4 – Block Treatment

PATS Application Form

Claim Number (Office use only)

This form can be completed online at www.sahealth.sa.gov.au/pats

Specialist or authorised officer is required to authorise and complete questions one to seven to confirm that PATS eligibility requirements are met. Patient/claimant must complete the 'Certification by patient' at the bottom of this form prior to lodgement. Please print using black or blue pen.

Patient Family Name

Date of birth / /

PATS Client Number

Patient Given Names

Medicare Number

Individual Ref. No.

Residential Address

This form is to be completed by the specialist only

1. Treating Specialist's details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Family name and initial

Specialty area

Provider number

Or stamp below

Practice location

Phone

Email

2. Treatment location

3. Does the patient require an escort during travel?

☐ Yes ☐ No *If yes, explain why an escort is required to travel with the patient by selecting one of the clinical criteria overleaf.*

4. Does the patient require accommodation near the specialist?

☐ Yes ☐ No

5. Does the patient require an escort to be accommodated with them?

☐ Yes ☐ No *If yes, explain why an escort is required to be accommodated with the patient by selecting one of the clinical criteria overleaf.*

6. Does the medical condition of the patient warrant air travel?

Forward Travel? ☐ Yes ☐ No Return Travel? ☐ Yes ☐ No

If yes, explain why air travel is required by selecting one of the clinical criteria overleaf.

7. Certification by treating Specialist

I certify that the information provided in this section is correct and has been completed by me (or my representative).

Date / /

Journey Dates	Mode of travel (car, bus, ferry, air, emergency) *Please provide tax invoices for travel other than fuel.*	Treatment Dates	Nights of accommodation approved	Signature of Specialist or Authorised Officer
Start / / End / /		Start / / End / /		
Start / / End / /		Start / / End / /		
Start / / End / /		Start / / End / /		
Start / / End / /		Start / / End / /		
Start / / End / /		Start / / End / /		

8. Certification by patient

This form must be signed and submitted by the patient and/or their guardian. *I certify that the information in this form is true and correct and that the expenditure shown was actually incurred. I hereby consent to Country Health SA Local Health Network (CHSALHN) obtaining further information from referring medical practitioners, treating specialists, other health professionals and travel accommodation providers where further information may be required to process or audit this application.*

Signature of patient

/ /

Government of South Australia
SA Health

Appendix I – Australia's peak health bodies and associations: relevant excerpts of policies

Medical body or association / *Policy*	**Relevant excerpts of their Code of Conduct or policy**
Medical Board of Australia (MBA) *Code of Conduct*	2.1 In clinical practice, the care of your patient is your primary concern. Providing good patient care includes: … 2.1.3 Facilitating coordination and continuity of care. 2.1.4 Referring a patient to another practitioner when this is in the patient's best interests. 2.1.5 Recognising and respecting patients' rights to make their own decisions. Maintaining a high level of medical competence and professional conduct is essential for good patient care. Good medical practice involves: 2.2.8 Supporting the patient's right to seek a second opinion. 2.2.12 Ensuring that your personal views do not adversely affect the care of your patient. Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves: 2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and **not using your objection to impede access to treatments that are lega**l. 2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care. *Referral* involves you sending a patient to obtain opinion or treatment from another doctor or healthcare professional. Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside your area of expertise. *Handover* is the process of transferring all responsibility to another healthcare professional. Good medical practice involves: 4.3.1 Taking reasonable steps to ensure that the person to whom you delegate, refer or handover has the qualifications, experience, knowledge and skills to provide the care required. **4.3.3 Always communicating sufficient information about the patient and the treatment they need to enable the continuing care of the patient.**

Australian Medical Association (AMA) *Position Statement: Conscientious Objection (2019)*	1.2 A conscientious objection occurs when a doctor, as a result of a conflict with his or her own personal beliefs or values, refuses to provide, or participate in, a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards. 1.3 A conscientious objection is **based on sincerely-held beliefs** and moral concerns, **not self-interest or discrimination**. 1.4 **It is acceptable for a doctor to refuse to provide or to participate** in certain medical treatments or procedures **based on a conscientious objection**. 1.5 A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection directly affects patients. **Doctors have an ethical obligation to minimise disruption to patient care** and must never use a conscientious objection to intentionally impede patients' access to care. 2.3 A doctor with a conscientious objection, should: • inform the patient of their objection, preferably in advance or as soon as practicable; • inform the patient that they have the right to see another doctor and **ensure the patient has sufficient information to enable them to exercise that right**; • **take whatever steps are necessary to ensure the patient's access to care is not impeded**; • continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking; • continue to provide other care to the patient, if they wish; • **refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;** • inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues. 2.4 The impact of a delay in treatment, and whether it might constitute a significant impediment, should be considered by a doctor if they conscientiously object, and is determined by the clinical context, and the urgency of the specific treatment or procedure. For example, termination of pregnancy services are time critical whereas other services require less urgency (such as IVF services). 3.1. Some health care facilities may not provide certain services due to **institutional conscientious objection** (for example, some institutions with religious affiliations will not provide termination of pregnancy, sterilisation or IVF services). In such cases, an **institution should inform the public of their conscientious objection and what services they will not provide** so that potential patients seeking those services can obtain care elsewhere (for example, this information could be highlighted on the institution's website, patient brochures and on posters clearly visible at the front of the facility).

Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPB) *Code of Conduct*	**2.1 Introduction** Care of the patient or client is the primary concern for health professionals in clinical practice. Providing good care includes: … c) facilitating coordination and continuity of care **2.4 Decisions about access to care** Practitioner decisions about access to care need to be free from bias and discrimination. Good practice involves: a) treating patients or clients with respect at all times … f) being aware of a practitioner's right to not provide or participate directly in treatments to which the practitioner objects conscientiously, informing patients or clients and, if relevant, colleagues of the objection, and not using that objection to impede access to treatments that are legal, and g) not allowing moral or religious views to deny patients or clients access to healthcare, recognising that practitioners are free to decline to provide or participate in that care personally.
Nursing and Midwifery Board of Australia (NMBA) *Code of Conduct for nurses* and *Code of Conduct for midwives*	**4.4 Conflicts of interest** People rely on the independence and trustworthiness of nurses [and midwives] who provide them with advice or treatment. In nursing [and midwifery] practice, a conflict of interest arises when a nurse [or midwife] has financial, professional or personal interests or relationships and/or personal beliefs that may affect the care they provide or result in personal gain. Such conflicts may mean the nurse [or midwife] does not prioritise the interests of a person as they should, and may be viewed as unprofessional conduct. To prevent conflicts of interest from compromising care, nurses [and midwives] must: a. **act with integrity and in the best interests of people when making referrals**, and when providing or arranging treatment or care b. **responsibly use their right to not provide, or participate directly in, treatments to which they have a conscientious objection**. In such a situation, nurses [and midwives] must respectfully inform the person, their employer and other relevant colleagues, of their objection and **ensure the person has alternative care options**
Pharmacy Board of Australia (PBA) *Code of Conduct** *Note these provisions are the same as the	**2.1 Introduction** Care of the patient or client is the primary concern for health professionals in clinical practice. Providing good care includes: … c) facilitating coordination and continuity of care **2.4 Decisions about access to care** Practitioner decisions about access to care need to be free from bias and discrimination. Good practice involves: a) treating patients or clients with respect at all times

ATSIHPB's *Code of Conduct* above	... f) being aware of a practitioner's right to not provide or participate directly in treatments to which the practitioner objects conscientiously, informing patients or clients and, if relevant, colleagues of the objection, and not using that objection to impede access to treatments that are legal, and g) not allowing moral or religious views to deny patients or clients access to healthcare, recognising that practitioners are free to decline to provide or participate in that care personally.
Australian Nursing and Midwifery Federation (ANMF) *Conscientious Objection Policy*	1. Nurses, midwives and assistants in nursing (however titled) have a right to refuse to participate in procedures which they judge, on strongly held religious, moral and ethical beliefs, to be unacceptable (conscientious objection). Fear, personal convenience or preference, are not sufficient basis for conscientious objection. 2. In exercising their conscientious objection, nurses, midwives and assistants in nursing must take all reasonable steps to ensure that the person's preference, quality of care, safety, and advance care directives are not compromised.
Pharmaceutical Society of Australia (PSA) *Code of Ethics for Pharmacists*	**Care principle 2: A pharmacist practices and promotes patient-centred care** A pharmacist: a. respects the dignity and autonomy of the patient. b. recognises and respects patients' diversity, cultural knowledge and skills, gender, beliefs, values, characteristics and lived experience, and does not discriminate on any grounds. … h. informs the patient when exercising the right to decline provision of certain forms of health care based on the individual pharmacist's conscientious objection, and in such circumstances, **appropriately facilitates continuity of care for the patient**.
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) *Position statement on the termination of pregnancy*	**4.2 Access** Non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality. **Access to termination services should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation.** Equitable access to services should be overseen and supported by health departments in each jurisdiction in the same way it is for other health services. Women have the right to access any medical services without their privacy being infringed or being subjected to harassment. **4.6 Workforce** …**No member of the health team should be expected to perform termination of pregnancy against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained**. …

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) *Code of ethical practice*	**2.6 Further opinion/ referral** Doctors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if: • the patient requests this; • the therapy required is beyond the individual doctor's expertise or experience; • the therapy required is in **conflict with the doctor's personal belief/value system**. If a doctor wishes to discontinue care of a particular patient, he/she **must make appropriate referral and with the patient's consent communicate relevant information to the new practitioner.**

Appendix J – Summary of the law regarding conscientious objection in Australian jurisdictions

State	Permits conscientious objections?	Who is the objection available to?	What particular steps in the abortion process can be objected to?	Is a referral required and what are these requirements?	Is there an exception in emergency situations and how is this described?
ACT	Yes	Authorised person (defined as nurse of doctor)	Prescribe, supply or administer an abortifacient, or carry out or assist in carrying out a surgical abortion	No, but must inform woman of the objection.	Yes, where necessary to preserve the life of the pregnant person.
NSW	Yes	Registered health practitioner	Performing, assisting, making decision whether to terminate, or advising about termination.	Yes, must provide person with information on how to locate or contact a medical practitioner that they believe does not have a conscientious objection, or transfer the person's care to another registered health practitioner or health service provider that can provide the service and does not conscientiously object.	Yes, this section does not limit any duty owed by a registered health practitioner to provide a service in an emergency.
NT	Yes	Registered medical practitioner; and ATSI health practitioner, authorised midwife, authorised nurse or authorised pharmacist	Advising on proposed termination or performing termination. For ATSI practitioner, midwife, nurse or pharmacist: assisting with performance of termination.	Yes, must inform woman and refer the woman, within a **clinically reasonable** time, to another medical practitioner **known** to not to have a conscientious objection	Yes, where necessary to preserve the life of the pregnant woman. Even ATSI practitioner, midwives and nurses are bound by this.
Qld	Yes	Registered health practitioner	Performing, assisting, making decision whether to terminate, or advising about termination.	Yes, must inform woman of objection. Must refer to another **health practitioner or health service provider** that they **believe** can provide the service and does not conscientiously object.	Yes, where necessary to save mother's life or life of another unborn child (s 23(1A)).
SA	Yes	Any person	Participation in treatment.	No.	Yes, where necessary to save the life, or to prevent grave injury to the physical or mental health of woman.
Tas	Yes	Any individual.	Participation in treatment.	Yes, must provide woman with list of prescribed health services so they can seek advice, information or counselling on the full range of pregnancy option.	Yes, where necessary to save the life of a pregnant woman or to prevent her serious physical injury. Nurses and midwives bound by this as well.

Vic	Yes	Registered health practitioner	Advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion.	Yes, must inform woman of objection and refer her to another registered health practitioner in the same regulated health profession who the objecting practitioner **knows** does not have a conscientious objection	Yes, where necessary to preserve the life of the pregnant woman. Objecting registered nurse must also assist in that circumstance.
WA	Yes	Any person, hospital, health institution or other institution or service	Participation in performance of abortion	No.	No, it can merely be 'justified' if it is causing serious danger to the woman's physical or mental health, seemingly leaving discretion to the doctor.

Appendix K – State-based Australian health departments: policies/guidelines on conscientious objection and referral [2245]

State Department / *Document*	Excepts of relevant Clinical Guideline, Standard or Policy
ACT Health *Canberra Hospital and Health Services Clinical Guideline: Termination of Pregnancy (TOP), Miscarriage or Fetal Death Management*	**Section 3 – Conscientious Objection** A medical officer who objects to being involved with terminations must inform the woman they have a conscientious objection and that another practitioner will care for her and refer the woman to a medical officer who performs the procedure. Health Professional staff with a conscientious objection to TOP should notify their manager in a timely manner of their objection.
NSW Ministry of Health *Policy Directive Pregnancy Framework*	**4.2 Conscientious objection** Any medical practitioner who is asked to advise a woman about termination of pregnancy, or to perform, direct, authorise or supervise a termination of pregnancy, and who has a conscientious objection to termination of pregnancy must: 1. Inform the woman that they have a conscientious objection and that other practitioners may be prepared to provide the health service she seeks; and 2. Take every reasonable step to direct the woman to another health practitioner, in the same profession, **who the practitioner reasonably believes does not have a conscientious objection** to termination of pregnancy. The term 'direct' is to be understood in its ordinary sense, that is, to direct or point to another source, rather than the requirement of a written referral as part of an ongoing working relationship. It may be as simple as directing the woman to another practitioner who they know has no such objection. This is to ensure that women receive **timely, accurate information from a professional who does not hold an objection** to the health service she seeks.
NT Department of Health *Clinical Guidelines for Termination of Pregnancy*	**2.2 Conscientious objection** Medical and health practitioners who have a conscientious objection to termination of pregnancy may decline to provide termination of pregnancy services. However, the Act requires a medical or health practitioner who has a conscientious objection to inform the woman of this. The medical or health practitioner **must then refer the woman, within two working days to another medical practitioner who does not have a conscientious objection or facility known to provide terminations of pregnancy and must provide the woman with relevant contact details.** The Act also allows a suitably qualified medical practitioner to direct an authorised health practitioner to assist in the performance of a termination of pregnancy. If a health practitioner has a conscientious objection to assisting with the provision of termination services, the health practitioner must inform the medical practitioner of this, and **it will be the responsibility of the suitably qualified medical practitioner to direct another authorised health practitioner who does not have a conscientious objection** in relation to the provision of termination services, to assist with the provision of the services as required.

[2245] SALRI notes that no information was publicly available for the Department of Health and Human Services in Victoria.

	This process should be undertaken in consultation with the woman to ensure the **relevant information is given to her and the services are provided as soon as possible**. A **suggested referral form for conscientious objectors** (called 'Referral for Pregnancy Services') can be downloaded from the Department of Health website.
Qld Health Department *Clinical Guidelines on the Termination of Pregnancy*	**2.3 Conscientious objection** Disclosure of objection: · Registered health practitioners must disclose their conscientious objection to a person asking for termination healthcare · For example: o If a medical practitioner asks for assistance from a nurse who holds a conscientious objection, the nurse is required to disclose this to the medical practitioner o If a woman requests termination healthcare from a medical practitioner who holds a conscientious objection, the medical practitioner must disclose this to the woman Referral or transfer of care: · If a woman requests termination healthcare, a registered health practitioner who has a conscientious objection to termination healthcare must refer the woman or transfer her care to: o Another registered health practitioner whom they believe can provide the requested termination healthcare and who does not have a conscientious objection OR o To a health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection Care that is not a matter for conscientious objection: · The conscientious objection provision does not extend to: o **Administrative, managerial or other tasks ancillary to the provision of termination healthcare** o **Hospitals, institutions or services as the right to conscientiously object is a personal and individual right**
SA Health *Standards for the Management of Termination of Pregnancy in South Australia* (March 2014)	**Facilities** …Local health services managers and medical practitioners have a responsibility to inform the community of the limitations regarding access to termination of pregnancy services within the local health service and the process of referral to an appropriate health service able to provide such a service should the need arise. **Workforce implications** …Health services that are unable to provide medical and/or surgical termination of pregnancy services must have defined clinical protocols to support staff in the **prompt referral** of the woman requiring these services.

Tasmanian Public Health Service *Ending a pregnancy: information for women*	**Considering your options** Some doctors have a conscientious objection to termination (they disagree with the procedure). Doctors with a conscientious objection do not have to provide you with information about, or help you to access, a termination — but they must provide you with a list of **prescribed health services** (services that provide information, advice or counselling about the full range of pregnancy options) as soon as they know you want a termination or want information about all options regarding your pregnancy.
WA Department of Health *Termination of pregnancy: Information and legal obligations for medical practitioners*	**3. Timing of referral** **Abortion before 20 weeks** **Importance of early referral** There is always a balance between referral early in pregnancy and allowing sufficient time for decision-making. However, it is important to ensure that women wanting termination of pregnancy are referred early, as the risk of complications rises with increasing gestation. **4. Medical Practitioners — ethical and legal obligations in detail** Medical practitioners are under no obligation to participate in a consultation and referral for pregnancy termination. However medical practitioners should demonstrate respect for the patient's values and assist the patient to access care which is consistent with the patient's values and wishes. This would involve **referring the woman as soon as possible** to another medical practitioner who can provide information and referral if she wishes. The law does not require medical practitioners to participate in a consultation and referral for pregnancy termination. Some medical practitioners may feel on moral or religious grounds that they are unable to counsel or refer for termination of pregnancy. They should make their position clear to the woman at an early stage and advise her to seek help elsewhere, from another medical practitioner or Women's Health Centre.

Appendix L – International health body policies: summary of key conscientious objection and referral principles

Name of body / *Policy name*	Respect for objector's right to act on their conscience	Respect for patient's autonomy	Objector must not impede access to healthcare	Requires some form of referral following conscientious objection	Process of referral specified
International Federation of Gynaecology & Obstetrics (FIGO) *Resolution on 'Conscientious Objection'*	Yes	Yes	Yes, and clarifies that timely access should be provided.	Yes	Inform patients of all medically indicated options for their healthcare. Refer patients to other practitioners who do not object. Provide **timely care** to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being.
International Confederation of Midwives (ICM) *International Code of Ethics for Midwives*	Yes	Not mentioned	Yes	Not mentioned	No
General Medical Council (GMC) *Good medical practice guidelines* (UK)	Yes	Yes	Yes	Not mentioned	Must make sure patient has enough information to exercise right to see another doctor. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. **If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made** for another suitably qualified colleague to take over your role.
Nursing and Midwifery Council (NMC) *The Code* (UK)	Yes	Not expressly mentioned	Not expressly mentioned	Yes	Arrange for a suitably qualified colleague to take over responsibility for that person's care.
Royal College of Obstetricians and Gynaecologists' (RCOG) *The Care of Women Requesting Induced Abortion Clinical Guideline* (UK)	Yes	Yes	Yes	Yes	Doctor must complete form HSA1 (Certificate A if in Scotland). **Referral** to an abortion provider should be made **within 2 working days**. Upon referral, women should be given the service provider's contact details.
Royal College of Nursing (RCN) *Framework on the Termination of Pregnancy* (UK)	Yes	Not expressly mentioned	Yes	Not mentioned	No

World Health Organisation (WHO) *Safe abortion: technical and policy guidance for health systems*	Yes	Yes	Yes	Yes	Must refer the woman to another willing and trained provider in the same, or another **easily accessible** health-care facility. **Where referral is not possible**, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health.
World Medical Association (WMA) *Statement on Medically-Indicated Termination of Pregnancy* * *Note, only specified for medically-indicated abortion	Yes	Yes	Yes	Yes	Ensuring the continuity of medical care by a qualified colleague.

Appendix M – International health bodies: excerpts of relevant policies

Provider / *Policy Name*	**Excerpts of Relevant Policy**
International Federation of Gynaecology & Obstetrics (FIGO) *Resolution on 'Conscientious Objection'*	Recognizing that physicians have an ethical obligation, at all times, to provide benefit and prevent harm for every patient for whom they care. Recognizing further that providers are obligated to **inform patients of all medically indicated options for their healthcare** and respect their choice (autonomy). Recognizing patients' rights to **timely access** to medical services. Acknowledging that **practitioners have a right to respect for their conscientious convictions** both not to undertake and to undertake the delivery of lawful services; and Noting the duty of practitioners as professionals to abide by scientifically and professionally determined definitions of reproductive health services and not to mischaracterize them on the basis of personal beliefs. FIGO affirms that to behave ethically, practitioners shall: 1. Provide public notice of professional services they decline to undertake on grounds of conscience; 2. **Refer patients** who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services; 3. Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being; and 4. In emergency situations, provide care regardless of practitioners' personal objections.
International Confederation of Midwives (ICM) *International Code of Ethics for Midwives*	III. c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
General Medical Council (GMC) *Good medical practice guidelines* (UK)	52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and **make sure they have enough information to exercise that right**. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you **must make sure that arrangements are made for another suitably qualified colleague to take over your role.**

General Medical Council (GMC) *Personal beliefs and medical practice guidelines* (UK)	12 Patients have a right to information about their condition and the options open to them. If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following: a Tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress. You may wish to mention the reason for your objection, but you **must be careful not to imply any judgement of the patient**. b Tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to. c **Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.** 13 **If it's not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made – without delay – for another suitably qualified colleague to advise, treat or refer the patient.** You must bear in mind the patient's vulnerability and act promptly to make sure they are not denied appropriate treatment or services. 15 You must not obstruct patients from accessing services or leave them with nowhere to turn. 16 Whatever your personal beliefs about the procedure in question, you must be respectful of the patient's dignity and views.
Nursing and Midwifery Council (NMC) *The Code* (UK)	**4 Act in the best interests of people at all times** To achieve this you must: 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care
Royal College of Obstetricians and Gynaecologists (RCOG) *The Care of Women Requesting Induced Abortion Clinical Guideline* (UK)	**Chapter 2: Summary of recommendations** **2.1 Commissioning and organising services** **Arrangements for the procedure** 4.22 A system should be in place to ensure that doctors within the abortion service **complete form HSA1** (Certificate A in Scotland) if a woman refers herself, or if the referring doctor is not willing to support the abortion. 4.24 **To minimise delay, service arrangements should be such that:** • **Referral to an abortion provider should be made within 2 working days.** • **Abortion services must offer assessment within 5 working days of referral or self-referral**.

	• Services should offer women the abortion procedure within 5 working days of the decision to proceed. • The total time from seeing the abortion provider to the procedure should not exceed 10 working days. • Women requiring abortion for urgent medical reasons should be seen as soon as possible. 4.25 Women should be informed that they have a right to delay or cancel appointments and/or the procedure should they wish. **4.26 Upon referral, women should be given the service provider's contact details.** **3.3 Professionals' rights: conscientious objection to abortion** The Abortion Act has a conscientious objection clause, which permits doctors (and nurses) to refuse to participate in any treatment authorised by the Act if it conflicts with their religious or moral beliefs. … The scope of the Act's conscientious objection clause was clarified in the House of Lords 1988 *Janaway* case. In that case it was held that 'participate' should be given its ordinary and natural meaning of actually taking part in treatment, and did not extend to typing a referral letter. **It is therefore likely that a refusal to participate in paperwork, administration or routine care (outside of treatment) connected with abortion procedures lies outside the terms of the conscientious objection clause**. … Doctors who have a conscientious objection to abortion must tell women of their right to see another doctor. NHS GPs who have contracted to provide contraceptive services and who have a conscientious objection to the abortion must, where appropriate, refer women promptly to another doctor. The **GMC's guidance covering personal beliefs and medical practice (2008) states: '**…**You should make sure that information about alternative services is readily available to all patients. Children and young people in particular may have difficulty in making alternative arrangements themselves**, so **you must make sure that arrangements are made** for another suitably qualified colleague to take over your role as quickly as possible.' … Like doctors, nurses have the right to refuse to take part in abortion but not to refuse to take part in emergency treatment. Hospital managers have subsequently been asked to apply the principles as described above, at their discretion, to those ancillary staff involved in handling fetuses and fetal tissue.
Royal College of Nursing (RCN) *Framework on the Termination of Pregnancy* (UK)	**2 Legal considerations** **Conscientious objection** Nurses and midwives who have a conscientious objection must inform their employer at the earliest opportunity. Under the 1990 legislation, nurses cannot refuse to provide nursing care for women before or after the termination of the pregnancy. It is equally important to acknowledge that where nurses may have an objection to terminating a pregnancy, they should be afforded respect for their decision and supported not to participate in care scenarios that may lead to conflict.

	3 Service provision and practice considerations **Access and referral** Termination services should therefore be easily accessible and should allow both direct referrals as well as referrals from health professionals. Providers of termination services should be committed to ensuring that women can access services as early as possible to reduce the possibility of associated health risks
World Health Organisation (WHO) *Safe abortion: technical and policy guidance for health systems*	**3.3.6 Conscientious objection by health-care providers** Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health. Women who present with complications from an unsafe or illegal abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviours. **4.2.2.5 Conscientious objection** Health-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health. Health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.
World Medical Association (WMA) *Statement on Medically-Indicated Termination of Pregnancy*	*NOTE the following provisions only applying to medically-indicated terminations of pregnancy (e.g. not abortions by choice on other grounds) as outlined below in 1. 1. Medically-indicated termination of pregnancy refers only to interruption of pregnancy due to health reasons, in accordance with principles of evidence-based medicine and good clinical practice. This Declaration does not include or imply any views on termination of pregnancy carried out for any reason other than medical indication. … 8. **Physicians have a right to conscientious objection to performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague**. In all cases, physician must perform those procedures necessary to save the woman's life and to prevent serious injury to her health.

	9. **Physicians must work with relevant institutions and authorities to ensure that no woman is harmed because medically-indicated termination of pregnancy services are unavailable**.
World Medical Association (WMA) *International Code of Medical Ethics*	**DUTIES OF PHYSICIANS IN GENERAL** A PHYSICIAN SHALL respect the rights and preferences of patients, colleagues, and other health professionals. **DUTIES OF PHYSICIANS TO PATIENTS** A PHYSICIAN SHALL owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.

Appendix N – Certificate and Notice (in the prescribed form)

188503

CRIMINAL LAW CONSOLIDATION (MEDICAL TERMINATION OF PREGNANCY) REGULATIONS 1996

CERTIFICATE TO BE COMPLETED WHEN AN ABORTION IS PERFORMED UNDER SECTION 82A OF THE CRIMINAL LAW CONSOLIDATION ACT 1935

SCHEDULE 1- Doctor's certificates and notice

A copy of this form must be retained by the doctor who performed the termination for a period of three years commencing on the date of the termination. The original form is to be delivered or posted in a sealed envelope *within 28 days of the termination of the pregnancy* to the Chief Executive, Department of Health (Pregnancy Outcome Unit), P.O. Box 6 Rundle Mall, Adelaide, SA 5000.

The envelope must be clearly marked with the words "STRICTLY CONFIDENTIAL".

PLEASE USE BLOCK LETTERS

PART A-CERTIFICATES

NAME, ADDRESS AND QUALIFICATIONS OF DOCTOR WHO PROPOSES TO TERMINATE PREGNANCY OR, IN THE CASE OF AN EMERGENCY TERMINATION, WHO HAS TERMINATED PREGNANCY

.....

.....

NAME, ADDRESS AND QUALIFICATIONS OF OTHER DOCTOR JOINING IN CERTIFICATE FOR ORDINARY TERMINATION OF PREGNANCY

.....

.....

FULL NAME AND ADDRESS OF PREGNANT WOMAN

.....

.....

PREGNANT WOMAN'S STATED PERIOD OF RESIDENCY IN SOUTH AUSTRALIA BEFORE THE DATE OF THIS CERTIFICATE.....

REASONS FOR UNDERTAKING TERMINATION OF PREGNANCY

.....

.....

DIAGNOSIS (Primary condition *must* be specified).....

.....

CERTIFICATE TO BE COMPLETED BEFORE AN ORDINARY TERMINATION

We certify that in the case of the woman named above (whom we have each personally examined) termination of pregnancy is justified under section 82A(1) *(a)* of the *Criminal Law Consolidation Act 1935* on the following grounds

*1. The continuance of the pregnancy would involve greater risk to the life of the pregnant woman than if the pregnancy were terminated.

*2. The continuance of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.

*3. There is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.

*(*Circle the appropriate number)*

SIGNED.....DATE.....

SIGNED.....DATE.....

CERTIFICATE TO BE COMPLETED FOLLOWING AN EMERGENCY TERMINATION

I certify that in the case of the woman named above (whom I have personally examined) termination of pregnancy was justified under section 82A(1) *(b)* of the *Criminal Law Consolidation Act 1935* on the following grounds:

*4. Termination of the pregnancy was immediately necessary to save the life of the pregnant woman.

*5. Termination of the pregnancy was immediately necessary to prevent grave injury to the physical or mental health of the pregnant woman.

*(*Circle the appropriate number)*

SIGNED.....DATE.....

PART B-NOTICE TO BE COMPLETED FOLLOWING TERMINATION OF A PREGNANCY

The pregnancy to which the above certificate relates was terminated at-

.....

(Name of hospital)

..... on.....

(Address of hospital) *(date of termination)*

SIGNED.....DATE.....

(Doctor who terminated the pregnancy)

188503

INFORMATION RELATING TO THE TERMINATION

(To be completed by the doctor who performed the termination)

1. Date of birth of woman: *(Day, Month, Year)*.....

2. Date of last menstrual period: *(Day, Month, Year)*.....

If unknown, or uncertain, give clinical estimate in completed weeks of gestation when pregnancy terminated

.....

3. Total number of **previous** pregnancies.....
   - Livebirths .....
   - Stillbirths .....
   - Spontaneous miscarriages .....
   - Ectopic pregnancies .....
   - Terminations.....

4. Number of previous terminations in South Australia *(1970 or after)* .....
   Year of last termination in South Australia:.....

5. Date of admission to place of termination of pregnancy: *(Day, Month, Year)*.....

6. Date of termination of pregnancy: *(Day, Month, Year)* .....

7. Date of discharge from place of termination of pregnancy: *(Day, Month, Year)* .....

8. Grounds for termination of pregnancy:
   (a) Medical condition of woman *(specify)*.....
   - Obstetric disease .....
   - Non-obstetric disease.....

   (b) Suspected medical condition of fetus *(specify)*
   - Genetic disorder .....
   - Non-genetic disorder .....

If account has been taken of the woman's actual or reasonably foreseeable environment, indicate reasons:

.....

.....

9. Method of termination: *(circle one)*
   1. Dilatation and curettage
   2. Hysterotomy – abdominal
   3. Hysterotomy – vaginal
   4. Hysterectomy
   5. Vacuum aspiration
   6. Intra-uterine injection
   7. Intravenous infusion
   8. Vaginal or cervical prostaglandin
   9. Dilatation and evacuation
   10. Medical *(specify)*.....
   11. Other *(specify)*.....

10. Was sterilisation of the woman undertaken *(circle one)*
    1. Yes
    2. No

11. Post-operative complications or death prior to the date of this notice: *(circle)*
    1. None
    2. Sepsis
    3. Haemorrhage-intra-operative
    4. Haemorrhage- post-operative
    5. Perforation of or trauma to body of uterus
    6. Anaesthetic complication
    7. Other *(specify)*.....
    8. Maternal death *(specify cause)*.....

    .....

12. If readmitted/transferred
    Place of transfer .....
    Date of readmission/transfer : *(Day, Month, Year)*.....
    Date of second discharge: *(Day, Month, Year)* .....
    Reason for readmission/transfer .....

OFFICIAL USE ONLY

Residency in South Australia 1. less than specified time.....2. more than specified time.....

Hospital where termination performed

Doctor performing termination

Doctor supporting termination

Date of receipt of notification

LGA

Postcode

Section of Act

MEDICAL TERMINATION OF PREGNANCY

EXTRACT FROM THE CRIMINAL LAW CONSOLIDATION ACT 1935

82A. (1) Notwithstanding anything contained in section 81 or 82, but subject to this section, a person shall not be guilty of an offence under either of those sections-

(a) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman-

(i) that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or

(ii) that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped,

and where the treatment for the termination of the pregnancy is carried out in a hospital, or a hospital of a class, declared by regulation to be a prescribed hospital, or a hospital of a prescribed class, for the purposes of this section; or

(b) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman.

(2) Subsection (1) *(a)* does not refer or apply to any woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the physical or mental health of a pregnant woman as is mentioned in subsection (1) *(a)* (i), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) The Governor may make regulations-

(a) for requiring any such opinion as is referred to in subsection (1) to be certified by the legally qualified medical practitioners or practitioner concerned in such form and at or within such time as may be prescribed and for requiring the preservation and disposal of any such certificate made for the purposes of this Act; and

(b) for requiring any legally qualified medical practitioner who terminates a pregnancy, and the superintendent or manager of the hospital in which the termination is carried out, to give notice of the termination and such other information relating to the termination as may be prescribed to the Chief Executive; and

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be prescribed, of notices or information given pursuant to the regulations; and

(d) declaring a particular hospital or a class of hospitals to be a prescribed hospital or a prescribed class of hospitals for the purposes of this section; and

(e) for providing for, and prescribing, any penalty, not exceeding two hundred dollars, for any contravention of, or failure to comply with, any regulations.

(5) Subject to subsection (6), no person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this section to which he has a conscientious objection, but in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it.

(6) Nothing in subsection (5) affects any duty to participate in treatment which is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman.

(7) The provisions of subsection (1) do not apply to, or in relation to, a person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes such a child to die before it has an existence independent of its mother where it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

(8) For the purposes of subsection (7), evidence that a woman had at any material time been pregnant for a period of twenty- eight weeks or more shall be *prima facie* proof that she was at that time pregnant of a child capable of being born alive.

(9) For the purposes of sections 81 and 82, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by this section.

(10) In this section and in sections 81 and 82- " **woman** " means any female person of any age.

Appendix O - Bibliography

A. Articles and Books

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