

Published by the Victorian Law Reform Commission

The Victorian Law Reform Commission was established under the *Victorian Law Reform Commission Act 2000* as a central agency for developing law reform in Victoria.

This report reflects the law as at 1 January 2008.

©March 2008 Victorian Law Reform Commission.
This work is protected by the laws of copyright.
Except for any uses permitted under the *Copyright Act 1968* (Cth) or equivalent overseas legislation, no part of this work may be reproduced, in any manner or in any medium, without the written permission of the publisher. All rights reserved.

The publications of the Victorian Law Reform Commission follow the Melbourne University Law Review Association Inc, *Australian Guide to Legal Citations* (2nd ed, 2002).

National Library of Australia Cataloguing-in-Publication

Victorian Law Reform Commission.
Law of Abortion: Final Report

Bibliography

ISBN 9780975846605 (pbk)

1. Abortion – Law and legislation – Victoria.
2. Fetus – Legal status, laws, etc – Victoria.

344.94504192

Ordered to be printed

Victorian Government Printer
No 88 Session 2006–08



Victorian
Law Reform
Commission

LAW OF ABORTION

Final Report 15

LAW OF ABORTION



Victorian Law Reform Commission

GPO Box 4637
Melbourne Victoria 3001 Australia
DX 144 Melbourne, Vic

Level 10, 10–16 Queen Street
Melbourne Victoria 3000 Australia

Telephone +61 3 8619 8619
Facsimile +61 3 8619 8600
TTY 1300 666 557
1300 666 555 (within Victoria)
law.reform@lawreform.vic.gov.au
www.lawreform.vic.gov.au

Contents

3	Abbreviations	46
4	Preface	47
5	Terms of Reference	48
5	Terminology	49
6	Executive Summary	50
8	Recommendations	50
9	PART 1: CURRENT LAW AND PRACTICE	
11	Chapter 1: Introduction	
12	Scope of Report	52
12	What is Not Under Review	52
12	Victorian Context	52
12	Our Process	52
12	Information Paper	53
12	Consultation	
13	Submissions	
13	Medical Panel	
13	About this Report	
15	Chapter 2: Current Law	
16	Introduction	
16	Charter of Human Rights and Responsibilities	
16	Crimes Act Provisions	
18	Menhennitt Rules	
20	Interstate Development of the Menhennitt Rules	
21	Abortion Law in other Australian Jurisdictions	
21	New South Wales	
21	Queensland	
22	South Australia	
22	Northern Territory	
23	Western Australia	
24	Tasmania	
24	Australian Capital Territory	
24	Common Law	
25	Abortion Law Overseas	
25	United Kingdom	
26	New Zealand	
27	Canada	
27	United States	
28	Related Legal Issues	
28	Consent to Treatment	
31	Chapter 3: Current Clinical Practice	
32	Overview	
32	Incidence of Abortion	
34	Abortion Services	
34	Public Providers	
35	Private Providers	
36	Abortion at Later Gestation	
36	Current Practice	
40	Relevance of Viability	
41	Fetal Testing: Abortion and Disability	
41	Diagnosis of Abnormality	
42	Access to Testing	
42	Reaction to Test Results	
44	Fetal Abnormality in Abortion Law?	
	Current and Future Access Issues	46
	Rural and Regional Issues	47
	Training and Availability of Staff	48
	RU486—Mifepristone	49
	Regulation of Medical Practice of Abortion	50
	General Regulation of Health Practitioners	50
	Registration of Clinics—DHS Regulation	52
	Registration of Births and Deaths	52
	Public Hospitals	52
	Professional Organisation Guidelines	53
55	PART 2: COMMUNITY VIEWS	
57	Chapter 4: Surveys of Community Attitudes	
58	Community Attitudes Data	
58	Review of Surveys	
58	Australian Survey of Social Attitudes	
59	Australian Election Study	
60	Southern Cross Bioethics Institute Survey	
61	Australian Federation of Right to Life Associations Survey	
63	Marie Stopes International Survey	
64	Opinions by Population Subgroup	
64	Unadjusted Analyses	
66	Adjusted Analyses of AuSSA 2003	
66	Key Findings	
68	Conclusions	
71	Chapter 5: Commission’s Consultation Outcomes	
72	Submissions	
72	Consultation Meetings	
72	Ethical and Legal Principles	
74	Policy Objectives	
76	Grounds for Lawful Abortion	
78	Gestational Limits	
79	Determining Gestational Limits	
80	Medical Profession Gatekeeping	
81	Notification Scheme	
81	Counselling	
81	Child Destruction	
81	Penalties	
82	Conclusions	
83	PART 3: LAW REFORM	
85	Chapter 6: Options for Reform	
86	Terms of Reference	
86	Legislative Options	
86	I Introduction	
87	Model A	
90	Model B	
93	Model C	
95	Chapter 7: Child Destruction	
96	Introduction	
96	The Offence	
97	Background to the Offence	
98	Problems with the Offence	
98	A Non-existent Problem	

Abbreviations

98	Criminalising Medical Decisions
99	Lack of Clarity in the Law
100	The Offence in Victoria
101	Is Reform Needed?
101	Complexity of the born alive rule
102	Legal Uncertainty about Late Therapeutic Abortions
103	Submissions and Consultations
103	Abolish
104	Retain but Enforce
104	Confine to Childbirth
105	Amend to Tighten
105	Options for Reform
106	Option 1: NSW Model
107	Option 2: ACT Model
108	Option 3: UK Model
108	Commission's Recommendation
111	Chapter 8: Other Legal and Policy Issues
112	Issues Where Legal Change is Justified
112	Conscience Clause
116	Issues Adequately Dealt with by Existing Law and Practice
116	Mandatory Information
118	Counselling
126	Cooling-off Periods
127	Targetted Regulation of Abortion Providers
128	Should There be Limits on Where Abortions are Performed?
132	Notification Schemes
133	Adverse Events Register
134	Additional Consent Requirements
137	Anti-coercion Legislation
137	Substantive Issues Beyond the Scope of this Reference
137	Truth in Advertising
138	Bubble Zones

APPENDICES

142	Appendix A: History of Abortion Law Policy
148	Appendix B: Ethics of Abortion
158	Appendix C: Legal Developments
162	Appendix D: Human Rights and Abortion
172	Appendix E: Consultations
173	Appendix F: Submissions

ACT	Australian Capital Territory
AES	Australian Election Study
AFRTL	Australian Federation of Right to Life Associations
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ART	assisted reproductive technology
AuSSA	Australian Survey of Social Attitudes
cl	clause
Cth	Commonwealth
CAT	<i>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>
CEDAW	<i>Convention on the Elimination of all forms of Discrimination against Women</i>
CERD	<i>Convention on the Elimination of all forms of Racial Discrimination</i>
CRC	<i>Convention on the Rights of the Child</i>
CRPWD	<i>Convention on the Rights of Persons with Disabilities</i>
HREOC	Human Rights and Equal Opportunity Commission
ICCPR	<i>International Covenant on Civil and Political Rights</i>
CESCR	<i>International Covenant on Economic, Social and Cultural Rights</i>
DHS	Department of Human Services
J	justice
MSI	Marie Stopes International
n	footnote
NHMRC	National Health and Medical Research Council
NSW	New South Wales
NT	Northern Territory
PAS	Pregnancy Advisory Service
pt	part
Qld	Queensland
r	regulation
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
s	section (ss plural)
SA	South Australia
SCBI	Southern Cross Bioethics Institute
UDHR	<i>Universal Declaration of Human Rights</i>
UK	United Kingdom
VBDR	Victorian Birth Defects Register
VCAT	Victorian Civil and Administrative Tribunal
VAED	Victorian Admitted Episode Dataset
WA	Western Australia

Preface

Chairperson

Professor Neil Rees

Part-time Commissioners

Paris Aristotle AM

Her Honour Judge Jennifer Coate*

The Honourable Justice David Harper

Her Honour Judge Felicity Hampel

Professor Sam Ricketson

His Honour Judge Iain Ross AO

* Judge Coate did not participate in this review.

In late September 2007 the Attorney-General asked the commission to provide advice about options for reform of the law of abortion and report back by 28 March. That advice was to be guided by the Victorian Government's commitment to decriminalise abortion and by its objective to modernise the law so that it is clear, widely understood, and reflective of current community standards. The terms of reference also indicate that while the government does not seek to restrict current access to services, reform of the law should not lead to an increase in the rate of abortion.

Unlawful abortion has been a crime since Victoria became a self-governing colony more than 150 years ago. Despite many calls for reform of the law, the Victorian Parliament has permitted the offence to remain on the statute book, unchanged, since 1865.

The commission was directed by its terms of reference to consider existing legal principles that govern abortion practices in Victoria. Those principles are not clear. For this reason, and for many others, it is unlikely that the principles are strictly adhered to in practice.

The commission was also directed by its terms of reference to consider 'existing practices concerning termination of pregnancy by medical practitioners'. To undertake this task, and to ensure that the commission was familiar with a broad range of medical issues associated with this reference, a panel of experts from the relevant health professions was established. Dr Christine Tippett, the President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, chaired that panel. Other panel members were: Dr Charles Barfield, Dr Andrew Edwards, Professor Fiona Judd, Dr Paddy Moore, Professor Michael Permezel, Dr Di Palmer, Associate Professor Les Sheffield, Associate Professor Beverley Vollenhoven, Dr Andrew Watkins, and two people who have chosen to remain anonymous. People were invited to join the panel because of their high professional standing, rather than any direct involvement in the provision of abortion services. I wish to thank all of the medical panel members for giving generously of their time and expertise to assist the commission.

Two academic lawyers—Dr Bronwyn Naylor (Monash Law School) and Professor David Studdert (Melbourne Law School)—acted as consultants to the commission. Both Dr Naylor and Professor Studdert provided invaluable advice and assistance.

All members of the commission belonged to the division responsible for this reference, other than Her Honour Judge Jennifer Coate, who was unavailable. I wish to express my gratitude to my fellow commissioners for the very thoughtful manner in which they dealt with this complex and sensitive reference. A similar expression of gratitude is due to the many members of the commission's staff who worked on the reference. Without their energy, commitment, and skill it would not have been possible to produce this report within such a short period.

Abortion is a topic which generates a strong response from some people. The commission met many people who have been leading advocates in the abortion debate. We also met people who are providers of abortion services. Without exception, the people we met were courteous and cooperative. I express my gratitude to them for the manner in which they conveyed their views to the commission.

It reflects well on the governance of our community that a topic such as abortion has been referred to an independent body for background information and advice about reform options before it is debated in parliament.

I hope that this report will be of assistance to all members of the Victorian Parliament and the broader community when abortion law reform is considered.



Professor Neil Rees

Chairperson

Victorian Law Reform Commission

Terms of Reference

THE LAW GOVERNING TERMINATION OF PREGNANCY

I, Rob Hulls MP, Attorney-General for the State of Victoria, refer aspects of the law governing termination of pregnancy to the Victorian Law Reform Commission. The commission is 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.
- 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.
- D. Legislative and regulatory arrangements in other Australian jurisdictions.

The commission should report no later than 28 March 2008.

BACKGROUND:

The *Crimes Act 1958* (Vic) provides that it is a criminal offence to bring about, or to attempt to bring about, or to assist a person to bring about, an unlawful termination of pregnancy. The circumstances in which termination of pregnancy is lawful has been left to judicial determination.

For many years in Victoria a woman has been able to lawfully seek a termination of her pregnancy by a medical practitioner in certain circumstances. Nearly 40 years have passed, however, since the primary Victorian case which explained the operation of the law and described the circumstances in which a termination of pregnancy would be lawful.

It is essential that the law is modernised, clear and widely understood. This reference is designed to provide the government with recommended options to have in place clear laws which reflect current clinical practice and community standards. The government's aim is that reform should neither expand the extent to which terminations occur, nor restrict current access to services.

Terminology

fetal abnormality

We use the term 'fetal abnormality' because it is used by doctors to describe a positive test or indication for certain genetic or other conditions. We do not wish to imply that a fetus which is diagnosed with such conditions is in any way abnormal.

fetus

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 terms.

interests

Throughout this report, the term 'interests' is used. This term does not imply any legal rights or status, rather, it has been used to describe where a person may have a concern or attach ethical significance to an act.

late abortion

This term is used to refer to abortions which take place after about 24 weeks gestation.

medical abortion

Abortion performed using drugs rather than surgery—includes prostaglandin drugs (such as misoprostol), methotrexate, and mifepristone (RU-486), alone or in combination

neonatal

The term 'neonatal' is used to describe children in the first month after birth.

perinatal

The term 'perinatal' is used to describe the period between a 20 week old fetus and a child aged up to 28 days.

positions in abortion debate

Many descriptions abound to characterise the various positions held by groups involved in the abortion regulation debate. We characterise groups according to their stance on decriminalisation, so refer to anti- or pro-decriminalisation or decriminalisation supporters or opponents.

surgical abortion

Abortions performed using surgical procedures.

therapeutic abortion

The term used in the law to refer to abortions performed by qualified medical practitioners.

Terms bolded in the report appear in the Glossary.

Executive Summary

This report is concerned with reform of the law of abortion in Victoria.

The commission was asked to provide legislative options to decriminalise abortion when performed by a medical practitioner. The offence of abortion remains in the Crimes Act despite a 1969 ruling by Justice Menhennitt that medical practitioners may lawfully perform abortions in some circumstances.

The report contains three legislative models for reform of the law of abortion and several recommendations about associated legal matters.

The report is divided into three parts. Chapter 2 provides an overview of the current law of abortion in Victoria and describes where it lacks clarity. The development of the Menhennitt rules is outlined, and information provided about abortion law throughout Australia and other countries.

In Chapter 3 we describe the incidence and availability of abortion services in Victoria. Only estimates of the rate of abortion are available. National studies show the Victorian rate to be below the national average, and possibly to have fallen in the past 12 years. The commission gathered considerable information about current clinical abortion practice to ensure the government was provided with options for reform that fit within its stated aim of not expanding or restricting current abortion services.

Abortion is readily available in Melbourne through public and private providers. There are no private abortion clinics in regional Victoria, and only a small number of regional public hospitals provide abortion. Most women in regional Victoria must travel to Melbourne to access abortion services. Abortion is regulated by health legislation, hospital regulations, and laws that govern the health profession. These laws are comprehensive and the commission does not recommend any further specific regulation of abortion services.

The second part of the report looks at community views about abortion. We analysed community attitudes data on abortion in Australia to develop options that 'reflect current community standards'. While the available survey data has various strengths and weaknesses, it shows that the majority of Australians support a woman's right to choose whether to have an abortion.

The commission conducted broad consultation for this review, meeting with 36 groups and individuals with differing views on decriminalisation of abortion. We received 519 submissions, also covering the full range of views on this issue. In this part we analyse the responses received in consultations and submissions. These responses informed all of the commission's work on this review and, therefore, are referred to throughout the report.

Part three of the report examines reform of abortion law. We present three possible models for reform of abortion law that take into account the government's intentions and objectives. The terms of reference state: abortion is to be decriminalised when performed by a medical practitioner; the new law is to be clear; the law should reflect current community standards; current clinical practice is not to be altered; and the law should not restrict current access to services or expand the rate of abortion. All three models sit within health legislation rather than the Crimes Act. With each model we describe the legislative changes that would be required for its implementation.

Model A codifies the Menhennitt rules and subsequent judicial rulings in other parts of Australia on the legality of abortion. Under this model an abortion is lawful with the woman's consent, and when a doctor determines that the abortion is necessary because of a risk of harm to the woman if the pregnancy is not terminated.

Three options are provided within this model for determining risk of harm. The first restates the Menhennitt rules: abortion must be a necessary and proportionate response to the risk of harm faced by a pregnant woman. The second restates NSW case law, which adds a description of the range of matters 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. The third option simplifies the determination of risk of harm.

Model B provides for a two-staged approach to regulation, with different rules for early and late abortions. Late abortions are defined as those where the pregnancy has exceeded 24 weeks gestation, which is consistent with current clinical practice. Abortions before that 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 a medical practitioner. Once a pregnancy passes

24 weeks gestation, abortion would be lawful if a doctor (or two doctors) determined that it was necessary to prevent risk of harm to the woman if the pregnancy continued. Risk of harm could be formulated in any of the three ways outlined in Model A.

Model C regulates abortion in the same way as all other medical procedures. In this model abortion is lawful with the woman's consent, and if performed by a medical practitioner. This model places decision-making responsibility with the woman, and service availability with the medical profession. It is the same as abortion legislation in the ACT.

RECOMMENDATIONS

Several changes are required to decriminalise abortions performed by medical practitioners, regardless of which of the three models for reform is chosen by parliament.

Sections 65 and 66 of the Crimes Act should be repealed and a provision included to make it clear that any common law offences relating to abortion cannot be revived and are abolished. A medical practitioner who performs an unlawful abortion should be liable to a professional rather than a criminal sanction.

It should remain a criminal offence for an abortion to be performed by an unqualified person. This may be achieved by including a new offence in the Crimes Act, or by amending the relevant health legislation. A pregnant woman who has an unlawful abortion should not be liable to any sanction.

The commission also recommends that the offence of child destruction in section 10 of the Crimes Act be repealed regardless of the model chosen. The offence lacks clarity and causes unnecessary complexity. Section 10 overlaps with section 65 because it could apply to late abortions, although it has never been used for this purpose in Victoria. It creates considerable uncertainty and may possibly leave medical practitioners who perform late therapeutic abortions vulnerable to criminal liability. The equivalent English offence was 'quarantined' from abortion law by a legislative amendment in 1990 to overcome these difficulties. If the Victorian Parliament wishes to regulate late abortion, it should do so through one of the models for abortion law reform set out in Chapter 7 rather than through complex and unclear child destruction laws.

Section 10 has been used in Victoria to prosecute assaults on pregnant women, late in the pregnancy, that are intended to harm the fetus. The commission recommends that this behaviour be covered by an amendment to the Crimes Act 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. This will allow prosecution of reckless as well as intentional behaviour. An assault causing harm to the fetus short of destruction can be prosecuted after the child is born if it is clear that the assault on the mother caused the injury. When an assault on the mother results in the fetus being born alive and then dying, manslaughter may be charged.

In part three of the report we also make recommendations about additional legal issues related to abortion law that arose during the review. We recommend inclusion of a conscience clause in the new abortion law. This makes it clear that individual health professionals have no duty to provide or assist with an abortion procedure, but must inform the patient of the conscientious objection and make an effective referral to another provider.

For all other issues that arose, the commission recommends no changes or additions to legislation because current laws are adequate. These issues include: provision of mandatory information to patients before an abortion; mandatory abortion counselling; specific regulation of abortion providers; mandatory reporting of abortions and adverse events; and specific requirements for consent by an adult when a young person seeks an abortion.

The report contains four appendices that provide background information to the review. The appendices describe: the historical development of the policy framework of abortion law in Australia and England; the major ethical arguments on abortion; the legal status of the fetus, and law concerning the relationship between a pregnant woman and fetus; and the applicability of international human rights law to abortion law.

Recommendations

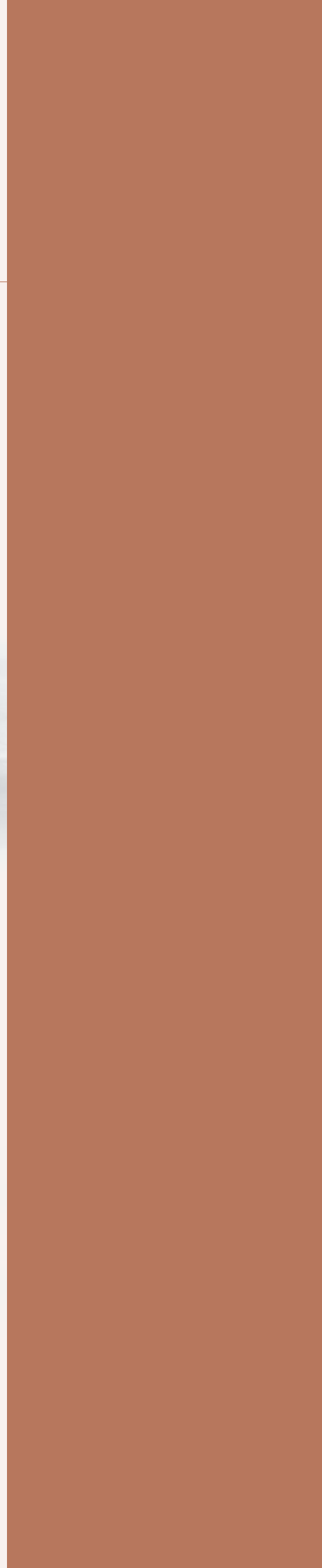
The commission has been asked to provide the government with advice on options for decriminalisation, as such the commission is not recommending one option over another. The full details of the three options for reform are in Chapter 6.

Regardless of the option the government chooses, the commission makes the following recommendations to improve the clarity of the law.

1. Section 10 of the *Crimes Act 1958* should be repealed.
2. Section 5 of the *Crimes Act 1958* 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.
3. The *Health Act 1958* should be amended to include a provision as follows:
 - Save for medical emergency, no person is under a duty to carry out or assist in carrying out an abortion.
 - A requirement that the person inform the patient of their conscientious objection and make an effective referral to another provider.
 - The provision should be clearly drafted to only apply to individuals who are part of the clinical therapeutic team. It should not apply to administrators, corporate services staff or to organisations.
4. Any new abortion law should not contain mandated information provisions.
5. Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling.
6. Any new abortion law should not contain a compulsory delay or cooling-off period before an abortion may be lawfully performed.
7. Any new abortion law should not contain restrictions on where abortion procedures may be performed. Existing health regulation is sufficient.
8. The *Crimes Act 1958* should be amended to include a provision that it is unlawful to perform an abortion unless the abortion is performed by, or under the supervision of a registered medical practitioner; **or** the *Health Services Act 1988* should be amended to include a provision that an abortion can only be lawfully performed by a medical practitioner.
9. It should not be an offence for a woman to perform or attempt to perform an abortion upon herself.
10. 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.
11. A woman should not be liable to any legal sanction if she knowingly permits a medical practitioner to perform an unauthorised abortion upon her.
12. Mandatory reporting of abortions and outcomes by private providers occurs under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*, and by public providers as part of their responsibilities under funding agreements. No further legislative requirement is necessary.
13. Adverse event reporting and management occurs under existing public health protocols and as a condition of registration under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*. No further legislative requirement is necessary.
14. The existing law governing consent and confidentiality for young people is adequate. No further legislative reform is required.
15. The *Children, Youth and Families Act 2006* requires registered doctors and nurses to notify the Department of Human Services or Victoria Police if they are of the reasonable belief that a person under 17 years is in need of protection. No further legislative requirement is necessary.
16. Any new abortion law should not include a specific anti-coercion provision.

Part 1

Current Law and Clinical Practice



Chapter 1 Introduction

CONTENTS

- 12 Scope of Report
- 12 What is not under Review
- 12 Victorian Context
- 12 Our Process
- 13 About this Report



Chapter 1

Introduction



SCOPE OF REPORT

- 1.1 This is the commission's Final Report on reform of abortion law. This report contains the commission's recommendations to government about options for decriminalising abortions performed by medical practitioners, and simplifying and clarifying the law.
- 1.2 On 26 September 2007 the Attorney-General and Deputy Premier, the Hon Rob Hulls, asked the Victorian Law Reform Commission to provide advice on options to clarify the existing law of abortion, and remove abortion offences from the *Crimes Act 1958* when performed by qualified medical practitioners.
- 1.3 The commission was to have regard to:
 - the existing practice of abortion by medical practitioners
 - existing legal principles that govern abortion
 - the law in other Australian jurisdictions
 - the government's commitment to modernise and clarify the law while reflecting current community standards and maintaining current clinical practice.
- 1.4 The full terms of reference are on p 5. The commission was required to report by 28 March 2008.

WHAT IS NOT UNDER REVIEW

- 1.5 The commission has 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.

VICTORIAN CONTEXT

- 1.6 Abortion is a crime in Victoria unless it falls within the exception for **therapeutic abortion** that was developed by a Supreme Court judge 39 years ago.¹
- 1.7 On 18 July 2007, the Hon Candy Broad introduced a Private Member's Bill to remove the crime of abortion from Victorian law.² The Bill, based on Australian Capital Territory (ACT) abortion legislation, sought to repeal sections 65 and 66 of the *Crimes Act*.³
- 1.8 On 20 August 2007, Premier the Hon John Brumby announced that the government would ask the Victorian Law Reform Commission for advice on options for abortion law reform that removed abortion offences from the *Crimes Act* and clarified the circumstances in which abortion was legal. He said that on receipt of the commission's advice the government would introduce a Bill to modernise abortion law, which would be put to a conscience vote.⁴

OUR PROCESS

INFORMATION PAPER

- 1.9 The commission released the short *Law of Abortion Information Paper* on 27 September 2007. The purpose of the paper was to explain the law in Victoria and in other Australian states and territories. Given the commission's short reporting time, it was not possible to produce a consultation paper or options paper for this review; however, the Information Paper was designed to provide sufficient information about the current law to inform people who wanted to make submissions.

CONSULTATION

- 1.10 The commission conducted broad consultation in the available time, meeting with 36 groups and individuals with different views about abortion. These included faith groups, public and private abortion providers, academics, health service providers, women's organisations and peak medical bodies.

- 1.11 Faith groups involved in the consultation process included the Catholic Church and a leading ethicist from the Catholic tradition, the Anglican Church, the Presbyterian Church of Victoria, the Australian Christian Lobby and the Jewish Community Council. Other faith groups made written submissions.
- 1.12 Consultations with the medical community helped the commission to understand current access to abortion and medical practice. The commission held 15 consultations with, individual doctors, the major public hospital providers of abortion services, privately run abortion clinics, women's health services, and peak medical bodies.
- 1.13 Meetings were also held with youth and disability service providers to discuss the particular issues abortion law reform raises for these groups.
- 1.14 The commission greatly appreciates the time these individuals and organisations committed to the consultation process.

SUBMISSIONS

- 1.15 To assist submission makers to focus on the issues raised by the terms of reference, 13 discussion questions were included in the commission's Information Paper. There was keen public interest in this project as abortion engenders a strong response from some members of the community.
- 1.16 We received 519 submissions. Many were from people who disagreed with the government's decision to decriminalise abortion and called for a change to the terms of reference to allow the commission to consider retaining and strengthening the criminal regime. Many others supported decriminalisation and called for abortion to be treated as a women's health issue.
- 1.17 Information obtained from consultations and submissions is referred to throughout this report and is summarised in Chapter 4.

MEDICAL PANEL

- 1.18 To assist us to understand current clinical practice we established a panel of medical experts, chaired by the President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Dr Christine Tippet. The other 12 members had backgrounds in gynaecology, obstetrics, paediatrics, genetic science, midwifery and counselling.
- 1.19 The commission met twice with the panel. The first meeting focused on ensuring our knowledge of current medical practice was accurate and complete. The second meeting assisted the commission to understand the implications for the medical profession of possible models of abortion law reform. The commission greatly appreciates the time and expertise provided by the panel members.

ABOUT THIS REPORT

- 1.20 This report is divided into four parts.
- 1.21 Part 1 considers the current law of abortion in Victoria and other comparable jurisdictions. We then look at current medical practice in Victoria, including: the number and rate of abortions; access to abortion; the need for any new law to accommodate advances in medical treatment, such as RU486; and regulation of medical practitioners who provide abortions. Our terms of reference require us to consider options for reform that neither increase the number of abortions nor restrict current access to services. It is therefore important for the public and decision makers to have a clear understanding of current medical practice.
- 1.22 In Part 2 we consider community views. It contains an analysis of major community attitude surveys dealing with abortion and the results of the commission's own consultations, including an analysis of the submissions received.

- 1 See Chapter 2 for a discussion of the current law.
- 2 Victoria, Parliamentary Debates, Legislative Council, 19 July 2007, 2144–2146 (Candy Broad).
- 3 Crimes (Decriminalisation of Abortion) Bill 2007 <www.legislation.vic.gov.au> at 8 February 2008.
- 4 Office of the Premier, 'Abortion Laws to be Referred to Law Reform Commission' (Media Release, 20 August 2007).

Chapter 1

Introduction



- 1.23 In Part 3 we discuss and make recommendations about possible reform of abortion laws. This begins with three options for legislative reform. In the following chapters the commission considers and makes recommendations about associated legal issues, such as the offence of child destruction. Counselling and other aspects of abortion service delivery are considered in the final chapter, as are legal issues including conscience clauses, consent requirements and regulation of who may perform abortions.
- 1.24 The Appendices consider the values and principles that underpin current laws and possible new laws. They begin with a review of the public policy issues that have historically informed abortion law, and are followed by a description of some of the ethical theories about abortion. Legal developments are then considered, before we turn to the applicability of human rights law to abortion.

Chapter 2 **Current Law**

CONTENTS

- 16 Introduction
- 16 Charter of Human Rights and Responsibilities
- 16 Crimes Act Provisions
- 18 Menhennitt Rules
- 20 Interstate Development of the Menhennitt Rules
- 21 Abortion Law in Other Australian Jurisdictions
- 24 Common Law
- 25 Abortion Law Overseas
- 28 Related Legal Issues



INTRODUCTION

- 2.1 The law of abortion¹ in Victoria is unclear. The government is considering whether new legislation, rather than a judge's ruling about the meaning of a criminal offence drawn from a 19th century British statute, should determine the lawfulness of abortion in Victoria. The terms of reference indicate a desire to modernise the law by decriminalising abortion performed by a medical practitioner and by clarifying the circumstances in which an abortion may lawfully be performed.
- 2.2 In this chapter we describe how our current law has evolved and indicate where it lacks clarity. We also describe the current law in other parts of Australia and in countries with similar legal systems. Finally, we provide a brief overview of related areas of law, such as those dealing with consent to medical treatment and substituted consent for people who lack the capacity to consent to their own treatment.
- 2.3 Laws that make abortion a serious criminal offence have been in operation since Victoria became a self-governing colony.² Those laws did not set out the circumstances in which an abortion was lawful. It has been left to the judiciary, in Victoria and elsewhere,³ to describe the circumstances in which an abortion may lawfully be performed. This happened in the late 1960s when the Victorian government of the day chose not to respond to calls for abortion law reform⁴ and when several medical practitioners were charged with performing unlawful abortions.⁵
- 2.4 During the trial of one of those doctors, the presiding Supreme Court judge, Justice Menhennitt, directed the jury about the circumstances in which an abortion was lawful.⁶ That ruling effectively changed the law in Victoria. Since that time, successive governments have permitted the 'Menhennitt rules' to become the law of abortion in Victoria by taking no action to repeal or revise the relevant provisions in the *Crimes Act 1958*. That law, which is similar to the law in many other parts of Australia,⁷ has been strongly criticised. Cica encapsulated many of those criticisms when she wrote:

*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 foetus, 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.*⁸

- 2.5 The relevant provisions in the *Crimes Act* have not been considered by the Victorian Supreme Court since the 'Menhennitt rules' were formulated nearly 40 years ago. The rules have been considered and developed, however, by courts in other states which have similar laws to those in Victoria. Because of these developments, and the passage of time since the Menhennitt ruling, it is not possible to describe the current state of Victorian abortion law with reasonable precision. It appears that no one has been charged with performing an unlawful abortion in Victoria for 21 years.⁹

CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

- 2.6 The *Charter of Human Rights and Responsibilities Act 2006* establishes a legislative framework for the protection and promotion of human rights in Victoria; however, the Charter does not affect current and future Victorian law on abortion and child destruction. This encompasses both the express terms of any statute and any judicial interpretation of statute law.¹⁰

CRIMES ACT PROVISIONS

- 2.7 There are three sections in the *Crimes Act* concerning abortion. They are sections 65 and 66, which are concerned solely with abortion, and section 10, which governs both late abortion and assaults upon pregnant women. Because these sections contain complex legal language, they are not easy to understand. Section 65 prohibits unlawful termination of pregnancy at any stage during the pregnancy. Section 66 prohibits supply of an instrument or substance knowing it will be used to unlawfully terminate a pregnancy. Section 10 prohibits unlawful

termination of a pregnancy during childbirth and in the later stages of her pregnancy. Section 10 also governs assaults on pregnant women during the later stages of pregnancy which result in damage to a fetus.

2.8 Section 65, which is headed 'Abortion', states:

*Whosoever being a woman 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, and whosoever with intent to procure the miscarriage of any woman whether she is or is not with child unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means with the like intent, shall be guilty of an **indictable offence**, and shall be liable to level 5 imprisonment (10 years maximum).*

2.9 The Act does not say when it is unlawful to act in this manner. It has been left to the courts to describe the circumstances in which intentional termination of pregnancy is unlawful and, as a result, to specify when it is lawful to have an abortion.

2.10 Offences under section 65 are treated very seriously, as is demonstrated by the maximum penalty of 10 years imprisonment. Other offences with a similar maximum penalty include: causing injury; threats to kill; indecent assault; assault with intent to rape; and indecent acts with a child under 16 years.¹¹

2.11 Section 66 of the Crimes Act, which is headed 'Supplying or procuring anything to be employed in abortion', states:

Whosoever unlawfully supplies or procures any poison or other noxious thing or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether with child or not, shall be guilty of an indictable offence, and shall be liable to level 6 imprisonment (5 years maximum).

2.12 This section makes it a criminal offence to knowingly assist another person who intends to bring about a miscarriage in a woman (whether she is actually pregnant or not) by unlawfully supplying any poisonous substance, or instrument, or other means. While this section has not been interpreted by a Victorian court, it is highly likely that the word 'unlawfully' has the same meaning in section 66 as it does in section 65.

2.13 Versions of sections 65 and 66 have formed part of the Victorian criminal law since 1864.¹² Both sections are based on provisions in a 19th century English statute.¹³ There have been no changes of substance to these Victorian statutory provisions since they were first enacted over 140 years ago.

2.14 Section 10 of the Crimes Act, which is headed 'Offence of child destruction', states:

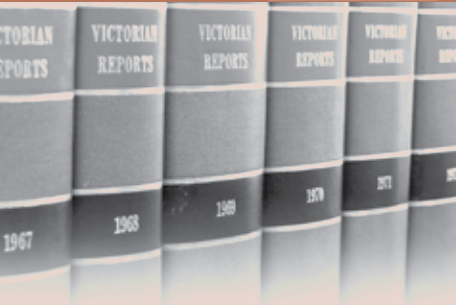
(1) *Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother shall be guilty of the indictable offence of child destruction, and shall be liable on conviction thereof to level 4 imprisonment (15 years maximum).*

(2) *For the purposes of this section 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.*

(3) *Where upon the trial of any person for the murder or manslaughter of any child or for **infanticide** or for any offence under section sixty-five of this Act the jury are satisfied that the person charged is not guilty of murder manslaughter or infanticide or of any offence under the said section sixty-five (as the case may be) but are satisfied that he is guilty of the indictable offence of child destruction, the jury may find him guilty of that indictable offence and he shall be liable to punishment accordingly.*

(4) *Where upon the trial of any person for the indictable offence of child destruction the jury are satisfied that the person charged is not guilty of that indictable offence but are satisfied that he is guilty of an offence under section sixty-five of this Act the jury may find him guilty of that offence and he shall be liable to punishment accordingly.*

- 1 By 'abortion' we mean an intentional termination of pregnancy brought about by the act of any person and by any means.
- 2 While the first Victorian statute was not enacted until 1864, English abortion statutes were applicable in Victoria (as the Port Phillip District of NSW) after the passage in England of the *Australian Courts Act 1828* s 24. See Kerry Petersen, *Abortion Regimes* (1993) 191; Robyn Gregory, *Corrupt Cops, Crooked Docs, Prevaricating Pollies and 'Mad Radicals': A History of Abortion Law Reform in Victoria, 1959–1974* (Unpublished PhD Thesis, RMIT University, 2005) 67. Applicable English statutes included the *Miscarriage of Women Act 1803* (known as *Lord Ellenborough's Act*), *Lord Lansdowne's Act 1828*, *Offences Against the Person Act 1828*; *Offences Against the Person Act 1861*. See Talina Drabsch, *Abortion and the Law in New South Wales* (2005) 14–15
- 3 Judicial interpretations of statutory provisions describe the circumstances in which abortions may be lawfully performed in NSW and Queensland. A similar situation existed in the UK until the Abortion Act in 1967. The law in these Australian states, and the UK, is discussed later in this chapter.
- 4 Gregory (2005) above n 2, 143–48.
- 5 Between 1961 and 1969, 16 charges were laid against doctors for abortion and about 11 charges were laid against backyard abortionists; see *ibid* 149.
- 6 *R v Davidson* [1969] VR 667.
- 7 The Victorian law is broadly similar to NSW, Queensland, and Tasmania.
- 8 Natasha Cica, 'The Inadequacies of Australian Abortion Law' (1991) 5 *Australian Journal of Family Law* 37, 66.
- 9 The last prosecution occurred in 1987. On 2 June 1987 a magistrate dismissed 11 charges of unlawfully procuring a miscarriage against a specialist, Dr Ian McGoldrick: 'McGoldrick cleared on 11 abortion counts' *The Age* (Melbourne) 3 June 1987, 3
- 10 Section 48 of the Charter expressly provides that 'nothing in this Charter affects any law applicable to abortion or child destruction, whether before or after the commencement of Part 2'.
- 11 *Crimes Act 1958* ss 18, 20, 39, 40, 47.
- 12 *Criminal Law and Practice Statute 1864* s 55.
- 13 Sections 58 and 59 in *Offences Against the Person Act 1861* (24 & 25 Vict, c 100, s 2). These offences are traceable back to a statute enacted in 1803 which is commonly known as *Lord Ellenborough's Act* (43 Geo III, c 58, s 1). There is a short history of the law of abortion in Victoria in Louis Waller, 'Any Reasonable Creature in Being' (1987) 13 *Monash University Law Review* 37. A history of abortion policy may also be found in Appendix A.



- 2.15 This section makes it a criminal offence for a person who intends to destroy the life of an unborn child capable of being **born alive** to unlawfully use any means to achieve this result. Section 10(2) creates the rebuttable presumption, for the purposes of this offence, that a woman who is at least 28 weeks pregnant is carrying an unborn child capable of being born alive. However, this does not preclude a finding, on the facts of a particular case, that a woman who has been pregnant for less than 28 weeks is carrying a child capable of being born alive.¹⁴
- 2.16 Section 10 overlaps with section 65, which covers the entire period of a woman's pregnancy. Sections 10(3) and (4) provide for alternative verdicts. Section 10(3) permits a jury to find a person guilty of child destruction when the person has been charged with murder, manslaughter or infanticide. Section 10(4) permits a jury to find a person guilty of the offence of unlawful abortion under section 65 when the person has been charged with child destruction.
- 2.17 Offences under section 10 are particularly serious, as is demonstrated by the maximum penalty of 15 years imprisonment. Other offences with a similar maximum penalty include: extortion with threat to kill; performing female genital mutilation; and causing a person to provide commercial sexual services (sexual servitude).¹⁵
- 2.18 Section 10 of the Crimes Act, which has been part of Victorian law since 1949,¹⁶ was drawn from an English statute enacted in 1929.¹⁷ The offence of child destruction was originally created in England 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 to convict a person of murder, manslaughter or infanticide, the offence of child destruction can be alternatively charged in cases of doubt.
- 2.19 While it does not appear to have been the intention of those people who prepared the initial English legislation,¹⁸ unlawfully terminating a pregnancy when a woman is carrying a child capable of being born alive falls within the ambit of both section 65 and section 10 of the Victorian Act.¹⁹ This overlap has been recognised in England²⁰ and it was rectified by legislative amendment in 1990.²¹ Section 10 has not been used in Victoria to deal with acts performed during childbirth, or for late abortion. It has been used, however, in cases involving attacks on women in the later stages of pregnancy with intent to harm the fetus.²²
- 2.20 The English statute has always contained a proviso that the offence of child destruction was not committed when an act was done in good faith with the intention of saving the life of the mother. When the offence of child destruction first became part of Victorian law in 1949, the English proviso was omitted and replaced by the word 'unlawfully'. This was a legislative attempt to ensure that Victorian medical practitioners, and courts, were granted more responsibility for determining the circumstances in which the destruction of a fetus during childbirth, or a late abortion, could be lawfully performed. It was also done to minimise the risk that the allowance for saving the life of the mother might be relied upon inappropriately.²³

MENHENNITT RULES

- 2.21 The word 'unlawfully' has not been defined in sections 10, 65 and 66 of the Crimes Act; its meaning has been left to the courts. While only section 65 has been considered by a Victorian court, it is highly likely that the word 'unlawfully' has the same meaning in section 66. While it is unlikely that the word has the same meaning when used in section 10, it is difficult to predict how a court would define 'unlawfully' if a case arose under that section.²⁴
- 2.22 The 1969 Menhennitt ruling was made during the trial of Dr Charles Davidson, who had been charged with several counts of unlawfully using an instrument with intent to procure the miscarriage of a woman.²⁵ The Menhennitt ruling in *R v Davidson* is an exercise in statutory interpretation rather than a statement about the **common law** of abortion. Justice Menhennitt was interpreting the word 'unlawfully' in a particular statutory context. To do so he looked at both the meaning given to the word by Justice Macnaghten in an earlier English case, *R v Bourne*,²⁶ when interpreting the similarly worded English statute,²⁷ and to common law principles that can assist when giving meaning to criminal law statutes.²⁸ *R v Bourne* was a case in which a leading medical specialist terminated the pregnancy of a 14-year-old girl who had been gang-raped by soldiers.

2.23 Justice Menhennitt began his ruling by setting out the circumstances in which a ‘therapeutic abortion’ would be lawful. He invoked the common law principle of necessity to reach the conclusion that a ‘therapeutic abortion’ was lawful. Although Justice Menhennitt did not expressly stipulate that only a medical practitioner could perform a therapeutic abortion, it seems clear by his use of the term ‘therapeutic’ that his remarks were limited to abortions performed by medical practitioners. He said a therapeutic abortion is lawful in the following circumstances:

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 by him was (a) necessary 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 continuation of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted.

2.24 A doctor, therefore, must honestly believe two things on reasonable grounds for an abortion to be lawful.²⁹ These are usually referred to as the elements of *necessity* and *proportionality*. First, the doctor must believe that termination of a pregnancy is *necessary* to preserve her from serious danger to her life, or to her ‘physical or mental health’. The terms ‘physical health’ and ‘mental health’ were not defined but the ruling contains the qualification that the danger to the woman’s health must extend beyond ‘the normal dangers of pregnancy and childbirth’. Secondly, the doctor must believe termination of the pregnancy to be a *proportionate* response to the serious danger faced by the woman.

2.25 Justice Menhennitt did not indicate what matters should be taken into account by a doctor when determining whether termination of a woman’s pregnancy was necessary to preserve her from serious danger to her life, or to her physical and mental health. Nor did he suggest any means by which a doctor may determine whether termination was a proportionate response to the woman’s particular circumstances.

2.26 According to Justice Menhennitt, an abortion was unlawful under section 65 of the Crimes Act when it did not fall within his description of the circumstances in which a therapeutic abortion was lawful. He set out the matters the prosecution must prove to satisfy a jury that an abortion was unlawful:³⁰

Accordingly, to establish that the use of an instrument with intent to procure a miscarriage was unlawful, the Crown must establish either (a) that the accused did not honestly believe on reasonable grounds that the act done by him was necessary 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; or (b) that the accused did not honestly believe on reasonable grounds that the act done by him was in the circumstances proportionate to the need 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.

2.27 This statement of the law is complex. The prosecution is required to prove one of two negative propositions to establish the mental element of the crime of abortion. The prosecution must prove beyond reasonable doubt that the accused person did not honestly believe on reasonable grounds that either:

- *it was necessary to terminate the women’s pregnancy to preserve her from serious danger³¹ to her life or to her physical or mental health; or*
- *terminating the woman’s pregnancy was a proportionate response to the need to preserve her from serious danger to her life or to her physical or mental health.*

2.28 The ruling made by Justice Menhennitt in *R v Davidson* has not been considered by a Victorian appellate court, or by the High Court of Australia. The commission is unaware of any Victorian Supreme Court judgment in which the Menhennitt rules have been considered, although a County Court judge accepted and applied them in 1972.³²

14 See, eg, *C v S* [1988] 1 QB 135; *Rance v Mid-Downs Health Authority* [1991] 1 QB 587.

15 *Crimes Act 1958* ss 27, 32, 60AB(2).

16 The *Crimes Act 1949* inserted this provision into the *Crimes Act 1928*.

17 *Infant Life Preservation Act 1929* (19 & 20 Geo 5, c 34).

18 See *R v Bourne* [1939] 1 KB 687, 691. Her Majesty’s Stationery Office, *Select Committee on the Infant Life (Preservation) Bill [HL] Special Report with Evidence*, House of Lords: Session 1986–1987 (1987); Her Majesty’s Stationery Office, *Report of the Select Committee on the Infant Life (Preservation) Bill [HL] with Evidence*, House of Lords: Session 1987–1988 (1988).

19 See, eg, *C v S* [1988] 1 QB 135 and *Rance v Mid-Downs Health Authority* [1991] 1 QB 587, which were cases involving the equivalent provision in the UK *Infant Life Preservation Act 1929*. The offence of child destruction is discussed in more detail in Chapter 12.

20 See, eg, Ian Kennedy and Andrew Grubb, *Medical Law: Text with Materials* (2nd ed, 1994) 869, 878; P Skegg, *Law, Ethics, and Medicine: Studies in Medical Law* (1988) 5.

21 A provision was added to the *Abortion Act 1967* 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: *Abortion Act* s 5(1), substituted by *Human Fertilisation and Embryology Act 1990* s 37(4).

22 Information provided by the Office of Public Prosecutions, 7 September 2007.

23 Section 10 is considered in more detail in Chapter 7.

24 See Chapter 7.

25 *R v Davidson* [1969] VR 667.

26 [1939] 1 KB 687; [1938] 3 All ER 615.

27 *Offences Against the Person Act 1861* s 58 (24 & 25 Vict, c 100).

28 Justice Menhennitt relied upon the common law principle of necessity: [1969] VR 667, 671.

29 While the doctor must hold the necessary beliefs on reasonable grounds, Menhennitt J emphasised that the test is subjective and not objective: *R v Davidson* [1969] VR 667, 672.

30 The physical elements of the offence are separate matters (eg that the accused person used an instrument with the intent to terminate a pregnancy).

31 As noted, the ‘serious danger’ must extend beyond the normal dangers associated with pregnancy and childbirth: *R v Davidson* [1969] VR 667, 672.

32 *R v Heath* (Unreported, County Court, Judge Southwell, 1972) in Waller (1987) above n 13, 44.



- 2.29 The Menhennitt rules do not provide the Victorian community with a clear statement about when an abortion is permissible because they were not designed for that purpose. The rules were designed for use by lawyers and jurors when the state of mind of a doctor charged with performing an unlawful abortion was a contested issue in a criminal trial.

INTERSTATE DEVELOPMENT OF THE MENHENNITT RULES

- 2.30 The Menhennitt rules have been considered in several NSW cases. While the decisions and rulings in those cases do not bind a Victorian court, it is highly likely that they would be persuasive, especially because sections 82 and 83 of the NSW *Crimes Act 1958* contain essentially the same wording as section 65 of the Victorian *Crimes Act*.³³ A majority of the High Court appeared to accept the correctness of these NSW cases in a recent decision.³⁴
- 2.31 In 1972, in *R v Wald*,³⁵ a judge of what is now the NSW District Court³⁶ followed, and elaborated upon, the Menhennitt ruling.³⁷ Judge Levine stated:

*In my view it would be for the jury to decide whether there existed in the case of each woman any economic, social or medical ground or reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health. It may be that an honest belief be held that the woman's mental health was in serious danger at the very time she was interviewed by a doctor, or that her mental health, although not then in serious danger, could reasonably be expected to be seriously endangered at some time during the currency of pregnancy, if uninterrupted. In either case such a conscientious belief on reasonable grounds would have to be negatived before an offence under s 83 of the Act could be proved.*³⁸

- 2.32 The practical effect of Judge Levine's ruling is that it identifies matters that a doctor may properly consider when determining whether that doctor holds the requisite beliefs about necessity and proportionality to lawfully terminate a pregnancy. These matters include the economic and social impact of continuing with a pregnancy. It also identifies a time period which may be taken into account by the medical practitioner when formulating those beliefs.
- 2.33 The statements made by Judge Levine in *R v Wald* have been approved by NSW courts in subsequent cases.³⁹ The most important is *CES v Superclinics (Australia) Pty Ltd* in which all three members of the NSW Court of Appeal accepted that *Wald* contained a correct statement of the law in NSW.⁴⁰ The question of the lawfulness of an abortion arose indirectly in *Superclinics*, which was an action in negligence by a woman (*CES*) against a medical practice for failure to diagnose her pregnancy. The plaintiff claimed that she would have terminated the pregnancy if the defendants had informed her she was pregnant. The trial judge dismissed the plaintiff's claim because he held that it would not have been lawful for her to have had an abortion at the time she consulted the defendants for medical advice.
- 2.34 When considering the circumstances in which an abortion was lawful, the trial judge⁴¹ and two of the three members of the NSW Court of Appeal⁴² accepted the correctness of *Wald* without any elaboration. Acting Chief Justice Kirby also accepted the correctness of the *Wald* test but referred to 'one anomaly in the test to which I must draw attention'. He stated:

*The test espoused by Levine DCJ seems to assert that the danger being posed to the woman's mental health may not necessarily arise at the time of consultation with the medical practitioner, but that a practitioner's honest belief may go to a reasonable expectation that that danger may arise 'at some time **during the currency of the pregnancy, if uninterrupted**' [emphasis added]. There seems to be no logical basis for limiting the honest and reasonable expectation of such a danger to the mother'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, for example 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 a mother's psychological health after the child was born when those circumstances might be expected to take their toll.⁴³

- 2.35 The decision of the NSW Court of Appeal in *Superclinics* was appealed to the High Court but the case was settled before the court's determination.⁴⁴ However, the High Court referred to the decision in *Superclinics* with apparent approval in the 2006 case *Harriton v Stephens*.⁴⁵ That case was a so-called 'wrongful life' action in negligence. Justice Crennan made passing reference to the abortion law in NSW and referred to the judgment of Acting Chief Justice Kirby in *Superclinics* with apparent approval.⁴⁶ Three of the other members of the High Court expressly agreed with the judgment of Justice Crennan,⁴⁷ and Justice Hayne made a similar passing reference to abortion law in NSW.⁴⁸ The other two members of the court, Justices Kirby and Callinan, decided the case without reference to abortion law.
- 2.36 Consequently, it is arguable, but by no means settled beyond doubt, that a majority of the High Court has endorsed Justice Kirby's comments in *Superclinics*. Justice Kirby approved the *Wald* test and extended it so that the medical practitioner may take into account dangers to the woman's health both during and after the pregnancy. It is likely, but not certain, that if a Victorian court were called upon to interpret section 65 of the Crimes Act it would adopt the Menhennitt rules as developed by Judge Levine in *Wald* and by Justice Kirby in *Superclinics*.

ABORTION LAW IN OTHER AUSTRALIAN JURISDICTIONS

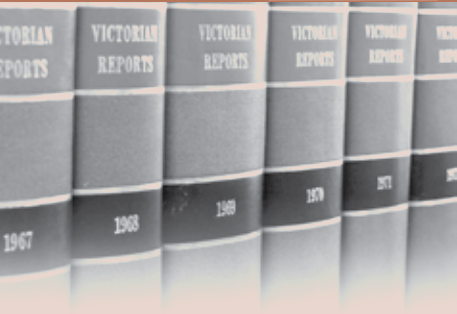
NEW SOUTH WALES

- 2.37 The provisions in the NSW Crimes Act that deal specifically with abortion are effectively the same as those in Victoria except that the offence of child destruction has never been part of NSW law.⁴⁹
- 2.38 A medical practitioner was recently convicted in NSW of the offence of unlawful abortion. In that case, *R v Sood*, Justice Simpson accepted that the statements made by Judge Levine in *Wald* and developed by Justice Kirby in *Superclinics* were a correct statement of the law.⁵⁰ The trial judge found Dr Sood guilty of unlawful abortion because the jury accepted that she could not have formed the requisite beliefs about necessity and proportionality for the abortion to be lawful because there was no conversation, or other form of communication, between the doctor and her patient which would have allowed her to form these beliefs.⁵¹ Dr Sood, who was subsequently deregistered as a medical practitioner,⁵² received a non-custodial sentence.⁵³

QUEENSLAND

- 2.39 The law in Queensland is broadly similar to the current Victorian law. Abortion is a criminal offence for the person performing the abortion, the woman undergoing the abortion, and anyone knowingly supplying drugs or implements for an abortion.⁵⁴ However, the *Criminal Code 1899* also provides a statutory defence: if the abortion was for the preservation of the mother's life, performed in good faith, with reasonable care and skill, and was reasonable having regard to the patient's state at the time and all the circumstances of the case.⁵⁵
- 2.40 The ruling of Judge McGuire in *R v Bayliss and Cullen* confirmed that the Menhennitt ruling applies in Queensland;⁵⁶ however, Judge McGuire excluded consideration of the social and economic effects of continuing with the pregnancy, which had been permitted in NSW following the decision in *R v Wald*.⁵⁷ This ruling was affirmed by a single judge of the Supreme Court in *Veivers v Connolly*: a civil case.⁵⁸ There have been no prosecutions of doctors for abortion offences since 1986.⁵⁹
- 2.41 The offence of child destruction exists in Queensland but the wording is different to the Victorian offence. The Criminal Code provides that it is a crime to prevent a child from being born alive 'when a woman is about to be delivered of a child'.⁶⁰ It is also an offence to unlawfully assault a pregnant woman and destroy the life of, or cause grievous bodily harm or transmit a serious disease to, a child 'before its birth'.⁶¹

- 33 The NSW Act deals separately with a woman taking steps to unlawfully procure her own miscarriage: s 82 and with a third person unlawfully taking those steps: s 83.
- 34 *Harriton v Stephens* (2006) 80 ALJR 791.
- 35 (1971) 3 DCR (NSW) 25.
- 36 Then called the Quarter Sessions.
- 37 Judge Levine expressly approved of the decision in *R v Davidson* before making the quoted remarks: (1971) 3 DCR (NSW) 25, 29.
- 38 (1971) 3 DCR (NSW) 25, 29.
- 39 See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47; *R v Sood* (Ruling No 3) [2006] NSWSC 762.
- 40 (1995) 38 NSWLR 47.
- 41 Newman J.
- 42 Priestley and Meagher JJA.
- 43 (1995) 38 NSWLR 47, 60.
- 44 Loane Skene, *Law & Medical Practice: Rights, Duties, Claims & Defences* (2nd ed, 2004) 352.
- 45 (2006) 80 ALJR 791.
- 46 (2006) 80 ALJR 791, 838 [246].
- 47 Gleeson CJ, Gummow and Heydon JJ.
- 48 (2006) 80 ALJR 791, 827 [177].
- 49 *Crimes Act 1958* (NSW), ss 82–84.
- 50 *R v Sood* (Ruling No 3) [2006] NSWSC 762, [30]–[42].
- 51 *R v Sood* [2006] NSWSC 1141, [23]–[25].
- 52 In *Re Suman Sood* (2006) No 774 of 2005 New South Wales Medical Tribunal decision <www.nswmb.org.au/system/files/f10f20/o585/SOOD.pdf> at 12 February 2008.
- 53 *R v Sood* [2006] NSWSC 1141.
- 54 *Criminal Code 1899* (Qld) ss 224–226. The maximum penalties are 14 years imprisonment for a person performing a termination, 7 years for a woman having a termination, and 3 years for supplying drugs or instruments.
- 55 *Criminal Code 1899* (Qld) s 282.
- 56 *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8.
- 57 *R v Wald* [1971] 3 DCR (NSW) 25.
- 58 *Veivers v Connolly* [1995] 2 Qd R 326.
- 59 Parliament of Australia Parliamentary Library, *Abortion Law in Australia*, Research Paper 1 1998–99 (31 August 1998) 24. A search of reports since 1998 reveals no prosecutions.
- 60 *Criminal Code 1899* (Qld) s 313(1).
- 61 *Criminal Code 1899* (Qld) s 313(2).



SOUTH AUSTRALIA

2.42 While the law in South Australia is similar to current Victorian law, there are important points of difference. The South Australian law is based upon the UK *Abortion Act 1967*. Even though unlawful abortion is a criminal offence, there is specific provision in the legislation for therapeutic abortion. Section 82A of the *Criminal Law Consolidation Act 1935* provides that an abortion is lawful when two medical practitioners 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.*⁶²

When determining the risk to the woman’s life, physical or mental health by continuing with a pregnancy, practitioners may take into account ‘the pregnant woman’s actual or reasonably foreseeable environment’.⁶³ The terms ‘physical or mental abnormalities’ and ‘seriously handicapped’ have not been defined. In situations of urgency, 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.⁶⁴

- 2.43 Abortions must be carried out in a hospital or a prescribed facility.⁶⁵ A woman must have resided in South Australia for a minimum of two months for the abortion to be lawful unless the grounds relied upon are fetal abnormality, or immediate threat to the life or the health of the woman.⁶⁶
- 2.44 South Australia has a complex ‘child destruction’ provision within its abortion laws. The first of the grounds for lawful abortion—risk to the life or 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 mother’s life.⁶⁷ For the purposes of that provision, there is a rebuttable presumption that a pregnancy of 28 weeks or more is **prima facie** proof that the child is capable of being born alive.⁶⁸
- 2.45 It remains 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.⁶⁹ Procurement or supply of instruments or substances, knowing that these will be used for an unlawful abortion, carries a penalty of up to three years imprisonment.⁷⁰
- 2.46 No person is under a duty 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.⁷¹

NORTHERN TERRITORY

- 2.47 Northern Territory legislation sets out the circumstances in which abortion is lawful and unlawful. The offences of abortion and of supplying things for the purpose of procuring an abortion remain within the *Criminal Code Act*.⁷² However, the circumstances in which an abortion is lawful are now set out in the *Medical Services Act*.⁷³ Abortions performed outside the provisions of the Medical Services Act are a criminal offence.⁷⁴
- 2.48 The Medical Services Act provides that therapeutic abortion is lawful in some circumstances. Different rules apply to different gestation periods. Abortion is permissible up to 14 weeks gestation if two medical practitioners believe that continuing with the pregnancy would cause greater harm to a woman’s mental or physical health than abortion, or if the child would be ‘seriously handicapped because of physical or mental abnormalities’.⁷⁵ These terms are not defined. Abortion is lawful up to 23 weeks gestation if a medical practitioner believes that it is immediately necessary to prevent serious harm to a woman’s physical or mental health.⁷⁶ Abortion is also lawful at any time if a medical practitioner believes that it should be performed

for the sole purpose of preserving a woman's life.⁷⁷ In all circumstances, therapeutic abortion is lawful only when appropriate consent has been given and the treatment is carried out in good faith and with professional care.⁷⁸

- 2.49 There is an offence of killing an unborn child in the Criminal Code Act. This offence may be committed when a 'woman or girl is about to be delivered of a child' and any person prevents the child from being born alive.⁷⁹

WESTERN AUSTRALIA

- 2.50 Western Australian abortion law was reformed in 1998.⁸⁰ The reforms followed a review of the *Health Act 1911* and the *Criminal Code Act Compilation Act 1913*, that was precipitated by the arrest and charge for unlawful abortion of two doctors in early 1998.⁸¹ The legislative changes in Western Australia were subject to review three years after coming into effect⁸² and the report was completed in 2002.⁸³

- 2.51 Abortion is a criminal offence in Western Australia unless authorised by section 334 of the Health Act.⁸⁴ It is lawful for a medical practitioner to perform an abortion up to 20 weeks gestation in the following circumstances:

- *the woman has given informed consent; or*
- *the woman will suffer serious personal, family or social consequences if the abortion is not performed; or*
- *serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or*
- *the pregnancy is causing serious danger to the woman's physical or mental health.*⁸⁵

'Informed consent' is defined at some length in the legislation and specific provisions apply to women under 16 years of age.⁸⁶ The procedure must be carried out by a medical practitioner 'in good faith and with reasonable care and skill'.⁸⁷

- 2.52 Abortion beyond 20 weeks is lawful when two medical practitioners drawn from a statutory panel of six agree that the mother or the fetus has a 'severe medical condition' that justifies the procedure.⁸⁸ The term 'severe medical condition' is not defined. Women cannot appeal the decision of the medical panel.⁸⁹ Abortions must be performed in an approved facility.⁹⁰ The Health Act stipulates that no person or institution is under a duty to participate in the performance of an abortion.⁹¹ A **notification scheme** applies for all abortions.⁹²

- 2.53 The consequences of performing an unlawful abortion are different depending upon whether the person performing the procedure is a medical practitioner. Medical practitioners face a maximum penalty of \$50 000.⁹³ A person who is not a medical practitioner is liable to five years imprisonment.⁹⁴

- 2.54 A general statutory defence applies to the crime of unlawful abortion. A person is not criminally responsible for administering surgical or medical treatment to a person for their benefit, or to an unborn child for the preservation of the mother's life, if the administration of the treatment is reasonable. The test is an inclusive one, 'having regard to the patient's state at the time and to all the circumstances of the case'. The procedure must also be undertaken in good faith and with reasonable care and skill.⁹⁵

- 62 *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a).
- 63 *Criminal Law Consolidation Act 1935* (SA) s 82A(3).
- 64 *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(b).
- 65 *Criminal Law Consolidation Act 1935* (SA) s 82A(1).
- 66 *Criminal Law Consolidation Act 1935* (SA) s 82A(2).
- 67 *Criminal Law Consolidation Act 1935* (SA) s 82A(7).
- 68 *Criminal Law Consolidation Act 1935* (SA) s 82A(7),(8).
- 69 *Criminal Law Consolidation Act 1935* (SA) s 81.
- 70 *Criminal Law Consolidation Act 1935* (SA) s 82.
- 71 *Criminal Law Consolidation Act 1935* (SA) ss 82A(5)–(6).
- 72 *Criminal Code Act* (NT) ss 208B, 208C.
- 73 The law was reformed in 2006; see *Medical Services Act* (NT) s 11.
- 74 *Criminal Code Act* (NT) ss 208B, 208C. In both cases the maximum penalty is 7 years imprisonment.
- 75 *Medical Services Act* (NT) s 11(1).
- 76 *Medical Services Act* (NT) s 11(3).
- 77 *Medical Services Act* (NT) s 11(4).
- 78 *Medical Services Act* (NT) ss 11(4), (5), (7).
- 79 *Criminal Code Act* (NT) s 170.
- 80 *Amendment (Abortion) Act 1998* (WA).
- 81 The prosecutions were withdrawn, see Skene (2004) above n 44, 349.
- 82 *Amendment (Abortion) Act 1998* (WA) s 8.
- 83 See *Acts Amendment (Abortion) Act 1998 Review Steering Committee [Western Australia], Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code Relating to Abortion* (2002).
- 84 *Criminal Code Act Compilation Act 1913* (WA) s 199.
- 85 *Health Act 1911* (WA) s 334(3).
- 86 *Health Act 1911* (WA) ss 334(5), 334(8)–(11).
- 87 *Criminal Code Act Compilation Act 1913* (WA) s 199(1)(a).
- 88 *Health Act 1911* (WA) s 334(7).
- 89 *Acts Amendment (Abortion) Act 1998 Review Steering Committee [Western Australia]* (2002) above n 83, 33.
- 90 Both the panel of six medical practitioners and the approval of the medical facilities are made by the Minister for Health for the purposes of s 334(7).
- 91 *Health Act 1911* (WA) s 334(2).
- 92 *Health Act 1911* (WA) ss 335, 335(5) (b).
- 93 *Criminal Code Act Compilation Act 1913* (WA) s 199(2).
- 94 *Criminal Code Act Compilation Act 1913* (WA) s 199(3).
- 95 *Criminal Code Act Compilation Act 1913* (WA) s 259.

- 2.55 There is an offence of killing an unborn child in the Criminal Code Act which has the same wording as the equivalent provision in the Northern Territory. This offence may be committed when a 'woman or girl is about to be delivered of a child' and any person prevents the child from being born alive.⁹⁶

TASMANIA

- 2.56 While unlawful abortion is a criminal offence in Tasmania, the *Criminal Code Act 1924* provides that therapeutic abortion is legally justified in some circumstances.⁹⁷ The Tasmanian Criminal Code was amended in 2001 to clarify the circumstances in which a therapeutic abortion would be lawful.⁹⁸
- 2.57 Abortion is permissible when two medical practitioners certify that continuation of the pregnancy would involve greater risk of injury to the woman's physical or mental health than abortion, and when the woman gives informed consent. 'Informed consent' is defined as: consent given by a woman after she has received counselling from her doctor about the medical risks associated with abortion or continuation of the pregnancy, and a referral to counselling about 'other matters relating to termination of pregnancy and carrying a pregnancy to term'.⁹⁹
- 2.58 The Criminal Code contains an offence of causing the death of a child before birth. The offence occurs when a person 'causes the death of a child which has not become a human being in such a manner that he would have been guilty of murder if such child had been born alive'.¹⁰⁰ There is a statutory exception that applies when the death is caused by actions taken in good faith to preserve the mother's life before or during childbirth.¹⁰¹

AUSTRALIAN CAPITAL TERRITORY

- 2.59 Abortion law was reformed in the ACT in 2002. The *Crimes (Abolition of Offence of Abortion) Act 2002* repealed the statutory and **common law offences** of abortion in the ACT thereby decriminalising abortion.¹⁰²
- 2.60 Abortion is treated by law in the same way as any other medical procedure, subject to Part 6 of the *ACT Health Act 1993*, which now regulates the practice. The Act defines abortion as 'causing a woman's miscarriage by administering a drug; or using an instrument; or any other means'.¹⁰³ Only a doctor may carry out an abortion.¹⁰⁴ A person must not carry out an abortion except in an approved medical facility, or part of a medical facility.¹⁰⁵ No person is under a duty to perform an abortion. People are also entitled to refuse to assist in carrying out the procedure.¹⁰⁶ A woman seeking or receiving an abortion faces no legal sanction.
- 2.61 There is an offence of child destruction in the ACT *Crimes Act 1990*.¹⁰⁷ It applies when a person unlawfully prevents a child from being born alive, or contributes to the child's death 'by any act or omission occurring in relation to a childbirth'. The word 'unlawfully' is not defined. There is an allied offence of intentionally or recklessly causing grievous bodily harm to a child, before it is born alive, during childbirth.¹⁰⁸

COMMON LAW

- 2.62 Abortion has been regulated by statute in Victoria since 1864 and in England since 1803.¹⁰⁹ While some abortions were made unlawful by the common law before the creation of the statutory offences, the extent to which abortion was prohibited before 1803 is unclear.
- 2.63 It appears that abortion after '**quickening**'¹¹⁰ was a common law offence.¹¹¹ In the most recent English judicial consideration of the law of abortion, Justice Munby stated:

*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 'misdemeanor' 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'.*¹¹²

2.64 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.¹¹³

ABORTION LAW OVERSEAS

UNITED KINGDOM

2.65 The legal regulation of abortion in the UK is complex. Abortion is governed by the *Abortion Act 1967* and by two criminal law statutes.¹¹⁴ Criminal law prohibitions apply to any abortion that is not performed in compliance with the Abortion Act. Abortion is lawful when two medical practitioners have the same opinion in relation to at least one of the following matters:

- *that the pregnancy has not exceeded its twenty-fourth week¹¹⁵ and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or*
- *that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or*
- *that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or*
- *that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.¹¹⁶*

The last three grounds apply regardless of gestational age.

2.66 The terms 'physical or mental abnormalities' and 'seriously handicapped' are not defined. When dealing with the grounds involving risk to the physical or mental health of a pregnant woman, medical practitioners may consider a 'woman's actual or reasonably foreseeable environment'.¹¹⁷ That term is not defined. A medical practitioner must perform the procedure in a hospital.¹¹⁸ In cases where an abortion is 'immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman', the opinion of a second medical practitioner is not

- 96 *Criminal Code Act Compilation Act 1913* (WA) s 290.
- 97 *Criminal Code Act 1924* (Tas) ss 134–135, 164.
- 98 *Criminal Code Amendment Act (No 2) 2001* (Tas).
- 99 *Criminal Code Act 1924* (Tas) s 164(9).
- 100 *Criminal Code Act 1924* (Tas) s 165(1).
- 101 *Criminal Code Act 1924* (Tas) s 165(2).
- 102 The *Health Regulations (Maternal Health Information) Act 1998* (ACT), which compelled certain information to be provided to women seeking a termination, was also repealed in 2002. The *Termination of Pregnancy Act 1978* (ACT) had previously been repealed in 1992.
- 103 *Health Act 1993* (ACT) s 80.
- 104 *Health Act 1993* (ACT) s 81. The maximum penalty for someone other than a doctor performing an abortion is five years imprisonment.
- 105 *Health Act 1993* (ACT) s 82. The maximum penalty for performing an abortion elsewhere is 50 penalty units, imprisonment for six months, or both.
- 106 *Health Act 1993* (ACT) s 84.
- 107 *Crimes Act 1900* (ACT) s 42.
- 108 *Crimes Act 1900* (ACT) s 43.
- 109 See Louis Waller, 'Any Reasonable Creature in Being' (1987) 13 *Monash University Law Review* 37, 39–40.
- 110 This is defined to mean 'the moment in pregnancy at which the first movements of the fetus are felt by the mother, usually in the fourth or fifth month': *Butterworths Medical Dictionary* (2nd ed, 1978) 1424–5.
- 111 Waller (1987) above n 13, 37–40.
- 112 *R (on the application of Smeaton) v Secretary of State for Health* [2002] EWHC 610, [83].
- 113 See Chapter 6.
- 114 *Offences Against the Person Act 1861* (UK) ss 58, 59; *Infant Life (Preservation) Act 1929* (UK) ss 1, 2. There is further complexity in the law as there is inconsistency between countries. The Abortion Act applies in England, Scotland and Wales, but does not apply in Northern Ireland. The Infant Life Preservation Act only applies in England and Wales and the Offences Against the Person Act applies in England, Wales and Northern Ireland. See House of Commons, Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07: Volume 1* HC 1045–1 (2007); D Capper, 'The Condition of Abortion Law in Northern Ireland' (2003) 54(3) *Northern Ireland Legal Quarterly* 320.

115 The 24-week upper gestational limit was introduced by an amendment to the Abortion Act by the *Human Fertilisation and Embryology Act 1990* (UK) s 37(1). The *Births Deaths and Registrations Act 1953* (UK) requires all stillborn children to be registered if born without signs of life after 24 weeks. See *Births and Deaths Registration Act 1953* (UK) s 41.

116 *Abortion Act 1967* (UK) s 1(1).

117 *Abortion Act 1967* (UK) s 1(2).

118 *Abortion Act 1967* (UK) s 1(3). A medical practitioner is not required to perform an abortion within a hospital should it be immediately necessary to save the life of the pregnant woman or to prevent grave permanent injury to her physical or mental health. See *Abortion Act 1967* (UK) s 1(4).

necessary.¹¹⁹ A doctor is not required to participate in any abortion procedure if he or she has a conscientious objection, unless it is required to save the life of the pregnant woman or prevent grave permanent injury to her physical or mental health.¹²⁰

- 2.67 An abortion that is not performed within the requirements of the Abortion Act is a criminal offence. Two separate, but overlapping, statutes—the *Offences Against the Person Act 1861* and the *Infant Life (Preservation) Act 1929*—govern unlawful abortions. The Offences Against the Person Act deals with all unlawful abortions, while the Infant Life (Preservation) Act deals with late abortions and acts of feticide during childbirth.
- 2.68 Section 58 of the Offences Against the Person Act makes it an offence to ‘unlawfully procure a miscarriage’ by administering ‘any poison or other noxious thing’ or using any instrument ‘with intent to procure the miscarriage of any woman’.¹²¹ While the term ‘miscarriage’ is not defined, it has been held that the ‘pill’, the ‘morning-after pill’ and intrauterine devices are not **abortifacient** substances that cause a ‘miscarriage’.¹²² This offence may be committed by a pregnant woman and by a third party.
- 2.69 It is also an offence to ‘unlawfully’ supply an instrument, poison or other noxious thing knowing it is to be used to procure an abortion.¹²³ The meaning of the word ‘unlawfully’ was originally determined by case law, most notably *R v Bourne*,¹²⁴ however, the case law is no longer applicable because section 5(2) of the Abortion Act now provides that any abortion not in accordance with that Act is unlawful.
- 2.70 The Infant Life (Preservation) Act makes it an offence to ‘destroy the life of a child capable of being born alive’ unless the act which caused the death of the child was done in good faith to preserve the life of the mother.¹²⁵ If a woman has been pregnant for 28 weeks or more, the child is presumed to be capable of being born alive.¹²⁶ The law was changed in 1990 to make it clear that this criminal offence is subject to the provisions in the Abortion Act.¹²⁷ Section 5(1) of the Abortion Act now provides that a medical practitioner who performs an abortion in accordance with that Act does not commit an offence under the Infant Life (Preservation) Act.
- 2.71 Aspects of UK abortion law have recently been reviewed by a parliamentary committee. In 2007, the House of Commons Science and Technology Committee released its report *Scientific Developments Relating to the Abortion Act 1967*. The terms of reference asked the committee to gather scientific and medical evidence from witnesses about the 24-week upper time limit on abortions in some circumstances. 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 upper gestation limit of 24 weeks that applies in some circumstances.

NEW ZEALAND

- 2.72 The law governing abortion in New Zealand is similar to the law in the UK. The *Crimes Act 1961* not only prohibits unlawful abortion but also sets out the grounds upon which a doctor may perform a lawful abortion.¹²⁸ The *Contraception, Sterilisation and Abortion Act 1977* sets out the procedures medical practitioners must follow when authorising an abortion.¹²⁹
- 2.73 The law draws a distinction between abortions performed before and after 20 weeks gestation. An abortion is lawful before 20 weeks gestation if two medical practitioners believe:¹³⁰
- *That the continuance of the pregnancy would result in serious danger to the life, or to the physical or mental health, of the woman; or*¹³¹
 - *That there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped;*¹³² or
 - *That the pregnancy is the result of incestuous sexual intercourse; or*
 - *That the woman or girl is severely subnormal within the meaning of section 138(2) of this Act.*

An abortion is only lawful after 20 weeks gestation if two medical practitioners believe the abortion is necessary to save the life of the woman, or to prevent serious permanent injury to her physical or mental health.¹³³

- 2.74 Abortions cannot be lawfully performed unless authorised by two medical practitioners,¹³⁴ one of whom must be a practising obstetrician and gynaecologist.¹³⁵ Facilities in which abortions are performed must be licensed.¹³⁶ A doctor can lawfully refuse to perform an abortion on the grounds of conscience but has an obligation to refer the woman for assessment when requested.¹³⁷

CANADA

- 2.75 Abortion is not separately regulated by law in Canada. In 1988 the Canadian Supreme Court held that the provisions in the Criminal Code which prohibited abortion were invalid because they were in conflict with the 'right to life, liberty and security of the person' enshrined in the *Canadian Charter of Rights and Freedoms*.¹³⁸ At the time, section 251 of the Canadian Criminal Code made abortion a criminal offence punishable by life imprisonment. However, it provided an exception when a hospital's therapeutic abortion committee accepted a medical practitioner's opinion that continuation of a woman's pregnancy would endanger her life or health.

- 2.76 The Canadian Supreme Court struck down these provisions because they failed to conform with principles of fundamental justice contained in the Charter. The court found the abortion committee requirement to be arbitrary and incapable of being applied in a fair and consistent manner across the country; it was therefore unconstitutional.¹³⁹

- 2.77 Chief Justice Dickson stated:

At the most basic physical and emotional level, every pregnant woman is told by the section that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations. Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress. Section 251 clearly interferes with a woman's bodily integrity in both a physical and emotional sense.

- 2.78 Since this decision in *Morgentaler* 20 years ago, no legislation has been passed which separately regulates abortion consistent with the *Canadian Charter of Rights and Freedoms*.¹⁴⁰ Consequently, abortion has been regulated in Canada since 1988 by the body of law that governs all other medical procedures.

UNITED STATES

- 2.79 Abortion is regulated by a combination of federal and state law in the United States (US). While criminal law and health law are primarily state matters, there have been many US Supreme Court decisions about abortion over the past 35 years. These have concerned the extent to which a woman's right to terminate her pregnancy is protected by the right to privacy in the Bill of Rights and, conversely, the extent to which state law may regulate abortion without infringing that right.

- 2.80 In the well-known case of *Roe v Wade*,¹⁴¹ the Supreme Court decided that the right to privacy, drawn from the 'due process' clause in the US Constitution's 14th amendment, allowed a woman to have an abortion in the early stages of her pregnancy without state interference. The court held that the reach of this privacy protection diminishes as the pregnancy progresses, thereby permitting some legislative regulation of late abortions. The principles to be drawn from *Roe v Wade* were described in a subsequent case:

It must be stated at the outset and with clarity that Roe's essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a

- 119 *Abortion Act 1967* (UK) s 1(4).
 120 *Abortion Act 1967* (UK) s 4(1), (2).
 121 Section 65 of the Victorian Crimes Act is based upon this provision.
 122 *R (on the application of Smeaton) v Secretary of State for Health* [2002] EWHC; [2002] 2 FLR 146; [2002] 2 FCR 193.
 123 *Offences Against the Person Act 1861* (UK) s 59. Section 66 of the Victorian Crimes Act is based upon this provision.
 124 [1939] 1 KB 687; [1938] 3 All ER 615.
 125 *Infant Life (Preservation) Act 1929* (UK) s 1.
 126 *Infant Life (Preservation) Act 1929* (UK) s 2.
 127 *Human Fertilisation and Embryology Act 1990* (UK) s 37(4).
 128 *Crimes Act 1961* (NZ) ss 183, 186, 187A.
 129 *Contraception, Sterilisation and Abortion Act 1977* (NZ) ss 32, 33.
 130 *Crimes Act 1961* (NZ) s 187A(1).
 131 When determining whether continuance of the pregnancy would result in serious danger to the life or to the physical or mental health of the woman, the medical practitioners may take into account 'the age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years' or whether there are 'reasonable grounds for believing that the pregnancy is the result of sexual violation': *Crimes Act 1961* (NZ) s 187A(2).
 132 The key terms are not defined.
 133 *Crimes Act 1961* (NZ) s 187A(3).
 134 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 29. Doctors apply for a licence through the Abortion Supervisory Committee, a committee established under s 10.
 135 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 32(2)(b)(i).
 136 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 21.
 137 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 46.
 138 *R v Morgentaler* [1988] 1 SCR 30.
 139 The increased risk to the woman due to delay caused by committee approval, and needing four physicians, meant that abortion would be unavailable in almost 25% of Canadian hospitals: Dickson CJ.
 140 The Canadian Government introduced a less restrictive bill to re-criminalise abortion post *Morgentaler* (Bill C-43) which was passed by the Commons but defeated in the Senate on a tied vote in 1991. The former provisions remain on the statute books but are not operative having been struck down by the Supreme Court.
 141 410 US 113 (1973).

woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.¹⁴²

Subsequent cases have dealt with the extent to which the state may impose preconditions upon access to abortion services and regulate abortion procedures without violating the *Roe v Wade* principles.¹⁴³

- 2.81 The regulation of abortion differs markedly from state to state in the US. Some states impose strict criminal prohibitions upon abortion after fetal viability, while others legislatively affirm a woman's qualified right to obtain an abortion. Many have a two-staged approach. Abortion is regulated in the same way as any other medical procedure in the earlier stages of pregnancy but then a line is drawn. In New York abortion is not regulated before 24 weeks gestation; in California it is before viability. In the later stages of pregnancy there must be threats to the life or health of the woman for abortion to be lawful in both states.
- 2.82 In other states the dividing line for the two-staged approach to regulation is drawn much earlier. In Texas, for example, abortions after 16 weeks gestation cannot be performed unless the woman has received a substantial amount of information, including coloured pictures of a fetus at various stages throughout a pregnancy. An abortion cannot be performed in Texas after viability unless it is necessary to prevent the death or substantial risk of serious impairment to the physical or mental health of the woman, or the fetus has a severe and irreversible abnormality.

RELATED LEGAL ISSUES

CONSENT TO TREATMENT

- 2.83 As abortion is performed as a medical or surgical procedure, it is appropriate to describe briefly the current law concerning consent to treatment by adults, young people and people unable to provide their own consent because of disability.
- 2.84 The common law governs consent to treatment by both adults and children in Victoria. There is also a statutory scheme which regulates consent to medical treatment by adults who do not have the capacity to provide consent. Master of the Rolls Lord Donaldson has provided a concise statement of the common law requirements for consent to treatment by an adult:

The law requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment of him [sic] is to be lawful, although the consent need not be in writing and may sometimes be inferred from the patient's conduct in the context of the surrounding circumstances. Treating him without his consent or despite a refusal of consent will constitute the civil wrong of trespass to the person and may constitute a crime ...

The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption which can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned. However a small minority of the population lack the necessary mental capacity due to mental illness or retarded development ... This is a permanent or at least a long term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment.¹⁴⁴

- 2.85 In Victoria the *Guardianship and Administration Act 1986* establishes a **substitute decision-making** regime for people who lack capacity to provide consent. It operates when an adult person with a short- or long-term disability is unable to make a broad range of decisions, and there is a need for another person to have the lawful authority to make those decisions. This includes decisions about medical treatment. In most instances, a person referred to in the legislation as the 'person responsible' is permitted to make medical treatment decisions.¹⁴⁵ That person may be a guardian, a primary carer, or a close relative of the person who is unable to make the decision.¹⁴⁶

- 2.86 There are some medical decisions that cannot be made by the person responsible. These decisions concern a ‘special procedure’, which is defined in the legislation as including ‘termination of pregnancy’.¹⁴⁷ Consent for a special procedure is valid only when given by the Victorian Civil and Administrative Tribunal (VCAT).¹⁴⁸ VCAT may give its consent to a special procedure only when it is satisfied that: the person concerned is incapable of giving consent; that capacity is unlikely to return within a reasonable time; and when the procedure would be in the person’s best interests.¹⁴⁹ The Public Advocate, who is sometimes appointed to assist VCAT in applications for consent to a special procedure, has published detailed practice guidelines to assist those involved.¹⁵⁰
- 2.87 There is no fixed age at which a child or young person may consent to his or her own medical treatment under the common law. A case-by-case determination is made about whether a young person possesses sufficient intellectual capacity and emotional maturity to consent to a particular treatment. This rule, which was first devised by the House of Lords in *Gillick v West Norfolk AHA*,¹⁵¹ has been endorsed by the High Court. In *Marion’s case*, Justice McHugh 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.*¹⁵²
- 2.88 The common law permits parents to give consent when a child or young person lacks the capacity to do so and the treatment is in their best interests. Justice McHugh explained the operation of the law in *Marion’s case*:
- [T]he common law would be socially unacceptable and deserving of condemnation if its doctrines led to the result that, in the absence of an emergency, the carrying out of an ordinary medical procedure on a minor constituted an assault whenever the minor lacked the capacity to consent to the procedure. Consequently, the common law has conferred power upon a parent who has the lawful custody of a minor to give a lawful consent to the carrying out of medical procedures on that minor ...*
- A parent has no authority ... to consent to medical treatment unless it can be seen objectively that the treatment is for the welfare of the child. If a parent purports to give consent to treatment which is not for the welfare of the child, the consent is of no effect. A person who acts on such ‘consent’ is guilty of assaulting the child if the treatment involves any physical interference with the child. Moreover, the parent’s authority is at an end when the child gains sufficient intellectual and emotional maturity to make an informed decision on the matter in question.*¹⁵³
- 2.89 In some states the common law rules have been augmented by legislation. This legislation permits young people above a particular age to consent to their own medical treatment and allows for the consent of one parent when young people are below a particular age. In NSW, for example, young people aged 14 years and over are presumed to be capable of consenting to medical treatment. Consent provided by the parent of a young person who is under 16 years of age is also presumed to be a valid consent.¹⁵⁴ There are no such legislative provisions in Victoria, so the common law tests apply.
- 2.90 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.¹⁵⁵

142 *Planned Parenthood of Southeastern Pennsylvania v Casey* 505 US 833, 846 (1992).

143 *Roe* established a trimester approach, whereby the State’s interest becomes more compelling the further the pregnancy advances. It also held that in matters of bodily integrity the court must have a high degree of scrutiny. See also *Planned Parenthood of South Eastern Pennsylvania v Casey* 505 US 833 (1992), *Stenberg, Attorney-General of Nebraska, et al v Carhart* 530 US 914 (2000); *Gonzales, Attorney General v Carhart et al* 550 US ___(2007). All of the relevant cases are discussed in Graham Gee, ‘Regulating Abortion in the United States after *Gonzales v Carhart*’ (2007) 70 (6) *Modern Law Review* 979.

144 *In re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, 787, 796.

145 *Guardianship and Administration Act* 1986 s 39(1)(b).

146 *Guardianship and Administration Act* 1986 s 37.

147 *Guardianship and Administration Act* 1986 s 3.

148 *Guardianship and Administration Act* 1986 s 39(1)(a).

149 *Guardianship and Administration Act* 1986 s 42E.

150 Office of the Public Advocate, *OPA Practice Guidelines Special Procedures* (2005) Office of the Public Advocate <www.publicadvocate.vic.gov.au> at 21 February 2008.

151 [1986] AC 112.

152 *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s case)* (1992) 175 CLR 218, 311.

153 *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s case)* (1992) 175 CLR 218, 311–312, 316.

154 *Minors (Property and Contracts) Act* 1970 (NSW) s 49. This body of law is being reviewed by the NSW Law Reform Commission.

155 See Chapter 8.

Chapter 3 Current Clinical Practice

CONTENTS

- 32 Overview
- 32 Incidence of Abortion
- 34 Abortion Services
- 36 Abortion at Later Gestation
- 41 Fetal Testing: Abortion and Disability
- 46 Current and Future Access Issues
- 50 Regulation of Medical Practice of Abortion

Current Clinical Practice



OVERVIEW

- 3.1 The terms of reference for this review require the commission to have regard to existing medical practices in Victoria concerning abortion. The background to the review, set out in the terms of reference, notes that our advice on options for reform should reflect current clinical practice. The government's stated aim is that reform should neither expand the extent to which abortions occur, nor restrict current practice.
- 3.2 The commission had limited time to investigate current clinical practice, and to attempt to determine the extent to which abortions occur. While many estimates of abortion numbers are available, comprehensive data is not published by the Department of Human Services (DHS). The commission obtained permission to publish some data provided by DHS discussed throughout this chapter.
- 3.3 As discussed in Chapter 2, abortion has been legally available in certain circumstances in Victoria since the ruling of Justice Menhennitt in *Davidson* nearly 40 years ago.² The ruling allowed medical practitioners to decide whether an abortion was necessary to preserve a woman from serious danger to her life or her physical or mental health if the pregnancy continued. The effect of the ruling was to allow the medical profession to govern the provision of abortion services in this state.

INCIDENCE OF ABORTION

- 3.4 A 2007 study by the Guttmacher Institute New York and the World Health Organization of worldwide estimates of the rate of induced abortions shows a decrease in recent years. In 1995 the estimate was 35 abortions per 1000 women aged 15–44 years, decreasing to 29 per 1000 in 2003.³ The decrease was most marked in developed countries, particularly in the former Soviet Union, and coincided with substantial increases in contraceptive use in the region.⁴
- 3.5 The study notes that unintended pregnancy is the cause of abortion. Every year 51 million unintended pregnancies in developing countries result from women not using contraception, with a further 25 million occurring because of incorrect or inconsistent use of contraception, or method failure.⁵ It states that meeting the need for contraception and improving the effectiveness of use 'are crucial steps toward reducing the incidence of unintended pregnancy'.⁶
- 3.6 Rates in jurisdictions similar to Australia in 2003 vary from 15 per 1000 women in Canada, to 17 in England and Wales, and 21 in the US and New Zealand.⁷
- 3.7 Accurate rates for Australia are difficult to come by. A 1990 study estimated the rate of abortions at 19.6 per 1000 women, and the number just below 80 000.⁸ The Guttmacher study estimates that Australia's rate in 1996 was 22 abortions per 1000 women, and that it decreased to 20 by 2003.⁹
- 3.8 The Australian Institute of Health and Welfare's (AIHW) National Perinatal Statistics Unit analysed data from Medicare and the National Hospital Morbidity Database to produce estimates of abortion in Australia in 2003 and 2004.¹⁰ It estimated the overall number of abortions in Australia in 2003 at 84 218 and the rate at 19.7 per 1000 women aged 15–44 years.¹¹ In 2004 the estimated number was 83 210 and the rate 19.3 per 1000 women aged 15–44 years. The estimates were obtained by combining data from the two sources, with different methodologies used for each state to take account of different inclusions or exclusions of procedures, and different legislation. The rate of abortion has changed little since 1990.
- 3.9 The AIHW reports also provide data for each state and territory. In 2003 the estimated number of abortions in Victoria was 19 896 and the rate 18.5.¹² In 2004 the estimated number was 20 772 and the rate 19.1.¹³ In both years the Victorian rate was below the national rate. The AIHW data provides breakdowns for each year and these are consistent. In each year women aged 20–24 have the highest rate of abortion and the majority of abortions occur in women aged 20–34.¹⁴
- 3.10 In Victoria data is collected by the Department of Human Services (DHS) from every public and private hospital and day procedure centre—this is known as the Victorian Admitted Episode Dataset (VAED). DHS provided VAED data on abortions to the commission.¹⁵ The DHS data

shows both lower rates and lower numbers of abortion than the AIHW study. In 2003/04 the estimated number was 19 350, dropping to 18 756 in 2006/07. A national study in 1996 reported 21 603 abortions in Victoria, which may indicate that the number of abortions is falling,¹⁶ but we cannot draw this conclusion from these two data sets as they are unlikely to be directly comparable. The DHS data shows the rate dropping from 17.94 in 2003/04 to 16.95 in 2006/07.¹⁷

3.11 The rate of abortion cannot be predicted by the restrictiveness or otherwise of legislation governing it—the two do not correspond. The Guttmacher–World Health Organization report found that

*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.*¹⁸

3.12 Rather, the rate of abortion is related to the rate of unplanned pregnancy, and the availability and use of contraception.¹⁹ That is, 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.

3.13 The Royal Women’s Hospital (the Women’s) submission made particular note of the improvement to women’s health in Victoria as a result of the legalisation of therapeutic abortion through the Menhennitt ruling:

No longer were women coming to the hospital with sepsis, including clostridial infections and uterine gangrene following a so-called ‘back-yard’ abortion at the hands of an unqualified ‘practitioner’.

3.14 A World Health Organization study released in 1964 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.²⁰

3.15 A recent study looking at data from the Women’s Pregnancy Advisory Service (PAS) contextualises abortion decisions.²¹ Almost one-quarter (24.9%) of women who contacted PAS did so less than one week after becoming aware of the pregnancy²² and two-thirds contacted PAS within two weeks. The average gestation of the pregnancy was seven weeks at the time of first contact with PAS. Eighty-five per cent of gestation recorded was between 4 and 11 weeks.

3.16 There was a lower response rate to questions about contraception use—less than one-third.²³ The responses indicate that while most women used contraception

1 Information provided in correspondence from Dr C W Brook, Executive Director, Rural and Regional Health and Aged Care Services, DHS, 12 March 2008.

2 *R v Davidson* [1969] VR 667.

3 Gilda Sedgh et al, ‘Induced Abortion: Estimated Rates and Trends Worldwide’ (2007) 370 *The Lancet* 1338.

4 *Ibid* 1343.

5 *Ibid* 1344.

6 *Ibid* 1344.

7 Gilda Sedgh et al, ‘Legal Abortion Worldwide: Incidence and Recent Trends’ (2007) 33 (3) *International Family Planning Perspectives* 106, 108. The Guttmacher Institute is the research arm of Planned Parenthood.

8 National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) 4.

9 Sedgh, (2007) above n 7, 108.

10 Narelle Grayson et al, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia* (2005) contains 2003 data; Paula Laws et al, *Australia’s Mothers and Babies 2004* (2006) contains 2004 data.

11 Grayson (2005) above n 10, 32.

12 *Ibid* 33. This data was extracted on the basis of state or territory of usual residence of the woman undergoing the abortion, rather than the location of the service provider. It may therefore include women who had an abortion in another state but advised that their usual residence was in Victoria. The rate is per 1000 women aged 15–44 years.

13 Laws (2006) above n 10, 50. The data was extracted on the same conditions as the 2003 data.

14 Grayson (2005) above n 10, 34; Laws (2006) above n 10, 52.

15 Information provided in correspondence from Dr C W Brook, Executive Director, Rural and Regional Health and Aged Care Services, DHS, 12 March 2008.

16 National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) Table 1.1, 4. The 1990 figures were obtained using both Medicare and Australian Casemix data.

17 Information provided in correspondence from Dr C W Brook, Executive Director, Rural and Regional Health and Aged Care Services, DHS, 12 March 2008. Rate is per thousand women per year aged 15–44—the standard reproductive age. DHS obtained numbers of women aged 15–44 years from: Australian Bureau of Statistics 3201.0 Table 2: Estimated resident population by single year of age, Victoria. The 2006/07 rate used numbers of women as at 30 June 2006 as the numbers as at June 2007 will not be available until June 2008.

18 Gilda Sedgh, ‘Induced Abortion: Estimated Rates and Trends Worldwide’ (2007b) 1343.

19 *Ibid* 1343–4.

20 Study cited in Robyn Gregory, ‘Corrupt Cops, Crooked Docs, Prevaricating Polies and ‘Mad Radicals’: A History of Abortion Law Reform in Victoria, 1959–1974’ (Unpublished PhD Thesis, RMIT University, 2004) 126.

21 The Key Centre in Women’s Health in Society, University of Melbourne, conducted research with PAS, funded by the Australian Research Council and VicHealth. This research examined the experiences of women who contacted PAS during the 12 months ending 10 September 2007. It includes an audit of information collected by PAS social work staff from 3827 women using the service. In-depth interviews with 60 women are also being undertaken. The study will be published in 2008.

22 This is a percentage of responses where this data was recorded: on this question data was missing for 564 or 15% of users.

23 1107 women out of 3827.



which failed or was incorrectly used, more than one-third did not use contraception.²⁴ While these results must be viewed cautiously because of the low response rate, it does indicate the need for better education about, and increased availability of, contraception.

- 3.17 Responses about previous pregnancy experiences showed that half of PAS users had previous pregnancy experiences, and for more than three-quarters of those users this had resulted in a child or children.²⁵ One-fifth of users had previously had an abortion.²⁶

ABORTION SERVICES

- 3.18 Most abortions in Victoria are provided in private clinics, with a substantial but lesser proportion provided through public hospitals. The commission consulted with all the major public hospital providers, and most of the private providers. Information obtained by *The Sunday Age* through an FOI request to DHS, published in October 2007, showed that approximately one-third of abortions are carried out in public hospitals and two-thirds in private.²⁷ The AIHW study looked at abortions by 'hospital sector' and found the same proportion apparent in national data.²⁸

PUBLIC PROVIDERS

- 3.19 Most abortions performed at public hospitals are conducted at the Women's and Monash Medical Centre (a large public hospital in Melbourne's south-east). Smaller numbers are performed at the Austin (Melbourne's north-east), Frankston (Melbourne's outer south), and Sunshine (Melbourne's west) Hospitals. Abortions are not performed at many regional hospitals. Mildura, Swan Hill, Geelong, and more recently Bendigo, hospitals are the only regional providers as far as the commission is aware. Information on abortion services in regional Victoria is not readily available.
- 3.20 The Women's is Victoria's main public service provider for women with unplanned pregnancy and has provided multidisciplinary psychosocial, clinical, medical, and surgical services for women for 30 years.²⁹ PAS takes approximately 7000 calls each year and provides counselling, information, and advocacy to support women to make their decisions and obtain timely access to clinical and other services. It provides services to women who are disadvantaged and dealing with issues such as family violence, assault, crisis, homelessness, or mental illness, and women who are culturally and linguistically diverse, or newly arrived refugees or immigrants. It is also the principal service provider for rural and regional women.
- 3.21 PAS offers women referral to a full range of reproductive choices, including abortion, **antenatal** care, parenting support, and adoption or alternative care arrangements. A recent study of outcomes for PAS users shows that the overwhelming majority of women who use the service have already made up their mind to have an abortion and are contacting the service to make arrangements, rather than to seek counselling.³⁰ Counselling is available for pregnancy decision making, support, and post-abortion counselling.
- 3.22 As abortion is time sensitive the Women's restricts service with a cap on numbers rather than using a waiting list system. Given the time sensitivity, in a straightforward case where the woman is sure of her decision, the abortion will take place within a week of contact. Most abortions are performed at 7–8 weeks gestation and the hospital's Choices Clinic provides abortions up to 18 weeks gestation.³¹ The hospital performs approximately 3000 abortions per year.
- 3.23 Where a woman seeks a termination at the Women's:
- the woman is referred to PAS for assessment if she has not come to the hospital through that service
 - this assessment will consider the woman's circumstances, including her capacity to pay, whether she can go to a private clinic and if her needs can be met by the hospital
 - PAS will respond to issues of mental health, violence or other crisis
 - PAS will make appointments for a Choices Clinic consultation
 - the Choices Clinic makes a medical assessment
 - the termination is performed or the pregnancy is continued. Approximately 80% of PAS clients proceed with an abortion.³²

- 3.24 The Choices Clinic confirms the woman's decision to undergo abortion. If the pregnancy is beyond 10 weeks gestation, it confirms gestation through ultrasound unless the woman attends with a reputable ultrasound report. A medical assessment of the woman's fitness for surgery is conducted, medical risk information is provided, informed consent is documented, and the abortion is then performed.³³ Abortions are almost all performed surgically unless this is medically contraindicated. The Choices Clinic is not just an abortion service but provides advice, consultation and treatment for contraceptive and sexual health requirements.
- 3.25 Monash is the other major public hospital providing an abortion service, though does not have the capacity of the Women's. Monash provides approximately 300 **surgical abortions** per year.³⁴ Counselling with a counsellor or psychologist is available. For abortions up to 14 weeks gestation the decision to proceed is made by the woman in consultation with one of the specialist doctors in the unit. For later gestations the doctor discusses the decision within the unit, so the decision is not made by a single practitioner. After 24 weeks decisions are made in consultation with a panel. This process is discussed under late abortion.
- 3.26 The Austin Hospital recently began an abortion service, performing approximately 200 abortions per year.³⁵ It estimates that half of its patients are from rural and regional areas and unable to afford an abortion at a private clinic. Terminations are all surgical and are performed up to 20 weeks gestation. After that a referral is made to the Women's or a private clinic.

PRIVATE PROVIDERS

- 3.27 In metropolitan Melbourne abortions are readily available through private clinics. All clinics provide abortions up to 14 weeks gestation, some up to 18 weeks, and one provides abortions at later gestations.³⁶
- 3.28 All clinics provide a same-day service for women at earlier gestations who are clear in their decision to have an abortion. However, some prefer women to attend an initial appointment and then return for the abortion. A same-day service is always provided for women who have travelled from regional Victoria or interstate and who are clear in their decision. A same-day service is not available for abortions at later gestation due to the more complex procedures required.
- 3.29 A similar process is followed by all private clinics for abortions at early gestation. The woman is seen by a counsellor who takes her medical history and details of the pregnancy, and provides medical and risk information about the abortion procedure.
- 3.30 As well as providing details of the procedure and medical risk information, a counsellor discusses the abortion decision with the woman to ensure she is clear in her decision and is giving free and informed consent. Further counselling is offered, though most women do not take this up. All private providers had clear policies of providing further counselling, or referral for external counselling, for women who displayed ambivalence about the abortion decision. Referral to external counsellors may create cost and therefore access issues for some women. Providers tended to be aware of this issue and able to provide a range of options. If ambivalence remains, all providers had a clear policy of refusing to provide the abortion.
- 3.31 If the on-site counsellor is satisfied that the woman is clear in her decision to proceed with an abortion, she sees a doctor who performs an ultrasound to establish gestation. In most cases this simply confirms gestation, as women usually know the stage of pregnancy. If she does not, an ultrasound confirms gestation to within 5 days if performed before 12 weeks gestation, and within 7 days up to 20 weeks gestation.³⁷ Private clinicians consulted thought an ultrasound was essential from a medical risk perspective, to ensure the doctor is appropriately prepared for the surgical procedure required.
- 3.32 For abortions up to 15 weeks gestation a surgical procedure of suction curettage is generally used, which clinics advised has remained much the same for more than 30 years. A World Health Organization report on abortion notes:

- 24 456 out of 1107 women.
- 25 Of the 1945 who had a previous pregnancy experience, 1483 resulted in a birth. In response to another question about whether the user currently had a child or children, 1622 (42.4%) responded 'yes'.
- 26 752 of the 3827 users.
- 27 Renee Switzer, 'Extra baby bonus? Teen abortions fall', *The Sunday Age* (Melbourne) 21 October 2007, 5.
- 28 Grayson (2005) above n 10, Table 4.11, 46.
- 29 Information about services provided by the Women's obtained from submission 507 (Royal Women's Hospital).
- 30 There were 3636 responses by users relating to the woman's 'decision about this pregnancy', and more than one response could be given; however, 3221 responses were 'requesting a termination of pregnancy'.
- 31 Later abortions are undertaken at the Women's for fetal abnormality through the Fetal Management Unit. Abortions after 24 weeks are subject to a panel process, discussed below.
- 32 By comparing two data sources—the Royal Women's Hospital *Clinical Report 2007* and the data from the PAS study—the hospital was able to estimate that 80% of clients proceed with an abortion. The *Clinical Report 2007* shows that in 2006 there were 3026 abortions (not including abortion for fetal abnormality). The PAS database (internal records, not publicly available) showed that in 2006 there were about 3800 women registered as PAS clients. Therefore, about 800 PAS clients, or 21%, did not have an abortion at the hospital in 2006. Some of these women may have had an abortion elsewhere but this cannot be determined from the hospital and PAS data. Information on PAS data provided by Annarella Hardiman, Manager, PAS, 24 January 2008. The Royal Women's Hospital, *Clinical Report 2007*, 62: <www.thewomens.org.au/uploads/downloads/HealthProfessionals/Publications/ClinicalReport/Clinical_Report.2007.pdf> at 28 February 2008.
- 33 Information provided by Dr Di Palmer, Medical Director, Choices Clinic, Royal Women's Hospital, 4 February 2008.
- 34 Information about the abortion services provided by the Monash Medical Centre obtained from consultation 26 (Professor David Healy).
- 35 Information provided by Dr Patricia Moore, Head of Gynaecology Unit, Austin Health, 30 January 2008.
- 36 Information about private providers from consultations 1 (Fertility Control Clinic), 9 (Croydon Day Surgery), 35 (Women's Clinic Richmond Hill); submission 1 (Fertility Control Clinic).
- 37 Philip Baker (ed) *Obstetrics by Ten Teachers* (18th ed, 2006) 86.



Procedures and techniques for early induced abortion are simple and safe. When performed by trained health care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures ... likelihood of dying as a result of an abortion performed with modern methods is no more than one per 100,000 procedures.³⁸

- 3.33 UK abortion guidelines for doctors note '... abortion is safer than continuing a pregnancy to term and ... complications are uncommon'.³⁹ A RANZCOG resource for health professionals on abortion contains a similar statement.⁴⁰
- 3.34 Some submissions pointed to particular risks associated with abortion, such as: increased risk of psychiatric illness, self-harm or suicide; greater likelihood of miscarriage of future pregnancies, or pre-term birth; and an increase in breast cancer risk.⁴¹ A recent UK parliamentary report on scientific developments relating to abortion found there was conflicting literature on the increased risk of future miscarriage or pre-term birth. A 'large well-designed 2006 study' showed no links, but other studies showed some links. The inquiry recommended no change to the current Royal College of Obstetricians and Gynaecologists guidelines, which state that abortion may be associated with 'a small increase' in the risk of these outcomes. The UK report found no causal connection between abortion and the other risks raised.⁴²
- 3.35 Most private clinics offer abortions as only one part of a general sexual and reproductive health care service. Patients attending for abortion receive information and advice about contraception, and can be prescribed or provided with contraception appropriate to their needs.

ABORTION AT LATER GESTATION

- 3.36 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,⁴³ 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 18000.⁴⁴ As discussed throughout this chapter, abortions post 20 weeks are available in the public and private hospital system in Victoria, though in hospitals are provided almost exclusively in cases of fetal abnormality. Late abortions for psychosocial reasons are available only through one private clinic. The medical profession characterise the reasons for late abortions as either 'fetal abnormality' or 'psychosocial', meaning any reason that goes to the physical or mental health of the woman.⁴⁵ When hospitals are unable or unwilling to provide a late abortion, some refer patients to the private clinic.⁴⁶

CURRENT PRACTICE

- 3.37 Most late abortions performed in public hospitals are undertaken at the Women's and Monash due to the expertise in those institutions. Both hospitals have set up termination review panels to consider all requests for abortion after certain gestations.⁴⁷ At the Women's the cut-off for referral to the panel is 23 weeks gestation; Monash is 24 weeks. These cut-off points were determined with reference to possible fetal viability, following investigation of doctors at the Women's for the offence of child destruction after a 32-week abortion in 2000.⁴⁸ They are designed to ensure decisions are made consultatively, and to support the doctor making the decision.⁴⁹
- 3.38 The Women's and Monash have developed expertise in the area of fetal abnormality, and have dedicated Fetal Management Units.⁵⁰ Decisions about late abortion are made through these units. The units receive fetal abnormality referrals at any gestation, from 12–14 weeks right through to term. Referrals are received from within the hospitals, the rest of Victoria, interstate and overseas. The units comprise multidisciplinary teams of obstetricians, social workers, midwives, geneticists, genetic counsellors, paediatricians, paediatric sub-specialists, ultrasonographers and a psychiatrist. Input can be sought from other appropriate sub-specialists, such as paediatric cardiologists. The Mercy Hospital for Women has a comparable but smaller multidisciplinary unit, although it does not perform any abortions.
- 3.39 At the Women's the termination review panel comprises a member of the executive who chairs the panel, a neonatal paediatrician, two medical divisional directors, one nursing divisional

- director, and the obstetrician managing the pregnancy. The chair, and therefore the executive of the hospital, has the power of veto.
- 3.40 At Monash the panel is constituted by the clinicians involved in the woman's care—obstetrician, ultrasonologist, geneticist, paediatrician, midwives, and resident staff—as well as a GP practising outside the hospital. An opinion may be sought from a member of the hospital executive and the hospital lawyer, but they do not have a power of veto.⁵¹
- 3.41 The panels at both hospitals do not always approve abortions that are supported by the Fetal Management Units.⁵² When considering requests for late abortions hospital panels consider the views of the nursing and medical staff who care for the women. If an abnormality is minor or the psychosocial reasons are considered less than compelling staff may be distressed if an abortion was to be undertaken.⁵³
- 3.42 A two doctor process also applies at the only private clinic in Melbourne that conducts late abortions. As part of the clinic's registration requirements, an abortion after 24 weeks must not be performed without the woman first attending a separate consultation with a doctor with counselling credentials.⁵⁴ This process builds in a second opinion, and provides another practitioner so that the final decision is a consultative one rather than one made by one doctor alone with the consent of the patient. It does, however, build in further delay.
- 3.43 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'⁵⁵ and 'onerous'.⁵⁶ The role of the doctor, and how many doctors should be involved in the decision, is considered further in Chapter 6.
- 3.44 The commission heard many criticisms of hospital panels and committees in consultations.⁵⁷ Panels have to be convened very quickly because of the **gestational limits** that have been set, making consistent membership impossible. We heard that inconsistent membership can lead to inconsistent decisions. It may also mean that various considerations are given different priority because the panels do not have formal guidelines for decision making. Unanimity is not required for panel decisions, which can lead to one person with strong views dominating the process and disproportionately affecting the outcome.
- 38 World Health Organization Geneva, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003) 14.
- 39 Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion, Evidence-Based Clinical Guideline No 7* (2004) 29. There follows a full discussion of the possible risks of abortion and incidence: 29–35.
- 40 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005) 10.
- 41 Eg consultation 2 (Endeavour Forum).
- 42 House of Commons, Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07: Volume 1*, HC 1045–1 (2007) 44–49.
- 43 Grayson (2005) above n 10, xvi; 42. This is a percentage of abortions where gestation is recorded. Gestation was not recorded in 5% of cases. There is no breakdown by state.
- 44 Figure of 309 obtained from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the year 2005*, 13, Table 7 <www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf> at 12 February 2008. Overall number of abortions from Renee Switzer, 'Extra baby bonus? Teen abortions fall', *The Sunday Age* (Melbourne), 21 October 2007, 5.
- 45 For instance, see division of data into 'fetal abnormality' and 'psychosocial' in the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44.
- 46 Medical Panel meetings 25 October 2007 and 3 November 2007. Consultation 24 (Fetal Management Unit—Royal Women's Hospital). In consultation 26, Professor Healy said the Monash Medical Centre did not, to his knowledge, make any referrals to the clinic.
- 47 For a comprehensive outline of the panel process at each hospital see Nicole Woodrow, 'Termination Review Committees: Are They Necessary?' (2003) 179 (2) *Australian Medical Journal* 92.
- 48 Ibid 92. As noted throughout this report, charges were not laid.
- 49 The Royal Women's Hospital, *Termination Review Process* <<http://intranet.thewomens.org.au/TerminationReviewProcess?printView=true>> at 10 September 2007.
- 50 All information about the Fetal Management Unit was obtained in consultation 24 (Fetal Management Unit—Royal Women's Hospital).
- 51 Woodrow (2003) above n 47, 93.
- 52 Information provided at Medical Panel meetings 25 October 2007 and 13 November 2007; consultation 24 (Fetal Management Unit—Royal Women's Hospital).
- 53 Information provided by Dr Christine Tippet, Director Maternal Fetal Medicine, Monash Medical Centre, 20 February 2008.
- 54 All private hospitals and day centres have to comply with the requirements of the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*. The Secretary of DHS can also set additional requirements as a condition of re-registration of a hospital/day centre. See also Carol Nader, 'Women face wait for late abortions', *The Age* (Melbourne), 13 October 2005.
- 55 Woodrow (2003) above n 47, 94.
- 56 A Briefing Compiled by Pro-Choice Forum, *Late Abortion: A Review of the Evidence—A Briefing Compiled by Pro-Choice Forum* (2004) 24.
- 57 Consultations 9 (Croydon Day Surgery), 24 (Fetal Management Unit—Royal Women's Hospital); Medical Panel Meetings 25 October 2007 and 13 November 2007.



- 3.45 It was also recognised that other problems could occur with a fixed panel. Consistent membership may lead to fixed views reflecting the bias of the panel members. In Western Australia abortion was decriminalised in 1998, and a specific ground included in legislation which allowed abortions post 20 weeks for a severe medical condition of the ‘mother or the unborn child’, which, in the opinion of two doctors from the panel, justified the procedure.⁵⁸ This wording clearly envisages abortions post 20 weeks for both fetal abnormality and in cases where the woman has a severe medical condition. There is nothing in the legislation which excludes a serious mental health condition from the maternal grounds for post-20 week abortions; however, the ministerial panel has only approved abortions in cases of fetal abnormality, refusing cases based on maternal health issues that were supported by the hospital.⁵⁹
- 3.46 The panel system leads to a loss of autonomy for the woman. Anecdotal information from Western Australia suggests ‘women resent the ultimate decision of late pregnancy termination being removed from their direct control’.⁶⁰ If the panel has the ultimate say rather than the medical care team this can ‘erode the doctor–patient relationship’.⁶¹ Medical staff who provide care to women in these situations emphasised how difficult these decisions are for women, and the importance of the fetal units in providing advice and support. An obstetrician from the Monash Fetal Diagnostic Unit has said:
- Why should the decision of a committee, which bears no long-term responsibility for the unborn child, prevail over an informed, conscientious, pregnant woman, especially when there is no sound legal basis for the committee’s decision-making?*⁶²
- 3.47 The gestational limit imposed by the panel process can lead to rushed decisions because women are advised that if they do not make a decision before the case goes to the panel they will lose the ability to make the decision. The two major hospitals conducting late abortions have set two different gestational limits at which the panel process is engaged. The commission heard that discussions at panel meetings can focus on the level of fetal abnormality, with consideration of the effect on the woman a secondary consideration.
- 3.48 The lack of transparency surrounding panel decisions has also been criticised.⁶³ Panel members are usually anonymous and the basis of their judgment not disclosed. The woman involved does not appear at the panel and is not directly represented. Panel decisions are final. In the event of refusal, a woman who is not prepared to accept the decision can access abortion privately if she has the means. Because hospital policies confine late abortions to fetal abnormality, women who want such abortions for other reasons have access to only one clinic in Melbourne.
- 3.49 Psychosocial reasons for abortion include issues related to the unwanted pregnancy that impact on the psychological and physical health of the woman, and socioeconomic issues. Recent commentary by an NZ obstetrician noted:
- Ultimately, except when it is obvious that a woman may be dying because of the pregnancy, all other reasons why a pregnancy may be interrupted before term delivery relate to the woman’s perception of the adverse effect that continuing would have on her long-term health. In this construct, it can be seen that the view of the woman may relate to either a fetal problem or her own situation. There are many reasons why women present after the first trimester of pregnancy. Lack of knowledge, continuing menses, cultural barriers, failed diagnosis of pregnancy and late diagnosis of fetal abnormality are all frequent reasons for late presentations, yet the indications for termination of pregnancy may be just as or more valid as in early request for abortion.*⁶⁴
- 3.50 In consultations the commission heard of many reasons for psychosocial late abortions. 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.⁶⁵ A US examination of late abortions noted that non-recognition or denial of pregnancy by young women is ‘not particularly unusual, especially among teenagers’⁶⁶ and that ‘women who seek late abortions typically are poor, young, and poorly educated’.⁶⁷

3.51 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.⁶⁸

3.52 Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity data on late termination shows that the majority of abortions for psychosocial reasons post 20 weeks gestation were undertaken by young women. Of the 180 such abortions in 2005, 58 were for women aged 20 and under and 61 for women aged 20–24—well over half of such abortions.⁶⁹ Non-recognition of pregnancy is more likely in women who have not had previous pregnancies. Submissions noted that late abortions are very rare,⁷⁰ very difficult to obtain,⁷¹ and are often sought for reasons that are particularly distressing for the woman:

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.⁷²

3.53 The commission heard that forcing a woman to proceed with an unwanted pregnancy has a greater negative impact than abortion, even at later gestation.⁷³ 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.

3.54 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.⁷⁴ Women who carry

58 *Health Act 1911* (WA) s 334(7)(a).

59 Information provided 1 February 2008 by Judy Straton, who was medical advisor to the Hon Cheryl Davenport MLC in 1998 when the legislation was debated in WA. The legislation was debated by the WA Parliament from February to May 1998; Jan Dickinson, 'Late Pregnancy Termination with a Legislated Medical Environment' (2004) 44 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 337, 338. This article does not contain criticism but notes that the panel has only allowed terminations for fetal abnormality.

60 Dickinson (2004) above n 59, 340.

61 Woodrow (2003) above n 47, 94.

62 *Ibid* 94.

63 Lachlan De Crespigny, 'Australian Abortion Laws: Do They Pose a "Health Hazard"?' (2005) 7 (1) *O&G* 52, 53.

64 Professor Peter Stone, 'Late Termination of Pregnancy', (Summer 2007) 9(4) *O&G* 31.

65 Consultation 9 (Croydon Day Surgery); Medical Panel meetings 25 October 2007 and 13 November 2007.

66 Nancy Rhoden, 'The New Neonatal Dilemma: Live Births from Late Abortions' (1984) 72 *Georgetown Law Journal* 1451, n 2.

67 *Ibid*.

68 House of Commons, Science and Technology Committee (2007) above n 42, 27; Marie Stopes International, *Late Abortion: A research study of women undergoing abortion between 19 and 24 weeks gestation, 4–6* <www.mariestopes.org.uk/documents/Late%20abortion.pdf> at 7 January 2008.

69 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the year 2005*, Table 7, 13: <www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf> at 12 February 2008.

70 Submissions 227 (Reproductive Choice Australia), 261 (Gippsland Women's Health Service), 410 (Key Centre for Women's Health in Society), 461 (Association for the Legal Right to Abortion), 501 (Liberty Victoria—Victorian Council for Civil Liberties).

71 Public hospitals only perform late abortions for fetal abnormality: submission 487 (Victoria Women's Trust).

72 Submission 227 (Reproductive Choice Australia).

73 Consultations 12 (Reproductive Choice Australia), 33 (Dr Lachlan de Crespigny).

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



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 and unhappy after the birth than mothers with wanted children, and to spank and slap their children more frequently.⁷⁵

- 3.55 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.⁷⁶ 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.⁷⁷

RELEVANCE OF VIABILITY

- 3.56 Many submissions to the commission raised the issue of fetal viability.⁷⁸ In Chapter 6 we discuss options for abortion law reform, one of which includes a gestational limit.
- 3.57 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.⁷⁹ A range of gestational ages was proposed for a gestational limit in the law, generally between 20 and 24 weeks. Some felt that 12 weeks was the correct cutoff.⁸⁰
- 3.58 Most decriminalisation supporters, including the Paediatric State Committee of the Royal Australasian College of Physicians, did not support gestational limits or fetal viability as the policy basis upon which it should be established:

[T]he possibility of criminal sanction for practitioners involved in such situations also represents a constraint upon both the decision making and the availability of sometimes necessary procedures. Doctors acting in good faith in difficult situations should not have to fear criminal sanction.⁸¹

- 3.59 Many people were concerned that introducing viability into the law would leave the law open to ongoing and continued public controversy.⁸² They pointed to the experience in the US where abortion law remains heavily contested due to its reliance on viability in setting gestational limits.
- 3.60 The medical profession recognises 22–26 weeks gestation as a ‘grey zone’, where some fetuses have survived, most with ongoing disability, through major medical intervention.⁸³ These survival rates do not apply to fetuses with existing disability, where survival depends on the nature and extent of the disability. Victorian Women with Disabilities Network felt that post viability, women deciding whether to have an abortion could centre on the fetus’s likelihood of survival considering the serious health problems it has, as well as the risk to their own physical and mental health.⁸⁴
- 3.61 A recent UK parliamentary inquiry considered whether the 24-week limit in its abortion legislation should be altered. Abortions can still be obtained in the UK post 24 weeks, though the tests to be satisfied are more stringent. The UK line is based on viability.⁸⁵ The House of Commons Science and Technology Committee looked at evidence on scientific and medical developments since the law was last amended in 1990, and concluded there was no justification for lowering the limit. It found no evidence that survival rates before 24 weeks gestation had significantly improved since the last amendment.⁸⁶ It also found no evidence to indicate that fetuses are sentient, or consciously feel pain, especially before 24 weeks.⁸⁷
- 3.62 The commission 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 legislation.⁸⁸ One submitter thought that professional guidelines should be developed for all terminations post 24 weeks.⁸⁹ In effect such guidelines already exist as public hospitals have developed their own and DHS imposes a regime on the only private clinic that undertakes such abortions. One submitter thought that abortions post 24 weeks should only be performed in hospitals due to the differing nature of late abortion procedures.⁹⁰

3.63 Concern was raised that any line lower than 24 weeks would not allow appropriate time to make decisions after routine testing, which occurs around 20 weeks.⁹¹ One participant noted that the 20-week limit in Western Australia resulted in women making ‘rushed’ decisions to stay within the gestational limit imposed by law.⁹²

FETAL TESTING: ABORTION AND DISABILITY

3.64 Testing for fetal abnormalities ‘is a routine aspect of antenatal care, offered to all women in some form or another’.⁹³ Tests should be discussed with women at initial antenatal visits, and their wishes determined. These tests are now such a routine part of pregnancy care that it may not always be clear to women why they are being performed.

DIAGNOSIS OF ABNORMALITY

3.65 ‘Screening tests are performed on all women in order to identify a subset of patients who are at high risk of a disorder (fetal abnormality).’⁹⁴ Screening tests are non-invasive and look for relatively prevalent disorders for which there are accurate prenatal **diagnostic tests**. Screening tests include:

- *Combined first trimester screening*. This test combines a blood test at approximately 10–12 weeks and ultrasound at 12–14 weeks gestation (nuchal translucency scan) to screen for likelihood of Down syndrome and Edwards syndrome.⁹⁵ It has a 90% detection rate.⁹⁶
- *Second trimester maternal serum screen*. This is a blood test done at approximately 15–20 weeks to indicate risk of Down syndrome, Edwards syndrome, and neural tube defects (anencephaly, encephalocele, spina bifida). It has a 70–80% detection rate for Down syndrome.⁹⁷
- *Second trimester ultrasound*. Performed at approximately 18–20 weeks to identify structural abnormality such as missing limbs, heart defects, gastrointestinal or renal tract abnormalities.

3.66 If high risk of Down syndrome is established, or possible structural abnormality detected, the woman is offered ‘diagnostic tests’ to diagnose the abnormality. These include:

- *Chorionic villus sampling*. Performed at approximately 12 weeks. A fine needle is inserted through the abdomen into the womb under ultrasound guidance and a sample of placental tissue taken. A rapid test known as FISH gives a clear result for most women within 24 hours. The sample is also cultured and a test result obtained in approximately two weeks.⁹⁸ There is a 1% risk of miscarriage from the procedure.⁹⁹

75 Reproductive Choice Australia, *RU 486/Mifepristone: A Factual Guide to the Issues in the Australian Debate*, 17 <www.reproductivechoiceaustralia.org.au/Articles/RU486_final-Feb06.pdf> at 12 February 2008.

76 Discussed in National Health and Medical Research Council (1996) above n 8, 26.

77 Reproductive Choice Australia, above n 75, 17.

78 We use the term ‘viable’ to describe a fetus able to survive independently of the mother, with or without medical assistance.

79 Submission 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne).

80 Submission 400 (Mrs Lisa Brick).

81 Submission 517 (Paediatric State Committee, Royal Australasian College of Physicians).

82 Eg consultation 12 (Reproductive Choice Australia).

83 John Keogh et al, ‘Delivery in the “Grey Zone”’: Collaborative Approach to Extremely Preterm Birth’ (2007) 47 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 273; House of Commons, Science and Technology Committee, (2007) above n 42, 15; Nuffield Council on Bioethics, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues* (2006) 70–74.

84 Submission 384 (Victorian Women with Disabilities Network).

85 The 24-week upper limit was introduced by an amendment to the Abortion Act by the *Human Fertilisation and Embryology Act 1990* (UK) s 37(1). Before 1990 there was no time limit in the Abortion Act but the *Infant Life (Preservation) Act 1929* imposed an effective 28-week limit on abortion law through the offence of child destruction. This is discussed in detail in Chapter 7.

86 House of Commons, Science and Technology Committee (2007) above n 42, 18.

87 *Ibid* 22–26.

88 Consultation 19 (Royal Women’s Hospital); Medical Panel meetings 25 October 2007 and 3 November 2007.

89 Consultation 14 (Anonymous).

90 Consultation 26 (Professor David Healy).

91 Consultation 14 (Anonymous); submissions 289 (Victorian Centres Against Sexual Assault Forum Inc), 327 (Children by Choice).

92 Consultation 14 (Anonymous).

93 Baker (2006) above n 37, 81.

94 *Ibid* 105.

95 Down syndrome is trisomy 21 and Edward syndrome is trisomy 18. The term ‘trisomy’ means there are three copies of the Chromosome instead of the normal pair, leading to birth defects.

96 *Ibid* 112.

97 Southern Health, *A Guide to Tests and Investigations for Uncomplicated Pregnancies* (2003) 16.

98 *Ibid* 17.

99 Derek Llewellyn-Jones et al, *Lewellyn-Jones Fundamentals of Obstetrics and Gynaecology* (8th ed, 2005) 42.



- *Amniocentesis*. Performed at or after 15 weeks. A fine needle is inserted through the abdomen into the womb under ultrasound guidance and a small amount of amniotic fluid removed for testing. FISH is also available with this test, though fetal cells are also obtained from the fluid, cultured and a test result obtained after two weeks. There is a 0.5% risk of miscarriage from the procedure.¹⁰⁰

ACCESS TO TESTING

- 3.67 In Victoria, all women receiving hospital maternity care are provided with the option of screening and diagnostic tests. This is the case whether the hospital is public or private, and whether denominational or not. Second trimester ultrasound is routine unless the woman raises a religious, cultural, or other objection to it; however, public hospitals are not funded to provide the first trimester screening tests, only the second trimester ultrasound. The commission was advised that this is because the first trimester screening tests are relatively new, having been available for less than 10 years, and that there is always a time lag between funding and new technology.¹⁰¹ The result is that in the public system women do not obtain abnormality testing until 18–22 weeks gestation, unless they arrange it privately at significant personal expense.
- 3.68 Those choosing, or compelled for financial reasons, to have all their care in the public sector, will have an inferior test (approximately 75% instead of 90% detection rate for Down syndrome) and with a later diagnosis (approximately 18 weeks' gestation instead of 12 weeks' gestation). For women who choose to have an abortion because of major chromosomal abnormality, later diagnosis will mean a more traumatic experience.
- 3.69 These discrepancies in access to testing have important consequences for women in the options available if fetal abnormality is detected. A purpose of testing is to permit women to make a decision about whether to continue with their pregnancy if fetal abnormality is detected. A RANZCOG statement on prenatal screening tests notes that some
- conditions are not compatible with live birth, some are associated with long-term and serious morbidity, and some require neonatal investigation or treatment. There is usually no intrauterine fetal therapy ... In the event of the diagnosis of an anomaly, the woman and her partner may choose to terminate or continue with the pregnancy.*¹⁰²
- 3.70 The stage of screening and hospital policies have a major impact on women's access to the option of abortion. For abnormalities that can be detected though early screening, women able to access such screening have the advantage of being able to make a decision about the pregnancy at an early gestation. If that decision is to have an abortion, the option is readily available at some public hospitals and all private clinics. The woman is therefore able, with counselling and support, to make her own decision about abortion.
- 3.71 For women attending public hospitals who are not aware of or cannot afford early screening, which we heard includes many rural women, initial screening for chromosomal abnormality does not occur until at least 18 weeks gestation and often later.¹⁰³ Diagnostic tests may then take two weeks or more. A woman may not receive a clear diagnosis until 22 weeks gestation or later. Women and their families then need time to consider what they wish to do. Access to screening therefore has an impact on the gestation at which a pregnancy may be terminated for chromosomal abnormality. Women who have money and information are more likely to have access to a straightforward, early, surgical abortion in cases of chromosomal abnormality.
- 3.72 This has also been recognised as an issue in the UK. A review of late abortion concluded that if early screening was made more accessible it would produce a 'modest reduction' in the number of abortions performed at later gestations.¹⁰⁴ However modest, this would significantly improve the situation for those women who, if they choose abortion, could do so at around 12 weeks gestation rather than 20.

REACTION TO TEST RESULTS

- 3.73 Genetic counselling is offered by the three major maternity hospitals in Melbourne. A booklet jointly produced by the hospitals states:
- The counsellor's role is to help you and your partner clarify your feelings, values and beliefs about diagnostic testing and what it might lead to ... Are you prepared to have a*

*diagnostic test that has extra risk of miscarriage?
Are you prepared to raise a child with Down
syndrome or have an abortion?*¹⁰⁵

- 3.74 While this suggests the full range of options are available to women, this is not necessarily the case. Although all maternity hospitals provide fetal testing, many, including most **denominational hospitals**, do not provide abortions. These hospitals generally refer women who want to consider abortion to the Women's or Monash. This referral causes some delay and means these women are further advanced in their pregnancy by the time they receive advice about their options.¹⁰⁶
- 3.75 Of the hospitals that do provide abortions, the final decision to proceed with late abortions is made by a hospital panel, not the woman and her caregivers, as would be the case for all other decisions in clinical practice. Access to fetal testing therefore impacts not only on the stage at which a woman might seek an abortion, but also on whether she will have access to abortion at all. Access to late abortion is discussed earlier in this chapter.
- 3.76 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 Women's Fetal Management Unit, only 10% choose to terminate their pregnancy. This is also the case in the UK, where abortion for fetal abnormality is allowed at any gestation.¹⁰⁷ The Women's undertakes approximately 100 late (after 18 weeks) abortions a year for fetal abnormality. Approximately half are before 20 weeks and half post 20 weeks.¹⁰⁸
- 3.77 The unit undertakes to give broad, impartial, detailed counselling about the particular fetal abnormality and inform the woman how or whether the fetal condition may be treated, both before and after birth. It may discuss abortion for some conditions as one of the possible management options. The woman sees all relevant specialists before making a decision about whether to continue the pregnancy and the unit aims to assist her to understand the implications for either decision.
- 3.78 Diagnosis of many fetal abnormalities is not possible until later gestation.¹⁰⁹ 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.¹¹⁰
- 3.79 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

100 Ibid.

101 Consultation 24 (Fetal Management Unit—Royal Women's Hospital).

102 RANZCOG, *College Statements*, 'Prenatal screening tests for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) and neural tube defects' (July 2007) <www.ranzcog.edu.au/publications/collegestatements.shtml> at 12 February 2008.

103 Consultation 24 (Fetal Management Unit—Royal Women's Hospital); submission 261 (Gippsland Women's Health Service).

104 Pro-Choice Forum (2004) above n 56, 5. The reduction would be modest because only chromosomal abnormalities can be detected with early screening—later abortions will still occur for major structural abnormalities because they cannot be diagnosed until later in pregnancy.

105 Southern Health (2003) above n 97, 17. The three major maternity hospitals are the Royal Women's Hospital, the Mercy Hospital for Women, and the Monash Medical Centre. The commission does not have information about what counselling occurs at other hospitals, though we are aware that many cases of fetal abnormality are referred to the Women's and Monash from other hospitals because of their expertise, and because they provide abortion.

106 Consultation 24 (Fetal Management Unit—Royal Women's Hospital).

107 In the UK in 2003 1941 abortions were performed for fetal abnormality, and approximately 19500 babies were born with abnormalities: A Briefing Compiled by Pro-Choice Forum (2004) above n 56, 5.

108 Consultation 24 (Fetal Management Unit—Royal Women's Hospital).

109 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 ('water 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, eg 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. With multiple pregnancies, serious abnormality or death of one twin is not uncommon.

Abortion, or 'fetal reduction', of the affected twin in cases of fetal abnormality is safer at later gestation. Death of one twin has a 50% risk of causing death or severe disability in the surviving twin. Again the prognosis is much clearer at later gestation. Information provided in submission 321 (confidential).

110 Consultation 32 (Associate Professor Lynn Gillam).



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.¹¹¹

- 3.80 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.¹¹²
- 3.81 Victoria has maintained a Birth Defects Register (VBDR) since 1982, which is overseen by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The council acknowledged the relationship between antenatal screening and abortion in its most recent annual report:

As a result of increasing uptake of prenatal ultrasound and diagnostic procedures, congenital abnormalities are now frequently being diagnosed leading on to terminations of pregnancy.¹¹³

- 3.82 In 2005, most (67.9%) pregnancies affected by chromosomal abnormalities that were reported to the VBDR were terminated, either before 20 weeks gestation (58.7%) or very soon after 20 weeks gestation (9.2%). The VBDR reports that the majority of chromosomal abnormalities, especially trisomy 16, which is the most common, lead to spontaneous miscarriage or death soon after birth.¹¹⁴ It noted significant increases in prevalence of some chromosomal abnormalities between 1994–2005, which it believes was primarily related to widespread early prenatal screening identifying cases that would previously have miscarried before being identified.¹¹⁵ Screening may therefore be leading to earlier abortion of fetuses that would otherwise have been miscarried.
- 3.83 The Women's published data on pre-20 week abortions in its 2007 *Clinical Report*. In 2005 there was a total of 2977 abortions at the hospital before 20 weeks gestation—65 were for fetal abnormality.¹¹⁶
- 3.84 The Council on Obstetric and Paediatric Mortality publishes data on post-20 week abortions in its annual report. This data is available because any death of a fetus post 20 weeks gestation must be reported.¹¹⁷ In 2005 there was a total of 309 abortions post 20 weeks in Victoria, 129 of which were for fetal abnormality.¹¹⁸ Of these, 105 occurred between 20 and 22 weeks gestation, 23 between 23 and 27 weeks gestation, and one post 28 weeks.¹¹⁹
- 3.85 Abortions for fetal abnormality at all gestations account for a very small proportion of overall abortions: there were approximately 354 in Victoria in 2006–07, less than 0.02% of total abortions.¹²⁰ In 2005–06 there were approximately 350 abortions for fetal abnormality, and in 2005 there were approximately 2600 birth defect cases reported to the VBDR.¹²¹ This suggests an abortion rate for fetal abnormality of approximately 13%, comparable to the estimate of the Women's of a 10% abortion rate through their Fetal Management Unit. As noted, some of the abortions in cases of chromosomal abnormality would have naturally miscarried.

FETAL ABNORMALITY IN ABORTION LAW?

- 3.86 Medical staff who care for women in pregnancy have expressed considerable concern about the possibility of gestational limits for abortion being included in any new legislation.¹²² This included concern that if women do not wait for definitive tests, many of which are assisted by later gestation, and do not have time to consider all their options, abortions of healthy, wanted fetuses may occur because women are afraid of having this option closed to them.¹²³ There is often uncertainty around diagnosis, which can be assisted by continuing to monitor fetal development until later stages of pregnancy.¹²⁴
- 3.87 Medical procedures like **fetal screening** and testing clearly raise moral and ethical dilemmas for parents, doctors, and society. British data shows that:

*Termination rates reflect the severity of the condition, with most parents choosing abortion for abnormalities such as anencephaly, which can only be lethal, and decreasing numbers for conditions where outcome and treatment may be more successful.*¹²⁵

- 3.88 Factors considered by parents include the severity of the abnormality and the impact it would have on the child, themselves as carers, and other immediate family members, including existing children and those not yet born. Prior attitudes and beliefs about abortion are also an important factor. The decision is an extremely distressing one, and there is no indication it is taken lightly by parents or doctors.¹²⁶
- 3.89 The ethical issues raised by fetal testing and abortions for fetal abnormality are extremely complex and difficult to resolve.¹²⁷ Screening for fetal abnormality has been described as a 'double-edged sword', placing women in a difficult and distressing position when the results of screening are not as they had hoped.¹²⁸ 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'.¹²⁹
- 3.90 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. In the UK¹³⁰ and South Australia¹³¹ the law specifically recognises severe fetal abnormality as a ground for abortion. The key term in both statutes—'seriously handicapped'—is not defined.¹³²
- 3.91 Legislation that specifically allows abortion for fetal abnormality is open to criticism for devaluing the existence of people who live with disabilities.¹³³ The UK Disability Rights Commission said of the UK legislation:
- The section is offensive to many people; it reinforces negative stereotypes of disability and there is substantial support for the view that to permit terminations at any point during a pregnancy on the ground of risk of disability, while time limits apply to other grounds set out in the Abortion Act, is incompatible with valuing disability and non-disability equally.*¹³⁴
- 3.92 The Disability Discrimination Legal Service submission cautioned against simplistic consideration of this issue. It was concerned about such a provision being implemented in Victoria without the views of the disability community being taken into account. If the ground was included in Victorian abortion law the service called for a definition of 'serious handicap', noting that moral judgments about what constitutes

- 111 Information provided by Dr Michael Permezel, Mercy Hospital for Women, 22 February 2008. Cytomegalovirus infection is associated with increased fetal mortality, but often results in no adverse outcome. In a small percentage of cases it causes fetal damage, manifesting mainly in microcephaly (small head circumference as a result of the brain not developing properly), blindness, and deafness: Philip Baker (ed *Obstetrics by Ten Teachers* (18th ed, 2006) 203.
- 112 Information provided by Dr Michael Permezel, Mercy Hospital for Women, 22 February 2008.
- 113 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44, 12.
- 114 Of such pregnancies 3.8% resulted in a perinatal death and only 28.3% survived beyond 28 days of birth: Consultative Council on Obstetric and Paediatric Mortality and Morbidity Victorian Perinatal Data Collection Unit, *Victorian Birth Defects Bulletin No. 4* (December 2007) 3 <www.health.vic.gov.au/perinatal/downloads/bdr_bulletindec07.pdf> at 12 February 2008.
- 115 *Ibid* 3.
- 116 The Royal Women's Hospital, *Clinical Report 2007*, 62 <www.thewomens.org.au/uploads/downloads/HealthProfessionals/Publications/ClinicalReport/Clinical_Report.2007.pdf> at 28 February 2008.
- 117 Under the *Births, Deaths and Marriages Act 1996* s 12(3)(a), notice must be given to the Registrar in all cases of stillbirth. A stillborn child is defined in s 4(1) as a child of at least 20 weeks gestation having exhibited no signs of life after birth.
- 118 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44, Table 6, 12.
- 119 *Ibid* Table 7, 13.
- 120 This includes some abortions after 20 weeks gestation. DHS advised that VAED data on such abortions should be treated with caution due to limitations in the relevant coding classification. The figure provided should therefore be considered an approximation of the total number. The Council on Obstetric and Paediatric Mortality, however, are certain that their data as to post-20 week abortions is accurate.
- 121 DHS data is presented by financial year: obtained from correspondence Dr C W Brook, Executive Director, Rural and Regional Health and Aged Care Services, DHS, 12 March 2008. Data on birth defects is presented by calendar year. Birth defects data is from: Consultative Council on Obstetric and Paediatric Mortality and Morbidity Victorian Perinatal Data Collection Unit (December 2007) above n 114, 3. The report does not give an overall figure for birth defect cases reported, but states that in 2005, 392 birth defect cases reported to the VBDR had a chromosomal anomaly, which presented 15% of all reported birth defects. This would make the overall
- number of birth defects approximately 2600.
- 122 Medical Panel meetings 25 October 2007 and 13 November 2007; consultations 1 (Fertility Control Clinic); 6 (Women's Health Victoria); 8 (Choices Clinic—Royal Women's Hospital); 9 (Croydon Day Surgery); 10 (Health Services Commissioner); 12 (Reproductive Choice Australia); 16 (Women's Health Goulburn); 24 (Fetal Management Unit—Royal Women's Hospital); 26 (Professor David Healy); 30 (Australian Medical Association Victoria).
- 123 Consultation 24 (Fetal Management Unit—Royal Women's Hospital); submission 410 (Professor Doreen Rosenthal).
- 124 Consultations 24 (Fetal Management Unit—Royal Women's Hospital), 26 (Professor Healy), 31 (RANZCOG), 32 (Associate Professor Lynn Gillam), 33 (Dr Lachlan de Crespigny).
- 125 A Briefing Compiled by Pro-Choice Forum (2004) above n 56, 22. Drawing on data from Department of Health [UK] *Publications and Statistics* <www.publications.doh.gov.uk> at 12 February 2008. See also Nuffield Council on Bioethics, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues* (2006) 61–63.
- 126 Consultations 9 (Croydon Day Surgery), 16 (Women's Health Goulburn North East), 26 (Professor David Healy), 31 (RANZCOG), 32 (Associate Professor Lynn Gillam), 33 (Dr Lachlan de Crespigny); submissions 231 (Public Health Association of Australia—Women's Health Special Interest Group), 261 (Gippsland Women's Health Service), 410 (Key Centre for Women's Health in Society).
- 127 Kristin Savell, 'Turning Mothers Into Bioethicists: Late Abortion & Disability' in Belinda Bennett et al (eds) *The Brave New World of Health* (forthcoming 2008).
- 128 Clare Williams et al, 'Women as Moral Pioneers? Experiences of First Trimester Antenatal Screening' (2005) 61 *Social Science & Medicine* 1983. Also Savell (forthcoming 2008) above n 127.
- 129 J Wyatt, 'Medical Paternalism and the Fetus' (2001) 27 *Journal of Medical Ethics* supp II ii, 15, quoted in Savell (forthcoming 2008) above n 127, 9.
- 130 See discussion in Chapter 2.
- 131 See discussion in Chapter 2.
- 132 See *Abortion Act 1967* (UK) s 1(1)(d); *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(b)(ii).
- 133 South Australia's legislation has been criticised in this way: Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29 (2) *UNSW Law Journal* 207. See also Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 12 (1) *University of New South Wales Law Journal Forum* 42.
- 134 Disability Rights Commission, Statement on section 1(1)(d) of the Abortion Act (5 July 2003) quoted in Savell (forthcoming 2008) above n 127, 5.



'quality of life' may be subjective and arbitrary. Victorian Women with Disabilities Network was opposed to inclusion of the ground in legislation, noting the problems with defining 'serious handicap'. It believed a disability ground to be unnecessary and that a woman should have the right to choose and make her own decision. It noted that inclusion of such provisions suggests that women who do not produce 'perfect' children have failed. Some women with disabilities had suggested to the network that including a 'serious handicap' ground also infers that their lives have no value.

3.93 Criticism of the South Australian provision notes the complexity of the issues involved:

The formulation of public policy and law about abortion on the basis of foetal 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.¹³⁵

3.94 Some people argue that abortion law should contain a specific ground of serious fetal abnormality to reflect the current widespread clinical practice of discussing the option of abortion with a woman when there are adverse test results.¹³⁶ 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.

3.95 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.¹³⁷ Three possible options for abortion law reform are outlined in Chapter 6. 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.¹³⁸ 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, 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.¹³⁹

CURRENT AND FUTURE ACCESS ISSUES

3.96 Abortion services within the few public hospitals that provide them are restricted by administrative decisions about overall service provision.¹⁴⁰ Decisions are based on funding, availability of surgery time and staff, and balancing the demand for this service with the many others that must be provided in public hospitals.

3.97 All public providers advised the commission they are unable to meet demand for abortion services. The Women's has approximately 5000 requests for abortion per year and provides approximately 3000.¹⁴¹ Some of these are funded through public health (the hospital's funding) and some by the patient claiming through Medicare. Of the 2000 requests where service cannot be provided, referral is made mostly to private clinics, where a Medicare rebate can be claimed but does not fully cover the cost of an abortion.

3.98 Costs at private clinics vary according to gestation, and are competitive at earlier gestations due to the number of clinics providing services. Part of the cost is covered by Medicare. As with many services, clinics offer reduced rates to low-income earners with health care, pension or student cards. Abortions above 15 weeks gestation involve a more complex procedure and therefore increased cost, which may create access issues for some women. Providers told us that if cost is a barrier they try to find an arrangement that ensures the service is not refused.

3.99 At gestations above 20 weeks, because there is only one private provider and the procedure is more complex again, costs are higher and may be a barrier for some women. Public hospitals provide abortion at later gestation only in cases of fetal abnormality. Access to late abortion for other reasons is therefore dependant on means.

RURAL AND REGIONAL ISSUES

3.100 Victorian women who live outside the metropolitan area generally have to travel to Melbourne to obtain an abortion.¹⁴² There are no private clinics operating in rural and regional Victoria and, as noted, very few public providers. In areas where there is a public hospital service, some women may have concerns about privacy and confidentiality, though the hospital in Bendigo has found that local access to abortion services is of greater importance to women.¹⁴³

3.101 In its submission, Women's Health Victoria highlighted the problems that lack of access to services cause for women in rural and regional Victoria, including the difficulty, inconvenience, and cost of travel to obtain an abortion.¹⁴⁴

3.102 Access problems for women in rural and regional Victoria were raised in many consultations.¹⁴⁵ These included: difficulty obtaining information or referral to abortion services; the cost and inconvenience of having to travel to Melbourne or interstate to obtain an abortion; lack of information about and access to fetal testing; delays in obtaining test results because of doctor availability; availability of counselling; and privacy. Women's Health Victoria noted 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.

3.103 Because impediments to access cause delays, it is likely that this results in later abortions.¹⁴⁶ The willingness of the medical profession to provide information and referral for abortion was considered in the UK parliamentary committee report on abortion services in that country. The committee found that conscientious objection by doctors, to the extent of not referring the patient to another doctor for information and advice on the issue, contributes to delay in women presenting for abortions.¹⁴⁷ Conscientious objection is considered in detail in Chapter 8.

135 Pringle (2006) above n 133, 217.

136 Medical Panel meetings 25 October 2007 and 13 November 2007. This was raised at the meetings and was not a view held by all panel members.

137 A similar argument was formulated 50 years ago by Glanville Williams: Glanville Williams, *The Sanctity of Life and the Criminal Law* (1958).

138 Model A and the regulation of late abortions under Model B.

139 Model C, and early abortion under Model B.

140 This can be contrasted with NSW where the Department of Health has an abortion policy for public hospitals: 'Framework for Terminations of Pregnancy in NSW Public Hospitals' Circular 2002/64 (2000). The requirements of the policy differ according to the gestation of the pregnancy, and generally accord with practice in Victorian public hospitals. We have been unable to locate the policy online. It is described in Kristin Savell, 'Is the "Born Alive" Rule Outdated and Indefensible?' (2006) 28 *Sydney Law Review* 625, n 138.

141 Information about the Royal Women's Hospital service comes from consultation 8 (Choices Clinic—Royal Women's Hospital); submission 507 (Royal Women's Hospital).

142 See 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; Elly Taylor, 'The Difficulties Young Rural Women Face in Trying to Obtain Surgical Terminations of Pregnancy' (Unpublished Postgraduate Diploma in Gender Studies Thesis, The University of Melbourne, 2007).

143 Dr John Edington, Acting Chief Medical Officer, Director Intensive Care, Bendigo Hospital (Paper presented at the Abortion in Victoria: Where are we Now? Where do we Want to Go? conference, University of Melbourne, 30 November 2007).

144 Women's Health Victoria has also produced an information paper highlighting these issues: Kerrilie Rice, *Difficulties in Access to Termination of Pregnancy Services* (2007).

145 Consultations 1 (Fertility Control Clinic); 3 (Association for the Legal Right to Abortion); 8 (Royal Women's Hospital), 10 (Health Services Commissioner); 11 (Family Planning Victoria); 16 (Women's Health Goulburn); 17 (Victorian Women's Trust); 21 (Women's Electoral Lobby); 23 (Victorian Women with Disabilities Network); 26 (Professor David Healy); 27 (Associate Professor Ian Pettigrew); 31 (RANZCOG); 32 (Associate Professor Lyn Gillam).

146 Taylor (2007) above n 142, 2, 29–30.

147 House of Commons, Science and Technology Committee (2007) above n 42. Several consultations confirmed this was a problem in Victoria: consultations 6 (Women's Health Victoria), 16 (Women's Health Goulburn North East).



TRAINING AND AVAILABILITY OF STAFF

- 3.104 A lack of medical staff to provide abortion services may have an impact on future access to abortion. Throughout the reference we heard that across Australia doctors providing abortion services are ageing, and younger doctors are not coming through to take their place.¹⁴⁸ This appears to be the result of a combination of factors.
- 3.105 First, older doctors have first-hand knowledge or experience of the terrible cost to women's health caused by the lack of access to safe, legal abortion before the Menhennitt ruling.¹⁴⁹ These doctors see abortion as an essential women's health service, as do staff generally in women's health services.
- 3.106 Secondly, many of those consulted thought the uncertain legal environment surrounding abortion stigmatises it. The fact that abortion is still a criminal offence was seen to negatively impact on the way the medical profession views it and deters medical practitioners from working in the area, causing workforce shortages.¹⁵⁰ Decriminalisation and the creation of a regulatory regime that created legal clarity were seen as likely to alleviate some of the workforce and access issues relevant to abortion.
- 3.107 Thirdly, we heard there is no government policy of ensuring access to abortion services, possibly because it has not been decriminalised. The Australian Medical Association (AMA) Victoria noted that the Medical Practitioners Board of Victoria does not have guidelines for abortion procedures because it is in the Crimes Act. Family Planning Victoria noted that public hospitals are not expected to provide abortion services as part of their service agreements, so most do not. As a result, doctors are not learning how to perform abortions.¹⁵¹ The Women's noted that the shortage of doctors currently being trained or already trained, and willing to perform abortions, makes it hard for them to attract, retain, and replace staff to provide the service.
- 3.108 In consultations, the commission heard that some major medical schools do not teach students about abortion. This was not seen as problematic by AMA Victoria and RANZCOG because training can occur later in hospitals, for both general practitioners and specialists. However, Women's Health Goulburn North East noted that because many maternity hospitals are faith-based, abortions are not provided and therefore procedures are not being taught to trainee doctors.
- 3.109 At Monash University abortion is part of the undergraduate core curriculum. It is examinable and students must witness an abortion, though they do not have to perform one. Monash students are told that one in three women they will care for may have had an abortion, and if they do not want to consider abortion, they must refer the patient to someone who will.¹⁵²
- 3.110 Issues of training and availability of staff are recognised within the profession:
- Awareness that abortion is a women's health issue and that the provision of safe abortion is fundamental to women's rights, reducing maternal mortality and morbidity are essential parts of training in obstetrics and gynaecology. Training in the provision of abortion services is important and there is a critical need for this in many places. This requires a supportive environment and involves not only doctors but all the healthcare workers who participate. Decriminalisation and integration of abortion services within gynaecological services may be the best way to achieve better service provision.*¹⁵³
- 3.111 A 1998 Medical Practitioners Board of Victoria report on late abortions noted that training and continuity of service is an even more acute problem in relation to such abortions. The board found there were only 'a very small number of well trained medical practitioners who are qualified and are willing to perform late term terminations'.¹⁵⁴ It said 'the deficits in training and succession planning would therefore appear to be a potential threat to the availability and continuity of high quality, comprehensive services for Victorian women'.¹⁵⁵ This was also seen to be an issue for training other staff involved in the provision of abortion services, such as nurses, social workers, psychologists and other counsellors.
- 3.112 In its submission, Family Planning Victoria noted that sexual and reproductive health is named as one of the Victorian Government's seven health promotion priorities for 2007–12. The seven areas were chosen after consultation with the community.

RU486—MIFEPRISTONE

- 3.113 Greater access to **medical abortion**—that is, non-surgical abortion where drugs are used to induce abortion—was raised in consultations and submissions as being likely to have considerable impact on access to and mode of future abortion provision.¹⁵⁶ Drugs used include prostaglandins (such as misoprostol), methotrexate, and mifepristone, alone or in combination.
- 3.114 Mifepristone is widely used overseas for medical abortion: in France since 1988 and in many other countries since the early 1990s. It is now available in more than 60 countries.¹⁵⁷ It has been found to be a safe and effective alternative to surgical abortion at early gestation.¹⁵⁸ UK medical guidelines recommend that wherever possible women should be offered a choice between medical and surgical termination in the early first trimester.¹⁵⁹ At up to 9 weeks gestation the abortion can occur at home, with arrangements in place for immediate access to medical care if required. Data from the Women's shows that many women contact them for abortion at around 6–7 weeks, and 85.5% make contact between 4–11 weeks gestation.¹⁶⁰
- 3.115 RANZCOG note that mifepristone is an effective abortifacient when combined with a prostaglandin two days later, resulting in an experience for the woman much like a spontaneous miscarriage. It notes that this method of abortion was initially used for gestations up to 7 weeks and then 9, but 'there is now good evidence that this combination may be used ... throughout the first and second trimesters'.¹⁶¹ It is over 95% effective in inducing complete abortion at an early gestation. It is more effective than methotrexate, which is currently widely available.¹⁶²
- 3.116 Mifepristone is not yet widely available in Australia, but is likely to be in the future as more pharmaceutical companies and medical practitioners obtain authorisation to market and prescribe it.¹⁶³ The wider availability of mifepristone may have a significant effect on access to abortion: it is cheaper than surgical abortion, allows earlier abortion, and 'could easily become part of the practice of those gynaecologists, general practitioners and family planning doctors who wish to provide it'.¹⁶⁴ RANZCOG notes that 'there is good evidence that medical abortion is the method preferred by many women when it is available to them and medically suitable'.¹⁶⁵
- 3.117 It is, however, important to note that whether the abortion is medical or surgical, women require the same access to: complete and accurate information
- 148 Consultations 6 (Women's Health Victoria), 8 (Choices Clinic—Royal Women's Hospital), 9 (Croydon Day Surgery), 10 (Health Services Commissioner), 13 (Medical Indemnity Protection Society).
- 149 Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856–1996* (1998).
- 150 Consultations 9 (Croydon Day Surgery), 10 (Health Services Commissioner).
- 151 This was also noted in consultation 16 (Women's Health Goulbourn North East).
- 152 Consultation 26 (Professor David Healy).
- 153 Stone (Summer 2007) above n 64, 31.
- 154 Medical Practitioners Board of Victoria, *Report on Late Term Terminations of Pregnancy* (1998) 42.
- 155 Ibid.
- 156 Consultations 1 (Fertility Control Clinic), 3 (Association for the Legal Right to Abortion), 11 (Family Planning Victoria), 12 (Reproductive Choice Australia), 13 (Medical Indemnity Protection Society), 16 (Women's Health Goulbourn North East), 17 (Victorian Women's Trust), 21 (Women's Electoral Lobby), 26 (Professor David Healy), 27 (Associate Professor Ian Pettigrew), 30 (Australian Medical Association Victoria), 32 (Dr Lyn Gillam), 35 (Women's Clinic Richmond Hill); Submissions 24 (Humanist Society of Victoria Inc), 135 (Dr Pieter Mourik), 185 (Associate Professor Kerry Petersen), 197 (Dr Caroline de Costa), 226 (Women's Health Victoria), 227 (Reproductive Choice Australia), 235 (Youthlaw), 261 (Gippsland Women's Health Service), 282 (Women's Health in the North), 314 (South West Community Legal Centre), 327 (Children by Choice), 338 (Dr Sally Cockburn), 461 (Association for the Legal Right to Abortion), 462 (Family Planning Victoria), 465 (Women's Health Grampians), 487 (Victorian Women's Trust), 497 (Campaign for Reproductive Rights). We note that anti-decriminalisation proponents use the term 'chemical abortion' to describe such procedures.
- 157 Caroline M de Costa, 'Early Medical Abortion in Australia: More Common than Statistics Suggest?' (2006) 185 (6) *Medical Journal of Australia* 341, 219.
- 158 Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline No 7* (2004) 53.
- 159 Ibid 53.
- 160 Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007. The results of the project will be published in 2008.
- 161 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005) above n 40, 16.
- 162 Ibid 17–19; see also de Costa (2006) above n 157, 219.
- 163 Permission must be obtained from the Therapeutic Goods Authority. See de Costa (2006) above n 157, 219–220.
- 164 De Costa (2006) above n 157, 379.
- 165 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *College Statement, Mifipristone* (2005) 1 <www.ranzcog.edu.au/publications/statements/C-gyn14.pdf> at 12 February 2008. More than half of abortions within approved gestational limits are performed using mifepristone in France (56%), Scotland (61%), and Sweden (51%). Mifepristone is least used for early abortion in England and Wales, where only 18% of eligible abortions are medical procedures: Rachel Jones and Stanley Henshaw (2002) *Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden, Perspectives on Sexual and Reproductive Health* (34) 3, 157 <www.agi-usa.org/pubs/journals/3415402.pdf> at 12 February 2008.



about procedures; counselling suitable to their needs; medical examination to confirm gestation and ensure the pregnancy is not **ectopic**; prescription by an appropriately trained practitioner; and relevant general sexual health care.¹⁶⁶

- 3.118 It is also important to note that availability of medical abortion has not been shown to increase the rate of abortion. In European countries where mifepristone has been available for some time there has been no increase in the overall rate or number of abortions,¹⁶⁷ but there has been a dramatic increase in the proportion of abortions performed at earlier gestations. In France, the proportion of abortions performed at or before seven weeks gestation increased from 12% in 1987 to 20% in 1997, while in Scotland, the proportion of all abortions that occur before 10 weeks gestation has increased from 51% in 1990 to 67% in 2000. Similarly, in Sweden, the proportion of abortions performed before nine weeks increased from 45% in 1991 to 65% in 1999.¹⁶⁸
- 3.119 Mifepristone became available in the US in September 2000. Although there are obviously many other factors that determine the abortion rate in the US, there is no indication that it led to an increase in abortions. Indeed the abortion rate in the US began to decline before 2000. The rate in 1997 was 21.9 per 1000 women aged 15–44; in 2001 it was 21.1; and in 2005 the rate was 19.4.¹⁶⁹
- 3.120 The likely increase in availability of medical abortion in the future must be taken into account in abortion law reform. Family Planning Australia’s submission noted that future access to mifepristone means that ‘legislators need to be careful not to restrict clinical options in a way that affects potential safe abortion procedures and practices’. This has been a problem with legislation in other jurisdictions, including the UK and New Zealand. The issues in those jurisdictions, and recommendations for how medical abortion should be considered in any new Victorian legislation, are considered in Chapter 8.

REGULATION OF MEDICAL PRACTICE OF ABORTION

- 3.121 Medical practice for abortion is comprehensively regulated in Victoria. Many people in consultations and submissions emphasised the importance of abortion being viewed as a women’s health issue, rather than an issue for criminal law. There was strong support for the removal of the Crimes Act provisions¹⁷⁰ and for abortion to either be regulated in the same way as other health procedures¹⁷¹ or for provisions about abortion to sit in health legislation.¹⁷²

GENERAL REGULATION OF HEALTH PRACTITIONERS

- 3.122 All doctors and health professionals are subject to comprehensive regulation under the *Health Professions Registration Act 2005*. The Act provides for the registration of health practitioners and a common system of investigation into their professional conduct, professional performance, and ability to practise.¹⁷³
- 3.123 The Medical Practitioners Board of Victoria is a statutory authority established under the Act to ensure medical practitioners maintain professional standards and practise both ethically and competently.¹⁷⁴ The board decides who is qualified and fit to practise medicine as well as dealing with doctors whose fitness to practise is in doubt because of concerns regarding their professional performance, conduct, or health.¹⁷⁵ The Act defines ‘unprofessional conduct’ and ‘professional misconduct’, both of which can lead to loss of registration and other sanctions.¹⁷⁶
- 3.124 Members of the public can approach either the board or the Health Services Commissioner with a complaint about a medical practitioner.¹⁷⁷ The board and the commissioner collaboratively determine which body should investigate a complaint.¹⁷⁸ Because the commissioner’s complaints process is conciliatory, only matters that can appropriately be dealt with through this method are delegated to her. The board therefore deals with cases of alleged professional misconduct by an individual medical practitioner because these cases are not deemed suitable for conciliation.¹⁷⁹
- 3.125 The board considers all complaints and, where appropriate,¹⁸⁰ refers the complaint to an investigating officer.¹⁸¹ After considering the findings of an investigation, the board may decide between various courses of action, including no action, referral for hearing to the relevant panel of the board, or referral to VCAT.¹⁸² Both the board and VCAT have disciplinary powers.¹⁸³

- 166 Caroline De Costa, 'Medical Abortion for Australian Women: It's Time' (2005) 183 (7) *Medical Journal of Australia* 378–80, 378–9.
- 167 Jones and Henshaw (2002) above n 165, 3, 157. Also available: Rachel Jones and Stanley Henshaw, *Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden*, Guttmacher Institute (May–June 2002) <www.guttmacher.org/pubs/journals/3415402.html> at 12 February 2008.
- 168 *Ibid* 156; de Costa (2005) above n 166, 379.
- 169 Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States* (January 2008) <www.guttmacher.org/pubs/fb_induced_abortion.html> at 30 January 2008.
- 170 Consultations 8 (Choices Clinic–Royal Women's Hospital), 9 (Croydon Day Surgery, Planned Parenthood of Australia), Consultation 10 (Health Services Commissioner), 17 (Victorian Women's Trust), 21 (Women's Electoral Lobby), 30 (Australian Medical Association Victoria), 32 (Associate Professor Lynn Gillam), 34 (Jewish Community Council of Victoria and Rabbi Aviva Kipen); submissions 1 (Fertility Control Clinic), 24 (Humanist Society of Victoria Inc), 94 (Women's Health Goulburn North East), 231 (Public Health Association of Australia—Women's Health Special Interest Group), 235 (Youthlaw), 261 (Gippsland Women's Health Service), 262 (Victorian Women Lawyers), 273 (Law Institute of Victoria), 282 (Women's Health in the North), 314 (South West Community Legal Centre), 327 (Children by Choice), 354 (Radical Women), 383 (Castan Centre for Human Rights Law), 384 (Victorian Women with Disabilities Network), 410 (Key Centre for Women's Health in Society), 449 (YWCA Victoria), 451 (Women's Health Victoria), 460 (Health Services Commissioner), 487 (Victorian Women's Trust), 497 (Campaign for Women's Reproductive Rights), 501 (Liberty Victoria—Victorian Council for Civil Liberties), 502 (Youth Affairs Council of Victoria Inc), 507 (Royal Women's Hospital).
- 171 Consultations 1 (Fertility Control Clinic), 3 (Association for the Legal Right to Abortion), 6 (Women's Health Victoria), 9 (Croydon Day Surgery, Planned Parenthood of Australia Group), 10 (Health Services Commissioner, 26 (Professor David Healy), 30 (Australian Medical Association Victoria), 32 (Associate Professor Lynn Gillam); submissions 1 (Fertility Control Clinic), 11 (Kate Oldaker), 23 (Mary Smith), 24 (Humanist Society of Victoria), 134 (Women's Health West), 152 (Rebecca Albury), 185 (Associate Professor Kerry Petersen), 227 (Reproductive Choice Australia), 231 (Public Health Association of Australia—Women's Health Special Interest Group), 410 (Key Centre for Women's Health in Society), 451 (Women's Health Victoria), 460 (Health Services Commissioner), 461 (Association for the Legal Right to Abortion), 462 (Family Planning Australia), 501 (Liberty Victoria—Victorian Council for Civil Liberties Inc), 503 (Australian Medical Association Victoria), 504 (Fitzroy Legal Service), 505 (Victoria Legal Aid), 507 (Royal Women's Hospital). See also Jo Wainer, 'Abortion and the Full Humanity of Women: Nearly There' (2007) 4 *Sexual Health* 219.
- 172 Consultation 29 (Youth Affairs Council of Victoria); submission 426 (Anglican Diocese of Melbourne).
- 173 *Health Professions Registration Act 2005* pt 1(1)(a).
- 174 Medical Practitioners Board of Victoria, *Making a Complaint to the Board* <http://medicalboardvic.org.au/pdf/InfoSheet_for%20Notifiers.pdf> at 11 February 2008.
- 175 *Ibid*.
- 176 *Health Professions Registration Act 2005* s 3.
- 177 Investigations may also be initiated by the board without a notification. See Ian Freckelton, '12 Into One: Regulation of Health Practitioners' (2007) 81 (10) *Law Institute Journal* 39, 40.
- 178 *Health Professions Registration Act 2005* s 43(2).
- 179 Sarah Middleton et al, 'The Rights and Interests of Doctors and Patients: Does the New Victorian *Health Professions Registrations Act 2005* Strike a Fair Balance?' (2007) 186 (4) *Medical Journal of Australia* 192–6, 193.
- 180 The board will not refer a matter for investigation if the notification is frivolous, vexatious, misconceived, or lacking substance, if the notification does not warrant investigation, or if the doctor is no longer registered by the board. Medical Practitioners Board of Victoria, *Board Investigations* <www.medicalboardvic.org.au/> at 11 February 2008.
- 181 *Ibid*. Under the Act, complaints are now referred to as 'notifications' and complainants as 'notifiers'. See *Health Professions Registration Act 2005* ss 3, 42.
- 182 *Ibid*. The board has a Health Panel and a Professional Standards Panel. A Health Panel is established under the *Health Professions Registration Act 2005* s 65(2) where the board believes a doctor's ability to practise is affected because of physical or mental health. A Professional Standards Panel is established under s 61(1) where there is evidence that a medical practitioner may have engaged in unprofessional conduct, professional misconduct or where there has been unsatisfactory performance: s 63(1). Serious matters are referred to VCAT. VCAT makes findings under s 77(1) regarding a doctor's character or ability to practise as well as determining whether unprofessional conduct or professional misconduct has occurred.
- 183 The board's powers are contained in *Health Professions Registration Act 2005* ss 40–41, 63(2), 67(2). VCAT's powers are contained in *Health Professions Registration Act 2005* s 77(4).



There is some right of review of decisions to VCAT.¹⁸⁴ A finding of serious unprofessional conduct by VCAT, and the associated penalty, can be appealed to the Supreme Court on a question of law.¹⁸⁵

REGISTRATION OF CLINICS—DHS REGULATION

- 3.126 Under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*, all private providers of abortion must be registered as day procedure centres or private hospitals. ‘Day procedure centres’ are defined in the *Health Services Act 1988* as premises which provide health services of a prescribed kind or kinds for which a charge is made and patients are treated in one day.¹⁸⁶ ‘Prescribed health services’ includes medical and surgical health services and obstetrics, as well as other specialty health services.¹⁸⁷ Registration is renewed every two years, or any shorter period specified by the DHS Secretary.¹⁸⁸ It is an offence under the Act to carry on business if the facility is not registered.¹⁸⁹ The Regulations establish not only a regime for registration but also strict criteria for: appointment of appropriate staff; patient management; record management; standard of premises and equipment; monthly reporting to the Secretary within a set time; and penalties for non-compliance.
- 3.127 The report to the Secretary must contain detailed information about patients and the procedures carried out.¹⁹⁰ This includes patients’ Medicare numbers, but not their names or addresses. Discussion about any need for further notification of abortions is in Chapter 8.

REGISTRATION OF BIRTHS AND DEATHS

- 3.128 The *Births Deaths and Marriages Act 1996* requires notification to the Registrar of Births, Death and Marriages within 21 days of the birth of any child born alive.¹⁹¹ If a termination resulted in delivery of a live fetus, even if death occurred shortly after, the birth must be registered as well as the death.
- 3.129 In the Act birth includes a stillbirth.¹⁹² ‘Stillborn child’ means a child of at least 20 weeks gestation or, if gestation cannot be reliably established, with a body mass of at least 400 grams at birth, who exhibits no sign of respiration or heartbeat, or other sign of life, after birth.¹⁹³ Abortion of a fetus that meets these criteria would therefore need to be registered as a ‘birth’ under this Act.
- 3.130 Notice of a stillbirth must be given to the Registrar within 48 hours, with a doctor’s certificate certifying the cause of death.¹⁹⁴ The hospital CEO or the doctor responsible for the care of the mother at the birth or who examined the child after birth is responsible for providing the notice.¹⁹⁵ The doctor’s certificate must be completed by the doctor who had care of the mother at the birth, or examined the child after birth.¹⁹⁶

PUBLIC HOSPITALS

- 3.131 The Health Services Act establishes public hospitals and other public health services as incorporated public authorities and sets out their governance arrangements, powers, and functions. The directors or members of the boards are appointed by the Governor in Council. The Act also specifies the powers DHS may exercise in relation to these public authorities. These powers range from providing funding (whether through service agreements or statements of priorities), through to giving directions. There are also provisions in the Act that enable the appointment of an administrator in the case of serious failure on the part of such a public health service or other public hospital to fulfil its functions.
- 3.132 DHS funds these public authorities to provide health services, and is therefore able to require compliance with relevant standards through conditions of funding. Given these arrangements it is not necessary to impose the same requirements as those imposed upon private providers of abortion services by way of regulations. These conditions of funding relate to a range of matters, including financial performance, the quality of services, and patient access.
- 3.133 Public hospitals and other public health services are required under the conditions of funding to report information to DHS, which is similar to the information that private hospitals report under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations*. Denominational hospitals, which DHS funds to provide public hospital services, also report this information as a condition of funding.¹⁹⁷

3.134 There is no general DHS policy on provision of abortion services. Public hospitals can make their own decision about whether to provide an abortion service at all, and the nature and extent of the service. Public providers expressed frustration with the lack of government policy in this area, which restricts access to services for rural women and places the burden of service provision on institutions that strongly believe abortion services to be a necessary component of women's health care.¹⁹⁸

PROFESSIONAL ORGANISATION GUIDELINES

3.135 There are no DHS guidelines for abortion in Victoria, though the regulation of public and private providers of abortion provides a regime for guidelines to be imposed where this is seen as necessary.

3.136 RANZCOG has produced a resource for health professionals on termination of pregnancy. It outlines best practice for the provision of abortion services, including counselling and support for women to make decisions and assess any post-abortion issues, medical assessment before abortion, abortion methods, and risk factors associated with abortion.¹⁹⁹

3.137 Comparable overseas jurisdictions that have decriminalised abortion have comprehensive guidelines for best practice in abortion provision. Two examples are the UK and British Columbia (Canada).²⁰⁰ These cover issues such as information for women, pre-abortion management, abortion procedures, after-care, detailed information on legal and ethical aspects of abortion, and data on methods and risks.²⁰¹ Women's Health Victoria emphasised the importance of abortion services being regulated as health services, and peak bodies developing guidelines for best practice.

184 *Health Professions Registration Act 2005* s 78(1).

185 *The Victorian Civil and Administrative Tribunal Act 1998* contains a general right of appeal to the Supreme Court on a point of law, see pt 5, s 148. See also Middleton (2007) above n 179, 194.

186 *Health Services Act 1988* s 3.

187 *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002* r 7. 188 *Health Services Act 1988* s 85(h).

189 *Health Services Act 1988* s 111. The penalty is 240 penalty units and 20 penalty units for each day the offence continues after conviction or service by the Secretary on the proprietor of notice of contravention, whichever first occurs.

190 *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002* r 47.

191 *Births Deaths and Marriages Act 1996* s 12(3)(a). See *R v David John Iby* [2005] NSWCCA 178, which held that a child may be considered born alive if there is 'any indicia of independent life', that it is a question of fact, and there is no single test of what constitutes 'life' for the purposes of the born alive rule.

192 *Births Deaths and Marriages Act 1996* s 4.

193 *Births Deaths and Marriages Act 1996* s 4.

194 *Births Deaths and Marriages Act 1996* ss 12(3), (4). The penalty for not doing so is 10 penalty units.

195 *Births Deaths and Marriages Act 1996* s 12(6).

196 *Births Deaths and Marriages Act 1996* s 12(5).

197 Denominational hospitals are hospitals operated by religious organisations. Public hospital funding and reporting information provided by Dianne Scott, Senior Policy Officer, DHS, 13 February 2008.

198 Submission 507 (Royal Women's Hospital). See also Taylor (2007) above n 142.

199 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2005) above n 40.

200 Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion*, Evidence-Based Clinical Guideline No 7 (2004); British Columbia Women's Hospital and Health Service and Provincial Health Services, *Best Practices in Abortion Care: Guidelines for British Columbia* (2004)

201 Royal College of Obstetricians and Gynaecologists (2004) above n 200.

Part 2

Community Views

CONTENTS

- 57 Chapter 4: Surveys of Attitudes
- 71 Chapter 5: Commission's Consultation Outcomes



Chapter 4 Surveys of Attitudes

CONTENTS

- 58 Community Attitudes Data
- 64 Opinions by Population Subgroup
- 66 Key Findings
- 68 Conclusions

Surveys of Attitudes



- 4.1 The terms of reference require the commission to consider and develop law reform options that reflect current community standards. This chapter examines several community attitude surveys on abortion. The following chapter describes in detail the main findings of our community consultation process.
- 4.2 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.

COMMUNITY ATTITUDES DATA

- 4.3 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. For that reason, the commission has examined general community attitudes to provide a broader social context for the findings. This has assisted the commission to identify points of consensus in what is a highly polarised debate.
- 4.4 We commissioned Professor David Studdert, Federation Fellow at the University of Melbourne, to analyse five studies. Professor Studdert holds a joint professorial appointment in the Faculty of Law and the Faculty of Medicine, Dentistry, and Health Sciences. He recently joined the university from the Harvard School of Public Health.

REVIEW OF SURVEYS

- 4.5 Public opinion about abortion is occasionally tested through snap polls and questionnaires, but over the past decade only a few published studies have attempted rigorous measurement of attitudes to abortion.
- 4.6 We identified five such studies. Each claims generalisable estimates of the population's views regarding abortion and various abortion-related issues.

AUSTRALIAN SURVEY OF SOCIAL ATTITUDES

Background

- 4.7 The Australian Survey of Social Attitudes (AuSSA) is a major national social survey. It is conducted biennially by survey researchers from the Australian Demographic and Social Research Institute at the Australian National University. The inaugural survey was conducted in 2003 and repeated in 2005, and the 2007 survey was recently in the field. The survey contains more than 200 questions on a wide range of topics, including work, taxes, government services, family life, education, and living standards.

Content

- 4.8 The 2003 and 2005 surveys presented an identical question on abortion. Appearing in a section entitled, Families and Relationships, the question is worded as follows:

Here are two statements about family planning today. Please tell us how much you agree or disagree with each of the following statements.

(a) A woman should have the right to choose whether or not she has an abortion.

(b) Unmarried women should have as much right to fertility treatment (IVF) as married women.

Results

- 4.9 In the 2003 AuSSA, 81% of respondents strongly agreed or agreed with the abortion proposition (ie proposition (a)), 9% disagreed or strongly disagreed, and the rest were neutral or could not decide. Results of the 2005 AuSSA were virtually identical: 79% of respondents agreed or strongly agreed and 10% disagreed or strongly disagreed.

Survey Strengths and Limitations

- 4.10 The survey is national in scope, well designed, and conducted by experienced researchers. Analyses from this survey series have been subjected to peer review and published in scholarly journals.
- 4.11 The sample size is large: 4270 respondents in 2003 and 3902 in 2005.¹
- 4.12 The response rates (44% in 2003 and 43% in 2005) would not be classified as 'high' by general standards of survey research, which creates some risks of **non-response bias**.² Response rates in the 40–50% range are generally regarded as 'fair'; however, it is probably reasonable to generalise cautiously from these results to attitudes of the Australian public at large regarding abortion.
- 4.13 A single question addresses abortion and its wording is non-specific. The term 'right to choose' is not defined. In addition, it is not possible to determine what proportion of the eight in ten respondents who agreed that a right to choose exists would also consider it acceptable to constrain that right in certain circumstances.
- 4.14 The question is paired with one eliciting respondents' opinions about unmarried women's access to in-vitro fertilisation (IVF). This creates some potential for responses that are affected by surrounding questions, or **framing bias**. This possibility is curtailed somewhat by the fact that the abortion question comes first. Also, it is not obvious how or in which direction the presence of the IVF question might skew responses to the abortion question.

AUSTRALIAN ELECTION STUDY

Background

- 4.15 The Australian Election Study (AES) is a national mail-back survey designed to gauge electoral behaviour and attitudes of Australian voters around the time of federal elections. Researchers from the Australian National University, Queensland University of Technology, and the University of Queensland run the survey.³
- 4.16 The AES surveys contain a wide range of questions covering political views and affiliations, as well as attitudes to social issues such as immigration, taxes, and work. A core set of questions repeats through successive waves, but each wave also focuses on a particular theme and introduces new questions.

Content

- 4.17 The seventh AES survey, conducted in 2004, contained the following question:

Which one of these statements comes closest to how you feel about abortion in Australia?

 1. *Women should be able to obtain an abortion readily when they want one.*
 2. *Abortion should be allowed only in special circumstances.*
 3. *Abortion should not be allowed under any circumstances.*
 4. *Don't know.*

Results

- 4.18 Fifty-four per cent of respondents chose option one, 35% chose option two and 4% chose option three.

Survey Strengths and Limitations

- 4.19 Like the AuSSA, this survey is national in scope, well designed, and conducted by an experienced team of survey researchers. Analyses of the 2004 data, as well as findings from previous waves, have been published in peer-reviewed literature.
- 4.20 The sample size is moderate with 1769 respondents in 2004.⁴

- 1 Response rates for surveys discussed are given for the surveys as a whole. With the exception of the AuSSA and AES, question-specific response rates were unavailable. There were 4219 respondents in the 2003 AuSSA and 3865 respondents in 2005, which yielded question-specific response rates of 43% and 42%, respectively. (These are slightly lower than the general response rates reported above): Shaun Wilson et al (eds) *Australian Social Attitudes: The First Report* (2005) 7.
- 2 Non-response bias refers to a problem with using results from a survey sample to generalise to the wider population; it arises when those who respond to a survey have systematically different profiles, attitudes, or experiences than those who do not respond.
- 3 The series began in 1987. During the most recent federal election (2007) the survey's 9th wave was in the field. A wave refers to each time the study is conducted.
- 4 There were 1721 respondents to the abortion question, yielding a question-specific response rate of 43%: C Bean et al, *Australian Election Study, 2004* (2005) 89.

- 4.21 The response rate (45% in 2004) is approximately the same as AuSSA's. This response rate is fair, and creates some potential for non-response bias, but generalising cautiously from the survey's abortion results is probably reasonable.
- 4.22 Although more specific than the abortion question in AuSSA, the AES question is also quite general. In particular, in option two the 'special circumstances' in which abortion 'should be allowed' are not defined.⁵

SOUTHERN CROSS BIOETHICS INSTITUTE SURVEY

Background

- 4.23 The Southern Cross Bioethics Institute (SCBI) was established in 1987 as an initiative of the Catholic aged care provider, Southern Cross Care. SCBI's website describes it as 'an independent, non-sectarian, autonomous institution committed to research into important bioethical issues affecting the whole community—locally, nationally and internationally'.⁶ The website goes on to say:

Southern Cross Bioethics Institute adheres to universal human values, human rights, and the laws of humanity, including the inviolable and inalienable right to life of every member of the human family, whatever the age, status or ability of that member, from conception to natural death.

- 4.24 In 2004, SCBI commissioned Sexton Market Research, a private market research company, to conduct a series of surveys and interviews to assess the attitudes of Australians to abortion. Financial support for the project came from an anonymous businessman. Researchers involved in the study have stated that '[t]he businessman concerned played no role in the research project beyond providing the necessary funding'.⁷
- 4.25 A selection of results from this research was published in a recent book by Drs John Fleming and Nicholas Tonti-Filippini—two bioethicists affiliated with the SCBI.⁸

Content

- 4.26 The research proceeded in four stages. Stage 1, conducted in December 2004, involved a telephone survey of 1200 adults drawn from all states and territories.⁹ Stage 2 involved qualitative research, based on data drawn from six focus groups convened in February 2005.
- 4.27 Stages 3 and 4 both involved additional telephone surveys of 1200 adults. There is limited information available about the survey methods used in these stages. It appears likely that the **sampling** technique and survey methodology resemble those used in stage 1.
- 4.28 The stage 3 survey focused on attitudes to sex education. The stage 4 survey focused on attitudes to RU486 (mifepristone), stem-cell research, cloning, and counselling.

Table 1: Attitudes to Abortion Access¹⁰

Q3. I will ask you now about some different social issues. Please give your own personal opinions, that is, how you feel personally on each issue. The first issue is whether women should have unrestricted access to abortion on demand, no matter what the circumstance. Do you agree or disagree with that view? [Is that strongly agree/disagree or somewhat agree/disagree?].

RESPONSE OPTION	STAGE 1
1. Strongly agree	37%
2. Somewhat agree	25%
3. Neutral	4%
4. Somewhat disagree	15%
5. Strongly disagree	19%
6. Undecided	1%

Table 2: Attitudes to Abortion Rate

Q9. With approximately 90 000 abortions conducted in Australia each year, some people we have spoken to have the opinion that there are too many abortions in Australia at present and it would be a good thing if the number of abortions was reduced. Do you agree or disagree with that point of view?¹¹

RESPONSE OPTION	STAGE 1	STAGE 3 ¹²
1. Strongly agree	39%	61%
2. Somewhat agree	25%	
3. Neutral	8%	39%
4. Somewhat disagree	11%	
5. Strongly disagree	18%	
6. Undecided	4%	

Table 3: Attitudes to Abortion Rate and Access

Q10. If ways could be found to reduce the number of abortions in Australia but still giving women the right to freely choose an abortion, do you think that would be a good thing or not?

RESPONSE OPTION	STAGE 1	STAGE 3	STAGE 4
1. Yes	87%	63%	88%
2. No	7%	9%	6%
3. Don't know	6%	28%	7%

Survey Strengths and Limitations

- 4.29 The specificity and range of abortion-related questions is superior to that of the AuSSA and AES, although ambiguities and uncertainties remain.
- 4.30 The stage 1, 2 and 3 surveys had response rates of 23%, 24% and 22%, respectively. These are low, introduce considerable potential for non-response bias, and make generalising to the population problematic.
- 4.31 There are several limitations with the survey design. Based on their wording, respondents may have perceived certain questions as non-neutral inquiries, which may have affected their response. For example, Q9 elicits views on the appropriateness of the frequency of abortion in Australia. The question is framed as a negative proposition, and the lead-in to it notes the opposition of 'some people we have spoken to'.¹³
- 4.32 Several parts of the general attitude questions are also vaguely worded. For example, Q10 elicits respondents' agreement with 'the right to freely choose an abortion', but predicates it on a contingency, namely, that 'ways could be found to reduce the number of abortions in Australia'. The term 'ways' is not defined or clarified.

AUSTRALIAN FEDERATION OF RIGHT TO LIFE ASSOCIATIONS SURVEY

Background

- 4.33 The Australian Federation of Right to Life Associations (AFRTLA) is 'a national coalition of pro-life groups' which 'works to affirm and protect human life from human **zygote** until natural death'.¹⁴ The AFRTLA commissioned Queensland market research company Market Facts to conduct a two-stage national opinion poll about abortion. Stage 1 was conducted in April–May 2005 and stage 2 in August–September 2005. There were 1200 respondents in each stage.

Content

- 4.34 Both stages had the same introduction and first three questions:

Abortion is an operation or procedure which involves termination of an unwanted or

- 5 'Special circumstances' could, in theory, be interpreted to mean indications ranging from catastrophic congenital defects to economic disadvantage.
- 6 Southern Cross Bioethics Institute, *Welcome to Southern Cross Bioethics* <www.bioethics.org.au> at 8 January 2008.
- 7 John Fleming and Nicholas Tonti-Filippini (eds), *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (2007) 49.
- 8 Ibid.
- 9 The names were selected randomly from the White Pages using a proportional random sampling technique: *ibid* 49.
- 10 The surveys contained a variety of questions about abortion. Results from the three main questions addressing general attitudes in stage 1 are summarised here. Stage 3 repeated two of those (Q9 and Q10) and stage 4 repeated one of them (Q10).
- 11 These response breakdowns come from personal communication with Mike Sexton of Sexton Market Research (16 January 2008). In *Common Ground* there is no breakdown. The results are reported as 64% say 'too high' and 36% say 'not too high'. Fleming and Tonti-Filippini (2007) above n 7, 58.
- 12 The responses were broken down further. See John Fleming and Nicholas Tonti-Filippini (eds) *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (2007) above n 7, 60.
- 13 Framing the question as a negative proposition, with recognition of support for one side of the proposition built into the question, is conventionally seen as an approach to be avoided when designing survey questions because of the response bias it may introduce.
- 14 Australian Federation of Right to Life Associations, *About Us* <www.righttolife.asn.au> at 8 January 2008.



difficult pregnancy, preventing the birth of a live child. Approximately 90 000 abortions are performed each year in Australia.

Q1 Do you believe abortion involves the taking of a human life? (YES/NO/Don't know)

Q2 Do you believe that by 20 weeks of pregnancy, the earliest point at which survival outside the womb is possible, that an unborn child is a human person with human rights? (YES/NO/Don't know)

Q3 Do you believe that abortion can harm the physical and/or mental health of a woman? (YES/NO/Don't know)

- 4.35 The stage 1 survey then posed questions eliciting views on abortion generally, counselling and 'cooling-off periods', parental consent for minors, and Medicare funding for abortions. The stage 2 survey asked respondents about the stages of pregnancy in which abortion should be allowed and the appropriateness of public funding of abortions at various gestational ages.

Major Abortion Questions

- 4.36 In stage 1, two questions elicited respondents' general views on abortion:

Q4. Do you support abortion for any reason whatsoever, that is, abortion on demand?

Q5. Do you support abortion for non-medical, that is, for financial or social reasons?

- 4.37 In stage 2 there were two questions about stages of pregnancy at which abortion should be allowed:

Q4. Up to what stage of pregnancy would you allow abortion?

1. At any time up to 13 weeks, that is 3 months

2. At any time up to 20 weeks, that is half-way through pregnancy

3. At any time during pregnancy up to birth

4. Not at all

5. Don't know

Q6. Would you allow late-term abortion after 20 weeks of pregnancy for non-medical, that is in cases of financial or emotional stress? (YES/NO/Don't know)

Results

- 4.38 Sixty per cent of stage 1 respondents said they supported 'abortion on demand', 32% said they did not, 8% said they didn't know. Thirty-nine per cent said they supported abortion for financial or social reasons and 51% said they opposed abortion for these reasons.
- 4.39 Thirty-nine per cent of stage 2 respondents said that they would allow abortion up to 13 weeks, 13% said up to 20 weeks, 6% said any time up to birth, and 34% said abortion should not be allowed at all.
- 4.40 Eighty-two per cent of respondents in stage 2 said they would not allow abortion after 20 weeks for non-medical reasons, 12% said they would allow it and the remainder said they did not know.

Survey Strengths and Limitations

- 4.41 The range and specificity of questions is strong. More than any other survey in the group under review here, the AFRTLA survey assembles a group of questions that delves into attitudes to various grounds for and gestational limits on abortion.
- 4.42 The response rates for both stages (in the range of 21–23% for stage 1 and approximately 20% for stage 2) are similar to those from the SCBI survey and, consequently, share the same vulnerability to non-response bias.
- 4.43 Inconsistencies are apparent between the responses to the general attitude question (stage 1, Q4) and the more focused questions (stage 1, Q5; stage 2, Q4 and Q6). These inconsistencies are reviewed in detail in the key findings section of this chapter.

4.44 Like the SCBI survey, the AFRTLA survey raises concerns about question design. For example, regardless of their accuracy, the survey's opening with the annual incidence of abortion and statement to respondents that the procedure prevents the birth of a live child may provoke a negative response. Similarly, the question eliciting views on late-term abortion is prefaced by the following statement:

The following question relates to late-term abortion, which is abortion after 20 weeks, or about 5 months, of pregnancy. In Australia premature babies can survive from 23 weeks, although some babies as young as 20 weeks have survived overseas.

4.45 A stage 2 question that elicits views on Medicare funding of abortion is also somewhat negatively loaded.¹⁵

4.46 Again, even if the information is correct, it is not balanced (eg by mention in the late-term abortion question of the incidence of long-term complications among very premature babies).¹⁶ This approach to question design increases risks that the survey question itself will shape responses, particularly among respondents without strong or well-formed views on the matter.

MARIE STOPES INTERNATIONAL SURVEY

Background

4.47 The Marie Stopes International (MSI) partnership is a non-government organisation headquartered in the UK which provides sexual and reproductive healthcare services. MSI has operations in 38 countries. The website of its Australian chapter states that the organisation 'strives to bring a quality of care, accessibility and consistency in sexual and reproductive healthcare to all Australians'.¹⁷ The services provided by MSI include education and counselling, abortion, vasectomy, contraception, and check-ups for sexually transmitted diseases.

4.48 MSI commissioned WebSurvey, a data collection and research agency specialising in online surveys, to survey a sample of women about their experience of unplanned pregnancies, particularly their use of counselling services. WebSurvey used an online service provider¹⁸ that links clients such as MSI with samples of consumers who are paid to respond to market research surveys.¹⁹

4.49 Invitations to participate were sent to 6593 women, weighted to be representative of Australian women by age and state of residence, and 2003 replied. Approximately half of those who replied reported experiencing an unplanned pregnancy and were eligible to participate.²⁰

4.50 The report of study findings is dated November 2006 but the date the survey was conducted is not given.²¹

Content

4.51 The survey contained 22 questions, including several open-ended ones. The questions covered counselling, support, and decision making during the unplanned pregnancy, outcome of the pregnancy, and views on abortion. The survey had a heavy emphasis on counselling issues.

4.52 Two questions elicited attitudes to abortion. One question addressed current views; the other enquired about views held at the time of the unplanned pregnancy. The basic question and response options are identical to the question posed in the 2004 AES, with slight alterations to wording to make the temporal distinction. The questions were:

Q13. Which of the following statements comes closest to your current views about abortion?

Q14. At the time of your unplanned pregnancy, which of these statements comes closest to how you felt about abortion?

4.53 The response options for both questions were:

1. Women should be able to obtain an abortion readily when they want one
2. Abortion should be allowed only in special circumstances
3. Abortion should not be allowed under any circumstances
4. Don't know.

15 The question eliciting views on Medicare funding of abortion is prefaced by the following statement: 'Over the past 35 years, Australian taxpayers have paid for more than 2 million abortions through Medicare and the public hospital system. As approximately 98% of abortions are performed for financial or social reasons, it has been said that abortion is the only elective surgery that Medicare covers'.

16 See discussion of child destruction in Ch 7 for information on survival rates and disability rates of very premature babies.

17 Marie Stopes International, *About Us* <www.mariestopes.com.au> at 8 January 2008.

18 Pureprofile, *Home* <www.pureprofile.com> at 8 January 2008.

19 Participants received \$1 for starting the survey, \$3 for completing it.

20 Websurvey, *What Women Want When Faced With an Unplanned Pregnancy: Key Findings* (2006).

21 Ibid.



Results

- 4.54 For question 13, 60% of respondents chose option 1, 30% chose option 2 and 3% chose option 3.
- 4.55 For question 14, 57% chose option 1, 28% chose option 2, and 7% chose option 3.
- 4.56 Thus, comparing respondents' feelings before and after their unplanned pregnancy, there was a slight shift towards support for abortion afterwards. The proportion of women who were opposed to abortion under any circumstances dropped from 7% to 3%.

Survey Strengths and Limitations

- 4.57 The sampling approach targeted a group of women who had direct personal experience with the type of circumstances that may force consideration of abortion, thereby eliminating some of the noise that surrounds off-the-cuff responses from general population samples. Sequencing questions in the way this survey did also has the potential to provide insight into how the experience of an unplanned pregnancy affects attitudes to abortion.
- 4.58 Both of the above strengths introduce weaknesses. Most importantly, the targeted nature of the sampling methodology means that the results are not generalisable to the whole population.²² The question sequencing, which asked women to think back to how they previously felt about abortion, possibly during quite an emotional period, demands a difficult cognitive exercise; the potential for **recall bias**²³ is fairly high.²⁴
- 4.59 The response rate to the MSI survey is incalculable because the number of eligible women (ie those who had experienced unplanned pregnancies) among the 4590 who did not respond to the invitation to participate is unknown.²⁵

OPINIONS BY POPULATION SUBGROUP

- 4.60 Except for the MSI survey, the findings present snapshots of opinion at the overall population level. Some published information is available on opinions within population subgroups.²⁶
- 4.61 Specifically, analyses of the 2003 AuSSA and AFRTLA survey show some systematic differences in beliefs held according to certain **demographic characteristics**.

UNADJUSTED ANALYSES

- 4.62 The 2003 AuSSA data suggested that:
- people who have no religion are more likely than those who do to agree that a woman has a right to choose whether she has an abortion, although support for the proposition is strong within both groups (93% v 77%) (Table 1)²⁷
 - men are only marginally less likely than women (80% v 82%) to agree that a woman should have the right to choose whether she has an abortion (Table 2)
 - although 82% of women of all ages agree that a woman should have the right to choose whether she has an abortion, a larger proportion of women aged under 50 than those over 50 agreed (Table 2)
 - among women 18–49 years of age, those without children were marginally more likely than those with children to agree with the right-to-choose statement (90% v 86%) (Table 2).

Table 4: Attitudes to Abortion by Religion, AuSSA 2003²⁸

Q. A woman should have the right to choose whether or not she has an abortion.

	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	CAN'T CHOOSE
Total	81%	7%	9%	2%
Doesn't have a religion	93%	5%	2%	1%
Does have a religion	77%	8%	13%	2%

Table 5: Attitudes to Abortion by Gender, Age, and Motherhood, AuSSA 2003²⁹

Q. A woman should have the right to choose whether or not she has an abortion.

	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	CAN'T CHOOSE
Total	81%	7%	9%	2%
Men	80%	8%	10%	2%
Women	82%	6%	9%	2%
Women aged 18–49				
All women 18–49 yrs	87%	5%	7%	2%
Have children	86%	5%	7%	2%
Do not have children	90%	5%	5%	1%

4.63 When examining predictors of attitudes to abortion at different stages of pregnancy, analyses of the AFTRLA survey data suggested that:

- a larger proportion of men than women supported abortion after 13 weeks of pregnancy (22% v 16%) (Table 6)
- outright opposition to abortion appears to increase with age after 35 years, with 29% of 35–44 year olds opposed to it, 33% of 45–54 year olds, 36% of 55–64 year olds, and 43% of respondents aged 65 years or older (Table 6)
- a larger minority of men than women supported late-term abortion (17% v 9%) (Table 7).

Table 6: Attitudes to Abortion at Different Stages of Pregnancy, AFTRLA survey³⁰

Q. Up to what stage of pregnancy would you allow abortion?

	UP TO 13 WEEKS	UP TO 20 WEEKS	ANY TIME UP TO BIRTH	NOT AT ALL	DON'T KNOW
Total	38%	13%	6%	34%	9%
Gender					
Male	35%	14%	8%	33%	10%
Female	41%	11%	5%	35%	8%
Age					
18–34 yrs	38%	18%	5%	32%	6%
35–44 yrs	38%	16%	8%	29%	10%
45–54 yrs	36%	15%	5%	33%	10%
55–64 yrs	45%	7%	5%	36%	8%
65+ yrs	36%	2%	6%	43%	12%

- 22 An additional concern about the generalisability of the MSI findings relates to the sample frame—people who had signed up with a private company to act as paid respondents in surveys. The women who had experienced unplanned pregnancies in this group may differ systematically from women who had experienced unplanned pregnancies in the wider community.
- 23 Recall (or reporting) bias occurs when the way a survey respondent answers a question is affected by deficiencies, ex post adjustments, or gaps in the respondent's memory and causing divergence from the 'true' response.
- 24 The likely effect of this bias is to understate the degree to which the experience of an unplanned pregnancy increased support for abortion.
- 25 Assuming the proportion was the same as among the 2003 women who *did* respond to the invitation (51%), the study response rate would be 30%. This falls between the poor response rates observed in the SCBI and AFTRLA surveys and the fair response rates in the AuSSA and AES. Hence, the potential for non-response bias, even for purposes of generalising to the population of women with unplanned pregnancies, must be taken seriously.
- 26 This section reproduces findings of previously published analyses. The scope of the project did not allow time to obtain and independently analyse the primary datasets. The sources of the data and analyses described in this section are Shaun Wilson et al (eds) *Australian Social Attitudes: The First Report* (2005); Katherine Betts, 'Attitudes to Abortion in Australia: 1972 to 2003' (2004) 12 (4) *People and Place* 22; Market Facts (Qld), *What Australians Really Think About Abortion: A Report on Comprehensive Independent Market Research* (2006).
- 27 Further breakdown by religion is also available; see Betts (2004) above n 26, 24, Table 2.
- 28 See Betts (2004) above n 26, 24, Table 2. Totals may not add up to 100% due to rounding.
- 29 See Betts (2004) above n 26, 25, Table 3. Totals may not add up to 100% due to rounding.
- 30 See Market Facts (Qld), *What Australians Really Think About Abortion: A Report on Comprehensive Independent Market Research* (2006) above n 26, 49. Totals may not add to 100% due to rounding.

Table 7: Attitudes to late-term abortion for non-medical reasons by gender and age, AFRTLA survey³¹

Q. Would you allow late-term abortion after 20 weeks of pregnancy for non-medical reasons, that is, in cases of financial or emotional stress?

	YES	NO	DON'T KNOW
Total	12%	81%	6%
Gender			
Male	17%	75%	8%
Female	9%	86%	5%
Age			
18–34 yrs	11%	82%	7%
35–44 yrs	11%	85%	3%
45–54 yrs	14%	81%	5%
55–64 yrs	14%	80%	6%
65+ yrs	12%	78%	10%

ADJUSTED ANALYSES OF AUSSA 2003

- 4.64 Analyses of subgroup differences in the AuSSA examined the association between responses to the right-to-choose statement and demographic characteristics in adjusted (multivariate) analyses.³²
- 4.65 Among men, marital status and religiousness were significant predictors of agreement with the right-to-choose statement. Specifically:
- men who said they had a religion were less likely to agree with the statement than men without a religion
 - men who never or sometimes attended religious services were more likely to agree with the statement than men who often attended services
 - divorced, separated or widowed men were less likely to agree with the statement than currently married or cohabiting men.
- 4.66 Among women, religiousness, education, and age were significant predictors of agreement with the right-to-choose statement. Specifically:
- women with a religion were less likely to agree with the statement than women without a religion
 - women who never or sometimes attended services were more likely to agree with the statement than women who often attended services
 - women with at least a Bachelor's degree were more likely to agree with the statement than women with less than a Bachelor's degree
 - women aged 65 and older were less likely to agree with the statement than women aged 18–34 years.

KEY FINDINGS

- 4.67 From a technical standpoint, the academic surveys (AuSSA and AES) present the strongest estimates of what Australians think about abortion.
- 4.68 The AuSSA waves from 2003 and 2005 suggest that approximately 80% of Australians support a woman's right to choose. In the 2004 AES, half of the respondents stated that women should be able to obtain an abortion 'readily' and another third thought it should be allowed but only in special circumstances; fewer than 1 in 20 respondents to the AES said that abortion should not be allowed under any circumstances.

- 4.69 The AuSSA and AES had response rates in the 40–50% range, which supports cautious generalisation to the views of the wider population. The primary weakness of these surveys, on the other hand, is that abortion is dealt with in a single question, which lacks specificity.³³
- 4.70 Consequently, the strongest conclusions that may be drawn from these two large-scale surveys actually pertain to the prevalence of public opposition to abortion, rather than the extent of support for it. The AuSSA and AES provide reasonable evidence for the conclusion that no more than 10% of the Australian population opposes abortion outright. In addition, on the basis of AES results, it is reasonable to conclude that approximately half of the population supports relatively open access to abortion services and an additional third supports access within certain limits.
- 4.71 The SCBI and AFRTLA surveys have some technical problems, as discussed. The impact of the low response rate on findings is difficult to predict. For sensitive issues such as abortion, the conventional wisdom is that low response rates undermine generalisability because people with relatively strong views are disproportionately likely to participate;³⁴ however, because abortion is an issue with passionate advocates on both sides of the debate, it is unclear how the bias would be and which way it would run.³⁵
- 4.72 Problems with survey design and question construction were apparent in both the SCBI and AFRTLA surveys. The resulting bias from this limitation can be predicted more confidently: it would likely run towards negative reactions. In other words, because of the way some questions were framed and worded, SCBI and AFRTLA results may tend to overstate opposition to abortion.³⁶
- 4.73 Nevertheless, a remarkable feature of the SCBI and AFRTLA surveys is that their general attitude questions generally support the main messages of the academic surveys.³⁷ In the case of the SCBI survey, 62% of respondents believed that women should have ‘unrestricted access to abortion on demand, no matter what the circumstance’. Excluding respondents whose views were neutral or undecided, the proportion increases to 72%. Given the scope of abortion access presented in the question, this is a high level of support indeed—one that is certainly not out of step with the 80% level of support found in the AuSSA and AES.
- 4.74 Similarly, 87% of respondents to the SCBI affirmed ‘the right to freely choose an abortion’, provided that ‘ways could be found to reduce the number of abortions in Australia’. This is a very high level of support although the question is hard to interpret because of the contingency attached to it. By implication, the ways chosen to reduce abortion would not interfere with free choice in individual cases. Public campaigns to reduce the number of unplanned pregnancies and provision of a broad range of pre-procedure counselling services are the type of interventions that may walk this line. One can only speculate on whether respondents contemplated these or other types of intervention.
- 4.75 Sixty per cent of respondents in stage 1 of the AFRTLA survey indicated support for abortion ‘for any reason whatsoever’, which essentially matches the level of support found in the SCBI survey (62%); however, the precise nature of that support is unclear. Responses to subsequent questions complicate the picture.
- 4.76 In the very next question, for example, a slight majority of respondents (51%) said they opposed abortion for financial or social reasons. Among stage 2 respondents who had an opinion about term limits, 56% favoured them (42% at 13 weeks and 14% at 20 weeks) and an additional 37% of respondents were against abortion altogether.³⁸ These figures cannot easily be reconciled with the 60% level of support for abortion ‘on demand’. Nor can the 82% of respondents who opposed late-term abortion after 20 weeks for non-medical reasons.
- 4.77 Hence, the AFRTLA survey appears to present mutually incompatible responses to general and specific attitude questions. Answers to the questions about gestational limits and non-medical motivations did not accurately capture respondents’ views about freedom of choice and abortion, or, as the report itself concludes, there exists ‘public confusion on what abortion on demand is’.³⁹

31 Ibid 50. Totals may not add to 100% due to rounding.

32 Wilson (2005) above n 1, 260, referring to analyses of the 2003 AuSSA.

33 In particular, what is meant by a ‘right to choose’ in the AuSSA and ‘special circumstances’ in the AES survey is not defined.

34 This randomness is especially upset in dedicated surveys such as SCBI’s and AFRTLA’s. People with neutral, weak, or private views have opportunities to disqualify themselves as soon as the nature of the survey is known, unlike respondents in the AuSSA or AES, who, faced with a broad range of questions, would have been surprised by the abortion question.

35 Elicitation of the views of random samples of non-respondents would be needed to develop estimates of whether and in which direction responses are skewed.

36 Respondents without strongly formed views on abortion going into the survey would have been particularly prone to this type of response bias.

37 It could be argued that such consistency should lessen concerns that the response and framing biases had a large effect on findings.

38 Of the sample 8.3% responded ‘don’t know’ to question 4; the percentages reported in this sentence exclude them from the calculations.

39 Market Facts (Qld), *What Australians Really Think About Abortion: A Report on Comprehensive Independent Market Research* (2006) above n 26, 10.



- 4.78 In any case, it may be inappropriate to place too much weight on responses to any of the AFRTLA questions in light of the survey's low response rate and design limitations. On the basis of the AFRTLA findings it is probably reasonable to conclude that the high level of support for women's right to abortion recedes somewhat when respondents are asked more precise queries about the timing of procedures and women's reasons for seeking abortions, but it is difficult to estimate the extent to which this occurs on the basis of the AFRTLA survey alone.
- 4.79 Results from the MSI survey are broadly consistent with those from a nearly identical question in the AES survey. In the AES survey, 86% of respondents (male and female) said women should be able to obtain an abortion 'readily' or in 'special circumstances'. In the MSI survey, 85% of respondents took this position at the time of their unplanned pregnancy and 90% felt this way afterwards.⁴⁰

CONCLUSIONS

- 4.80 Professor Studdert reached the following overall conclusions.
- 4.81 Available data on the attitudes of Australians to abortion is not particularly strong. In the two strongest surveys from a methodological viewpoint, the information comes from single general questions, which permit a limited view of community sentiment. Two other surveys commissioned by groups with conservative positions about abortion ask more specific questions, but suffer from poor response rates and problems in survey design.
- 4.82 In view of these limitations, 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.

40 Confining the AES results to female respondents would likely have brought the MSI and AES results even closer into line.

Chapter 5

Commission's Consultation Outcomes

CONTENTS

72 Submissions

72 Consultation Meetings

82 Conclusions

Commission's Consultation Outcomes

- 5.1 Despite a short time frame set by the terms of reference, the commission was able to meet with a sizeable number of people interested in this review. The commission also received many submissions from organisations and members of the public.

SUBMISSIONS

- 5.2 The commission received 519 written submissions: 433 were from individuals and 86 were from organisations.
- 5.3 Eighty submissions were either in a standard form or based on a pro-forma circulated by interest groups; 90% of these objected to abortion decriminalisation on principle. They then divided into different approaches to reform. Some stated no preferred model. Others proposed that additional justification and procedural requirements be included in any new law.¹
- 5.4 The commission received 30 signatures on two different petitions, and copies of two more petitions sent to Members of Parliament or other entities were forwarded to the commission.²
- 5.5 Of the written submissions that were not in a standard form or based on a pro-forma, the majority could be broadly described as opposed to decriminalisation. These submissions tended to be very short or simply stated their opposition to decriminalisation on moral or religious grounds.

CONSULTATION MEETINGS

- 5.6 The commission held 36 meetings with organisations and individuals with an interest in abortion law reform. A list of those consulted is included in Appendix F.
- 5.7 The commission appreciates the time and effort that people made, often at short notice, to participate in the process. The meetings provided a wealth of information about current practice and people's insights into key issues in decriminalisation reform. A clearer idea of preferred legislative options was also developed through frank and open discussion.
- 5.8 The following analysis examines responses obtained through submissions and consultations to the questions posed in our Information Paper. Although the terms of reference have the removal of abortion from the Crimes Act as their starting point, the views of those opposed to decriminalisation are included in the interests of transparency.

ETHICAL AND LEGAL PRINCIPLES

Autonomy

- 5.9 Professional bodies, including the Law Institute of Victoria, Victorian Women Lawyers, the Public Health Association of Australia, and the Australian Medical Association (AMA) Victoria supported decriminalisation.³ They characterised abortion as a matter between a woman and her doctor, with autonomy as the fundamental principle that the law should respect.⁴ 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'.⁵
- 5.10 Autonomy was also strongly argued by community groups, health organisations and disability organisations,⁶ which saw no place for the criminal law in regulating what they considered was a woman's personal decision.⁷

Moral Objections

- 5.11 The Right to Life Association, Endeavour Forum, Australian Christian Lobby, the Salt Shakers, World Federation of Doctors Who Respect Human Life (Queensland Branch), and the Australian Family Association 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.⁸ Many submitters argued that abortion is potentially harmful to women and that autonomy is a hollow promise.⁹

Religious Perspectives

- 5.12 There was significant reference to religious teachings in written submissions, particularly from members of the Catholic community. Anglicans, Presbyterians, and representatives of the Jewish faith also took part in meetings. Pentecostal and Baptist groups made written submissions. Across these traditions, there is a range of approaches to abortion.
- 5.13 The Catholic Archdiocese of Melbourne and other Catholic organisations maintained strong opposition to decriminalisation.¹⁰ In contrast, 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'.¹¹ It went on to say '[o]ur consensus view is the gradualist position which argues that while the embryo/foetus is fully human from the time of conception, it accrues moral significance and value as it develops'.¹²
- 5.14 Although the Uniting Church did not make a formal submission, the commission understands that '[t]he church affirmed the dignity of life but understood there were circumstances where an abortion was the only decision a mother could make'.¹³
- 5.15 Consultation with the Jewish Community Council 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.¹⁴
- 5.16 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.¹⁵
- 5.17 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.¹⁶
- 5.18 A review of the major philosophical and theological perspectives on abortion can be found in Appendix B.

Human Rights

- 5.19 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, and others stressed privacy, equality, and health rights.¹⁷ In contrast, the Catholic Justice Agency argued that international human rights law confers rights upon the fetus.¹⁸ Still

- 1 Some submissions based on concerns raised by the Endeavour Forum and Charles Francis QC stated their opposition to the terms of reference and proposed alternative terms of reference. The Australian Christian Lobby, Right to Life Australia, Dr Nicholas Tonti-Filippini, and others felt the terms of reference were restrictive.
- 2 These petitions had 328 signatures between them, but because they were petitions to other bodies they were treated as one submission only for each of the two petitions.
- 3 Submissions 231 (Public Health Association of Australia Women's Health Special Interest Group), 262 (Victorian Women Lawyers), 273 (Law Institute of Victoria), 449 (YWCA Victoria), 503 (AMA Victoria).
- 4 The AMA stressed in its submission that doctors have a wide range of views on abortion which may not necessarily coincide with the AMA's position.
- 5 Submission 517 (Paediatric State Committee, Royal Australasian College of Physicians).
- 6 Eg submissions 226 (Women's Health Victoria), 235 (Youth Law), 384 (Victorian Women with Disabilities Network), 460 (Health Services Commissioner), 462 (Family Planning Victoria), 501 (Liberty Victoria), 507 (Royal Women's Hospital).
- 7 Professor Rebecca Albury noted that 'women who later revise their thinking and regret their decisions deserve support, but reproductive decisions are like any other important decisions; the state cannot legislate against those mistakes or it would find itself outlawing marriage (because of the high divorce rate)...': submission 152.
- 8 Submissions 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne), 458 (Caroline Chisholm Society), 124 (Catholic Women's League of Victoria & Wagga Wagga).
- 9 Submissions 8 (Presbyterian Church of Australia), 82 (Women's Forum Australia).
- 10 However, the principle of double effect allows for circumstances where a fetus may die as a result of a life saving intervention. 'The protection due to the unborn child, however, would not morally forbid the performing of medically indicated procedures designed to save the life of a pregnant woman without any direct assault on the life of the fetus, even though death may be foreseen as an unwanted side effect of the procedure': submission 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne).
- 11 Submission 426 (Anglican Diocese of Melbourne). This position was supported by the Anglican Dean of Bendigo, the Very Reverend Peta Sherlock, the Reverend Ken Parker, of Castlemaine, and Reverend David McMillan, of Maldon parish: Adrian Lowe, 'Change abortion law: Anglican leaders back review', *The Advertiser* (Bendigo), 19 December 2007, 3.
- 12 Submission 426 (Anglican Diocese of Melbourne).
- 13 Barney Zwartz, 'Anglicans call for new stance on abortion', *The Age* (Melbourne), 15 December 2007, 9.
- 14 Consultation 36 (Jewish Community Council of Victoria and Rabbi Faitel Levin).
- 15 Consultation 34 (Jewish Community Council and Rabbi Aviva Kipen).
- 16 Ibid.
- 17 Submission 314 (South West Community Legal Centre).
- 18 Submission 452 (Catholic Justice Agency of the Archdiocese of Melbourne).

others argued that human rights law should confer fetal rights, as should domestic law.¹⁹ Human rights law and abortion is discussed in detail in Appendix D.

Ethical Obligations

- 5.20 Some submitters placed a strong emphasis upon the ethical duty of doctors to provide the best, individualised care to their patients and to observe the principle of autonomy. They saw no place for the criminal law in clinical decision making. Some, including AMA Victoria, stated that the profession is adequately regulated and legal proscription potentially interferes with the patient–doctor relationship.
- 5.21 Others disagreed, citing the principle of ‘do no harm’ as an ethical basis for why doctors should not perform abortions.²⁰ Some argued that decriminalisation is more about protecting doctors and what they describe as an ‘abortion industry’ than protecting women.²¹
- 5.22 Privacy and confidentiality concerns were raised by individuals and organisations. The Youth Affairs Council of Victoria raised specific concerns about the interrelationship between health information confidentiality and consent. These issues are discussed further in Chapter 8.²²
- 5.23 Conscience clauses that allow medical staff to refuse to take part in abortions were discussed by many people. Most saw some value in such a provision; however, there was some divergence about its efficacy and content. Conscience clauses are discussed in detail in Chapter 8.

POLICY OBJECTIVES

Certainty and Clarity in the Law

- 5.24 Many people sought clarity and certainty in the law. For decriminalisation opponents, a more stringent application of the Menhennitt ruling was a priority, with some wanting a further tightening of conditions for lawful abortions.²³ Others argued that the Menhennitt ruling was conceptually flawed and that there should be an absolute prohibition on abortion.²⁴
- 5.25 Many groups were concerned that the Menhennitt ruling lacked clarity, and that the current law was outmoded. Professional bodies including the Law Institute of Victoria put this case strongly. AMA Victoria argued that ‘the legislation cries out for ... a more straight forward legal footing under which medical practitioners can work’.²⁵
- 5.26 Some medical practitioners felt that the Menhennitt ruling provided the right balance of circumstances to consider. In particular, they welcomed the focus upon the woman’s circumstances and the capacity to apply the test to individual cases, thereby preserving what they saw as their ethical duty to work in the patient’s best interests.²⁶
- 5.27 Despite some divergence over the Menhennitt grounds, there was a strong belief that the potential for criminal prosecution puts both women and practitioners at risk.²⁷ The stigma associated with abortion still being a criminal offence was also cited as a reason for women delaying abortions and for suffering humiliation and distress.²⁸
- 5.28 There was also a view that abortions should not be illegal when they are performed frequently as this weakens respect for the law.²⁹

Safe, Quality Services

- 5.29 Many organisations stressed the policy aim of ensuring positive health outcomes through access to safe, legal abortion. They argued that criminalising abortion does not stop women having abortions, just safe ones.³⁰
- 5.30 Others disagreed strongly, arguing that abortion is available on demand in Victoria and the Menhennitt rules were flouted by the profession, particularly in the private sector.³¹ Among people who suggested significant additional procedural elements in any new law, there was a strong call for abortions to be limited to public hospitals.³²
- 5.31 On a related issue, submissions from Right to Life Australia and others argued that the decline in maternal deaths associated with abortion was not due to a liberalising of abortion following the Menhennitt ruling, but the post-war advent of antibiotics. They took the view that the often cited connection between backyard abortion and criminal penalty was a myth.³³

Abortion and Reproductive Health Policy

- 5.32 A significant proportion of health organisations wanted abortion to be seen as an element of a broader commitment to sexual and reproductive health.³⁴ The interrelationships between domestic violence, unwanted pregnancy and abortion were also noted.³⁵
- 5.33 They argued that improved sex education and contraception could contribute to declining rates of abortion.³⁶ It was noted that sexual and reproductive health is included as one of the Victorian Government's seven health promotion priorities for 2007–12.³⁷
- 5.34 The description of abortion as an aspect of health care was strongly opposed by others. They felt that describing abortion as a health matter trivialised moral aspects of decision making, and underplayed what they saw as abortion's significant physical and psychological health impacts upon women.³⁸

Access and Equity

- 5.35 Geographical inequities in access to abortion services, fetal testing, and counselling were frequently raised.³⁹ Practitioners and health service workers from the regions confirmed this.⁴⁰ Inequities based on age, income, disability, and cultural background were also identified. Many decriminalisation supporters thought that a main policy aim should be to address these existing inequities, and in particular to promote timely access to services.⁴¹

Effective Decision Making

- 5.36 Decriminalisation supporters strongly argued that women's reproductive decisions should be respected by the law, and that this was a legitimate policy goal. They stressed accessible, non-judgmental service provision, including non-directive counselling as the means to ensure effective decisions.⁴²
- 5.37 Decriminalisation opponents disagreed strongly with characterising abortion as a choice issue. They argued that the policy imperative should be to provide the best possible protection for the mother and child.⁴³ They felt that abortion was not a real choice and were concerned that women are not supported (through either decision-making or procedure-associated counselling).⁴⁴
- 5.38 These people felt that abortion was a profound decision with particular moral significance that required a strict set of conditions and procedural steps before it should attain lawful status. Dr Nicholas Tonti-Filippini presented a detailed submission based on this premise, which also drew upon the findings in the publication *Common Ground*.⁴⁵ While maintaining their strong opposition to decriminalisation, several organisations supported this approach, including the Presbyterian Church of Australia, the Australian Christian Lobby and the Respect Life Office.⁴⁶

19 One person argued that the Charter of Human Rights and Responsibilities should be amended to confer the right to life upon the fetus: submission 155 (Mr David J Perrin).

20 Submission 316 (Westgate Catholic Deanery Social Justice Group).

21 Submission 252 (National Civic Council).

22 Submission 502 (Youth Affairs Council of Victoria).

23 Eg, submission 12 (Paul Johnson).

24 Consultation 7 (Right to Life Australia).

25 Consultation 30 (AMA Victoria).

26 Consultation 31 (RANZCOG fellows).

27 See, eg, consultation 13 (Medical Indemnity Protection Society); submissions 451 (Women's Health Victoria), 383 (Castan Centre for Human Rights Law), 461 (Association for the Legal Right to Abortion).

28 Consultation 16 (Women's Health Goulburn North East); submissions 487 (Victorian Women's Trust), 451 (Women's Health Victoria).

29 Submission 290 (Professor Loane Skene, University of Melbourne).

30 Submission 261 (Gippsland Women's Health).

31 Submission 38 (Festival of Light Australia).

32 Submissions 27 (Frank Gashumba), 29 (Zoe Matthews).

33 Consultation 7 (Right to Life Australia); submission 276 (Family Council of Victoria).

34 Eg, consultation 17 (Women's Trust Victoria); submission 134 (Women's Health West).

35 'Partner violence is a strong predictor of termination and other reproductive outcomes among young Australian women. Education has a protective effect. Prevention and reduction of partner violence may reduce the rate of unwanted pregnancy': Angela Taft and Lyndsey Watson, 'Termination of Pregnancy: Associations with Partner Violence and Other Factors in a National Cohort of Young Australian Women' (2007) 31 (2) *Australian and New Zealand Journal of Public Health* 135.

36 Submission 152 (Professor Rebecca Albury, University of Wollongong).

37 Consultation 11 (Family Planning Victoria).

38 A standard submission stressed this issue, see, eg, submission 209 (Mrs ML Rowlinson).

39 Eg, consultation 10 (Health Services Commission).

40 Eg, consultations 16 (Women's Health Goulburn North East), 27 (Associate Professor Ian Pettigrew).

41 Eg, submission 487 (Victorian Women's Trust).

42 See, eg, submission 410 (Key Centre for Women's Health in Society, University of Melbourne).

43 Consultation 25 (Respect Life Office, Catholic Archdiocese of Melbourne).

44 See, eg, consultation 20 (Australian Family Association).

45 John Fleming and Nicholas Tonti-Filippini (eds) *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (2007).

46 Consultations 4 (Presbyterian Church of Victoria), 5 (Australian Christian Lobby), 25 (Respect Life Office, Catholic Archdiocese of Melbourne).

- 5.39 Some submitters felt that adoption was not adequately promoted as a choice for pregnant women, either by individual medical practitioners and counsellors or by the state government,⁴⁷ although the Key Centre for Women's Health said adoption is one of the issues women currently consider during options counselling.

Lowering the Abortion Rate

- 5.40 There was general agreement across submissions and consultations that the rate of abortions should decrease⁴⁸ and a range of views about how to achieve this outcome. Some argued that decriminalisation would increase the rate of abortion because it would send a message to the community that abortion is a legitimate action.⁴⁹ These people generally felt that the criminal law acted as a deterrent to abortion.⁵⁰
- 5.41 Others argued strongly against this, citing evidence from other jurisdictions where decriminalisation had not significantly escalated abortion rates. In particular, they referred to the experience in Canada, which has a lower rate of abortion than Australia.⁵¹ They also drew on historic experience of prohibition not deterring the practice but sending it underground and emphasised lowering the rate of unplanned or unwanted pregnancy through health policy and contraception.

Workforce Issues

- 5.42 Some people argued that because abortion is the only medical procedure subject to criminal law it contributes to a reluctance to work in the area.⁵² Workforce issues were raised consistently in meetings with health organisations, particularly concerns about workforce planning in rural and regional Victoria.⁵³

GROUNDS FOR LAWFUL ABORTION

Consent

- 5.43 A significant majority of decriminalisation supporters argued that consent should be the only requirement of lawful abortion performed by a qualified practitioner.⁵⁴ Under this model, the only issue is whether the woman has reached her decision following the usual standards that apply to consent to other medical procedures.⁵⁵
- 5.44 Decriminalisation opponents wanted further requirements that the woman must meet before an abortion could be lawful.
- 5.45 Some people felt that equality interests required that the father of the fetus should have to give consent.⁵⁶ A small minority of submissions included grandparents and others in the class of persons who should give consent.⁵⁷
- 5.46 A significant proportion of pro-forma submissions supported parental consent requirements for all women aged under 16 years.⁵⁸ The Presbyterian Church of Australia argued that the permission of the Family Court should also be required for people 'under age'.⁵⁹ Dr Nicholas Tonti-Filippini recommended that the permission of the Family Court should be required for young women 'whose age or immaturity makes them vulnerable'.⁶⁰
- 5.47 Youth and health organisations were strongly opposed to mandated parental consent for all young women under 16 years.⁶¹ They thought the existing law of consent operated to protect the best interests of the young woman involved. Consent issues and young people are discussed further in Chapters 2 and 8.
- 5.48 There was strong consensus from all submissions and consultations that coercion should not be tolerated; however, there was disagreement about whether coercion is a significant problem. There was specific concern that women with a disability be respected in their decision making.⁶²
- 5.49 Several submitters were concerned that pressure was applied on women not to have an abortion. They were particularly concerned about protesters outside clinics. Some, including the Health Services Commissioner, suggested 'bubble zone' legislation.⁶³ Groups such as the Helpers of God's Precious Infants were strongly opposed to such a proposal.⁶⁴ These issues are discussed further in Chapter 8.

Threat to Life

- 5.50 Most decriminalisation opponents felt strongly that save for circumstances where the woman's life was at immediate risk abortion should be unlawful.⁶⁵
- 5.51 Others argued that advances in health care meant risks associated with pregnancy are so minimal that instances where a threat to the life of the woman existed would be very rare.⁶⁶
- 5.52 A minority argued that the fetus had primacy over the mother's life.⁶⁷ Some organisations felt abortion should also be prohibited following rape, for example Pro Life Australia and the Respect Life Office, Catholic Archdiocese of Melbourne.

Physical and Mental Health

- 5.53 Decriminalisation opponents generally rejected physical and mental health issues as legitimate justifications for lawful abortion. Some argued that it was disproportionate to abort a fetus on the basis of maternal health.⁶⁸ Others said the grounds for abortion were currently too wide, and that if Menhennitt rules were codified the test would need to be much tighter.⁶⁹
- 5.54 Others felt that abortion worsens women's physical and mental health.⁷⁰ Some submissions raised concerns about the alleged link between breast cancer and abortion, along with infertility, post-abortion syndrome, depression and suicide. Anne Lastman, author of *Redeeming Grief*, wrote in her submission: 'abortion deeply wounds women whether they choose to accept that or not'.⁷¹
- 5.55 These propositions were strongly contested. Chapter 3 discusses the debate and evidence around physical effects of abortion.
- 5.56 Decriminalisation supporters generally argued that consent was the only factor that should determine legality, but there was support for physical and mental health grounds being recognised as legitimate factors within the woman's decision.⁷²

Social and Economic Factors

- 5.57 Decriminalisation supporters also felt that social and economic factors, during and after pregnancy, were legitimate factors for women to consider when making reproductive decisions.⁷³ There was a strong preference that the law not include specific grounds that a woman must satisfy.⁷⁴
- 5.58 Decriminalisation opponents often felt strongly that these factors should not be included as grounds for lawful abortion and saw their possible inclusion as bad public policy.⁷⁵ They argued that the State should provide better income and other support such as

47 Consultation 7 (Right to Life Australia).

48 Cf the view that as the current rate of abortion is an indicator of demand for services, it is therefore not too high or too low. See Jo Wainer 'From the backyard to the moral high ground' (Paper presented at 'Abortion in Victoria: Where are we now? Where do we want to go?' conference, University of Melbourne, 30 November 2007) <www.kcwhs.unimelb.edu.au/_data/assets/pdf_file/0007/76237/abortconf_Dr_Wainer.pdf> at 27 February 2008.

49 Submission 117 (John Purcell).

50 Submission 3 (Margaret Ryan).

51 Submission 185 (Associate Professor Kerry Petersen, La Trobe University).

52 Consultations 8 (Choices Clinic, Royal Women's Hospital), 31 (RANZCOG fellows).

53 Consultation 16 (Women's Health Goulburn North East).

54 See, eg, submissions 231 (Public Health Association of Australia Women's Special Interest Group), 460 (Health Services Commissioner), 461 (Association for the Legal Right to Abortion), 503 (AMA Victoria).

55 There was also concern that the term 'qualified practitioner' be defined to reflect the availability of both surgical and medical termination of pregnancy. See, eg, submission 227 (Reproductive Choice Australia).

56 See, eg, submissions 484, (World Federation of Doctors who Respect Life, Victorian Division), 519 (Mr Chris Whelan).

57 Submissions 145 (Roger McWhinney), 375 (Mrs Julia Conlon).

58 Eg, submission 27 (Mr Frank Gumbusha).

59 Consultation 4 (Presbyterian Church of Victoria).

60 Submission 15 (Dr Nicholas Tonti-Filippini).

61 Submission 502 (Youth Affairs Council of Victoria).

62 Consultation 23 (Victorian Women with Disabilities Network); submission 515 (Disability Discrimination Legal Centre).

63 Consultation 10 (Health Services Commissioner); submissions 1 (Fertility Control Clinic), 134 (Women's Health West).

64 Submission 476 (Helpers of God's Precious Infants).

65 For those of the Catholic faith, and among some anti-abortion groups, the saving of a woman's life was allowed insofar as it did not include the deliberate destruction of the fetus. This is discussed further in Chapter 7.

66 Eg, the Endeavour Forum, which uses 'termination of pregnancy' to describe these circumstances (eg emergency surgery to remove an ectopic pregnancy) and 'abortion' to describe all other circumstances: consultation 2 (Endeavour Forum Inc.).

67 Consultation 7 (Right to Life Australia).

68 See, eg, consultation 20 (Australian Family Association).

69 Submission 454 (Australian Christian Lobby).

70 Submission 38 (Festival of Light Australia).

71 Submission 44 (Victims of Abortion). Several submissions referred to Ms Lastman's publications along with those of Melissa Tankard Reist and the Women's Forum Australia as evidence for what they described as negative psychological outcomes after abortion.

72 Submission 24 (Humanist Society of Victoria).

73 Submission 326 (Ann Roberston).

74 There was support among clinicians who preferred a Menhennitt-type test, that psychosocial factors include conditions during and after pregnancy.

75 Submission 436 (Ad Hoc Interfaith Committee on Abortion and Reproductive Technology).

housing.⁷⁶ Others felt that social and economic risks were overplayed and their inclusion would result in abortions of convenience. Some suggested that women should go through with their pregnancy and then adopt.⁷⁷

Fetal Abnormality

- 5.59 There was no support for the inclusion of fetal abnormality as a specific ground for lawful abortion in future legislation.⁷⁸
- 5.60 Those opposed to abortion rejected it on the argument about fetal interests. Those in favour of autonomy-based decriminalisation did not find it necessary.
- 5.61 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.⁷⁹
- 5.62 A discussion of clinical issues and fetal abnormality can be found in Chapter 3.

GESTATIONAL LIMITS

- 5.63 The majority of submissions and consultation participants were opposed to including gestational limits in any new law of abortion. Opposition was for different reasons.
- 5.64 Decriminalisation supporters were generally opposed to the introduction of gestational limits.⁸⁰ They viewed the stage of pregnancy as a factor the woman considers in her autonomous decision making.⁸¹ AMA Victoria reported that gestational age is a factor that informs a medical practitioner's clinical judgment.
- 5.65 Supporters stressed that a tiny proportion of abortions in Victoria are after 20 weeks and were concerned a new law might focus on a minority of cases to the detriment of law reform generally.⁸²
- 5.66 Many felt that women having late abortions generally did so under extreme circumstances. It was argued that imposing a blanket prohibition on such terminations would be particularly harsh.⁸³
- 5.67 There was an associated concern that decision making may be compromised by having to rush into a decision when factors arise later in pregnancy. This was a strong concern of RANZCOG fellows and the Health Services Commissioner. Specific issues around delays caused by lack of access to health services, including fetal testing in rural and regional areas, were also raised in consultations with regional groups and practitioners.⁸⁴
- 5.68 It was also emphasised that gestational limits create more hoops for women to jump through which, in some cases, means women will travel interstate to access abortions that cannot be accessed within their state.⁸⁵

*[A] staged approach should not be taken. I believe that once the law can be brought into question at any time during a pregnancy, then real access to quality, timely health care for women will be compromised.*⁸⁶

- 5.69 A significant majority of anti-decriminalisation submitters were also opposed to including gestational limits in abortion legislation because they consider conception to be the point at which the fetus has rights. These same people were very concerned about late abortion.⁸⁷
- 5.70 Some argued that the offence of child destruction should apply to abortion from 20 weeks. This proposal featured in pro-forma submissions.⁸⁸ Others took a different approach and argued that a gestational limit be included in abortion legislation so abortion after that time would be a crime.⁸⁹ The Caroline Chisholm Centre for Health Ethics proposed that after 24 weeks delivery be induced and the child adopted.⁹⁰
- 5.71 A small group of pro-decriminalisation submitters felt that a staged approach to abortion was advantageous. They felt this recognised different maternal reactions, as well as the differences in viability between a fetus at an earlier gestation and at a later stage.⁹¹
- 5.72 The Anglican Diocese of Melbourne favoured a gradualist approach to abortion law:

*While we believe that the destruction even of an early embryo is of moral significance, we believe the moral significance increases with the age and development of the foetus. The significance increases gradually over time, in parallel with its physical development.*⁹²

- 5.73 One submitter felt that a staged approach was advantageous as it recognised the benefit of earlier terminations for women, as well as reflecting community values.⁹³
- 5.74 Some felt that perceived community attitudes about late abortion justified a different approach. They argued that if late abortion is going to be regulated differently, then some clarity is required for practitioners and women. They did not support an absolute prohibition beyond a gestational point. Instead they argued for additional, clearly defined justifications (broadly based on the woman's health and wellbeing) to apply.⁹⁴ They did not support criminal sanction for abortions performed later in pregnancy.

DETERMINING GESTATIONAL LIMITS

- 5.75 Many submitters did not suggest an appropriate gestational limit because they felt consent should be the only consideration.⁹⁵ Gestational limits were seen to: cut across the woman's right to choose;⁹⁶ make women navigate hurdles;⁹⁷ and interfere with best-practice standards of care,⁹⁸ which involve the decision being made by a woman in consultation with her doctor.⁹⁹
- 5.76 Some submitters felt that viability was the important indicator for any gestational limit.¹⁰⁰ They argued that the fact a child could be born alive was significant,¹⁰¹ some citing current premature neonatal clinical practice.¹⁰² One submitter summed up this view:

*[W]e think the abortion time limit should be lowered as far as possible. It is inconsistent to have intensive care professionals working to save the lives of unborn children, while in other hospitals some unborn children of the same gestational age may be legally aborted.*¹⁰³

- 5.77 Many criticisms of using viability as a basis for a gestational limit were raised. Many submitters felt that imposing a gestational limit was arbitrary¹⁰⁴ and extremely problematic.¹⁰⁵ Health professionals felt that gestational limits in law did not have adequate medical justifications,¹⁰⁶ were problematic in implementation,¹⁰⁷ lacked flexibility to deal with exceptional cases,¹⁰⁸ and did not allow for appropriate medical care, which sometimes necessitates a late abortion.¹⁰⁹ One submitter noted that late abortion will usually involve complex and unique characteristics particular to the woman involved:

There is an individualising nature about late-term abortions that needs to be acknowledged. There

- 76 Eg, submission 452 (Catholic Justice Agency).
- 77 Consultation 7 (Right to Life Australia).
- 78 Out of 519 submissions, seven indicated support for a specific ground. Their argument was usually based on possible restrictive interpretations of Menhennitt or concerns about a prohibition on women making a decision to abort subsequent to testing.
- 79 Submission 384 (Victorian Women with Disabilities Network)
- 80 See, eg, submission 507 (Royal Women's Hospital).
- 81 See, eg, submission 461 (Association for the Legal Right to Abortion).
- 82 See, eg, consultation 26 (Professor David Healy, Chair, Monash University Department of Obstetrics and Gynaecology).
- 83 Eg, submission 327 (Children by Choice).
- 84 Consultation 27 (Associate Professor Ian Pettigrew).
- 85 Consultation 1 (Fertility Control Clinic).
- 86 Submission 319 (Tanya Mammone).
- 87 Many cited polling undertaken on behalf of the Southern Cross Bioethics Institute, which indicates strong support in the community for a woman's 'right to choose' but unease about terminations later in pregnancy. This data is discussed in Chapter 4.
- 88 Eg, submission 29 (Zoe Matthews).
- 89 Submission 15 (Dr Nicholas Tonti-Filippini).
- 90 Submission 299 (Caroline Chisholm Centre for Health Ethics).
- 91 Submissions 15 (Dr Nicolas Tonti-Filippini), 16 (Mario Farrugia).
- 92 Submission 426 (Anglican Diocese of Melbourne).
- 93 Submission 502 (Youth Affairs Council of Victoria).
- 94 Consultation 15 (Dr Ian Freckelton, University of Melbourne).
- 95 Submissions 136 (Emily's List Australia), 340 (ALP Brunswick South Branch), 498 (Union of Australian Women), 505 (Victoria Legal Aid).
- 96 Submissions 24 (Humanist Society of Victoria), 262 (Victorian Women Lawyers), 384 (Victorian Women with Disabilities Network).
- 97 Consultation 1 (Fertility Control Clinic).
- 98 Submission 134 (Women's Health West).
- 99 Consultation 3 (Association for the Legal Right to Abortion); submissions 134 (Women's Health West), 152 (Rebecca Albury), 231 (Public Health Association of Australia Women's Health Special Interest Group).
- 100 Submission 299 (Caroline Chisholm Centre for Health Ethics); consultation 27 (Associate Professor Ian Pettigrew).
- 101 Submissions 15 (Dr Nicholas Tonti-Filippini), 16 (Mario Farrugia), 67 (Archbishop Denis J Hart), 259 (Michael Anstis), 299 (Reverend Kevin McGovern), 300 (Bryan Rogers), 382 (Richard Reardon), 499 (Knights of the Southern Cross).
- 102 Submissions 171 (Margaret Green), 300 (Bryan Rogers). We discuss neonatal survival rates in Chapter 7.
- 103 Submission 240 (DA, ET and JM Cook).
- 104 Submissions 262 (Victorian Women Lawyers), 501 (Liberty Victoria).
- 105 Consultations 1 (Fertility Control Clinic), 6 (Women's Health Victoria), 8 (Royal Women's Hospital), 9 (Croydon Day Surgery), 10 (Health Services Commissioner), 12 (Reproductive Choice Australia), 16 (Women's Health Goulburn), 24 (Foetal Management Unit, Royal Women's Hospital), 26 (Professor David Healy), 30 (AMA Victoria); submissions 10 (Mrs CD Crosbie Gooldd), 24 (Humanist Society of Victoria), 227 (Reproductive Choice Australia), 262 (Victorian Women Lawyers).
- 106 Consultation 9 (Croydon Day Surgery).
- 107 Consultation 6 (Women's Health Victoria).
- 108 Consultations 8 (Royal Women's Hospital), 16 (Women's Health Goulburn); submission 461 (Association for the Legal Right to Abortion).
- 109 Consultations 8 (Royal Women's Hospital), 24 (Foetal Management Unit, Royal Women's Hospital), 30 (AMA Victoria).

*will always be extreme cases where abortions will need to be performed beyond the first trimester and well into the second trimester. The law needs to recognise that this is the case.*¹¹⁰

- 5.78 Some people expressed concern that any gestational limit in abortion law would be subject to controversy and change since medical technology is constantly evolving. There is little consensus on upper gestational time limits across jurisdictions.¹¹¹ Any gestational limit would necessitate constant legislative review to ensure it was consistent with evolving medical practice.¹¹² Reproductive Choice Australia noted:

[U]sing viability as a cut off makes for an inherently unstable law. As technology changes, and doctors with different skills in neonatology move from state to state, pressure will come from abortion opponents to change the law again to take account of each new medical claim with regard to viability. The unstable nature of the law would mean that the willingness of medical practitioners to perform terminations will be diminished.

- 5.79 It was also clear from submissions that there was no general agreement about where a line based on viability should be drawn. Some submitters felt that no point in time is acceptable for an abortion to be performed.¹¹³ Others felt that gestational limits are too difficult to set and that the fetus should be protected from conception.¹¹⁴ The range of proposals for where a line based on viability should be placed was generally between 20 and 24 weeks, though one submitter believed it should be 12 weeks,¹¹⁵ and Reproductive Choice Australia thought it should be 26.
- 5.80 Some submitters argued that current law and clinical practice has a focus on the woman, rather than fetal interests.¹¹⁶ 'Using viability as a cut off point intrudes on the therapeutic relationship by placing the focus on a metric assessment rather than health and well-being of the woman.'¹¹⁷ These people saw a woman's wellbeing as the only acceptable basis for a staged approach.¹¹⁸ For example, a gestational limit might be imposed that only requires more support or in-patient care of the woman if the termination occurs later in gestation.
- 5.81 Family Planning Victoria supported a gestational limit of 24 weeks, after which abortions should only be allowed for serious risks to the mother or fetal abnormality. It also acknowledged that the imposition of such a limit raises complex questions about forcing a woman to carry an unwanted fetus¹¹⁹ and the State's responsibility to provide for the fetus if it is born.¹²⁰ One submitter said '[t]here is a difference between a technical ability to prevent a foetus dying and a woman's ability to provide for and parent a child to her satisfaction and the child's requirements'.¹²¹

MEDICAL PROFESSION GATEKEEPING

- 5.82 Decriminalisation supporters consistently took the view that the role of medical practitioners was to advise women about risks and options, and apply their clinical judgement in line with ethical standards and the existing law of consent.¹²² They were generally opposed to requirements for multiple practitioner sign off, or decision-making panels.¹²³
- 5.83 The Public Health Association of Australia, along with other organisations, including AMA Victoria, was concerned that a requirement for multiple practitioners approving abortions might create access barriers for rural women in 'receiving appropriate medical care'.¹²⁴
- 5.84 There was very little support from medical professionals for mandatory panels for late abortion, as is the case in Western Australia. Consultations revealed significant concerns that the Western Australian panel system had led to women travelling interstate to have an abortion after 20 weeks.¹²⁵ One RANZCOG fellow was supportive of the WA model.
- 5.85 Some doctors argued that decision-making panels should be a matter of best practice within large hospitals but need not be a legislative requirement.¹²⁶ The Anglican Diocese of Melbourne strongly affirmed the role of hospital ethics committees for late abortions.¹²⁷

- 5.86 Decriminalisation opponents strongly welcomed a requirement for more than one doctor's approval and/or panels.¹²⁸ A range of options was put forward about the number of practitioners, the size and function of panels, and who might be involved (doctors, gynaecologists, obstetricians, and psychiatrists).¹²⁹
- 5.87 Dr Nicholas Tonti-Filippini argued for a stepped process which involved an initial consultation with a GP who must not be associated with an abortion provider, such as a hospital or clinic. The GP would be required to arrange and refer to independent counselling, and in cases of mental health concerns also arrange for a psychiatric assessment. Having completed these steps, the woman would then attend a specialist obstetrician/gynaecologist or appropriately qualified GP for a second approval. Once approved, the woman could then proceed to have a lawful abortion carried out by the specialist.
- 5.88 Options about the role of medical practitioners in deciding upon the lawfulness of abortion are detailed in the legislative models described in Chapter 6.

NOTIFICATION SCHEME

- 5.89 There was strong consensus around the need for accurate data; however, depending on a person's views on decriminalisation, the nature of the data collected and its purpose was disputed.
- 5.90 Decriminalisation supporters generally welcomed the collection of accurate non-identifiable, demographic data for service planning purposes¹³⁰ that was compliant with health information privacy principles.¹³¹ Consultations tended to elicit the response that a formal notification scheme was not necessary but existing data sources and dissemination could be improved.¹³²
- 5.91 Decriminalisation opponents sometimes took the view that existing data should be better used. A sizeable number of pro-forma submissions suggested a notification scheme be extended to include an **adverse events** register above and beyond current systems.¹³³
- 5.92 Data issues are discussed in Chapter 8.

COUNSELLING

- 5.93 There was strong consensus that good quality, non-directive counselling was a priority, but there was significant divergence about who should deliver counselling, whether it should be compulsory, and whether legislation should mandate minimum information.
- 5.94 Counselling, information, and cooling-off periods are discussed in more detail in Chapter 8.

CHILD DESTRUCTION

- 5.95 Decriminalisation supporters argued that the offence of child destruction should be repealed and replaced with specific provisions about assault upon a pregnant woman,¹³⁴ or that section 10 be amended to make it clear it did not apply to abortion.¹³⁵
- 5.96 Pro-forma submissions argued that section 10 should remain and the 28-week presumption lowered to 20 weeks, effectively making late abortion a criminal offence.¹³⁶ Others wanted the existing offence to remain in its current form.¹³⁷
- 5.97 The offence of child destruction is discussed in depth in Chapter 7.

PENALTIES

- 5.98 The Information Paper did not have a specific question about penalties and so views on this issue were largely gathered from consultations.
- 5.99 There was consensus among decriminalisation supporters that if gestational limits are included then penalties should be professional rather than criminal. There was support for the application of the *Health Professions Registration Act 2005* and a role for the Medical Practitioners Board of Victoria.¹³⁸
- 5.100 Decriminalisation opponents want to see criminal penalties continue to apply.
- 5.101 There was consensus that abortions performed by a non-qualified person be a criminal offence.

- 110 Submission 501 (Liberty Victoria).
- 111 Submission 504 (Fitzroy Legal Service).
- 112 Submissions 227 (Reproductive Choice Australia), 134 (Women's Health West), 274 (Justin Tan).
- 113 Submission 6 (Endeavour Forum Inc.).
- 114 Submission 291 (Annaliese Wursthorn).
- 115 Submission 400 (Mrs Lisa Brick).
- 116 Submissions 185 (Associate Professor Kerry Petersen), 227 (Reproductive Choice Australia) 461 (Association for the Legal Right to Abortion), 507 (Royal Women's Hospital).
- 117 Submission 185 (Associate Professor Kerry Peterson).
- 118 Submission 461 (Association for the Legal Right to Abortion).
- 119 Submission 508 (Catherine Mayes).
- 120 Consultation 11 (Family Planning Victoria).
- 121 Submission 282 (Women's Health in the North).
- 122 Eg, submission 449 (YWCA Victoria).
- 123 Eg, consultation 11 (Family Planning Victoria). Consultation 13 (Medical Indemnity Protection Society) was in favour of two practitioners' opinions but 30 (AMA Victoria) was opposed.
- 124 Submissions 231 (Public Health Association of Australia, Women's Health Special Interest Group), 262 (Victorian Women Lawyers); 503 (Australian Medical Association); 504 (Fitzroy Legal Service).
- 125 Consultation 6 (Women's Health Victoria).
- 126 Eg, consultations 10 (Health Services Commissioner), 26 (Professor David Healy, Monash University Department of Obstetrics and Gynaecology).
- 127 Submission 426 (Anglican Diocese of Melbourne).
- 128 Eg, consultation 5 (Australian Christian Lobby).
- 129 Submissions 12 (Paul Johnson), 65 (Reverend Dr Robert Weatherlake), 148 (Mary Anne Yang).
- 130 Eg, consultation 11 (Family Planning Victoria).
- 131 Submission 273 (Law Institute of Victoria).
- 132 Consultation 21 (Women's Electoral Lobby).
- 133 Eg, submission 9 (Charles Francis AM, QC, RFD).
- 134 See, eg, consultations 12 (Reproductive Choice Australia), 15 (Dr Ian Freckelton), 34 (Jewish Community Council of Victoria and Rabbi Aviva Kipen); submissions 273 (Law Institute of Victoria), 505 (Victorian Legal Aid).
- 135 See, eg, consultation 21 (Women's Electoral Lobby).
- 136 See, eg, submission 69 (Geoff and Margaret Webber).
- 137 Submission 100 (Rita M Joseph).
- 138 Consultation 15 (Dr Ian Freckelton).

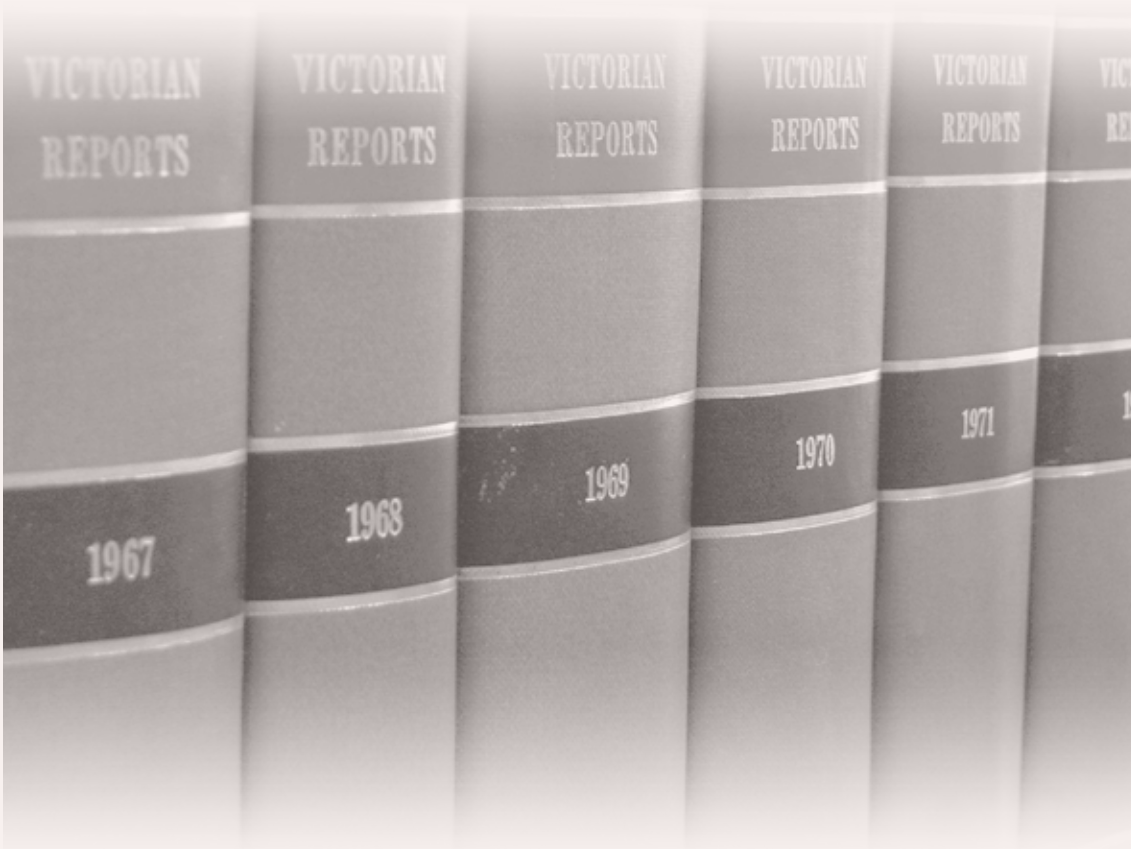


CONCLUSIONS

- 5.102 Among organisations which participated in our review, some but not all faith communities were opposed to decriminalisation. Most professional organisations supported law reform that removes abortion from the Crimes Act, as determined by our terms of reference.
- 5.103 The Public Health Association of Australia, AMA Victoria, the Paediatric State Committee of the Royal Australasian College of Physicians, the Health Services Commissioner, and the Law Institute Victoria supported decriminalisation models that treat abortion as a matter between a woman and her doctor, with autonomy as the policy basis for law reform.
- 5.104 There was a divergence of opinion about whether access to abortion should be regulated differently throughout a woman's pregnancy. Decriminalisation supporters were generally against a complete prohibition on abortion beyond a gestational limit.
- 5.105 Strong consensus was identified around supporting women in decision making. The desirability of good quality, non-directive counselling was a given for most people; however, opinions differed about what makes for effective support and counselling and the issue of compulsory counselling was highly contentious.

Part 3

Law Reform



CONTENTS

- 85 Chapter 6: Options for Reform
- 95 Chapter 7: Child Destruction
- 111 Chapter 8: Other Legal Issues

Chapter 6 Options for Reform

CONTENTS

- 86 Terms of Reference
- 86 Legislative Options
- 87 Model A
- 90 Model B
- 93 Model C

Options for Reform

TERMS OF REFERENCE

- 6.1 Several government policies and objectives, referred to in the terms of reference, have shaped the commission's options for reform of the law of abortion.
- 6.2 It is important to identify these policies and objectives.
- The terms of reference make it clear that it is governmental policy to decriminalise abortion. The Attorney-General has sought advice from the commission about options to 'remove from the *Crimes Act 1958* offences relating to terminations of pregnancy where performed by a qualified medical practitioner'.
 - The government aims to clarify the law. The terms of reference note that it is 'essential that the law is modernised, clear and widely understood'.
 - The government aims to modernise the law so that it reflects 'current community standards'.
 - The government does not seek to alter current clinical practice.
 - The government does not want new laws to cause a change in the rate of abortion or to restrict access to abortion services: 'reform should neither expand the extent to which terminations occur, nor restrict current access to services'.

LEGISLATIVE OPTIONS

INTRODUCTION

- 6.3 The commission has devised three legislative models which reflect the policies and objectives referred to in the terms of reference.
- 6.4 The models are designed to operate in conjunction with the laws that regulate the relationship between doctor and patient and govern the medical profession. All three models for reform allow abortion to be lawful only when performed by, or under the supervision of, a qualified medical practitioner.
- 6.5 There are several legal issues associated with reform of the law of abortion that require consideration, regardless of the model that is ultimately chosen. The offence of child destruction in section 10 of the *Crimes Act* is dealt with in Chapter 7. A broad range of reform proposals suggested in submissions, or which commended themselves to the commission once the models had been prepared, are considered in Chapter 8.
- 6.6 Some women, such as those who are very young or are profoundly cognitively impaired, may not have the capacity to consent to an abortion. The commission believes it is unnecessary to enact special legislation to deal with these instances. The existing law appropriately protects the interests of vulnerable people and regulates the activities of medical practitioners.¹
- 6.7 The models differently regulate decision making about abortion.
- 6.8 Model A restricts the ground upon which a woman may have an abortion at any time throughout her pregnancy to the *risk of harm* to her if the pregnancy is not terminated. Final decision-making responsibility rests with the medical practitioner who performs or supervises the abortion.
- 6.9 Model B allows a woman to have final decision-making responsibility about an abortion until the end of her 24th week of pregnancy. After that point, decision-making responsibility shifts to her medical practitioner, who must determine if there is a risk of harm (as described in Model A) to her for an abortion to be lawful.
- 6.10 Models A and B contain a professional sanction if a medical practitioner performs an abortion which is not authorised by law. A medical practitioner who performs an unauthorised abortion would be deemed to have engaged in professional misconduct.
- 6.11 Model C allows a woman to have final decision-making responsibility about an abortion throughout her pregnancy.

MODEL A

Codification of the current circumstances in which an abortion is lawful: risk of harm to a woman governs access to abortion throughout pregnancy (the Menhennitt rules)

1. GENERAL DESCRIPTION

- 1.1 Under this model, the Menhennitt rules, or a variant of those rules, would continue to govern the circumstances in which an abortion is lawful. However, those rules would be included in legislation, and the consequences of failing to comply with those rules would change. This model would cause the Menhennitt rules, or a variant of them, to receive parliamentary endorsement almost 40 years after they were devised.
- 1.2 While this model would not materially alter the circumstances in which an abortion is lawful, it would alter the sanctions that apply when a medical practitioner performs an abortion which is not authorised by law.² Those sanctions would become professional rather than criminal.
- 1.3 This model may be characterised as one in which a women's consent to an abortion is a necessary but not sufficient reason for an abortion to be lawful. Once consent is given a medical practitioner would have a restricted, discretionary power to determine whether it is lawful to perform an abortion.
- 1.4 An abortion would be lawful only when a doctor was satisfied that it was necessary because of the risk of harm to the woman if the pregnancy was not terminated. If not satisfied of this the doctor must refuse an abortion. Thus, while both a pregnant woman and her doctor would have roles in the decision-making process, the doctor would be the ultimate decision maker.

2. CIRCUMSTANCES IN WHICH AN ABORTION WOULD BE LAWFUL

- 2.1 An abortion would be lawful in the following circumstances:
 - A woman consents³ to the surgical or medical procedure which is used to terminate her pregnancy.
 - A medical practitioner determines that the abortion is necessary because of the *risk of harm* to the woman if the pregnancy is not terminated.
 - That medical practitioner performs, or supervises the performance of, the abortion.

The risk of harm is determined in one of the following ways.

OPTION 1

The medical practitioner honestly believes on reasonable grounds that: (1) the abortion is necessary to preserve the woman from serious danger to her life, or to her physical health or mental health; and (2) the risk of having the abortion is proportionate to the risk faced by the woman if the pregnancy is not terminated.

This option describes the risk of harm in very broad terms and provides no guidance concerning the matters that may be taken into account by the medical practitioner when reaching a belief about this matter. This option is a restatement of the Menhennitt rules.⁴ It is vague and may not provide the clarity sought by the medical profession and the broader community.

OPTION 2

The medical practitioner honestly believes on reasonable grounds that: (1) the abortion is necessary to preserve the woman from serious danger to her life, or to her physical or mental health. In reaching a decision the medical practitioner may take into account economic, social or medical matters that

- 1 The existing law is described in Chapter 2.
- 2 The commission has recommended that it be an offence for a person who is not a medical practitioner to perform an abortion in any circumstances: see Chapter 8.
- 3 The law of consent to medical treatment is considered in Chapter 2.
- 4 The Menhennitt rules are discussed in Chapter 2.

may affect the woman's physical or mental health if she continues with the pregnancy and that may arise at any time during the pregnancy or later; and (2) the risk of having the abortion is proportionate to the risk faced by the woman if the pregnancy is not terminated.

The second option describes a range of matters which may have an impact upon a woman's physical or mental health if the pregnancy is not terminated and which may be taken into account by a medical practitioner when determining whether an abortion is necessary because of the risk of harm to the woman. This option is a restatement of the law of abortion that has developed over time through case law in NSW.⁵

OPTION 3

The medical practitioner honestly believes on reasonable grounds that the abortion is necessary to preserve the woman from a risk of harm to her life, or to her physical or mental health.

Option 1 and Option 2 expressly require the medical practitioner to make a decision about the proportionality of the risk of harm to a woman having an abortion with the risk of the harm that she may suffer if the pregnancy is not terminated. The third option does not expressly refer to proportionality. The rationale for the separate proportionality requirement, drawn originally from the English decision in *Bourne*⁶ upon which the Menhennitt rules were based, may no longer exist for several reasons.

First, abortion is now a much safer procedure than it was in 1938 when *Bourne* was decided.

Secondly, the law now promotes the notion that patients as well as doctors have a role in deciding whether the risks associated with a medical procedure are proportionate to the harm that may be suffered if there is no treatment.⁷ The law that governs all medical procedures requires a doctor to advise a patient of material risks associated with the procedure.⁸

Thirdly, the law that governs all medical procedures requires a medical practitioner to exercise proper clinical judgment before determining whether an abortion is necessary because of the risk of harm to a woman. When making this clinical judgment the doctor must consider and balance the risks associated with having an abortion with the risk of harm that the woman may suffer if the pregnancy is not terminated.

Options 1 and 2 stipulate that the risk of harm to the woman must involve a *serious* danger to her life, or to her physical or mental health. It is arguable that this form of words adds an unnecessary degree of complexity to the task of determining whether there is a risk of harm to the woman in proceeding with the pregnancy. In practice, it would be difficult to determine whether a risk of harm crosses a threshold that causes it to become a serious risk to a person's life or health.

The third option contains a simpler and clearer formulation of the risk of harm to a woman and it appears to reflect current clinical practice more closely than the first two options.

3. CONSEQUENCES OF PERFORMING AN ABORTION THAT IS NOT LAWFUL

- 3.1 An abortion that does not fall within the circumstances set out in Model A would be unlawful. The legal response to an unlawful abortion would depend upon the identity of the person who performed it.
- 3.2 It would be a criminal offence for an unqualified person to perform an abortion in any circumstance.⁹
- 3.3 An abortion performed by a medical practitioner when it was not lawful to do so would result in a professional sanction. A medical practitioner who performed an unauthorised

abortion would be deemed to have engaged in professional misconduct, rendering that person liable to sanction under the provisions of the *Health Professions Registration Act 2005*.¹⁰ To prove that an abortion was unlawful, it would be necessary to establish that the medical practitioner did not hold an honest belief on reasonable grounds that the abortion was necessary because of the risk of harm to the woman.

- 3.4 A pregnant woman who has an unlawful abortion would not be liable to any legal sanction.¹¹

4. COMMENTARY

- 4.1 Under Model A, final decision-making authority rests with a medical practitioner. A medical practitioner would be required, at the risk of serious professional sanction, to refuse a woman an abortion unless satisfied that there was a risk of harm to her if the pregnancy was not terminated. A woman who was unable to satisfy a medical practitioner that she faced risk of harm by not having an abortion would be compelled to continue with her pregnancy.
- 4.2 While this model would be a legislative affirmation and restatement of the existing judge-made law about lawful abortion in Victoria, it probably does not reflect current clinical practice and current community standards.
- 4.3 The policies upon which this model is based may be described as follows:
- Abortion is an exception to a woman's general right to determine what medical procedures she will undergo and what relationships she will enter.¹²
 - the exception operates throughout a woman's pregnancy
 - the exception exists because there are other matters which should be taken into consideration when the medical procedure is abortion, 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 practitioner is the best-placed person to determine whether an abortion is necessary because of risk of harm to a woman.
 - If a medical practitioner determines that a woman faces a risk of harm in continuing with her pregnancy, an abortion may be performed at any stage of her pregnancy.
 - A medical practitioner who performs an abortion when not authorised by law should be liable to professional sanction.

5. LEGISLATION REQUIRED TO IMPLEMENT MODEL A

- 5.1 The following legislative recommendations accompany this model:
- repeal sections 65 and 66 of the Crimes Act
 - include a provision in the Crimes Act which provides that any common law offences relating to abortion cannot be revived and are abolished¹³
 - include a provision in the *Health Act 1958* which provides that a medical practitioner is authorised to perform an abortion upon a woman if the woman consents and if the medical practitioner determines that an abortion is necessary because of the *risk of harm* to the woman if the pregnancy is not terminated
 - *risk of harm* to the woman may be defined as set out in options 1, 2 or 3.
 - include a provision in the Health Act which provides that a medical practitioner who performs an abortion when not authorised to do so engages in 'professional misconduct' for the purposes of the Health Professions Registration Act
 - refer to the legislative recommendations in connection with section 10 of the Crimes Act in Chapter 7 and in relation to associated legal issues in Chapter 8.

5 Cases are discussed in Chapter 2.

6 [1939] 1 KB 687; [1938] 3 All ER 615.

7 See, eg, *Rogers v Whitaker* (1992) 175 CLR 479; *Chappel v Hart* (1998) 195 CLR 232.

8 See, eg, *Rosenberg v Percival* (2001) 205 CLR 434.

9 See Chapter 8

10 If abortion is to be decriminalised but regulated differently to other medical procedures there must be a sanction for those medical practitioners who perform abortions when it is not lawful to do so. The most appropriate sanction in these circumstances appears to fall within the area of professional licensing and regulation. The *Health Professions Registration Act 2005* governs the licensing and professional conduct of health practitioners. The term 'professional misconduct' is used to describe the most serious forms of improper and unauthorised conduct by a health professional. The most serious penalties which may be imposed following a finding of professional misconduct include a fine (maximum \$50 000) and cancellation of registration.

11 See Chapter 8

12 Consent to medical treatment is considered in Chapter 2.

MODEL B

A two-staged approach to the regulation of abortion: a woman's decision during early pregnancy; medically determined risk of harm to the woman governs late abortion

1. GENERAL DESCRIPTION

- 1.1 Under this model, different legal rules govern decision making about abortion during two distinct stages of a woman's pregnancy. A line determined by gestational age would separate the two stages. The stages are referred to as 'early' and 'later' for the purposes of this model.
- 1.2 During the early stages of a pregnancy the same body of law that regulates the provision of other medical services would govern access to abortion. Abortion, like all other medical procedures, would be a private decision for a woman in consultation with her doctor. A woman would be the final decision maker because her consent would provide the legal authority for an abortion that was performed, or supervised by, a medical practitioner.
- 1.3 During the later stages of a pregnancy a medical practitioner would be the final decision maker. An abortion would not be lawful unless a medical practitioner was satisfied that it was necessary because of the risk of harm to the woman if the pregnancy continued.
- 1.4 Determining where to place the gestational line that divides the two stages of this model is a task of considerable complexity. Current clinical practice and experience elsewhere are important. The commission has concluded that 24 weeks gestation is the most appropriate point at which to place the dividing line. A committee of the Westminster Parliament recently affirmed this placement of the line, which has formed part of British abortion law for many years. It is current clinical practice in Victoria for the decision-making processes about abortion to change once a woman's pregnancy reaches a stage around 24 weeks gestation.

2. CIRCUMSTANCES IN WHICH AN ABORTION WOULD BE LAWFUL

- 2.1 An abortion would be lawful in the following circumstances:
 1. if the pregnancy has not exceeded its 24th week, when a woman consents to the surgical or medical procedure used by a medical practitioner to terminate her pregnancy¹⁴
 2. once the pregnancy has exceeded its 24th week, if
 - a. a woman consents to the surgical or medical procedure which is used to terminate her pregnancy
 - b. a medical practitioner determines that the abortion is necessary because of the risk of harm to the woman if the pregnancy is not terminated, or two medical practitioners independently determine that the abortion is necessary because of the risk of harm to the woman if the pregnancy is not terminated
 - c. that medical practitioner (or one of them if the two medical practitioner option is chosen) performs, or supervises the performance of, the abortion
 - d. the risk of harm may be determined in one of the ways set out in options 1, 2, and 3 in Model A.

OPTIONS

This model contains two ways of dealing with the requirement for medical determination of risk of harm to a woman before an abortion may be lawfully performed. The determination could be made by one medical practitioner alone, or by two medical practitioners acting independently of each other.

There are arguments in favour of both options.

If the determination must be made by two medical practitioners, acting independently of each other, issues of cost, delay, and fairness of access to health services will arise and may exacerbate existing inequities. Some people may regard this requirement as unnecessarily intrusive because abortion is a deeply private decision.

There are two reasons, however, why it may be beneficial to require a determination by two independent medical practitioners.

First, it is common clinical practice to rely upon more than one medical practitioner's opinion whenever the 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. Late abortion decisions in public hospitals are made by committees of health professionals, known as Termination Review Panels.¹⁵ In the private system, the opinion of an additional medical practitioner is sought, as a matter of good clinical practice, when a woman requests a late abortion.

3. CONSEQUENCES OF PERFORMING AN ABORTION THAT IS NOT LAWFUL

- 3.1 An abortion that does not fall within the circumstances set out in this model would be unlawful.
- 3.2 It would be a criminal offence for an unqualified person to perform an abortion in any circumstances.
- 3.3 An abortion performed by a medical practitioner when it was not lawful to do so would result in a professional sanction. A medical practitioner who performs an unauthorised abortion would be deemed to have engaged in professional misconduct rendering that person liable to sanction under the provisions of the *Health Professions Registration Act 2005*.¹⁶ To prove that an abortion was unlawful it would be necessary to establish that the medical practitioner did not hold an honest belief on reasonable grounds that the abortion was necessary because of the risk of harm to the woman.
- 3.4 A pregnant woman who has an unlawful abortion would not be liable to any legal sanction.

4. COMMENTARY

- 4.1 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.
- 4.2 This model is broadly similar to British abortion laws.¹⁷ It occupies a middle ground when considered in the context of the Australian jurisdictions that have recently amended their abortion laws.¹⁸

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.

13 See Chapter 8.

14 The issue of consent is considered in Chapter 2.

15 Current clinical practice is considered in Chapter 3.

16 If abortion is to be decriminalised but regulated differently to other medical procedures there must be a sanction for medical practitioners who perform abortions when it is not lawful. The *Health Professions Registration Act 2005* governs the licensing and professional conduct of health practitioners. The term professional misconduct is used to describe the most serious forms of improper and unauthorised conduct by a health professional. The most serious penalties which may be imposed for a finding of 'professional misconduct' include a fine (maximum \$50 000) and cancellation of registration.

17 See Chapter 2.

18 Those jurisdictions are WA, Tasmania, the ACT and the NT: see discussion in Chapter 2.



- 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.

5. LEGISLATION REQUIRED TO IMPLEMENT MODEL B

5.1 The following legislative recommendations accompany this model:

- repeal sections 65 and 66 of the Crimes Act
- include a provision in the Crimes Act which provides that any common law offences relating to abortion cannot be revived and are abolished¹⁹
- include a provision in the Health Act which provides that a medical practitioner²⁰ is authorised to perform an abortion upon a woman when her pregnancy has exceeded its 24th week, when the woman consents to the abortion, and the medical practitioner is satisfied that the abortion is necessary because of the risk of harm to the woman if the pregnancy is not terminated.²¹
- risk of harm to the woman may be defined as set out in options 1, 2, or 3 in Model A.
- include a provision in the Health Act which provides that a medical practitioner who performs an abortion when not authorised to do so engages in professional misconduct for the purposes of the Health Professions Registration Act
- refer to the legislative recommendations in connection with section 10 of the Crimes Act in Chapter 7 and in relation to associated legal issues in Chapter 8.

MODEL C

A woman's decision: abortion governed by the same body of legal rules which regulate other medical procedures

1. GENERAL DESCRIPTION

- 1.1 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.
- 1.2 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.
- 1.3 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.

2. CIRCUMSTANCES IN WHICH AN ABORTION WOULD BE LAWFUL

- 2.1 An abortion would be lawful if a woman consents to the surgical or medical procedure which is used by a medical practitioner to terminate her pregnancy.

3. CONSEQUENCES OF PERFORMING AN ABORTION THAT IS NOT LAWFUL

- 3.1 It would be a criminal offence for an unqualified person to perform an abortion in any circumstances.
- 3.2 A woman who has an unlawful abortion would not be liable to any legal sanction.²²

4. COMMENTARY

- 4.1 Under Model C final decision-making authority rests with a pregnant woman. A woman's right to elect to terminate her pregnancy is constrained only by the State's role in ensuring that a qualified person performs this and any other surgical or medical procedure.
- 4.2 This model is probably reflective of some current clinical practice.
- 4.3 This model is the same as the law in the ACT and in Canada.
- 4.4 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.
 - Abortion should be regulated in the same way as any other medical procedure.

5. LEGISLATION REQUIRED TO IMPLEMENT MODEL C

- 5.1 The following legislative recommendations accompany this model:
 - repeal sections 65 and 66 of the Crimes Act
 - include a provision in the Crimes Act which provides that any common law offences relating to abortion cannot be revived and are abolished
 - refer to the legislative recommendations in connection with section 10 of the Crimes Act in Chapter 7 and in relation to associated legal issues in Chapter 8.

19 See Chapter 8.

20 The opinion of two medical practitioners, acting independently of each other, is an alternative means of dealing with this medical determination.

21 Under this model early abortion may be dealt with in one of two ways. The law could be silent on early abortion, which would mean that it would be governed by the same body of law which regulates all other medical procedures. Alternatively, there could be an 'avoidance of doubt' provision in the Health Act. This would make it clear that an abortion would be lawful where the pregnancy has not exceeded its 24th week if the procedure is performed, or supervised, by a medical practitioner and the woman consents.

22 See Chapter 8.

Chapter 7 Child Destruction

CONTENTS

96	Introduction
96	The Offence
97	Background to the Offence
98	Problems with the Offence
100	The Offence in Victoria
101	Is Reform Needed?
103	Submissions and Consultations
105	Options for Reform
108	Commission's Recommendations

INTRODUCTION

7.1 Reform of abortion law raises several associated legal issues which are considered in this chapter and Chapter 8. The offence of child destruction must be considered in any change to abortion laws because of the overlap between it and the abortion offence in section 65 of the Crimes Act, which covers the entire period of a pregnancy.¹

THE OFFENCE

7.2 Section 10 of the Crimes Act, which is headed 'Offence of child destruction', states:

- (1) *Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother shall be guilty of the indictable offence of child destruction, and shall be liable on conviction thereof to level 4 imprisonment (15 years maximum).*
- (2) *For the purposes of this section 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.*
- (3) *Where upon the trial of any person for the murder or manslaughter of any child or for infanticide or for any offence under section sixty-five of this Act the jury are satisfied that the person charged is not guilty of murder manslaughter or infanticide or of any offence under the said section sixty-five (as the case may be) but are satisfied that he is guilty of the indictable offence of child destruction, the jury may find him guilty of that indictable offence and he shall be liable to punishment accordingly.*
- (4) *Where upon the trial of any person for the indictable offence of child destruction the jury are satisfied that the person charged is not guilty of that indictable offence but are satisfied that he is guilty of an offence under section sixty-five of this Act the jury may find him guilty of that offence and he shall be liable to punishment accordingly.*

7.3 This section makes it a criminal offence for a person to intend to destroy the life of an unborn child capable of being born alive by *unlawfully* using any means to achieve this result. Section 10(2) of the Crimes Act creates the rebuttable presumption that a woman who has been pregnant for 28 weeks or more is carrying a child capable of being born alive. This does not preclude a finding on the facts of a particular case that a woman who has been pregnant for less than 28 weeks is carrying a child capable of being born alive.²

7.4 Sections 10(3) and (4) provide for alternative verdicts. Section 10(3) permits a jury to find a person guilty of child destruction when the person has been charged with murder, manslaughter, or infanticide. Section 10(4) permits a jury to find a person guilty of the offence of unlawful abortion under section 65 when the person has been charged with child destruction.

7.5 The Victorian offence of child destruction was drawn from the Infant Life Preservation Act, enacted in England in 1929. The offence was originally created in England to deal with lethal acts intentionally performed during childbirth where there was doubt about whether the child was born alive. To convict a person of murder, manslaughter, or infanticide, the prosecution must prove the child was born alive. If that is in doubt, the offence of child destruction can be charged as an alternative.

7.6 The offence is an anachronism, developed to cover a potential former, rather than current, problem: the calculated and intentional killing of a child in the process of childbirth to avoid punishment for infanticide or murder. Punishment could, theoretically, be avoided due to a gap between abortion and homicide laws.

7.7 The offence creates a lack of clarity in Victorian law, which has three different aspects. First, an unlawful abortion³ that occurs at a stage when a fetus is capable of being born alive falls within the ambit of both section 65 (abortion) and section 10 (child destruction) of the Crimes

Act.⁴ The reach of those offences may not be the same because the Menhennitt ruling about the meaning of the word ‘unlawful’ in section 65 may not apply to the child destruction offence.⁵ Secondly, the offence has been interpreted, and used, in Victoria as applying in circumstances far removed from abortion: that is, when harm has been caused to a viable fetus following an assault on a pregnant woman. Thirdly, the offence requires the fetus to be ‘capable of being born alive’, which is a concept that has a contested meaning. It draws in the complexities of the common law ‘born alive’ rule and confuses the lines between child destruction, abortion, and homicide offences.

BACKGROUND TO THE OFFENCE

- 7.8 The common law does not recognise a fetus as a ‘person’ until it is a ‘reasonable creature in being’, that is, a being separate and independent of the mother. Before that it was considered ‘part of the viscera of the mother’.⁶
- 7.9 Under the common law a child was not considered alive, and therefore capable of being murdered, until ‘fully born’ and ‘independently functioning’. Fully born meant that the entire body of the child had left the body of the mother.⁷ The presumption was that a child was born dead, unless there was clear evidence of life independent from the mother.
- 7.10 This common law rule was developed when stillbirth was common due to complications in the pregnancy or during childbirth. In the developing world, where medical care is not routinely available or not of a high standard, infant and maternal mortality are still high.⁸ The requirement of proof of live birth was a natural development in those circumstances. The high standard of medical care available in the developed world means that stillbirth is now relatively rare.⁹
- 7.11 A criminal prosecution requires proof beyond reasonable doubt. Therefore any prosecution for killing a person first requires proof that a life existed to be taken: ‘A child’s death is no concern of the law of homicide if it occurs before or during birth’.¹⁰
- 7.12 There was initially confusion about whether independent functioning required ‘independent circulation’, and whether that meant not only breathing but detachment from the umbilical cord.¹¹
- 7.13 The born alive rule was clarified in Victoria by Justice Barry in the case of *R v Hutty*. A baby had to be completely delivered from the mother’s body and ‘living by virtue of the functioning of its own organs’.¹² The common law principle that a fetus is not a person, with legal rights, until born is a fundamental part of our legal system. The born alive evidentiary rule has evolved with medical advances, and was recently confirmed as part of Australian common law in the case of *Iby*.¹³ The finding in that case was that any sign of independent life was sufficient to satisfy the rule.¹⁴

1 *Crimes Act 1958* s 65.

2 See, eg, *C v S* [1988] 1 QB 135; *Rance v Mid-Downs Health Authority* [1991] 1 QB 587.

3 That is, an abortion that does not comply with the Menhennitt ruling as to the circumstances in which therapeutic abortion is lawful.

4 See, eg, *C v S* [1988] 1 QB 135 and *Rance v Mid-Downs Health Authority* [1991] 1 QB 587, cases that involved the equivalent provision in the UK *Infant Life Preservation Act 1929*. Case law and commentary in England relating to the equivalent offence clearly demonstrates that the offence of child destruction can apply to late abortions.

5 This is discussed further under The Offence in Victoria.

6 J Barry ‘The Child en Ventre sa Mere’ (1941) 14 *Australian Law Journal* 351, 353 quoted in Kristin Savell, ‘Is the “Born Alive” Rule Outdated and Indefensible?’ (2006) 28 *Sydney Law Review* 625, 627.

7 *R v Poulton* (1832) 5 Carr, 172 ER 997 (1832) See also Glanville Williams, *The Sanctity of Life and the Criminal Law* (1958) 19.

8 Every year 60 million women give birth at home with no skilled care. More than 500000 women die from complications of pregnancy and childbirth, 4 million newborn babies die every year before they are a month old, and 3 million are stillborn. Nearly all maternal and newborn deaths occur in the developing world: Save the Children, *State of the world’s mothers 2006—Saving the lives of mothers and newborns* (May 2006) 3 <www.savethechildren.org/publications/mothers/2006/SOWM_2006_final.pdf> at 20 February 2008.

9 This was discussed in *R v Iby* (2005) 63 NSWLR 278, 284 where the natural rate of stillbirth was stated to be approximately 0.5% of total births.

10 P Skegg, *Law, Ethics, and Medicine: Studies in Medical Law* (1988) 20.

11 *R v Enoch and Pulley* (1833) 5 Carr, 172 ER 1089 (1833); *R v Ann Crutchley* (1837) 7 Carr, 173 ER 355; *R v Trilloe* (1842) Carr and M 650, 174 ER 674. And see discussion in *Ibid* 20–23.

12 *R v Hutty* [1953] VLR 338.

13 *R v Iby* (2005) 63 NSWLR 278.

14 *R v Iby* (2005) 63 NSWLR 278, 288.

PROBLEMS WITH THE OFFENCE

- 7.14 The English Infant Life Preservation Act¹⁵ created the offence of child destruction, from which the Victorian offence was developed. It originated from a private member's Bill introduced by Lord Darling after judicial comment in a criminal trial.¹⁶ In June 1928 Justice Talbot said: 'It is a felony to procure abortion and it is murder to take the life of a child when it is fully born, but to take the life of a child while it is being born and before it is fully born is no offence whatever'.¹⁷
- 7.15 House of Lords debate in 1928 on the Infant Life Preservation Bill—the offence was later designated 'child destruction' by parliamentary draftsmen—does not provide certainty about the intention of the Bill. Some members were strongly of the view that the provision was not intended to have any effect upon abortion law, but to fill a perceived gap *between* abortion law and the laws of homicide and infanticide. Others saw destruction of the child before it was fully born as akin to abortion, and if not undertaken by the woman herself, most likely to be done by abortionists.¹⁸
- 7.16 Three concerns were raised during debate on the original Bill in 1928, which are still relevant in Victoria today.¹⁹

A NON-EXISTENT PROBLEM

- 7.17 The first was that the 'mischief' intended to be overcome by the offence did not exist, rather it was feared that it would arise with publication of the existence of the perceived gap. During parliamentary debate it was argued that the offence was unnecessary because there were no instances 'in the whole history of the administration of Criminal Law', including coronial inquiries, where an improper act had been done to a child during birth by anyone but the mother.²⁰ Women who killed their children in those circumstances were quite appropriately charged with infanticide. The offence of child destruction requires a degree of intention and wilfulness that is generally not present in cases of women killing children during or shortly after birth.
- 7.18 Infanticide was a relatively new offence when the debate occurred, having been created in 1922.²¹ It was introduced to recognise two things particular to that type of killing, and to provide for a penalty of life imprisonment rather than a sentence of death.²² First, it recognised the 'disturbance of mind': 'The malice was generally less in this class of murder because... of the general state of health and mind of the perpetrators of them'.²³ Secondly, it acknowledged the particular circumstances of infanticide: 'Generally, there was not that malignity in these cases which characterises other forms of murder. As the statistics showed, this crime was mostly committed by illegitimate mothers to hide their shame'.²⁴
- 7.19 The mischief section 10 was enacted to deal with has not eventuated. Rather, the child destruction provision has only been used for completely different criminal behaviour. It appears to have been used only once in England, and not at all in Victoria for its original purpose which was to deal with acts performed during childbirth, or for late abortion.²⁵ Instead, in England and Victoria, it has been used in cases involving attacks on women in the later stages of pregnancy with intent to harm the fetus.²⁶

CRIMINALISING MEDICAL DECISIONS

- 7.20 The second concern raised about the Bill was that extending the offence to people other than the mother opened up the possibility of midwives and doctors being charged over a decision to save the mother rather than the child, which Lord Atkin considered 'inadvisable' and 'unnecessary'. He argued that the offence would place the onus on the doctor to prove that he acted in good faith and the action was necessary, rather than the prosecution having to prove that the doctor did not act in this manner. 'It appears to me that doctors have been harried quite enough by litigation and to add this burden to the cares of an ordinary practitioner is perfectly horrible'.²⁷ The proviso that the offence of child destruction was not committed when an act was done in good faith, with the intention of saving the life of the mother,

was considered inadequate because it still allowed midwives and doctors to be charged, and required argument that the act was done for that reason.

- 7.21 Lord Atkin thought the perceived gap in the law was more appropriately filled by extending the offence of infanticide 'to include the killing of a child by the mother in the course of delivery' rather than creating a new offence.²⁸ 'The course of delivery' would be deemed to continue until the child had an existence independent of the mother.²⁹ Allowing the offence to apply to someone other than the mother went further than necessary according to Lord Atkin, because there were no instances of anyone other than the mother harming a child during birth.³⁰
- 7.22 This was not disputed in parliamentary debates. The 'good many' cases referred to by Justice Talbot where the person could not be punished because of the perceived gap, and which led to the private member's Bill, related to cases of infanticide.³¹ There was no agreement among the Lords that the lack of punishment was itself a problem. The class system was still entrenched in the UK, and the debate referred specifically to the circumstances of these infanticide cases being 'nearly always' those of young, unsupported, unmarried girls giving birth, often without care or attendance.³² Lord Dawson commented: 'For my part the fact that there is a gap in the law leaves me cold, when I feel all the time that this class (women in this situation) do not require conviction and it is a pity almost if they are convicted'.³³
- 7.23 Concerns about the gap in the law had first been raised in the mid-19th century. It appears the Bill was passed because of concern that publication of Justice Talbot's comments, alerting women and abortionists to the gap, would lead to abortionists being hired to destroy the child during birth.³⁴ However, Lord Atkin did not believe that professional abortionists would consider themselves safe because of this gap, or that a woman who coldly and deliberately killed her child during 'the actual act of delivery' would truly believe she could argue this and be acquitted because of the gap.³⁵

LACK OF CLARITY IN THE LAW

- 7.24 The third concern was that the offence overlapped with the abortion laws, which Lord Atkin saw as 'unnecessary, and, indeed ... undesirable'.³⁶ Lord Atkin stated:

*In so far as it deals with the offence of killing a child, the provision as to twenty-eight weeks after conception seems to be quite unnecessary, because such an act as that would, as I am advised and as I understand, always be covered by the law as to procuring abortion.*³⁷

15 The Act does not apply throughout the UK, but in England and Wales only (see section 3(2)).

16 Several previous attempts had been made to introduce legislation to fill the gap, none of which were accepted. There were Bills proposed in: 1867 (after the report of the Capital Punishment Commission of 1866); 1874 (part of the Homicide Law Amendment Bill of 1872–74); and by the Draft Code of 1879, which attempted to introduce an offence of a mother neglecting to obtain reasonable assistance for birth with the intention that the child should die. For details of the history of earlier proposals to remedy the gap see D Seaborne Davies, 'Child-Killing in English Law' (1937) *Modern Law Review* 203; JJ Keown, 'The Scope of the Offence of Child Destruction' (1988) 104 *Law Quarterly Review* 120.

17 Stated in the course of Talbot J's charge to the Grand Jury at Liverpool Assizes, extracts from which—including this quote—were quoted by Lord Darling in debate on the Child Destruction Bill: UK, *Parliamentary Debates*, House of Lords, 21 June 1928, 71, 617–18 (Lord Darling).

18 United Kingdom, *Parliamentary Debates*, House of Lords, 22 November 1928, 74, 440–441 (The Lord Chancellor (Lord Hailsham)). No assistance can be gained from debate in Commons as the Bill was passed without debate there.

19 In England the overlap has been recognised and the child destruction provision quarantined from abortion laws. This is discussed later.

20 UK, *Parliamentary Debates*, House of Lords, 22 November 1928, 74, 427 (Lord Atkin).

21 *Infanticide Act 1922*, later repealed and replaced by the *Infanticide Act 1938*.

22 A woman convicted of infanticide was sentenced as if for manslaughter. The crime of murder still carried a penalty of death. Commentators noted that many women were acquitted of murder in such cases because judges and juries sympathised with the circumstances of these cases and did not believe the women deserved to hang. The offence of infanticide was therefore also an attempt to increase convictions in such cases. See Seaborne Davies (1937) above n 16 218–219.

23 Ibid 221.

24 Ibid 221.

25 There are no reported cases in the UK. A search of the internet on 12 December 2007 revealed only one prosecution in the UK relating to the original purpose of the legislation. A 22-year-old mother of two was convicted of child destruction after allegedly using an illegal abortionist (who was not identified or charged, though the police investigation is ongoing) to end her pregnancy and disposing of the fetus sometime between 28 and 32 weeks gestation: Nick Britten, *Jury convicts mother who destroyed foetus* (27 May 2007) Telegraph <www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/05/26/nabort26.xml> at 12 December 2007. There are no reported cases in Victoria of child destruction. There was a police investigation of a late abortion at the Royal Women's Hospital in 2000 to see if any of the doctors involved should be charged with child destruction, but no charges resulted: Julie-Anne Davies, '32 Weeks: 5½ Years', *The Bulletin* (Sydney) 8 January 2008.

26 Examples in the UK include: *R v Virgo* [1989] Crim LR 233; *R v Johnson and Lorraine* [1990] Crim LR 661; *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245. In Victoria information provided by the Office of Public Prosecutions on 7 September 2007 from internal records noted two unreported cases where accused people were charged with attempted child destruction over attacks on pregnant women.

27 UK, *Parliamentary Debates*, House of Lords, 22 November 1928, 72, 272 (Lord Atkin).

28 Ibid 426.

29 Ibid 425 (Lord Atkin).

30 Ibid 427.

31 Ibid 269 (Lord Darling). Conviction for infanticide required proof that the child had been born alive. Judges and juries contrived to avoid conviction of women in this circumstance, particularly when the death penalty still applied: Seaborne Davies (1937) above n 16, 217–219.

32 UK, *Parliamentary Debates*, House of Lords, 22 November 1928, 72, 271 (Lord Atkin).

33 Ibid 273 (Lord Dawson of Penn).

34 UK, *Parliamentary Debates*, House of Lords, 6 December 1928, 74, 440 (The Lord Chancellor Lord Hailsham).

35 Ibid 446, 448 (Lord Atkin).

36 Ibid 428.

37 UK, *Parliamentary Debates*, House of Lords, 22 November 1928, 72, 272 (Lord Atkin).

- 7.25 There was no agreement between the Lords about whether the offence overlapped with abortion.³⁸ For example, while Lord Atkin clearly thought it did, Earl Russell remarked during debate 'it does not deal with abortion or anything in the nature of abortion'.³⁹
- 7.26 Noted commentators have expressed no doubts about the overlap, or about the problems left unresolved by the offence. Professor Glanville Williams noted in 1958:

The legislation penalizes the destruction of unborn infants and infants not completely born. It thus straddles part of the law of abortion and the no-man's land between abortion and murder, and obviates some of the difficulties connected with the proof of birth without exempting the prosecution from having to prove an act of killing with the requisite mental state (mens rea).

- 7.27 Keown notes that the overlap was well recognised by the Home Office when the offence was enacted. A Home Office comment on the Bill stated 'there can be no harm in overlapping between the Bill and section 58 of the *Offences Against the Person Act, 1861* (abortion)' because the penalty for both was the same and they could be charged in the alternative on indictment.⁴⁰
- 7.28 This contrasts with a 1987 House of Lords Select Committee examining the application of the Act in relation to abortion, which noted:
- It is plain that it was not the intention of the author of the Bill or of the House that the Bill should overlap the law of abortion or the law of murder. The Bill had the purpose only of filling a well known and clearly defined gap in the criminal law.⁴¹*
- 7.29 These differences of opinion from authoritative sources demonstrate the ongoing lack of clarity associated with this offence.

THE OFFENCE IN VICTORIA

- 7.30 The issue of overlap with the offence of unlawful abortion was not considered when the offence of child destruction was introduced into Victorian law in 1949. It was widely believed that section 10 did not interfere with the law of abortion. During parliamentary debate, a member of the Legislative Council quoted from a memorandum of the Chief Justice's law reform committee, which had considered the Bill: 'It is thought that this provision will fill a gap in the criminal law between the offences of abortion and murder'.⁴²
- 7.31 While the overlap was not recognised or discussed during parliamentary debates, it does exist and it produces uncertainty in Victorian law. Unlawfully terminating a pregnancy when a woman is carrying a fetus capable of being born alive falls within the ambit of both section 65 (abortion) and section 10 (child destruction) of the Victorian Crimes Act.⁴³ This overlap causes great uncertainty for the medical profession and women when a woman has reached a stage in her pregnancy when the fetus may be capable of being born alive.
- 7.32 The English statute has always contained a proviso that the offence of child destruction was not committed when an act was done in good faith with the intention of saving the life of the mother. When the offence of child destruction first became part of Victorian law in 1949, the English proviso was omitted and replaced by the word 'unlawfully'. This change has further confused the meaning of this offence in Victoria.
- 7.33 Victorian Parliamentary debate about the offence in 1949 suggests that the proviso was omitted and replaced by the word 'unlawfully' in an attempt to ensure Victorian medical practitioners, and courts, were granted more responsibility for determining when the destruction of a fetus during childbirth, or the later stages of pregnancy, could be lawfully performed. Specific reference was made to the UK case of *Bourne*⁴⁴ and its 'broad interpretation of' preserving the life of the mother: 'By the insertion of the word "unlawfully" ... that position will still obtain to the extent that the courts will determine what is unlawful'.⁴⁵ In clear reference to medical practitioners, concern was expressed that 'no person shall suffer for an act on his part that is not unlawfully done'.⁴⁶
- 7.34 The parliamentary intention of delegating law-making responsibility to the judiciary has not been achieved because the meaning of the word 'unlawfully' in section 10 has not been

considered by a Victorian court. It is unlikely, however, that the word has the same meaning in that section as it does in the Menhennitt rules, which are concerned with the meaning of the word unlawfully in section 65. This is because 'potential life' is not one of the factors which must be considered when determining whether conduct is unlawful for the purposes of the section 65,⁴⁷ but it is a factor which may arise when construing the word for the purposes of section 10. The Menhennitt rules are directed towards the interests of the woman alone.⁴⁸

- 7.35 Section 10 seems concerned with the interests of a potential life as well as those of a pregnant woman, except when there is a risk to the woman's life. When the risk to the woman falls short of death, it appears that for an abortion to be lawful a medical practitioner must determine whether termination is a necessary and proportionate response to the health risk faced by the woman, and at the same time consider the potential life of the fetus. This is a balancing task of extraordinary, perhaps impossible, complexity, especially in the absence any guidance about how to weigh the competing considerations.

IS REFORM NEEDED?

- 7.36 Use of the words 'capable of being born alive' in section 10 raises questions about the relevance of the born alive rule to this provision. The application of the rule to the section is unclear.

COMPLEXITY OF THE BORN ALIVE RULE

- 7.37 Although the offence of child destruction was introduced to overcome the need for proof that a child was in fact born alive for the offences of murder or manslaughter to be charged, it raises a raft of other problems through the requirement of proof that the child was capable of being born alive.
- 7.38 How does a court determine the factual question of whether a particular fetus was capable of being born alive? The words invite argument about the meaning of 'born alive' and about whether the fetus in question was 'capable' of being born alive. Is a fetus that exhibits any signs of life born alive or does it need to be viable in terms of being able to maintain an independent, ongoing existence?⁴⁹ Both interpretations are problematic because of their uncertainty and propensity to change over time because of medical advances.⁵⁰
- 7.39 The English High Court and Court of Appeal considered this issue in *C and another v S and others*.⁵¹ The Court of Appeal held that 'born alive' meant capable of ongoing life. For a normal healthy fetus this was determined to be when lungs are sufficiently developed for the infant to be able to breathe, either naturally or with assistance.⁵² After this decision it was argued in England that viability was an inappropriate and 'flimsy'

38 UK, *Parliamentary Debates*, House of Lords, 6 December 1928, 74, 430 (Lord Merrivale) and 444 (Earl Russell).

39 *Ibid* 444 (Earl Russell).

40 Quoted in Keown (1988) above n 16, 128.

41 Her Majesty's Stationery Office, *Select Committee on the Infant Life (Preservation) Bill [HL] Special Report with Evidence* House of Lords: Session 1986–1987 (1987) 6.

42 Victoria, *Parliamentary Debates*, Legislative Council, 11 May 1949, 1253 (Archibald Fraser).

43 See, eg, *C v S* [1988] 1 QB 135 and *Rance v Mid-Downs Health Authority* [1991] 1 QB 587, which were cases involving the equivalent provision in the UK *Infant Life Preservation Act 1929*.

44 *R v Bourne* [1939] 1 KB 687, [1938] 3 All ER 615.

45 Victoria, *Parliamentary Debates*, Legislative Council, 11 May 1949, 1252 (Archibald Fraser).

46 *Ibid* (WJ Beckett).

47 *Crimes Act 1958* ss 65, 66. The rationale for these statutory offences may have changed over time. Prof Waller has written that the legislative intention of the original UK statute of 1803 was 'to protect women from being forced to undergo abortions'. He states that by 1861 the UK legislation 'deals with abortion from the standpoint of protecting the foetus rather than the mother, and of doing so on moral grounds': Louis Waller, 'Any Reasonable Creature in Being', 1987 13 *Monash University Law Review*, 40. When describing the same UK law almost a century later Prof Glanville Williams wrote: 'The chief evil of an abortion is no longer thought to be the loss of the unborn child, but the injury done to the mother by the unskilled abortionist': Williams (1958) above n 7, 146.

48 See Chapter 2 for a detailed discussion of the Menhennitt rules.

49 See discussion in Ian Kennedy and Andrew Grubb, *Medical Law* (3rd ed, 2000) 1429–1436.

50 See discussion in Savell (2006) above n 6, 637–639.

51 *C and another v S and others* (1987) 1 All ER 1230.

52 *C and another v S and others* (1987) 1 All ER 1242.

basis on which to proscribe abortion because of its uncertainty.⁵³ Lung development cannot be accurately determined in utero.⁵⁴ The ability to breathe as the sole determinant of viability also does not take into account extremely premature births that can result in serious congenital abnormalities. A 22-week fetus may occasionally survive, but is likely to suffer serious and ongoing disabilities 'in which case the pure fact of viability alone should not be the only guiding factor over an abortion decision'.⁵⁵

- 7.40 The lack of certainty and clarity created by this provision are evidenced by the fact that legislators in 1929 clearly considered 28 weeks gestation to be the earliest time a fetus may be viable, whereas it is now recognised there is a 'grey zone' of viability from 23–26 weeks.⁵⁶ In this zone 'the wishes of parents (as to whether treatment should be offered) should be paramount'.⁵⁷ While such a grey zone is appropriate for medical decisions about treatment of newborns, it is too uncertain to be suitable for use in the criminal law.
- 7.41 If section 10 is retained in Victorian law, it will remain unclear whether the born alive rule, with all of its own uncertainty, applies, or whether the offence is limited to cases where a fetus is found to be capable of ongoing life.
- 7.42 The born alive rule has most recently been developed through application in murder or manslaughter cases.⁵⁸ In relation to homicide or manslaughter, a major issue is raised if unlawful injury is inflicted on a pregnant woman resulting in miscarriage of a fetus that is born alive but dies sometime later due to the unlawful injury.
- 7.43 In the recent decision of *Iby*, the NSW Court of Appeal considered the born alive rule in the context of a manslaughter charge resulting from a dangerous driving incident that resulted in the premature birth and subsequent death of a child.⁵⁹ The court questioned the continuing relevance of the rule in light of its basis on 'the primitive state of medical knowledge at the time it was adopted' and the high incidence of stillbirth at the time, which we have discussed.⁶⁰ Given medical advances, the court considered there to be a 'strong case for abandoning the born alive rule completely'.⁶¹
- 7.44 *Iby* significantly extended the meaning of born alive in NSW through Chief Justice Spigelman's ruling that 'any sign of life after delivery is sufficient'.⁶² He also noted that the authorities had recognised different criteria as indicating life, which were 'not necessarily reconcilable', and that this was because it was an evidentiary rather than substantive rule.⁶³ Rulings therefore had to be understood in the context of the particular facts of the case.

LEGAL UNCERTAINTY ABOUT LATE THERAPEUTIC ABORTIONS

- 7.45 Late abortions occur in a small number of cases in Victoria, many for severe fetal abnormality and some for other reasons. If the child destruction provision remains in Victorian legislation, medical practitioners who perform abortions in any of these circumstances will remain vulnerable to criminal liability.
- 7.46 In the UK from 1967 (when the Abortion Act was introduced) until 1990, the medical profession was greatly concerned about the lawfulness of late abortions because of the child destruction provision. The overlap between child destruction and abortion law was recognised⁶⁴ and child destruction was quarantined from abortion law by a legislative amendment in 1990. A provision was added to the Abortion Act to make it clear that a registered medical practitioner performing an abortion in accordance with the provisions of the Act could not commit the offence of child destruction.⁶⁵
- 7.47 Although no medical practitioners have been charged with performing a late abortion in Victoria, the termination of a pregnancy at 32 weeks by doctors at the Women's in 2000 did lead to a child destruction investigation. Fetal abnormality was raised in this case, but the lawfulness of the abortion centred on the risk to the woman, who was suicidal. Ultimately, criminal charges were not pursued against the staff involved. The conduct was probably not considered to be unlawful under section 10 because there was clear evidence that all staff involved genuinely believed the woman would commit suicide if the abortion was not performed.⁶⁶

SUBMISSIONS AND CONSULTATIONS

- 7.48 In our Information Paper, we asked whether the offence of child destruction needed to be changed in any way and, if so, how. Many people who provided submissions did not address the issue of child destruction. In consultations, many participants had not considered the interrelationship of the abortion and child destruction provisions, and therefore did not have an established view about how it should be amended.
- 7.49 Responses that were received in submissions and consultations were divided into four categories:
- wanting the current offence abolished
 - retaining it but ensuring it is properly enforced, or retaining but amending it to lower the 28 week presumption, or link it to viability
 - confining its operation to childbirth
 - amending it to make it clear that it does not apply to lawful abortions performed by medical practitioners.

ABOLISH

- 7.50 Those who argued that section 10 should be abolished generally expressed concern that the provision is confusing, overly complex, outdated, and ambiguous.⁶⁷ There was also concern that as the original intent of the provision is unclear, interpretation is variable and the provision had been used to intimidate doctors.⁶⁸ Similarly, the Campaign for Women's Reproductive Rights felt that retaining the offence of child destruction for pregnancies beyond 28 weeks puts medical practitioners, and women, at risk of prosecution.
- 7.51 Some expressed concern that if sections 65 and 66 of the Crimes Act are repealed, it needs to be made clear that the offence of child destruction cannot be used as another way to criminalise abortions.⁶⁹ Many submitters thought that as the offence is no longer used for the purpose it was enacted for, it was more appropriate to repeal it and enact clear provisions that effect the intended purpose.⁷⁰
- 7.52 For example, Dr Jo Wainer submitted that it would be more appropriate to repeal section 10 and extend the law of assault to take into account damage to a fetus caused by assault of a pregnant woman. Many submitters agreed that section 10 should be amended to apply only in cases of assault of a pregnant woman with intent to harm the fetus, or an assault provision created.⁷¹
- 7.53 In consultations, many others supported the introduction of an assault offence that recognised the aggravating circumstance of pregnancy.⁷² Some of these also thought section 10 should be repealed, others that its application should be clearly confined to killing a child at childbirth and not abortion.

53 RD Mackay, 'The Relationship Between Abortion and Child Destruction in English Law' (1988) 7 (2) *Medicine and Law* 177, 181–2.

54 'Respiratory distress syndrome of the newborn infant caused by immaturity of the fetal lung continues to be a clinical problem. Unfortunately, currently available tests continue to demonstrate low diagnostic specificity and remain poor predictors of fetal lung immaturity': DG Grenache and AM Gronowski, 'Fetal Lung Maturity' (January 2006) 39(1) *Clinical Biochemistry* 1. A paediatric specialist on our Medical Panel advised there is no antenatal test that will determine, in extreme preterm situations, whether an extreme preterm infant will survive, survive with disability, or not survive at all.

55 Ibid 181. For data on rates and types of disability for children born at 22–26 weeks see J Keogh et al, 'Delivery in the "Grey Zone": Collaborative Approach to Extremely Preterm Birth' (2007) 47 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 273; Nuffield Council on Bioethics, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues* (2006) 71–72; British Medical Association, *Abortion Time Limits: A Briefing Paper from the BMA May 2005: Part Two—Factors Influencing Views on Abortion Time Limits: Fetal Viability* <www.bma.org.uk/ap.nsf/Content/AbortionTimeLimits-Factors~viability> at 14 September 2007.

56 Keogh (2007) above n 55.

57 David Ellwood, 'Is There a "Borderline of Viability"?' (2007) 47 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 261.

58 *R v Iby* (2005) 63 NSWLR 278; *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245.

59 *R v Iby* (2005) 63 NSWLR 278.

60 *R v Iby* (2005) 63 NSWLR 278, 284.

61 *R v Iby* (2005) 63 NSWLR 278, 288.

62 *R v Iby* (2005) 63 NSWLR 278, 288.

63 *R v Iby* (2005) 63 NSWLR 278, 285, and see discussion by Savell (2006) above n 6, 629–633.

64 See, eg, Kennedy and Grubb (2000) above n 49, 1418, 1428; P Skegg, *Law, Ethics, and Medicine: Studies in Medical Law* (1988) 5.

65 *Abortion Act 1967* s 5(1), substituted by *Human Fertilisation and Embryology Act 1990* s 37(4).

66 Savell (2006) above n 6, 648; Davies (8 January 2008) above n 25.

67 Consultations 9 (Croydon Day Surgery), 15 (Dr Ian Freckleton), 12 (Reproductive Choice Australia), 33 (Dr Lachlan de Crespigny), 35 (Women's Clinic Richmond Hill); 24 (Fetal Management Unit—Royal Women's Hospital); submissions 227 (Reproductive Choice Australia), 235 (Youthlaw), 273 (Law Institute of Victoria), 504 (Fitzroy Legal Service).

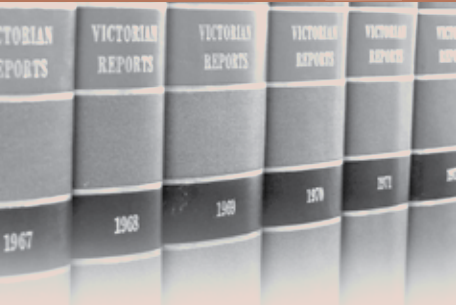
68 Submissions 461 (Association for the Legal Right to Abortion), 505 (Victoria Legal Aid); consultation 3 (Association for the Legal Right to Abortion).

69 Eg, submission 487 (Victorian Women's Trust).

70 Ibid.

71 Submissions 24 (Humanist Society of Victoria), 152 (Rebecca Albury), 154 (Maryse Usher), 226 (Women's Health Association of Victoria), 231 (Public Health Association of Australia, Women's Health Special Interest Group), 261 (Gippsland Women's Health Service), 314 (South West Community Legal Centre), 340 (ALP Brunswick South Branch), 426 (Anglican Diocese of Melbourne), 507 (Royal Women's Hospital).

72 Consultations 3 (Association for the Legal Right to Abortion), 6 (Women's Health Victoria), 11 (Family Planning Victoria), 17 (Victorian Women's Trust), 21 (Women's Electoral Lobby), 31 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists), 32 (Dr Lyn Gillam), 34 (Jewish Community Council of Victoria and Rabbi Aviva Kipen).



- 7.54 In its submission, Fitzroy Legal Service said that utilising the child destruction provisions in cases of assault was inappropriate because it does not recognise that the injury is to the pregnant woman through loss of the child. It supported the NSW model of defining grievous bodily harm (serious injury in Victoria) to include 'the destruction (other than in the course of a medical procedure) of the foetus of a pregnant woman, whether or not the woman suffers any other harm'. It submitted that this avoids any overlap with abortion and is an appropriate recognition of the harm caused to the woman by such acts.
- 7.55 Liberty Victoria submitted that repeal of section 65 of the Crimes Act necessarily requires section 10 to be altered. Considering the original intent of the provision, and the fact that the UK has recognised and rectified the overlap, it submitted that section 10 should be abolished. Fitzroy Legal Service agreed, submitting:
- When incorporated into Victorian law ... this provision effectively overlapped with ss 65 and 66 of the Crimes Act to create an additional offence when the woman was 28 weeks or more pregnant. This overlap seems unnecessary. Any act done before birth should be covered by abortion regulations. Any act done once the foetus is breathing independently of the mother should be covered by murder, manslaughter or infanticide laws. If there is concern about this, it may be beneficial to specify that destruction of a foetus in the birth process (with the clear exceptions of saving the life or physical mental health of the mother) can also be prosecuted as murder, manslaughter or infanticide.*
- 7.56 The Law Institute of Victoria and Children by Choice submitted that the term 'capable of being born alive' makes the balancing task required overly complex and difficult for medical practitioners to implement in their daily roles. Furthermore, it does not accord with the approach taken in the Menhennitt ruling, which is directed to the interests of the woman alone.
- 7.57 The Law Institute of Victoria, Victoria Legal Aid, and Victorian Women Lawyers submitted that section 10 should be repealed and replaced with provisions which make the following circumstances criminal offences:
- wilful or negligent destruction of a child during birth
 - assault or violence against a pregnant woman with an intent to harm or reckless disregard as to the harm caused to the fetus.
- 7.58 These organisations also submitted that a legislative provision specifically preclude lawful abortion or 'distinguish between abortion which is performed with the consent of the woman, and the offence of child destruction'.

RETAIN BUT ENFORCE

- 7.59 The Respect Life Office felt that the offence of child destruction should be retained and enforced to protect 'viable' children. The Australian Family Association also favoured retaining the child destruction provisions and felt they should not be weakened. The Presbyterian Church of Victoria favoured retaining child destruction; however, it acknowledged that the current law is unclear.
- 7.60 A significant proportion of submitters stated that the child destruction provision should be retained in its current form.⁷³ Some of these submitters also felt that not only was it necessary it be retained, but that it also be enforced or 'not weakened'.⁷⁴
- 7.61 The National Civic Council felt that the child destruction provision should be retained as it 'recognises the development of a child in the later stages of pregnancy, one who is viable outside the womb, and is deserving of protection in spite of not yet having been born alive'.
- 7.62 Two submitters believed police were failing to enforce the law.⁷⁵ One argued that the failure to enforce the provision has led to 'inconsistency between a third party killing the pre born child by negligence or intention, without the consent of the mother of the pre born child; and an abortionist killing the same child, with the consent of the mother of the pre born child'.⁷⁶

CONFINE TO CHILDBIRTH

- 7.63 Some who preferred the abolition of the provision noted that if a decision was made to retain child destruction, it should apply only during childbirth.⁷⁷ This is the model that operates in the

ACT. These people generally also favoured a specific assault offence against pregnant women. Others noted that if the original intention of the provision was to only apply during childbirth, it should be amended to reflect that.⁷⁸

- 7.64 A significant number of submitters expressed the view that any changes to the provision should specify that the offence of child destruction does not, or should not, relate to abortion.⁷⁹ Moreover, medical practitioners performing lawful abortion procedures should not be subject to criminal sanctions.⁸⁰

AMEND TO TIGHTEN

- 7.65 Those who favoured retaining the offence of child destruction generally also wanted an amendment to lower the current 28-week presumption.⁸¹ The alternative gestational limits proposed ranged from 20 weeks to 23 weeks in consultations, and from 6 to 24 weeks in submissions.⁸² The Australian Christian Lobby specifically noted that among ‘pro-life’ groups, late abortions are viewed as falling within the offence of child destruction. Of the pro-forma submissions, many argued that section 10 should remain and the 28-week presumption lowered to 20 weeks, effectively making late abortion a criminal offence. Others wanted the existing offence to remain in its current form.
- 7.66 Those who favoured 20–24 week presumptions were generally arguing on the basis of viability. For example, Rabbi Faitel Levin believed that viability gives greater ethical worth to the fetus, that is, a fetus is a potential human being from conception, but that this potential has more meaning as the fetus develops, particularly from the point of viability.
- 7.67 Dr Tonti-Filippini argued that the child destruction provision should be shifted back to a gestational limit of 23 weeks or 600 grams, and that the viability clause should be retained to arguably allow the provision to apply to cases below the gestational limit.

OPTIONS FOR REFORM

- 7.68 The problems caused by the overlap between the child destruction and abortion offences have not been recognised or debated by the legal profession in Victoria;⁸³ however, all the problems that have been discussed in the UK for many years are relevant here, because we have essentially the same offence in our criminal laws. While section 10 remains in its present form there is potential for it to be used to charge medical practitioners who perform late abortions, as well as pregnant women who have late abortions. This has been clearly demonstrated by the investigation of the doctors involved in the late abortion at the Royal Women’s Hospital in 2000, and by the recent prosecution of a woman in the UK.⁸⁴

73 Submissions 12 (Paul Johnson), 145 (Roger McWhinney), 180 (Jeremy Peet), 188 (David Forster), 252 (National Civic Council), 316 (Westgate Catholic Deanery Social Justice Group), 324 (Rodney Schneider), 332 (Pat Healy), 334 (Anthony Krohn), 362 (Rosaria Righiele), 407 (John Keble), 435 (Brian Gleeson), 452 (Catholic Justice Agency), 467 (Suryan and Therese Chandrasegaran).

74 Submissions 12 (Paul Johnson), 180 (Jeremy Peet), 188 (David Forster), 252 (National Civic Council), 288 (Anonymous).

75 Submissions 12 (Paul Johnson), 252 (National Civic Council).

76 Submission 12 (Paul Johnson).

77 Consultations 10 (Health Services Commissioner), 17 (Victorian Women’s Trust), 21 (Women’s Electoral Lobby), 31 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists) (some participants only).

78 Submissions 226 (Women’s Health Association of Victoria), 261 (Gippsland Women’s Health Service), 314 (South West Community Legal Centre).

79 Submissions 136 (Emily’s List), 183 (Barb Jennings), 226 (Women’s Health Association of Victoria), 261 (Gippsland Women’s Health Service), 269 (Stef Puszka), 279 (Elyse Brown), 281 (Rhiannon Platt), 314 (South West Community Legal Centre), 319 (Tanya Mammon), 450 (Victorian Young Labor), 453 (Young Labor Left Victoria), 483 (Margaret Pekin), 498 (Union of Australian Women), 499 (YWCA), 500 (Scott Bloodworth), 501 (Liberty Victoria), 508 (Catherine Mayes), 510 (Public Health Association of Australia, Women’s Health Special Interest Group).

80 Submissions 134 (Women’s Health West), 152 (Rebecca Albury), 226 (Women’s Health Association of Victoria), 261 (Gippsland Women’s Health Service), 314 (South West Community Legal Centre), 462 (Family Planning Victoria), 503 (Australian Medical Association Victoria), 507 (Royal Women’s Hospital).

81 Consultations 2 (Endeavour Forum), 5 (Australian Christian Lobby), 7 (Right To Life Australia); submissions 15 (Dr Nicholas Tonti-Filippini), 249 (Agnes Mary Hanna), 291 (Professor Loane Skene), 357 (Anonymous), 400 (Lisa Brick), 417 (Anonymous), 458 (Caroline Chisholm Society).

82 Consultations supporting 20 weeks: 2 (Endeavour Forum); 22 weeks: 5 (Australian Christian Lobby); 23 weeks: Dr Nicholas Tonti-Filippini. Submissions supporting 6 weeks: 194 (Katie Lindorff); 14 weeks: 259 (Michael Anstis); 20 weeks: 9 (Charles Francis), 121 (Barry and Helen Lauritz), 233 (Brendan Griffin), 255 (Waverly Catholic Deanery), 272 (Desmond Kelly), 357 (Anonymous), 372 (Mary McInerney), 396 (Mark Godfree), 417 (Anonymous), 458 (Caroline Chisholm Society), 252 (National Civic Council), 202 (James Jackson); 21 weeks: 249 (Agnes Mary Hanna); 24 weeks: 120 (Rebecca Carey), 299 (Caroline Chisholm Centre for Health Ethics), 290 (Professor Loane Skene).

83 This is not true within the medical profession, where the issue has been raised for some time. See, eg: Lachlan de Crespigny and Julian Savulescu, ‘Abortion: Time to Clarify Australia’s Confusing Laws’ (2004) 181(4) *Medical Journal of Australia* 201; Lachlan De Crespigny, ‘Australian Abortion Laws: Do They Pose a “Health Hazard”?’ (2005) 7 (1) *O & G* 52; Thomas Faunce, ‘The Carhart Case and Late-Term Abortions—What’s Next in Australia?’ (2007) 15 *Journal of Law and Medicine* 23.

84 Britten (27 May 2007) above n 25.

- 7.69 Three options for reform of the child destruction provision were considered by the commission and discussed with people in consultations.

OPTION 1: NSW MODEL

Repeal section 10 and clarify that destruction of a fetus through assault of a pregnant woman constitutes 'serious injury' to the woman.

- 7.70 In Victoria, section 10 has been viewed as only being applicable to the destruction of viable fetuses through assault on the pregnant mother. The Office of Public Prosecution advises that its records show this to be the only situation in which anyone has been charged with this offence.⁸⁵ One option for reform is to repeal the child destruction provision and replace it with an offence clearly designed for the purpose for which it is used.
- 7.71 There has never been an offence of child destruction in NSW. A 2003 review of the law of manslaughter in NSW suggested the creation of an offence of 'killing an unborn child' similar to the Victorian child destruction provision;⁸⁶ but while this report was being considered the case of *R v King* arose.⁸⁷ 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'.⁸⁸ The Director of Public Prosecutions 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.
- 7.72 The NSW government decided to codify this ruling rather than create a child destruction offence. This was achieved through an addition to the definition of 'grievous bodily harm' in the NSW Crimes Act. 'Grievous bodily harm' now includes destruction of the fetus of a pregnant woman, other than in the course of a medical procedure, whether or not the woman suffers any other harm.⁸⁹
- 7.73 The Attorney-General noted that the government would not make any legislative change that interfered with the law of abortion.⁹⁰ He also noted that altering the definition affected a range of offences that may be charged when a criminal act resulted in destruction of the fetus of a pregnant woman:
- The amendment will cover a range of situations from maliciously inflicting grievous bodily harm with intent under section 33 of the Crimes Act, which carries a maximum penalty of 25 years imprisonment, to causing grievous bodily harm by an unlawful or negligent act, which carries a maximum penalty of two years imprisonment under section 54 of the Crimes Act.*⁹¹
- 7.74 The NSW option for reform overcomes the inherent evidentiary difficulties and shifting ground problems of fetal viability in section 10. Further, it avoids the common law issue of whether there is 'a creature in being' to which harm can be done. It appropriately reflects the seriousness of the offence and, most importantly, differentiates between abortions and criminal acts by third parties resulting in fetal death.
- 7.75 This approach to reform of the law applicable to assaults upon pregnant women does not prevent the creation of different laws for late abortions—that is a quite separate policy decision to be made by government. However, the commission's strong view is that if any such laws are introduced they should deal with abortion alone for the sake of clarity.
- 7.76 Charges of manslaughter have been made in various circumstances of fetal death in NSW in recent years. These cases demonstrate further why a child destruction provision may no longer be necessary.
- 7.77 In 2006 a doctor was charged with manslaughter relating to a second trimester abortion.⁹² Dr Sood was also charged with unlawful abortion. At the trial there was conflicting evidence about whether the 22–24 week old fetus was born alive. The jury acquitted Dr Sood of manslaughter because it was not satisfied that the fetus was born alive. Nevertheless, Dr Sood was found guilty of unlawful abortion and was sentenced to a two year good behaviour bond.

Although she had performed the abortion at the request of the patient, she had made none of the enquiries required by the ruling in *Wald*.⁹³ She therefore could not be said to ‘honestly and genuinely hold’ the belief that the abortion was necessary. Dr Sood was also dealt with by the NSW Medical Tribunal for professional misconduct and was deregistered and ordered not to apply to re-register as a medical practitioner for 10 years.⁹⁴

- 7.78 It is clear that defendants may be charged and convicted of manslaughter in circumstances where there has been an unlawful act resulting in the death of a fetus after live birth. This is so even for a non-viable fetus that demonstrates ‘any sign of life after birth’.⁹⁵ It is likely that a Victorian court would find that a fetus had been born alive, even if it had lived for only a short time with the assistance of medical technology.⁹⁶
- 7.79 It is also likely that a Victorian court would take a similar approach to that in *King*, and find that the fetus was part of the mother, allowing a serious injury charge to be laid. Rather than await clarification by a court, the commission believes the clearest and safest way forward is to amend the statutory definition of ‘serious injury’ in the Crimes Act.
- 7.80 It may seem anomalous that this option would see the same criminal conduct resulting in different charges, depending on whether the fetus was born alive or stillborn. If a fetus were stillborn following a criminal assault upon a pregnant woman, a charge of intentionally or recklessly causing serious injury to the woman would apply. If a child were born alive, manslaughter could be charged.
- 7.81 There are two responses. First, the criminal law governing offences against the person has always been concerned with the effect of the conduct as well as the state of mind of the perpetrator. An assailant who shoots and kills will be charged with murder, whereas one who shoots and misses but has precisely the same intent, will be charged with attempted murder.
- 7.82 Secondly, any differences or similarities in the seriousness of the criminal conduct can be taken into account at sentencing. The maximum penalty for manslaughter and intentionally causing serious injury is the same—20 years imprisonment.⁹⁷

OPTION 2: ACT MODEL

Retain section 10 but confine it to childbirth.

- 7.83 The ACT child destruction offence prohibits behaviour ‘occurring in relation to a childbirth and before the child is born alive’ that ‘prevents the child from being born alive’ or ‘contributes to the child’s death’.⁹⁸ There is no case law to explain the meaning of this provision.⁹⁹ It has been suggested that the words ‘in relation to a childbirth’ would prevent this section applying to an abortion ‘unless it was performed at the very end of pregnancy, when delivery has already commenced or is very imminent’.¹⁰⁰ This was the conduct originally targeted by the English Infant Life (Preservation) Act.
- 7.84 Our medical panel expressed concern that this model leaves a doctor’s liability unclear when a decision must be made during childbirth about whether to save the mother or the child. Although this is not a common occurrence, the panel advised that there are still cases where complications during birth make it necessary to perform action that risks killing the child to save the mother.¹⁰¹
- 7.85 The medical panel raised the concern that the term ‘childbirth’ could be open to broad interpretation.¹⁰² A provision such as this could leave the medical profession open to criminal liability for late abortions performed because of fetal abnormality. The ACT model would allow only completely destructive abortion procedures, which would not result in ‘childbirth’. This would cause undue interference with current medical practice. It would also cause additional distress to parents who wish to deliver an intact fetus to assist with the grieving process when an abortion is undertaken because of severe abnormality.¹⁰³ Some may also wish the fetus to be delivered alive. In common with the current Victorian child destruction provision, the ACT law is problematic because it places in jeopardy medical practitioners who bring about a live birth of a fetus with severe abnormality at the request of the parent(s).

- 85 Information supplied by Karen Argiropoulos, Senior Solicitor, Office of Public Prosecutions, 7 September 2007 and 15 January 2008.
- 86 Criminal Law Review Division, NSW Attorney General’s Department, *Review of the Law of Manslaughter in New South Wales* (2003).
- 87 *R v King* 2003 NSWCCA 399; *R v King* [2004] NSWCCA 444.
- 88 *R v King* 2003 NSWCCA 399 [3].
- 89 *Crimes Act 1900* (NSW) s 4(1).
- 90 New South Wales, *Parliamentary Debates*, Legislative Assembly, 7 December 2004, 13390 (Mr Bob Debus, Attorney-General).
- 91 *Ibid.*
- 92 *R v Sood* [2006] NSWSC 1141 (Unreported, Simpson J, 31 October 2006). See Chapter 2 for facts of case.
- 93 *R v Wald* (1971) 3 NSWDCR 25, adopting the ruling of Menhennitt in *R v Davidson* [1969] VR 667.
- 94 *Re Suman Sood* (2006) No 774 of 2005 NSW Medical Tribunal decision <www.nswmb.org.au/system/files/f10/f20/o585/SOOD.pdf> at 12 February 2008.
- 95 *R v Iby* (2005) 63 NSWLR 178 [64].
- 96 *R v Iby* (2005) 63 NSWLR 178 [46]–[65].
- 97 *Crimes Act 1958* s 5 (punishment for manslaughter), s 16 (intentionally cause serious injury).
- 98 *Crimes Act 1900* (ACT) s 40.
- 99 A search of ACT Reports on Lexis Nexis on 27 November 2007 revealed no cases on child destruction.
- 100 Parliamentary Library, Parliament of Australia, *Abortion Law in Australia*, Research Paper 1 1998–99 (1998) 32.
- 101 Medical Panel meeting, 13 November 2007.
- 102 *Ibid.*
- 103 Consultations 19 (Royal Women’s Hospital), 24 (Fetal Management Unit—Royal Women’s Hospital).

- 7.86 The potential for a charge of manslaughter is also raised when a fetus is born alive. These issues were considered in the NSW review of manslaughter laws.¹⁰⁴ The terms of reference for the review included an ‘examination of whether the Crimes Act provisions concerning manslaughter should be amended in such a way as to allow a charge of manslaughter to be brought in circumstances where an unborn child dies’. The review was also to consider whether NSW should legislate to introduce the offence of child destruction.¹⁰⁵
- 7.87 During the review, the AMA expressed concern that the proposed offence would render medical practitioners and/or patients liable to be charged in circumstances where late abortions currently occur. This includes fetal reduction in a multiple pregnancy and abortion for fetal abnormality.¹⁰⁶ Mervyn Finlay QC, who conducted the review, did not think that manslaughter would apply in either case, though may have assumed that such abortions would not result in the delivery of a live fetus. He recommended against extending manslaughter to circumstances in which a fetus dies in utero.¹⁰⁷
- 7.88 After consideration, the offence of child destruction was not introduced in NSW, with the assault provision introduced instead. A clear intention to prevent overlap with abortion laws was expressed within the review and by the NSW government when introducing the assault offence.
- 7.89 Other jurisdictions have retained child destruction and introduced an assault offence. For example, in Queensland section 313(1) of the Criminal Code has an ACT style child destruction provision that is confined to circumstances where the woman is ‘about to be delivered of a child’. Section 313(2) then creates a specific offence of assault of a pregnant woman. The offence is committed if the assault destroys the life of, does grievous bodily harm to, or transmits a serious disease to the child before its birth.¹⁰⁸ Both offences carry a maximum penalty of life imprisonment.

OPTION 3: ENGLISH MODEL

Retain section 10 but quarantine its operation from lawful abortions.

- 7.90 Until 1990 England experienced the same problem of overlap between child destruction and abortion laws as currently exists in Victoria. When first enacted in England the Abortion Act contained no time limits for lawful abortions. The legality of an abortion had to be assessed in the light of the child destruction provisions of the Infant Life (Preservation) Act. Between 1967 and 1990 there was considerable debate about the difficulties generated by late abortions being governed by both the Abortion Act and the Infant Life (Preservation) Act. In 1990 the Abortion Act was amended to provide that ‘[n]o offence under the Infant Life (Preservation) Act shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act’.¹⁰⁹ Consequently, the offence of child destruction is of no effect when a medical practitioner performs an abortion in compliance with the Abortion Act.¹¹⁰
- 7.91 The English provision is not a considered response to the overlap between abortion and child destruction laws. It was an amendment to the Abortion Act, enacted in haste, during debate about a broader range of issues.¹¹¹ It has been criticised for not providing clear protection for health professionals other than medical practitioners involved in an abortion, such as nurses.¹¹² It does not assist with clarity and simplicity of laws and leaves on the statute book an offence that appears to have never been used for its original purpose of fetal destruction during childbirth, and only once for a late abortion.¹¹³

COMMISSION’S RECOMMENDATION

- 7.92 The commission believes the current child destruction provision should be repealed.
- 7.93 Section 10 of the Crimes Act regulates two quite distinct activities—late abortion and assaults upon pregnant women which result in harm to a fetus. It regulates neither of them with clarity. Section 10 has never been used in Victoria for its original purpose, which was to overcome a perceived gap in the law and prohibit any person from ‘unlawfully’ destroying a fetus during childbirth.

- 7.94 There is no evidence to suggest that there is, or ever has been, a practice of destroying fetuses during childbirth. It is not possible to predict how section 10 may operate in practice because of the difficulty in giving meaning to the term ‘unlawfully’.
- 7.95 If the parliament wishes to regulate late abortion, it should do so under laws specifically designed to deal with abortion. If the parliament wishes to clarify the law concerning assaults upon pregnant women, the Crimes Act should be amended to make it clear that destruction of a fetus caused by assault of a pregnant woman falls within the definition of ‘serious injury’ to the woman. The current assault provisions in the Act probably cover this behaviour but legislative amendment will remove any doubt.
- 7.96 Unlawful injury to a pregnant woman may also result in a fetus being born alive and surviving but with significant injury. If the injury to the child is directly attributable to the injury to the mother, the principles set out in *Iby* would apply. Once the child is born, which may be some time after the injury occurred, the accused person could be charged with causing injury to the child as long as causation is clear.¹¹⁴ The nature of the charges will depend on the nature and extent of the injuries, and whether there was any specific intent on the part of the accused to injure the fetus.
- 7.97 Incorporating the change into the definition of ‘serious injury’, rather than creating a separate offence, will provide clarification of the law applicable in the circumstances that may result in unlawful destruction of a fetus as a result of injury to the mother. The definition of serious injury applies to various offences, including intentionally causing serious injury, recklessly causing serious injury and some driving offences.
- 7.98 The recommended amendment overcomes the difficulty inherent in the current provision in its application to assaults upon pregnant women—the requirement that a child be capable of being born alive for its destruction to be acknowledged. It also allows recognition of the harm caused when the fetus is destroyed as a result of reckless rather than intentional behaviour. The current child destruction provision requires proof of intention to destroy the fetus.

RECOMMENDATIONS

1. Section 10 of the *Crimes Act 1958* should be repealed.
2. Section 5 of the *Crimes Act 1958* 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.

104 Criminal Law Review Division, NSW Attorney General’s Department (2003) above n 86.

105 *Ibid* 8–9. See also discussion of the review and consideration of fetal viability in the law in: Savell (2006) above n 6, 646–650.

106 Criminal Law Review Division, NSW Attorney General’s Department (2003) above n 86, 101. ‘Fetal reduction’ refers to abortion of one fetus in a multiple pregnancy.

107 *Ibid* 100.

108 See Stephen Gabriel, ‘Child Destruction: A Prosecution Anomaly Under Both the Common Law and the Criminal Codes’ (1997) 21 *Criminal Law Journal* 32 for background on introduction of this offence in Queensland.

109 *Abortion Act 1967* (UK) s 5, inserted 1 April 1991 by *Human Fertilisation and Embryology Act 1990* s 37(4).

110 Kennedy and Grubb (2000) above n 49, 1429.

111 *Ibid* 1419.

112 *Ibid* 1429.

113 Maisha Mohamed, 22, is believed to be the first expectant mother to be convicted under the 78-year-old law. She never admitted what she did and no body has ever been found. From newspaper reports it appears that she has largely been punished for her lack of remorse and lack of assistance to police in identifying the illegal abortionist. She was sentenced to 12 months in prison, which the judge suspended for 12 months. If there had been no child destruction provision she could have been charged with procuring an illegal abortion: Britten (27 May 2007) above n 25.

114 A similar situation exists in civil law, where a fetus injured by the negligent act of another has a cause of action upon birth: *Watt v Rama* [1972] VLR 353.

Chapter 8
**Other Legal and Policy
Issues**

CONTENTS

- 112 Issues Where Legal Change is Justified
- 116 Issues Adequately Dealt with by Existing Law and Practice
- 137 Substantive Issues Beyond the Scope of this Reference

- 8.1 Many issues associated with reform of the abortion laws were raised through consultations, submissions, and the commission’s research. Some were outside our terms of reference, and are discussed below for completeness and for further consideration by government. For those within the terms of reference the commission makes recommendations about how they can be best addressed, regardless of the model chosen for abortion laws.

ISSUES WHERE LEGAL CHANGE IS JUSTIFIED

CONSCIENCE CLAUSE

- 8.2 Conscience clauses arise as an issue in abortion law reform because there is a general expectation that practitioners will provide medical services.¹ Abortion laws in some other places excuse people from providing these services when they have strong religious or ethical objections to the practice.
- 8.3 ‘Conscience’ is generally taken to mean a conviction or belief based upon a moral assessment, rather than a mere prejudice.² A conscience clause is a provision within the law ‘which relieves persons whose conscientious or religious scruples forbid their compliance with it’.³
- 8.4 Abortion conscience clauses are sometimes called refusal clauses.⁴ Such clauses are included in legislation to make it clear that no medical practitioner is under a duty to perform an abortion if doing so would go against his or her conscience. While conscience clauses exist in many jurisdictions, their scope varies.

Australian Examples

- 8.5 Conscience clauses feature in abortion laws in the ACT, Northern Territory, South Australia, Tasmania, and Western Australia. In all instances, the provision applies only in non-emergency situations.
- 8.6 In the ACT, Northern Territory, and Tasmania, the conscience clause attaches to individuals and includes those assisting with the procedure, such as nurses and anaesthetists.⁵ In South Australia, the person relying on the clause carries the **onus of proof** as to its application.⁶ In contrast, the Western Australian provision also attaches to health institutions.⁷
- 8.7 In NSW, conscientious objection to abortion is included in the NSW Health Policy Directive *Framework for Terminations in New South Wales Public Health Organisations*, which applies to all public health settings. It includes an obligation to transfer the care of the patient to another medical specialist (or health professional) onsite or at another Area Health Service facility.⁸

International Examples

- 8.8 Section 4 of the *Abortion Act 1967* (UK) is broadly similar to the South Australian provision. It provides that a health worker who declines to participate in the provision of abortion services because of a conscientious objection bears the burden of proving that objection in any subsequent legal proceedings.⁹ Once again, it does not apply in emergencies, for example to save the life of the pregnant woman. Nor does it apply to treating the results of an abortion, for example after care.¹⁰
- 8.9 National Health Service regulations¹¹ require medical practitioners to make an effective referral in circumstances where they have a conscientious objection to certifying approval for lawful abortion.¹²
- 8.10 The House of Lords has considered section 4. In that case, a receptionist working in a health centre refused to type a letter referring a patient for an assessment of whether the pregnancy should be terminated. The receptionist claimed that section 4 applied as she had a strong moral objection to abortion on religious grounds, and that the typing of the letter fell within the definitional scope of participation. The court found against the receptionist, holding that the term ‘participate’ should be given its ordinary meaning, which is, actually taking part in the treatment.¹³ Thus, the **proximity** test for the UK conscience provision is reasonably narrow, covering only those involved in the treatment team.¹⁴

- 8.11 In New Zealand a doctor, nurse, or other person who has a conscientious objection to abortion is not required to assist in the performance of an abortion.¹⁵ The doctor has an obligation to refer the woman on for assessment if requested.¹⁶
- 8.12 The New Zealand legislation also contains a non-discrimination provision for those who refuse to undertake abortions on the grounds of conscience.¹⁷ If people suffer loss due to such unlawful discrimination, they are entitled to receive damages.¹⁸
- 8.13 Abortion laws in the US vary from state to state. The Californian conscience provision applies to any person with staff privileges at a hospital or medical facility. They must have first filed a written statement with the employer indicating their refusal to participate on moral, ethical, or religious grounds.¹⁹ The protection extends to non-profit hospitals and facilities operated by religious organisations and corporations, as long as they have posted notice of their refusal to provide abortions in an area open to prospective patients.²⁰ The conscience clause does not apply in emergencies.²¹
- 8.14 A non-penalty clause protecting individuals, including medical students, is included in the Californian scheme.²² An employer may not refuse employment to a person based on their refusal to participate in abortions, unless that person would normally be assigned to that part of the medical facility where abortion patients are cared for. It is therefore lawful to enquire whether a potential employee would refuse to participate in abortions on conscience grounds.²³

Current Law and Practice in Victoria

- 8.15 In Victoria there is no statutory conscience provision for abortion; however, a conscience provision does attach to the performance of **assisted reproductive technology** in Victoria.
- 8.16 Section 152 of the *Infertility Treatment Act 1995* states:
- (1) Despite any Act, law or agreement to the contrary, a person who has a conscientious objection to research involving the use of gametes or embryos or to a treatment procedure does not have to participate in that research or procedure unless it is necessary to do so because it is likely that a person who is or was a participant in the research or procedure will otherwise die.*²⁴
- 8.17 Professional codes of ethics apply to abortion, in common with all other medical procedures. The Australian Medical Association's *Code of Ethics*
- articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society. This code has grown out of other similar ethical codes stretching back into history including the Hippocratic Oath.*²⁵
- 8.18 The code contains a conscience provision:
- [W]hen a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere ...*
- Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.*
- Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.*²⁶
- 8.19 The assumptions underpinning these provisions are that the conscience provision applies to individual practitioners and that it includes a corresponding obligation to ensure an alternative provider is available. The AMA conscience provision is not absolute. In cases of emergency, practitioners must set aside their objections and perform the procedure.

Community Views

- 8.20 The commission sought community views on this issue by including a question in the Information Paper.

- 1 The AMA Code of Ethics states a practitioner 'may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency'. Australian Medical Association, *Code of Ethics* (2004) <www.ama.com.au/web.nsf/tag/amacodeofethics> at 18 February 2008.
- 2 Ian Kennedy and Andrew Grubb, *Medical Law* (3rd ed, 2000) 1443.
- 3 A Delbridge, et al (eds) *The Macquarie Dictionary* (3rd ed, 1997) 465.
- 4 Opponents of such clauses often refer to them as such.
- 5 *Health Act 1993* (ACT) s 84; *Medical Services Act* (NT) s 11(6)–(7); *Criminal Code Act 1924* (Tas) s 164(7)–(8).
- 6 *Criminal Law Consolidation Act 1935* (SA) s 82A(5)–(6).
- 7 *Health Act 1911* (WA) s 334(2).
- 8 Department of Health [NSW], *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations*, Policy Directive PD2005_587 (25 May 2005) 5.
- 9 In Scotland, that burden is discharged through a statement on oath: *Abortion Act 1967* (UK) s 4(3).
- 10 JK Mason and GT Laurie, *Mason and McCall Smith's Law and Medical Ethics* (7th ed, 2006) 161.
- 11 *National Health Service (General Medical Services) Regulations 1992* (SI 1992 No 635) sch 2, [12].
- 12 Kennedy and Grubb (2000) above n 2, 1446–1447.
- 13 *Janaway v Salford AHA* [1989] AC 537, [1988] 3 All ER 1079 (HL).
- 14 Mason and Laurie (7th ed, 2006) above n 10, 162.
- 15 *Contraception, Sterilization and Abortion Act 1977* (NZ) s 46(1)(a).
- 16 Istar Ltd, *Legal Information* (20 May 2006) Abortion Services in New Zealand <www.abortion.gen.nz/legal/index.html> at 7 January 2007.
- 17 *Contraception, Sterilization and Abortion Act 1977* (NZ) s 46(2).
- 18 *Contraception, Sterilization and Abortion Act 1977* (NZ) s 46(3).
- 19 *California Health and Safety Code*, ch 2 § 123420(a).
- 20 *California Health and Safety Code*, ch 2 § 123420(c).
- 21 *California Health and Safety Code*, ch 2 § 123420(d).
- 22 *California Health and Safety Code*, ch 2 § 123420(b).
- 23 *California Health and Safety Code*, ch 2 § 123420(a).
- 24 See NHMRC, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2007) 23, which contains a no disadvantage provision for staff and students.
- 25 AMA (2004) above n 1.
- 26 Ibid.

- 8.21 Some people did not think a clause was necessary because no medical practitioner is forced to perform a procedure in practice. However, mindful of access issues, most did not object to a provision being included in legislation as long as it included a duty to refer the patient to another provider.²⁷ Some felt that practitioners should have a sign in their waiting room explaining that they did not undertake the procedure.²⁸
- 8.22 Several, including the Health Services Commissioner, remained opposed on the basis that it duplicated existing ethical standards.²⁹ The Australian Medical Association did not support the inclusion of a conscience clause.³⁰
- 8.23 Among others, there was strong support for a conscience clause based on respect for freedom of religion and thought.³¹ There was some divergence about content. A small minority argued that a practitioner should not be under a duty to perform an abortion in any circumstances.³² Others allowed for emergencies, for example if the woman's life is at risk.³³
- 8.24 Some took the view that a practitioner should not be required to make a referral, as that would also go against the conscience of the practitioner.³⁴
- 8.25 Some argued that the provision should extend to all health professionals and that specific non-discrimination provisions should be included to protect the career prospects of practitioners who invoke the conscience clause.³⁵
- 8.26 Some also argued that the conscience provision should extend to chemists (contraception and morning-after pill), educational institutions, and teaching hospitals.³⁶

Policy Issues

- 8.27 It is important to balance the rights of individuals to operate within their own moral and religious beliefs with the equally important ethical consideration doctors have to act in the best interest of patients. It is also important to minimise unintended consequences, for example exacerbating inequities in access, or increasing the risk of delay.
- 8.28 Evidence gathered in consultations suggests that significant geographic inequities exist in access to abortion by women living in rural and regional Victoria.³⁷ The problem may be exacerbated by a practitioner's refusal if he or she is the only practitioner in an area, or if all or most practitioners in an area refuse to provide services. This inequity is further entrenched if major regional public facilities do not provide abortion, or if the practitioner refuses to make a referral.³⁸
- 8.29 While conscience provisions are relatively common in abortion laws, there is significant variance as to their scope. In framing a provision, it is important not to trivialise the important ethical consideration of the best interests of the patient.
- 8.30 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.³⁹
- 8.31 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.⁴⁰
- 8.32 As freedom of conscience is generally understood to be held by individuals, the conscience provision should not extend to corporations.⁴¹ This is consistent with existing conscience provisions in other Victorian laws.⁴²
- 8.33 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.⁴³
- 8.34 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.⁴⁴

- 8.35 Changing anti-discrimination laws to protect the rights of people who choose to rely upon a conscience clause seems unnecessary. While existing anti-discrimination laws protect people from discrimination on religious grounds, a person's objection to abortion may not necessarily be religious.⁴⁵ If the law of abortion established moral values or conscience as a ground of discrimination, it would significantly extend the scope of current equal opportunity law into areas of great uncertainty.⁴⁶ Changing equal opportunity law in this way is well beyond the terms of reference of this inquiry.
- 8.36 During the commission's consultations, no firm evidence was provided which established that health workers are discriminated against because they choose to avoid the provision of abortion services. It is unlikely that a person with a moral objection to abortion would want to work in a private clinic providing that procedure. Within public hospitals, the moral decisions of staff members are respected and no person is forced to perform an abortion.
- 8.37 Similarly, there is no evidence that career paths are affected by refusing to participate in abortion procedures.⁴⁷ Several hospitals, including some regional public hospitals, do not perform abortions at all and do not suffer a penalty as a result.
- 8.38 Our terms of reference require us to ensure the maintenance of current clinical practice standards. If legislative provision is made for people who have a conscientious objection to providing abortion services, the content of any new law is best guided by the principles contained in the AMA *Code of Ethics*. That code requires medical practitioners to inform patients of their refusal. The code also requires practitioners to provide women with sufficient information so they may seek and find treatment elsewhere. This simple rule provides an appropriate balance between the needs of the practitioner and the patient.

RECOMMENDATIONS

3. The *Health Act 1958* should be amended to include a provision as follows:

- **Save for medical emergency, no person is under a duty to carry out or assist in carrying out an abortion.**
- **A requirement that the person inform the patient of his or her conscientious objection and make an effective referral to another provider.**
- **The provision should be clearly drafted to only apply to individuals who are part of the clinical therapeutic team. It should not apply to administrators, corporate services staff or to organisations.**

- 27 Eg submission 261 (Gippsland Women's Health Service). AMA Victoria noted that this is the current standard in the AMA Code of Ethics: consultation 30 (Australian Medical Association Victoria).
- 28 Eg, submission 282 (Women's Health in the North).
- 29 Consultation 10 (Health Services Commissioner). See also consultation 12 (Reproductive Choice Australia); submission 461 (Association for the Legal Right to Abortion).
- 30 Submission 503 (Australian Medical Association Victoria).
- 31 This is consistent with survey data from the Australian Federation of Right to Life Associations, which found that 62.7% of Victorians 'support conscientious objection to allow doctors and nurses to opt out of having to perform abortions against their will': Market Facts (Qld), *What Australians Really Think About Abortion: A Report on Comprehensive Independent Market Research* (2006) 20. The strengths and limitations of this survey are discussed in Chapter 4.
- 32 Eg, submission 252 (National Civic Council).
- 33 Submission 255 (Waverly Catholic Deanery).
- 34 Consultations 18 (Dr Nicholas Tonti-Filippini); 32 (Associate Professor Lyn Gillam).
- 35 Submission 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne).
- 36 Submission 444 (Ambrose Centre for Religious Liberty).
- 37 See Chapter 3 for further discussion.
- 38 The interplay of the conscientious objection provision and access in rural and remote areas arose in the review of the Western Australian legislation. Particular concerns about the availability of nursing staff were identified: *Acts Amendment (Abortion) Act 1998 Review Steering Committee [Western Australia], Report to the Minister for Health on the Review of Provisions of The Health Act 1911 and The Criminal Code Relating to Abortion* (2002) 28–29.
- 39 Case studies provided by women in regional Victoria: submission 94 (Women's Health Goulburn North East).
- 40 The therapeutic team would include all clinical and nursing staff. It would not include administrators or those charged with corporate services.
- 41 Including non-profit or religious bodies.
- 42 *Fertility Treatment Act 1995* s 152.
- 43 See, eg, *RJR-MacDonald Inc v Canada (Attorney General)* [1995] 3 SCR 199. Free speech extends to commercial speech—tobacco advertising laws contravened freedom of expression. There is no reason to extend the provision to organisations because the new law of abortion will not establish a positive duty to perform abortions.

44 National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) 19. Note: in 1996 the NHMRC released an information paper which included recommendations from an expert panel commissioned by its Women's Health Committee. Due to a range of opinions within the NHMRC, it did not endorse the recommendations of the panel, instead releasing the panel's findings and recommendations as an information paper

45 *Equal Opportunity Act 1995* s 6(j).

46 If a non-discrimination provision was included, it would need to have full coverage, ie, it would also need to protect practitioners who perform abortions but who may also seek to provide non-abortion services in institutions with a policy of not providing abortions on religious or ethical grounds.

47 It is unlikely that a person with a moral objection to abortion would apply for a position in a private abortion clinic; however, if an anti-discrimination provision was included an exception would need to be drawn for abortion clinics and some parts of public hospitals, along the lines of that contained in the Californian code.

ISSUES ADEQUATELY DEALT WITH BY EXISTING LAW AND PRACTICE

MANDATORY INFORMATION

- 8.39 The general standard of disclosure by a medical practitioner embodies the principle that doctors must provide information that a patient would consider relevant before deciding whether to have a particular medical procedure. This includes the nature, risks, and benefits of any medical procedure and availability of alternatives.⁴⁸
- 8.40 A significant number of anti-decriminalisation pro-forma submissions to the commission argued that the law should require a person to be given additional mandatory information in cases of abortion. They proposed that visual images of the fetus, gestational age information, and a list of medical risks be provided to women before they can lawfully terminate a pregnancy.⁴⁹ Some also included pictures of abortions in the list of items women must be shown.⁵⁰
- 8.41 Medical practitioners and professional associations tended to think the existing law of disclosure, which requires practitioners to advise of risks, was adequate. Many people did not consider the provision of additional mandatory information to be necessary.⁵¹

Overseas Experience

- 8.42 Mandatory information schemes do not feature in abortion laws in the UK or New Zealand, although they are a common feature of abortion laws in the US. They are often associated with compulsory counselling and cooling-off periods.
- 8.43 In the US, 33 states have a specific law or policy on informed consent for abortion. Ten of these re-state existing standards on informed consent. The other 23 have mandated additional information, which is typically developed by the state's health agency.
- 8.44 Information ranges from ultrasounds of the fetus⁵² and footage of an abortion, to written medical risk information. Some of this risk information is heavily contested, for example, six states include information about the alleged link between abortion and breast cancer.⁵³ Some states, such as Texas, also require information to be given that states there is a link between future infertility and abortion.
- 8.45 While medical practitioners are allowed to distance themselves from the materials in four of these states, they are still required to give them to patients.⁵⁴
- 8.46 In all 23 states the woman is required to be given information about the particular abortion procedure she has requested. This is in line with the general standard of consent. In 18 states, information about abortion techniques that the woman will not be having is also given. For example, information about techniques used at later gestations is mandated, even though the majority of women have terminations in the first trimester.
- 8.47 Similarly, in 22 states, written information is given about the development of the fetus at two weekly intervals throughout the entire pregnancy. 'With nearly 90% of all abortions occurring at or before 12 weeks, information on the development of a fetus after that point is generally not germane to most patients.'⁵⁵

Australian Examples

- 8.48 No Australian legislation mandates additional information specific to abortion.⁵⁶
- 8.49 Two states specify that informed consent is required before abortion and then define the attributes of that consent. For example, the Western Australian legislation requires a medical practitioner to adequately advise on risks of abortion and proceeding with the pregnancy.⁵⁷ In Tasmania, a medical practitioner must provide the woman with 'counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term'.⁵⁸

Current Law and Practice in Victoria

- 8.50 Doctors in Victoria, like the remainder of the Australian medical community, have a duty to disclose material risk under the common law.⁵⁹

- 8.51 The *Wrongs Act 1958* applies to all medical procedures, including abortion. It provides that a person satisfies the **duty of care** only if he or she takes reasonable care in giving a warning or information about risk.⁶⁰
- 8.52 Medical risks and procedure information about abortion is available on the Victorian Government website the Better Health Channel.⁶¹ This website also provides information about abortion counselling.

Policy Issues

- 8.53 Current law requires practitioners to inform women of the nature, risks, and benefits of medical procedures, including abortion. 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.
- 8.54 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.
- 8.55 During consultations, some decriminalisation opponents argued that the medical profession is currently failing to advise women of the full risks of abortion. In particular, they alleged a strong link between abortion and breast cancer, infertility, depression, and suicide.⁶² Some argued that there was a 'post abortion syndrome',⁶³ however, the current medical and scientific consensus is that these are not material risks.⁶⁴
- 8.56 Every patient is different; legally required information risks both under- and over-inclusiveness. The commission believes that appropriately qualified medical practitioners, rather than legislators, can best determine the relevant information to be given to a patient after bearing in mind the questions asked and concerns raised by each individual.⁶⁵
- 8.57 While there is a reasonable community expectation that women seeking abortion are provided with accurate and balanced information, it is doubtful that many people would support women having to view what most would consider distressing images.⁶⁶
- 8.58 There is a risk that information may aim to encourage women to reach a particular decision. Experience of mandated information in the US is that the policy purpose is to dissuade women from proceeding with abortion.⁶⁷ This does not fit the policy aim of allowing people to make informed decisions based on accurate information.
- 8.59 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.

- 48 See *Rogers v Whittaker* (1992) 175 CLR 479.
- 49 Consultation 5 (Australian Christian Lobby).
- 50 Submission 72 (Mr and Mrs Calilhanna).
- 51 Eg, consultation 30 (Australian Medical Association Victoria); submission 147 (Dr Leslie Cannold).
- 52 Rachel Benson Gold and Elizabeth Nash, 'State Abortion Counseling Policies and the Fundamental Principles of Informed Consent' (2007) 10 (4) *Guttmacher Policy Review* 6. Thirteen states have a requirement associated with ultrasound: *ibid* 10.
- 53 *Ibid* 11.
- 54 *Ibid* 8.
- 55 *Ibid* 10.
- 56 Information was required in the ACT from 1998 to 2002; however, it did not effect the lawfulness of a termination under the Crimes Act. The requirement was abolished in 2002. *Health Regulations (Maternal Health Information) Act 1998* (ACT) as repealed by *Health Regulations (Maternal Health Information) Repeal Act 2002* (ACT).
- 57 *Health Act 1911* (WA) s 334(5)(a). The Western Australian Department of Health has also issued guidance to practitioners: *Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term/Guidelines for Counselling*, and has produced a standard leaflet to give to women.
- 58 *Criminal Code Act 1924* (Tas) s 164(9)(a).
- 59 *Rogers v Whittaker* (1992) 175 CLR 479. See also *Health Services Act 1988* s 9(e). One of the objects of this statute is to ensure users of health services are provided with sufficient information to make informed decisions about their health care.
- 60 *Wrongs Act 1958* s 50.
- 61 *Abortion Procedures* (May 2006) Better Health Channel <www.betterhealth.vic.gov.au> at 17 January 2008.
- 62 Some people claimed that women who have had an abortion 'are six times more likely to die than women who have not had an abortion (due to suicide, accidents, homicide, drugs, breast cancer, drink driving) ... this is because there is a change in a woman's psyche after having an abortion. Because you have killed your own child, you do not care as much about preserving your own life': consultation 2 (Endeavour Forum). Studies that claim abortion in young women may be associated with increased risks of mental health problems include David M Fergusson, L John Horwood, Elizabeth M Ridder, 'Abortion in Young Women and Subsequent Mental Health' (2006) 47(1) *Journal of Child Psychology & Psychiatry* 16.
- 63 See, eg, Anne Lastman, *Redeeming Grief: Abortion and Its Pain* (2007).

64 The medical risks of abortion were discussed in Chapter 3. Psychological effects are discussed in this chapter.

65 As part of assessing the clinical appropriateness of a procedure for each individual patient.

66 There is some support for visual images. See Southern Cross Bioethics Institute Survey 2004—53% support 'showing the stage of development of the fetus with models/diagrams' discussed in John Fleming and Nicholas Tonti-Filippini (eds) *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (2007) 105. The strengths and limitations of this survey are discussed in Chapter 4.

67 Eg, *Woman's Right to Know Act 2003* (Texas). See *Health and Safety Code 2003* (Texas) ch 171.

RECOMMENDATION

4. Any new abortion law should not contain mandated information provisions.

COUNSELLING

- 8.60 Counselling was an important issue in consultations. There was strong consensus that women should be supported in decision making. However, there was a divergence about what counselling means. There was also a range of views about whether the law should compel women to attend counselling before having an abortion.

What is Counselling?

- 8.61 Professional counselling utilises ‘a set of advanced interpersonal skills which emphasise processes of facilitation’. It enables people to develop self-understanding and to make changes or decisions. It may involve working with current problems, immediate crises, or long-term difficulties.⁶⁸
- 8.62 Counselling in a clinical setting is not giving advice. ‘A counsellor does not suggest, advise or persuade.’⁶⁹ In this regard, counselling is fundamentally different to a doctor’s duty of disclosure about the risks and benefits of a procedure. That is better defined as information provision rather than counselling. Some commentators refer to this as ‘pre-procedure counselling’.⁷⁰
- 8.63 Counselling is an integral feature of abortion services and may include emotional support in decision making. This is sometimes referred to as ‘options counselling’ or ‘decision-making counselling’.
- 8.64 A woman may also require emotional support at times of particular stress. This is sometimes called ‘support counselling’.⁷¹ This counselling can take place at any time before and/or after the abortion. It is not about decision making but instead assists the woman to work through issues as they arise. For example, the woman may need support in her relationship with her partner or family.
- 8.65 A woman may need ongoing support, which may include therapeutic counselling after the procedure (post-abortion counselling). Therapeutic counselling ‘aims to help people with the consequence of their decision and to help them resolve problems which may arise as a result’.⁷² This counselling may be short or long term.

Decision-making Counselling

- 8.66 Decision-making counselling ‘focuses on the meaning of information to the woman respecting her individual ethical values and beliefs as well as the likely consequences of her decision-making’.⁷³ It necessarily involves the consideration of alternatives: continuing the pregnancy, relinquishing for adoption, and abortion.
- 8.67 Even though there may be significant overlap between pre-procedure information and decision-making counselling, their aims are quite distinct. 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.
- 8.68 Decision-making counselling is ‘client centred and non-directive’.⁷⁴ It 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. This is consistent with the ethical principles underpinning professional practice.

Regulation of Counsellors

- 8.69 In Australia, counselling is largely unregulated in that any person, or organisation, may describe himself or herself as a counsellor; however, there are professional associations that set minimum standards for education, clinical supervision, and continuing professional development.⁷⁵ In addition, professions that undertake counselling activities, such as social work, also have their own professional bodies and standards.⁷⁶ Organisations such as the Royal Women’s Hospital also have clinical guidelines that contain specific benchmarks.⁷⁷

- 8.70 The Psychotherapy and Counselling Federation has published professional standards that include ethical guidelines.⁷⁸ These guidelines include principles of respect for human dignity; recognition of diversity; privacy; confidentiality; informed consent; professional competence and lawful conduct. They include ethical responsibilities to avoid harm, to promote autonomy, and consider the social context of their clients and connections to others.⁷⁹
- 8.71 The Australian Association of Social Workers' *Code of Ethics* also emphasises self-determination and autonomy of clients.⁸⁰ Therefore, 'within any counselling setting, an unbiased, non-judgemental, respectful and evidence based approach by the counsellor is ethically and professionally mandated'.⁸¹

Current Law and Practice in Victoria

- 8.72 The UK's Royal College of Obstetricians and Gynaecologists has prepared clinical guidelines for people who provide abortion services. These guidelines include the need for some people to have support in decision making.⁸² This includes psychosocial aspects such as counselling. It also requires culturally and disability-sensitive service delivery, including the provision of interpreters to assist women who may need them.

Counselling Service Provision

- 8.73 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.⁸³
- 8.74 Providers determine their own clinical approaches and service ethos. Some are members of professional bodies, such as the Australian Association of Social Workers, and others are not.
- 8.75 Medicare payments are available for pregnancy support counselling by general practitioners and, on referral, by other health professionals. Victorian women may also use the Commonwealth-funded National Pregnancy Support Telephone Helpline.⁸⁴
- 8.76 In public hospitals and private abortion clinics, women are offered further counselling to support them in their decision making. Women may receive additional counselling or therapy before and after the procedure.⁸⁵ For example, at the Fertility Control Clinic the woman may attend multiple counselling sessions and may consult the clinical psychologist.⁸⁶ Similarly, at the Women's Clinic on Richmond Hill patients may see a counsellor or external psychologist.⁸⁷ Psychologists and

- 68 Psychotherapy & Counselling Federation of Australia, *Professional Standards* (2006) 4 <www.pacfa.org.au/files/PACFA_Professional_Standards_0906.pdf> at 18 February 2008.
- 69 Carl Rogers 'The process of therapy' (1992) *Journal of Consulting and Clinical Psychology* 60, 163 cited in Brooke Calo, 'The Violence of Misinformation: Compulsory Independent Counselling and the Current Abortion Debate' (2007) 19 *Women Against Violence* 10, 11.
- 70 Eg, submission 15 (Dr Nicholas Tonti-Filippini).
- 71 Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion, Evidence-Based Clinical Guideline No 7* (2004) 36.
- 72 *Ibid* 37.
- 73 National Health and Medical Research Council (1996) above n 44, 30.
- 74 Submission 15 (Dr Nicholas Tonti-Filippini).
- 75 Eg, Psychotherapy and Counselling Federation of Australia.
- 76 Australian Association of Social Workers, *Code of Ethics* (1999) 14 <www.aasw.asn.au/adobe/about/AASW_Code_Of_Ethics-2004.pdf> at 9 January 2008.
- 77 Royal Women's Hospital, *Pregnancy Advisory Service—Intake Services for Women with Unplanned Pregnancy* [unpublished].
- 78 The Psychotherapy and Counselling Federation of Australia is the peak body for 39 psychotherapy member associations and counselling member associations. It maintains a national register of counsellors and psychotherapists.
- 79 Psychotherapy and Counselling Federation of Australia (2006) above n 68.
- 80 Australian Association of Social Workers (1999) above n 76.
- 81 Susie Allanson, 'Pregnancy/Abortion Counselling: False Providers, Mandatory Counselling, Ultrasound & "Cooling Off"' (2007) 19 *Women Against Violence* 5, 6.
- 82 Royal College of Obstetricians and Gynaecologists (2004) above n 71, 9.
- 83 Eg, Caroline Chisholm Society. 'The CCS position is that abortion is a tragedy for mother and child. The CCS stated values of respect for life and compassion and caring form the core of its work with women and families.': submission 458 (Caroline Chisholm Society).
- 84 Announced in March 2006, the National Pregnancy Support Telephone Helpline is funded by the Department of Health and Ageing, Pregnancy Helpline (11 February 2008) <www.health.gov.au/pregnancyhelpline> at 18 February 2008.

- 85 Private, external counselling costs are likely to be borne by the woman. This may create a barrier for women on low incomes.
- 86 Consultation 1 (Fertility Control Clinic).
- 87 Consultation 35 (Women's Clinic on Richmond Hill).

counsellors are also available at the Monash Medical Centre.⁸⁸ In the only private clinic providing late abortions, counselling must be offered to all patients. A psychological assessment is required before a late abortion proceeds.⁸⁹

- 8.77 As part of general clinical standards '[f]ollow up appointments are offered to virtually all women who terminate a pregnancy, although many women choose not to attend'.⁹⁰ This consultation will check physical recovery, contraceptive needs and an assessment of general emotional state. Follow-up counselling may be arranged.⁹¹
- 8.78 The major public provider of abortions in Victoria is the Royal Women's Hospital. Its Pregnancy Advisory Service (PAS) provides a range of services to women experiencing unplanned or unwanted pregnancy.⁹² The PAS Intake Service, which is the initial contact point, coordinates each woman's care. Support includes working through options of adoption, abortion, and continuing with the pregnancy. Pre- and post-abortion counselling is offered to all women using the service.⁹³
- 8.79 The particular needs of women having abortions following diagnosis of fetal abnormality requires specialist support, including access to skilled counselling services and time to consider their decision.⁹⁴ The Women's, Monash, and Mercy Hospital for Women all have fetal management units where specialist counselling and support is available. The Women's and Monash include the option of abortion, which is provided within those hospitals. The Mercy does not perform abortions.⁹⁵

Women's Views of Counselling

- 8.80 There is consensus among providers that the
- majority of women who seek an abortion are informed, have considered their decision thoughtfully and for some time, and are clear in their decision not to continue this particular pregnancy at this particular time in their life for a set of unique and individual reasons.*⁹⁶
- 8.81 The Key Centre in Women's Health in Society at the University of Melbourne is conducting research with PAS at the Women's, funded by the Australian Research Council and VicHealth.⁹⁷ This research examines the experiences of women who have contacted PAS during the 12 months ending 10 September 2007. It includes an audit of information collected by PAS social work staff from 3827 women using the service.⁹⁸ In-depth interviews with 60 women are also being undertaken.
- 8.82 Interviews conducted as part of the research suggest that reasons for seeking abortion are complex and contingent upon individual circumstances.⁹⁹ Preliminary data found that women value counselling that enables them to consider all their options but does not try to dissuade them from decisions they have made.¹⁰⁰ The audit found that 12.5% of women accepted counselling.¹⁰¹
- 8.83 Thus, while women are offered additional counselling, many choose not to have it, having already made up their minds.¹⁰²
- 8.84 This is consistent with the Marie Stopes International commissioned survey of women who experienced unplanned pregnancy.¹⁰³ This survey found that 75% of women did not wish to speak to a counsellor before deciding how to proceed.¹⁰⁴ Among survey participants, the most common place to obtain counselling was an abortion clinic (45%). Of those women who obtained counselling, 46% said the most helpful thing was that counselling was non-judgmental; 80% expressed satisfaction with the service provided.¹⁰⁵

Psychological Effects and Counselling

- 8.85 Some people, such as Melinda Tankard-Reist, believe strongly that current counselling provision is inadequate.¹⁰⁶ Others claim that 'for some women abortion results in mild, moderate or severe psychological and emotional harm'.¹⁰⁷
- 8.86 It is important not to denigrate the experience of some women who do find abortion to have an emotional impact; however, this does not necessarily equate with psychological harm

It is generally recognised by health bodies that the vast majority of women do not suffer psychological harm from abortion.¹⁰⁸ Some may express feelings of relief afterwards.¹⁰⁹

8.87 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists reports:

[P]sychological studies suggest: there is mainly improvement in psychological wellbeing in the short term after termination of pregnancy; there are rarely immediate or lasting negative consequences; there may be an association between termination of pregnancy and some adverse mental health markers: these may reflect pre-existing conditions.¹¹⁰

8.88 In 2007 the UK House of Commons Science and Technology Committee reviewed the evidence on psychological risks of abortion. It identified the strengths and limitations of various studies, and concluded that there is no strong evidence to contradict the Royal College of Obstetricians and Gynaecologists' guidelines on the risk to mental health of induced abortion.¹¹¹ Those guidelines state:

[S]ome studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared to women who give birth and to non-pregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect a continuation of pre-existing conditions.¹¹²

Experience in Other Jurisdictions

Overseas Legislation

- 8.89 In the US, 32 states have mandatory counselling; however, most of this is related to mandated information. Seven states require counselling to be delivered in person, at least 18 hours before the procedure; 17 states require women to be given a list of agencies that provide counselling or other services to help women carry their pregnancies to term.¹¹³
- 8.90 Mandatory counselling is not a feature of abortion laws in other countries, such as the UK, New Zealand, or Canada.
- 8.91 The New Zealand Abortion Supervisory Committee regulates the provision of counselling. A licence to provide abortion services is granted only if the committee is satisfied that 'adequate counselling services are available to women considering having an abortion in the institution, and are offered to such women whether or not they ultimately have an abortion'.¹¹⁴ Women are not forced to attend such counselling.

- 88 Consultation 26 (Professor David Healy).
- 89 Consultation 9 (Croydon Day Surgery).
- 90 National Health and Medical Research Council (1996) above n 73, 31.
- 91 Ibid.
- 92 PAS provides a range of interdisciplinary professional services, including support, counselling, advocacy, and clinical services.
- 93 The other major provider of publicly funded counselling in Victoria is Family Planning Victoria. Both the Royal Women's Hospital and Family Planning Victoria 'provide professional services that are highly regarded by the community. Their counselling models represent best practice as found in many other contemporary models internationally': submission 509 (Annarella Hardiman).
- 94 National Health and Medical Research Council (1996) above n 73, 29.
- 95 The multi-disciplinary team at the Royal Women's Hospital includes obstetricians, paediatricians, genetic counsellors, social workers, and a psychiatrist. All the women referred to the unit are provided with counselling; about 10% decide to terminate their pregnancy: consultation 24 (Fetal Management Unit—Royal Women's Hospital).
- 96 Submission 509 (Annarella Hardiman).
- 97 Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007. The results of the project will be published in 2008.
- 98 This data is unpublished and requires careful interpretation. The data arises from a conversation in which women volunteer information rather than respond to direct questions. This is not a questionnaire survey. Although this process has limitations, it also has advantages in the range and depth of information supplied, and the fact that it is information gathered as women consider their decision making around abortion or continuation of a pregnancy.
- 99 See also Pamela Adelson, Michael S Frommer and Edith Weisberg, 'A Survey of Women Seeking Termination of Pregnancy in New South Wales' (1995) 163 *The Medical Journal of Australia* 419. 'Partner violence is the strongest predictive factor of pregnancy termination among young Australian women': Angela Taft and Lyndsey Watson, 'Termination of Pregnancy: Associations with Partner Violence and Other Factors in a National Cohort of Young Australian Women' (2007) 31(2) *Australian and New Zealand Journal of Public Health* 135, 141.
- 100 Submission 410 (Key Centre for Women's Health in Society, University of Melbourne).
- 101 Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007.
- 102 Family Planning Victoria reported that most women using its service are very clear about the decision and do not require counselling; however, they do require information about how to navigate the health system and access abortion services: consultation 11 (Family Planning Victoria).
- 103 Websurvey, *What Women Want: When Faced with an Unplanned Pregnancy: Key Findings* (2006). The strengths and limitations of this survey are discussed in Chapter 4.
- 104 When asked to think back to their experiences of unplanned pregnancy, 14% reported speaking to a counsellor and 86% did not; 30% who were counselled did not wish to have counselling, 18% who wanted counselling before making a decision did not receive it: *ibid* 8.
- 105 Ibid.
- 106 Melinda Tankard Reist, *Giving Sorrow Words: Women's Stories of Grief after Abortion* (2000) 26.
- 107 Selena Ewing, *Women & Abortion: An Evidence Based Review* (2005) 17. See also submissions 276 (Family Council Victoria), 516 (Joseph Santamaria).
- 108 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': Billie Bonevski and Jane Adams, *Psychological Effects of Termination of Pregnancy: A Summary of the Literature: 1970–2000* (2001); Websurvey (2006) above n 103, 24.
- 109 Bonevski and Adams (2001) above n 108, 4.
- 110 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005) 4.
- 111 House of Commons, Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07: Volume 1*, HC 1045–1 (2007) 47.
- 112 Royal College of Obstetricians and Gynaecologists (2004) above n 71, 9.
- 113 Guttmacher Institute, *State Policies in Brief* (2008) <www.guttmacherinstitute.org/statecenter/spibs/spib_MWPA.pdf> 11 January 2008.
- 114 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 21(1)(e).

8.92 The committee is also charged with the duty of ensuring that sufficient and adequate counselling facilities are available throughout New Zealand for women who may seek advice on abortion.¹¹⁵ It is empowered to approve agencies for the provision of such counselling services.¹¹⁶

Australian Legislation

8.93 The Tasmanian Criminal Code requires a medical practitioner to counsel a woman seeking an abortion about the medical risks involved and refer her to counselling.¹¹⁷ The woman is not compelled to attend counselling.

8.94 In Western Australia it is lawful for a medical practitioner to perform an abortion up to 20 weeks gestation if a woman has given 'informed consent'.¹¹⁸ That term is defined to include:

- (a) counselling on medical risk of termination and pregnancy;
- (b) the opportunity of referral for further counselling;
- (c) available post procedure or post birth counselling.¹¹⁹

8.95 While medical risk counselling is mandatory, reflecting the general duty of disclosure, women are not compelled to attend counselling under (b) or (c).¹²⁰

8.96 Counselling must be undertaken by a person other than the practitioner (or the practitioner's assistants) carrying out the abortion.¹²¹

Clinical Guidelines and Administrative Regulation

8.97 Non-legislative measures that aim to promote best practice in abortion care have been adopted in some jurisdictions. These range from administrative regulations (policy directives), to professional standards (clinical guidelines), and best practice frameworks adopted across all providers (practice guidelines). These generally include counselling.

8.98 The *Framework for Terminations in New South Wales Public Health Organisations* sets the boundaries of local protocols on the delivery of abortion services. This policy directive requires that all women seeking an abortion in public health settings are offered counselling, before and after the procedure.¹²²

8.99 The New Zealand Abortion Supervisory Committee has also produced counselling standards that cover qualifications, ethics, and supervision.¹²³

8.100 British Columbia has a comprehensive set of guidelines: *Best Practices in Abortion Care—Guidelines for British Columbia*. This set of care principles provides detailed guidance on counselling associated with abortion, including decision-making counselling, post-abortion counselling, contraception counselling, and counselling and care for women with a history of experiencing violence, including sexual violence.

8.101 The Royal College of Obstetricians and Gynaecologists' Clinical Guideline, *The Care of Women Requesting Induced Abortion*, deals with patient support and counselling. It recommends that **care pathways** be available to women with additional support needs, including those with psychiatric history, poor social support, or where there is evidence of coercion.¹²⁴ It also recommends referral for further counselling after the abortion be available.¹²⁵

8.102 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' publication, *Termination of Pregnancy: Resource Guide for Professionals*,¹²⁶ states that 'supportive non-judgemental counselling should support decision-making prior to termination of pregnancy ...'¹²⁷ It goes on to say 'a follow up appointment should be arranged and strongly encouraged, to include ... arrangements for further review and counselling as necessary'.¹²⁸

Community Views

8.103 As described in Chapter 5, community consultations revealed strong consensus for supporting women in decision making. Many people highlighted the desirability of good quality, non-directive counselling.

- 8.104 This is consistent with community attitudes as measured by the SCBI Survey 2004,¹²⁹ which found that 80% of participants thought that counsellors 'should not try in any way to influence the woman's decision'.¹³⁰
- 8.105 Among consultation participants, views on how far the law should intervene in the clinical practice of counselling were divergent. The issue of compulsory counselling was highly contentious.
- 8.106 Most organisations had a strong preference that non-directive counselling be available but not compulsory. Women's Health West, noting personal experience of counselling in a mandatory setting, said 'we found that 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'.¹³¹ It was argued that compulsion and counselling was an oxymoron, and that mandated counselling would be an unnecessary legal addition.¹³²
- 8.107 Some people raised concerns about what they saw as '**truth in advertising**' regarding counselling services, so that women were made aware that a counsellor was from an organisation or value system opposed to abortion on principle.¹³³ This is discussed in more detail later in this chapter.
- 8.108 Other people took the view that abortion services were under-regulated.¹³⁴ They were often concerned that counselling is undertaken by the same organisation providing the abortion, particularly private clinics.¹³⁵ Some felt legislation should prohibit this practice.¹³⁶
- 8.109 Some people wanted legislation to require compulsory counselling, mandated information and cooling-off periods.¹³⁷ These tended to be people who also took an absolute position opposing abortion.¹³⁸ A few looked to examples from the US, where in addition to the usual standards of consent, additional obligations are placed upon the doctor and patient before an abortion may proceed.
- 8.110 Among others there was some preference for the law to include a requirement for referral to counselling, without it being compulsory for women to attend. This was an important feature in Dr Tonti-Filippini's model and was supported by the Respect Life Office.¹³⁹

Policy Issues

- 8.111 Comprehensive service delivery and care in the area of abortion includes 'the provision of accurate, balanced information and access to counselling which provides for the exploration of all options in a supportive, non-judgemental manner'.¹⁴⁰
- 8.112 The commission believes that any woman seeking counselling about abortion, including post-abortion counselling, is entitled to receive it. Only those counsellors operating within the professional and ethical standards discussed earlier should provide

115 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 14(1)(e).

116 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 31.

117 *Criminal Code 1924* (Tas) s 164.

118 *Health Act 1911* (WA) s 334(3)(a).

119 *Health Act 1911* (WA) s 334(5).

120 The Western Australian Health Department produces a list of counsellors, and funds six agencies to provide counselling. Other organisations also provide counselling. Post-20 weeks counselling is provided at King George Hospital.

121 *Health Act 1911* (WA) s 334(6).

122 Evidence of pre-procedure counselling from an appropriately qualified health care professional must be documented as having been offered. Records of counselling either by a medical practitioner or counsellor must be included in the patient file. Department of Health [NSW] (25 May 2005) above n 8, s 3.1.

123 Abortion Supervisory Committee, Counselling Advisory Committee, *Standards of Practice for the Provision of Counselling* (1998) <www.abortion.gen.nz/docs/guides98.pdf> at 14 January 2008.

124 Royal College of Obstetricians and Gynaecologists (2004) above n 71, 9.

125 *Ibid* 13.

126 This document does not provide guidelines or recommendations on best practice. The aim is to provide a referenced, evidence-based resource for health professionals ...': Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2005) above n 110, 5.

127 *Ibid* 2.

128 *Ibid* 7.

129 The limitation and strengths of the SCBI survey are discussed in Chapter 4.

130 Fleming and Tonti-Filippini (2007) above n 66, 105–106.

131 Submission 134 (Women's Health West).

132 Eg, submissions 185 (Associate Professor Kerry Petersen), 327 (Children by Choice).

133 Submission 227 (Reproductive Choice Australia).

134 Eg, submission 454 (Australian Christian Lobby).

135 Eg, submission 12 (Paul Johnson).

136 Submission 82 (Women's Forum Australia). See also Submission 458 (Caroline Chisholm Society).

137 Some cited evidence for community support from the Southern Cross Bioethics Institute Survey; however, the survey question included the statement 'often these women would prefer not to have an abortion but don't know what else to do. Do you support the idea of women in these sorts of situations having access to counselling about alternatives to abortion or not?': Fleming and Tonti-Filippini (2007) above n 66, 106–107.

138 Eg, submission 6 (Endeavour Forum).

139 Consultation 25 (Respect Life Office, Catholic Archdiocese of Melbourne); submission 15 (Dr Nicholas Tonti-Filippini).

140 'Joint Position Statement by the Royal Women's Hospital, Royal Children's Hospital Centre for Adolescent Health, Family Planning Victoria and Women's Health Victoria' (2007) 19 *Women Against Violence* 46, 75.

such 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.

- 8.113 Women who have existing emotional distress may require additional support, for example, if the pregnancy is the result of rape. Women who are substance dependent or have a mental health disability may also require additional support.¹⁴¹
- 8.114 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.
- 8.115 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.¹⁴² While such benchmarks are not a legal matter, they could promote best practice in the field and would be consistent with existing policy commitments to promote sexual and reproductive health.¹⁴³

Independence

- 8.116 The independence of counsellors was an issue for some people who participated in our consultations. On the face of it, requiring counsellors to be independent of providers may seem attractive;¹⁴⁴ however, research cited in the NHMRC *Information Paper on Termination of Pregnancy* suggests that women are 'less concerned with the settings in which counselling is provided than about the quality of counselling'.¹⁴⁵
- 8.117 Independent counselling is already provided and is publicly funded. Funding rules for Medicare payments for pregnancy support counselling and the National Pregnancy Support Telephone Helpline specify that 'counselling may not be undertaken by professionals with links to abortion providers'.¹⁴⁶
- 8.118 Take up rates for the Telephone Helpline appear to have been much lower than the tender process scoping expected.

*In its first seven months of operation, the helpline received 2238 calls—an average of about 320 a month for its 11 plus counsellors. It had fewer than 150 calls in its first two months and while an advertising campaign brought about a surge of calls in July and August, demand fell back to 376 calls in November.*¹⁴⁷

- 8.119 Since most women use in-house counselling services, in either public hospitals or private clinics, a legal requirement that counselling be limited to external providers would mean 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 care pathway.
- 8.120 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.¹⁴⁸ 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.
- 8.121 A few groups inferred that counsellors in abortion clinics, or public hospitals providing abortion services, have a stake in promoting abortion.¹⁴⁹ This was not borne out in evidence given to the commission. Data from the Women's indicates that of known outcomes for women using PAS, 88% proceeded with an abortion through the hospital.¹⁵⁰ The remainder either cancelled, did not attend for the procedure, or were known to have continued with the pregnancy.¹⁵¹

Compulsion

- 8.122 The commission did not find 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.

- 8.123 In arguing for compulsory counselling, people generally came from the position that abortion is such a traumatic event, with long-term consequences, that women need counselling regardless of whether they request it. This suggests that women are not fully capable of making their own decisions and require protection.¹⁵²
- 8.124 The commission recognises that abortion is a decision of deep moral significance for many people. The woman herself is the best person to make such a decision. This includes deciding upon the nature or extent of any counselling she needs, in consultation with her clinician.
- 8.125 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.
- 8.126 Professional counselling processes are based on an 'ethos of respect for clients, their values, their beliefs, their uniqueness and the right to self determination'.¹⁵³ They are, by their very nature, non-directive and non-coerced. As Dr Tonti-Filippini notes in his submission, '[c]o-erced counselling is not counselling'.¹⁵⁴
- 8.127 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.

Referral

- 8.128 A small number of people called for mandatory referral for counselling. Dr Tonti-Filippini recommended a *statutory requirement for independent counselling requirements that reflect a distinction between supportive decision-making counselling and pre-procedure counselling, and which require referral to properly trained pregnancy counsellors for the former (as is required under the Infertility Treatment Act) and provision of the latter according to information that are evidence-based.*¹⁵⁵
- 8.129 In examining this proposal, the commission noted three elements: an interrelationship with existing disclosure duties, consistency with other areas of health law, and the efficacy of mandating referral.

Relationship with Medical Risk Information and Consent

- 8.130 As Dr Tonti-Filippini notes, despite being quite separate issues, information provision is often conflated with counselling. This may result in 'counselling' having multiple meanings in legislation. For example, in the Western Australian legislation the term 'counselling' is used to describe both the duty of disclosure to achieve effective consent in one section¹⁵⁶ and an ongoing therapeutic relationship in the next.¹⁵⁷

141 In the Women's PAS audit, of the 380 women self identifying as having specific needs, 108 reported mental health issues, 54 reported alcohol or other drug use. Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007.

142 See, eg, British Columbia Women's Hospital and Health Service and Provincial Health Services, *Best Practices in Abortion Care: Guidelines for British Columbia* (2004).

143 Sexual and Reproductive Health is one of seven health promotion priorities of the Victorian Government. See Department of Human Services, *Role of Department of Human Services in health promotion* (29 October 2007) <www.health.vic.gov.au/healthpromotion/role/index.htm> at 20 February 2008.

144 This view corresponds with the findings of the SCBI-commissioned survey that for a government-funded pregnancy counselling service, 52% trusted abortion clinics to offer completely objective or non-directive counselling, compared to 61% for faith-based (Centacare/Anglicare), 78% Family Planning Association, and 83% for GPs. The SCBI survey does not appear to have a category for 'pro life' organisations/counsellors: Fleming and Tonti-Filippini (2007) above n 66, 126.

145 National Health and Medical Research Council (1996) above n 44, 30.

146 The Hon John Howard MP, Prime Minister, and the Hon Tony Abbott MP, Minister for Health and Ageing, 'Pregnancy Support Counselling' (Media Release, 2 March 2006).

147 Sean Parnell, 'Watch on Abbott's abortion hotline', *The Australian* (Sydney) 4 January 2008, 3.

148 Angella Duvnjak and Barbara Buttfeld, 'Ignorant Fools: The Construction of Women's Decision-Making in Recent Abortion Debates in Australia' (2007) 19 *Women Against Violence* 20, 23.

149 'Greed not love is the motivating factor behind the abortion industry': submission 276 (Family Council of Victoria). Some suggested that coercion might possibly occur in for-profit clinics: submission 82 (Women's Forum Australia).

150 Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007.

151 Similar results were recorded in South Australia. In 2005 the Pregnancy Advisory Centre, Woodville, provided decision-making support and counselling to over 400 women; 45% of who continued with the pregnancy: Calo (2007) above n 69, 17.

152 Some decriminalisation opponents also argued that current counselling practice did not provide complete information about the consequences of abortion.

153 Psychotherapy and Counselling Federation of Australia, *Professional Standards* (2006) above n 68, 4.

154 Submission 15 (Dr Nicholas Tonti-Filippini).

155 Ibid.

156 *Health Act 1911* (WA) s 5(a).

157 *Health Act 1911* (WA) s 5(b)-(c).



- 8.131 This creates confusion about the role of the medical practitioner and adds unnecessary complexity to the law, which was noted in the review of the Western Australian legislation. It was reported that medical practitioners were directing women to attend counselling services in the mistaken belief that it was mandatory to do so to access abortion services.¹⁵⁸
- 8.132 Greater clarity is achieved by treating information provision and counselling as separate issues. Information provision is primarily a legal issue, while counselling is a therapeutic matter.
- 8.133 A medical practitioner must provide a patient with evidence-based information about abortion as part of the legally mandated duty of care to a patient.¹⁵⁹ Failure to fulfil this duty exposes the practitioner to a claim in negligence and professional sanction.

Consistency with other Victorian Laws

- 8.134 The commission is mindful that counselling and information provision is mandatory for consent under the *Infertility Treatment Act 1995* and associated regulations.¹⁶⁰ While both ART and abortion deal with potential human life, ART is a relatively recent activity that raises unique issues.
- 8.135 The consequences of a having a child through ART are complex. Legal issues associated with ART that require specific consideration include donor interests and information rights of the child once born.
- 8.136 Decisions about research using embryos is another important consideration when contemplating ART.¹⁶¹

Efficacy of Referral as a Legal Requirement

- 8.137 It is difficult to determine the practical value of a statutory requirement to refer to counselling, since referrals can already be made and such a provision could not compel women to undertake counselling.
- 8.138 While a compulsory referral for counselling might have symbolic value, it does little to further the underlying values of the existing practice. It risks delving into areas of clinical judgment and patient autonomy that need not be disturbed by the law.
- 8.139 While counselling is important, it is a clinical matter best left to professional judgment based on a woman's particular circumstances. The commission therefore believes that the law should not include a requirement for compulsory counselling, or for compulsory referral to counselling.
- 8.140 The commission encourages the Minister for Health to initiate the development of uniform standards of practice to inform pregnancy and abortion counselling services, and to encourage accountability and quality.

RECOMMENDATION

- 5. Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling.**

COOLING-OFF PERIODS

- 8.141 In places where the law mandates compulsory counselling, a minimum time between counselling and the abortion procedure is often included. This is often referred to as a cooling-off period.
- 8.142 Twenty-four US states have a cooling-off period; generally, 24 hours.¹⁶² There is no cooling-off period in any Australian jurisdiction, in the UK or New Zealand.¹⁶³
- 8.143 In Victoria there is no legislatively mandated cooling-off period; however, proper professional practice dictates that women should not be pressured into making decisions and are encouraged to take the time they need to reach a decision.
- 8.144 Indirect cooling-off periods may already occur due to resource limitations in public hospitals, access issues for rural and regional women, and costs associated with private abortions.

Community Views

- 8.145 In the commission's consultations, decriminalisation opponents tended to support the inclusion of a cooling-off period. A wide range of times was suggested (between 24 hours and three weeks).¹⁶⁴
- 8.146 This is consistent with SCBI survey data, which claimed that among people surveyed 79% supported a cooling-off period; 40% believed a seven-day period was appropriate; 24% said two days was appropriate; and 10% thought one day was sufficient.¹⁶⁵
- 8.147 The survey question was preceded by another question that included this preliminary statement: 'a pregnant woman can go directly to an abortion clinic, without consulting anyone first, ask for an abortion, and have the abortion that day, without any questions asked about the reasons or the circumstances'.¹⁶⁶ The framing of the question in this way may have provoked a response supporting cooling-off periods.
- 8.148 There was strong opposition to legislated cooling-off periods from others, including AMA Victoria.¹⁶⁷ Among some women's groups it was felt that the concept of 'cooling off' was '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'.¹⁶⁸
- 8.149 Others felt that cooling-off periods were unnecessary, 'as few women choose to, or are able to access abortion immediately'.¹⁶⁹ It was further argued that imposed cooling-off periods may delay access to safe first trimester abortion. There was particular concern about rural and regional women who could face additional travel and accommodation costs if they had to make multiple journeys to Melbourne.

Policy Issues

- 8.150 The policy goal of informed decision making protects principles of personal wellbeing and autonomy.¹⁷⁰ 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.
- 8.151 'Cooling off' implies that a decision would otherwise be made abruptly or in the heat of the moment.¹⁷¹ It assumes the woman's judgment is flawed or that she requires further time or information to reach a different decision.
- 8.152 Evidence suggests that most women are firm in their decision. A PAS audit found that of 3636 responses, 306 women reported being ambivalent or undecided.¹⁷² The audit found that 72% of the women had a partner in pregnancy who was 'aware and supportive' of the woman's needs in the situation.¹⁷³
- 8.153 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. This point was made by the Fetal Management Unit at the Women's, which felt that 'a fixed or legislated period distorts the flexibility required in clinical practice where time to contemplate and work through issues needs to be tailored to the woman and those who are supporting her'.¹⁷⁴
- 8.154 The commission believes the current law governing all medical procedures deals appropriately with the timing of consent. No further legislative requirement is necessary.

RECOMMENDATION

- 6. Any new abortion law should not contain a compulsory delay or cooling-off period before an abortion may be lawfully performed.**

TARGETTED REGULATION OF ABORTION PROVIDERS

- 8.155 During consultations, some people expressed concern that abortion facilities are under-regulated. Their concerns tended to focus on private clinics, ranging across clinical standards, counselling provision, and the commercial activities of some clinics.

158 Acts Amendment (Abortion) Act 1998 Review Steering Committee [Western Australia] (2002) above n 38, 17.

159 *Rogers v Whittaker* (1992) 175 CLR 479.

160 *Infertility Treatment Act 1995* ss 10, 11, 16, 17. See also *Infertility Treatment Regulations 1997*.

161 *Infertility Treatment Act 1995* ss 27, 31, 32.

162 Gutmacher Institute (2008) above n 113, 1.

163 A 72 hour cooling-off period applied in the ACT from 1999 to 2002 but it did not affect the lawfulness of a termination under the Crimes Act. The requirement was repealed in 2002. *Health Regulations (Maternal Health Information) Act 1998* (ACT) as repealed by *Health Regulations (Maternal Health Information) Repeal Act 2002 No 25* (ACT).

164 The Presbyterian Church of Victoria suggested seven days, the Australian Christian Lobby suggested three days: consultation 4 (Presbyterian Church of Victoria); submission 454 (Australian Christian Lobby).

165 Fleming and Tonti-Filippini (2007) above n 66, 104.

166 *Ibid*.

167 Consultation 30 (Australian Medical Association Victoria) cf consultation 15 (Dr Ian Freckelton) who was supportive of cooling-off periods so long as they did not lead to discrimination in access to services, eg, young people, low income, rural and regional women, etc.

168 Susie Allanson, 'Pregnancy/Abortion Counselling: False Providers, Mandatory Counselling, Ultrasound & "Cooling Off"' (2007) 19 *Women Against Violence* 5, 9.

169 Submission 509 (Annarella Hardiman).

170 Benson Gold and Nash (2007) above n 52, 7.

171 Consultation 24 (Fetal Management Unit—Royal Women's Hospital).

172 Information provided at meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007.

173 This suggests that the majority of women using the Women's service discuss the decision with their partners, or at least inform them of the intention to terminate the pregnancy: *ibid* 3.

174 Consultation 24 (Fetal Management Unit—Royal Women's Hospital).

- 8.156 They proposed several additions to the current **regulatory framework**. These included restrictions on where abortions could be performed, additional data and reporting requirements, changes to the law of consent, and targeted anti-coercion legislation. Generally, decriminalisation supporters did not share these concerns. They noted existing legal requirements and health regulations, which they considered were adequate.¹⁷⁵

Current Regulation in Victoria

- 8.157 The regulation of abortion services was discussed in detail in Chapter 3.
- 8.158 Abortion services in public hospitals are required to meet the clinical and service standards of public health services in Victoria. In common with all other public hospitals, they are regulated by the Health Services Act. Hospitals may also operate local protocols and benchmarks.¹⁷⁶
- 8.159 Private clinics are regulated by DHS under the Health Services (Private Hospitals and Day Procedure Centres) Regulations. These regulations include: staffing levels; registers and record keeping; care and management of patients; complaints procedures; suitability and upkeep of premises and equipment; and infection control. DHS may include additional requirements for individual clinics as part of their conditions of licence.
- 8.160 The Health Professions Registration Act requires medical practitioners to be registered by the Medical Practitioners Board of Victoria. This legislation establishes a scheme for dealing with professional conduct and performance. Relevant professional association standards, including codes of ethics, also apply. Complaints can also be made to the Health Services Commissioner.¹⁷⁷
- 8.161 A person must not hold himself or herself out to be a registered health professional if not lawfully registered.¹⁷⁸ A non-registered person commits an assault if consent is given in the mistaken belief that the person was registered.¹⁷⁹ If a woman consented to an abortion, knowing that the person was not registered, the offence of abortion would occur.¹⁸⁰

SHOULD THERE BE LIMITS ON WHERE ABORTIONS ARE PERFORMED?

- 8.162 Some people sought a blanket prohibition on private clinics providing abortions.¹⁸¹ Others argued that abortions should only be undertaken in public hospitals by salaried doctors.¹⁸² Some suggested a licensing system.¹⁸³ It was claimed these changes were necessary for several reasons.
- 8.163 Dr Tonti-Filippini summarised the allegations made about private providers:

[T]ermination of pregnancy may occur in coercive circumstances or by private for profit practitioners in circumstances of conflict of interest and possibly lacking services and support, and thus akin to backyard abortion, or in circumstances in which there has been insufficient opportunity for the woman to explore the nature of her decision...¹⁸⁴

Experiences in Other Jurisdictions

- 8.164 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.
- 8.165 In some jurisdictions abortions must be performed in facilities licensed especially for that purpose. In most Australian jurisdictions this may include public and private providers.
- 8.166 In the ACT, the Health Act provides that abortions may be carried out only in an approved medical facility.¹⁸⁵ The minister approves facilities and may not unreasonably refuse or delay a request for approval.¹⁸⁶ There is no prohibition on private clinics.¹⁸⁷ Nor is there a prohibition in Queensland.
- 8.167 In Western Australia there is a mix of providers. 'Over 90% of abortions in Western Australia were carried out in the private sector in 2005.'¹⁸⁸ Abortions after 20 weeks may only be performed in facilities approved by the minister.¹⁸⁹ Currently, this is the King Edward Memorial Hospital.¹⁹⁰
- 8.168 The Northern Territory legislation requires abortions to be carried out in a hospital as declared by the minister.¹⁹¹ Similarly, in South Australia abortions may be carried out only in a hospital or class of hospital declared by regulation.¹⁹²

8.169 In the UK, abortions may be undertaken in National Health Service hospitals, primary care trust services, and in places approved by the minister.¹⁹³ This includes private clinics such as those operated by the British Pregnancy Advisory Service.

8.170 In New Zealand, the Abortion Supervisory Committee undertakes licensing of abortion providers.¹⁹⁴ Both public and private providers are licensed. Section 19 of the Contraception, Sterilisation and Abortion Act allows for abortions under 12 weeks gestation to be carried out in a facility with a 'limited licence'.¹⁹⁵ For those over 12 weeks gestation, the procedure must be carried out in a facility with a full licence, that is, where there are, among other things, facilities for an overnight stay.¹⁹⁶ The District Health Boards, which are responsible for the delivery of public health services at a regional level, are required by their service agreements with the New Zealand Ministry of Health¹⁹⁷ to ensure that abortion services are provided to women who meet the criteria for lawful abortion.¹⁹⁸

Medical Abortion (RU486)

8.171 When abortion legislation was introduced in other jurisdictions, it was a surgical procedure; however, as medical abortion has become more common new legal issues have arisen.

8.172 Problems arose in New Zealand following the introduction of mifepristone (RU486) in 2001 because of uncertainty about the definition of 'performing' an abortion.¹⁹⁹ The High Court decided that with respect to medical abortions, women must take the medication in a licensed facility but they do not need to remain at the facility between the sets of tablets.²⁰⁰ Nor is it compulsory for them to stay in a licensed hospital or clinic until the fetus is expelled and the abortion is complete.²⁰¹

8.173 Following the recent House of Commons Scientific and Technology Committee inquiry, UK legislation may now be changed so women do not have to visit a clinic to obtain the second dose of medication. In the US, the second stage of a medical abortion is frequently self-administered by the woman in her own home.²⁰²

8.174 The committee concluded that:

*[s]ubject to providers putting in place the appropriate follow up arrangements, there is no evidence relating to safety, effectiveness or patient acceptability that should serve to deter Parliament passing regulations which would enable women who chose to do so taking the second stage of early medical abortion at home, or that should deter Parliament from amending the Act to exclude the second stage of early medical abortion from the definition of 'carrying out a termination. This would enable a trial to take place.'*²⁰³

175 Eg, consultation 3 (Association for the Legal Right to Abortion).

176 Eg Royal Women's Hospital, 'Pregnancy Advisory Service—Intake Services for Women with Unplanned Pregnancy' (unpublished).

177 *Health Services (Conciliation and Review) Act 1987*.

178 *Health Professions Registration Act 2007* s 80.

179 They may also be charged with the offence of abortion: *Crimes Act 1958* s 65.

180 It would be unlikely that the defence established in *Menhennitt* would apply as it is generally understood that the defence only applies to medical practitioners. Although Justice *Menhennitt* did not expressly stipulate that only a medical practitioner may perform a lawful abortion, the use of the term 'therapeutic' suggests that his remarks were limited to abortions carried out by registered practitioners. The NSW case of *Wald* expressly refers to medical practitioners.

181 Submission 454 (Australian Christian Lobby).

182 Submission 6 (Endeavour Forum).

183 Along the lines of that which operates for Assisted Reproductive Technology services: submission 15 (Dr Nicholas Tonti-Filippini).

184 Submission 15 (Dr Nicholas Tonti-Filippini).

185 *Health Act 1993* (ACT) s 82.

186 *Health Act 1993* (ACT) s 83.

187 Marie Stopes International operates a clinic in the ACT.

188 J Straton, et al, *Induced Abortion in Western Australian 1999–2005; Report of the WA Abortion Notification System* (2006) 11.

189 *Health Act 1911* (WA) s 334(7)(b).

190 *Notes for Medical Practitioners on Abortion Legislation in Western Australia* (2003) Department of Health (February 2003) 10 <www.health.wa.gov.au/Publications/documents/9389%20-%20Abortig%20Internal%20pg.pdf> at 16 January 2008.

191 *Medical Services Act* (NT) s 11(1)(c).

192 *Criminal Law Consolidation Act 1935* (SA) s 82A(1).

193 *Abortion Act 1967* (UK) s 1(3).

194 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 14.

195 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 21(2).

196 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 21(1).

197 These agreements detail the range and quantity of services provided using public funding.

198 Ministry of Health, *Final Service Coverage Agreement 2003/04* (2003) <www.moh.govt.nz/moh.nsf/0/9C4925F9A0F14113CC256D5F0077AF17> at 22 February 2008.

199 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 18 requires that no abortion shall be 'performed' elsewhere than in a licensed institution; s 37 provides an exception for emergencies.

200 Generally, the woman takes the mifepristone (RU486) tablet on the first day; 36–48 hours later the woman returns and prostaglandin is administered, either orally or by pessary.

201 *Re a case stated by the Abortion Supervisory Committee* [2003] 3 NZLR 87.

202 House of Commons, Science and Technology Committee (2007) above n 111, 39.

203 *Ibid* 42.

Policy Issues

- 8.175 In Victoria, about two-thirds of all abortions are undertaken in private clinics.²⁰⁴ Prohibiting abortion from taking place in these clinics, which are appropriately regulated under existing laws, would represent a major change to service patterns. It would also require significant additional public hospital resources because demand for abortion services would shift to the public sector.²⁰⁵
- 8.176 Restricting abortion services to public hospitals would be appropriate only if there was evidence that practitioners in private settings are less able to meet clinical standards or have a conflict of interest which impacts upon the quality of service.²⁰⁶ That evidence does not exist. Private clinics are inspected by DHS, which has appropriate regulatory powers that permit intervention if there are clinical concerns.
- 8.177 The commission was advised that private clinics have referral arrangements with tertiary hospitals for complex cases.²⁰⁷ Clinics also follow adverse event reporting and management.²⁰⁸
- 8.178 The commission notes the view of AMA Victoria that limiting a procedure to a particular category of registrant is neither practical nor desirable.²⁰⁹ ‘Clinical data would support the availability of a range of settings, as complication rates are low in both free standing clinics and hospitals, whether in the public or private sectors, and whether staff are specialists or general practitioners.’²¹⁰
- 8.179 It is important that the law does not restrict the development of best clinical practice for either surgical or medical abortion.
- 8.180 The commission believes appropriate regulation of private providers of abortion services currently occurs under the Health Services (Private Hospitals and Day Procedure Centres) Regulations. No further regulation is necessary.

RECOMMENDATION

- 7. Any new abortion law should not contain restrictions on where abortion procedures may be performed. Existing health regulation is sufficient.**

Who Can Perform Abortions?

- 8.181 Some laws expressly provide that only registered medical practitioners may perform abortions.²¹¹ This has been interpreted to include circumstances where people acting under the supervision of a registered practitioner participate in an abortion.²¹²
- 8.182 The commission has not received any information which suggests that unqualified people, often referred to as ‘backyard abortionists’, are offering abortion services in Victoria. There is little doubt, however, that backyard abortionists have operated in Victoria in the past.²¹³
- 8.183 The commission believes it should be an offence for an unqualified person to perform an abortion in any circumstances and has included this in each of the legislative options described in Chapter 6.²¹⁴
- 8.184 There are two legislative options available to penalise unqualified abortion practitioners.

Option 1—Health Act

- 8.185 The first option is to insert a provision into the Health Act stating that an abortion can only be lawfully performed by a medical practitioner. This would activate the provision in the Health Professions Registration Act, which renders it unlawful for an unqualified person to perform services that must be performed by a medical practitioner.²¹⁵
- 8.186 It should be noted that the penalty for this offence is 60 **penalty units**.²¹⁶ Some people may not consider this adequate given the risk of harm associated with unqualified abortion.²¹⁷

Option 2—Crimes Act

- 8.187 The other option is to create a stand-alone offence in the Crimes Act. Such an offence would include the following elements:

a. A person commits an offence if he or she performs an abortion when they are not a medical practitioner or a person acting under the supervision of a medical practitioner.

b. Performing an abortion includes a reference to attempting to perform an abortion; and doing any act with intent to procure an abortion, whether or not the woman concerned is pregnant.

8.188 Under the models proposed in Chapter 6, this would be the only abortion-related offence in the Crimes Act.

No Penalties for the Woman

8.189 The commission is unaware of any woman being charged in Victoria, since 1969, with attempting to perform an abortion upon herself or charged as an accessory to an abortion performed upon herself by another person. It seems appropriate, though, 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
- liable to any legal sanction if she knowingly permits a medical practitioner to perform an unauthorised abortion upon her.

8.190 The commission believes new abortion legislation should be drafted to make it clear that a woman commits no legal wrong if a non-qualified person performs her abortion. Each of the legislative options set out in Chapter 6 applies this principle.

RECOMMENDATIONS

8. The Crimes Act 1958 should be amended to include a provision that it is unlawful to perform an abortion unless it is performed by, or under the supervision of, a registered medical practitioner or

The Health Act 1988 should be amended to include a provision that an abortion can only be lawfully performed by a medical practitioner, or under the supervision of a medical practitioner.

9. It should not be an offence for a woman to perform or attempt to perform an abortion upon herself.

10. 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.

11. A woman should not be liable to any legal sanction if she knowingly permits a medical practitioner to perform an unauthorised abortion upon her.

204 See Chapter 3.

205 The Women's is operating at capacity within existing resources and clinical priorities: consultation 8 (Choices Clinic, Royal Women's Hospital).

206 See, eg, submission 15 (Dr Nicholas Tonti-Filippini). Some people also believe that at least some conflict of interest arises because of the private, for-profit status of the provider (as opposed to public). If this was the case, then logically, the same problem would occur in any private day centre, regardless of the procedure. This calls into question the ethical status of a major component of our health system.

207 The Women's reported that it has arrangements with private clinics, where the clinic may refer the woman if it is not comfortable performing the procedure, or if it is not safe to continue the procedure. Clinics may also refer patients where there are complex psychosocial factors involved and the woman requires more counselling but cannot afford private counselling: consultation 8 (Choices Clinic, Royal Women's Hospital). Cf consultation 18 (Dr Nicholas Tonti-Filippini).

208 Confirmed in email from Women's Clinic on Richmond Hill, 4 December 2007.

209 Submission 503 (Australian Medical Association Victoria).

210 National Health and Medical Research Council (1996) above n 44, 18.

211 Eg, *Criminal Code Act 1913* (WA) s 199.

212 For medical abortion, the practitioner is not required to personally perform each action needed for the treatment. '[The] doctor need not do everything with his own hands; the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with his directions and of which a registered medical practitioner remains in charge throughout': *Royal College of Nursing of the UK v Department of Health and Social Security* (1980) 1 All ER 545 (Lord Diplock).

213 See, eg, Robyn Gregory, 'Corrupt Cops, Crooked Docs, Prevaricating Polies and 'Mad Radicals': A History of Abortion Law Reform in Victoria, 1959-1974' (Unpublished PhD Thesis, RMIT University, 2004).

214 Such an offence was discussed by many consultees, eg, submission 397 (Dr Steven Tudor and Alison King, School of Law, La Trobe University).

215 *Health Professions Registration Act 2005* s 80(1)(d).

216 The penalty is 300 units for a body corporate: *Health Professions Registration Act 2005* s 80(1).

217 The value of a penalty unit is \$110.12: *Government Gazette* No G19, 10 May 2007, 804.

NOTIFICATION SCHEMES

8.191 Another issue raised in consultations was the accuracy and publication of abortion data. The related but separate issue of adverse event reporting was also considered.

Data Notification

- 8.192 We discussed incidence of abortion in Chapter 3. There is no accurate data about the rate of abortion in Australia because 'there is no uniform method of data collection, collation or publication, and all the data sources that are available have deficiencies'.²¹⁸
- 8.193 There are significant limitations with obtaining abortion data from Medicare records, hospital separations records, or extrapolating from South Australian data.²¹⁹ South Australia, and more recently Western Australia, are the only Australian states or territories that collect and routinely publish comprehensive data on abortions because their abortion laws include a notification requirement.²²⁰ South Australian data is used for extrapolations because it has been collected for over 10 years.
- 8.194 An AIHW study notes the shortcomings of existing data sets, which do not include a wider range of information on the circumstances and clinical outcomes of abortions. The existing national routinely collected data sets do not uniformly include information on the diagnosis, reason/indication for the induced abortion, complications, gestation, anaesthetics, socioeconomic characteristics, or category of medical practitioner undertaking the procedure. They also do not include comprehensive information on pre- and post-abortion services, such as counselling and contraception, or on risk factors.²²¹
- 8.195 The AIHW study suggests ways to develop the National Hospital Morbidity Database, Medicare data, the Australian Bureau of Statistics perinatal mortality data, data on abortions for congenital anomalies, and voluntary or mandatory reporting by non-hospital facilities.²²²

Existing Data Collection in Victoria

- 8.196 In Victoria since 2002–03, all private abortion providers must be registered as day procedure centres or private hospitals.²²³ As part of that registration, clinics are required to provide detailed statistical returns to DHS.²²⁴ This includes: the patient's record number; admission date; admission source; date and country of birth; indigenous status; postcode and locality; marital status and sex; type of care received and procedures carried out; health fund and level of insurance; Medicare number; date of discharge; discharge destination; and final diagnoses on discharge. The last two requirements would disclose any adverse events resulting from an abortion. A penalty of 40 units applies for failure to provide the required information every month.
- 8.197 As the effect of this requirement is to provide mandatory reporting of data to DHS, the commission does not believe it is necessary to create any further legislative requirement for reporting the incidence of abortion. It would simply replicate existing requirements; unnecessary legislation is undesirable.
- 8.198 Public health services and other public hospitals are required under the conditions of funding to report information to DHS; this includes the same kind of information that private hospitals report. Denominational hospitals also report this information as a condition of funding.
- 8.199 As reporting is already occurring in Victoria, the remaining issue is dissemination of abortion data. The data currently collected by DHS is not published. Many submissions and consultations discussed the importance of such data being available for future policy development, some seeing it as particularly important for the development of strategies to reduce the number of abortions.²²⁵
- 8.200 Failure to disseminate abortion data does not encourage informed discussion of issues, or targeted, well-informed policy making for abortion, reproductive health, and education. Clinical policy and health policy in this area would be assisted by the routine publication of this information. The Health Act contains a general provision requiring the DHS Secretary to ensure comprehensive health data is collected and to 'analyse and disseminate this information widely to members of the public'.²²⁶

- 8.201 If accurate national data is to become available, Victoria must enter an agreement with other states and territories to improve and standardise data. The AIHW notes that essential components for enhanced routine reporting are:
- national agreement on the aims and objectives of the collection
 - the scope of collection, including gestation
 - the data elements to be collected
 - process and outcome measures
 - the definition of induced abortion.
- 8.202 It suggests a program of data development, ideally occurring under the auspices of the National Health Information Agreement governance arrangements to ensure national standardisation of data.

RECOMMENDATION

12. Mandatory reporting of abortions and outcomes by private providers occurs under the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002, and by public providers as part of their responsibilities under funding agreements. No further legislative requirement is necessary.

ADVERSE EVENTS REGISTER

- 8.203 Some people²²⁷ suggested that in addition to general data collection, there be a specific, additional requirement for abortion providers to keep and submit records of outcomes of procedures so that information can be published that would assist future patients to make informed decisions.²²⁸
- 8.204 Adverse events are usually understood to be in the context of medical mishap or mistake rather than a feature of a general data collection. The AIHW defines them as ‘incidents in which harm resulted to a person receiving health care’.²²⁹

Current Regulation

- 8.205 In Victoria, private hospitals and day procedure centres are required to maintain adverse event records on site. These are inspected by DHS as part of the renewal of a clinic’s registration under the Health Services (Private Hospitals and Day Procedure Centres) Regulations.²³⁰ A medical management meeting or committee, independent of the clinic, may also review reports of adverse events.²³¹ Evidence of ongoing quality improvement activities is an expectation for renewal of registration of all facilities
- 8.206 Public hospitals notify any major incidents to the DHS Sentinel Event Reporting System. There are also internal hospital procedures that deal with adverse events, including a weekly review of the surgical list and an annual audit of cases.²³²
- 8.207 Patient records include outcomes of abortion procedures where known. If a patient does not attend a follow-up consultation or does not advise of a complication this information cannot be captured. The Austin Hospital reports: ‘Our unit has not had a sentinel event. Our audit shows a very low rate of complication which is commensurate with the published rate in the medical literature’.²³³

Policy Issues

- 8.208 There is no evidence that adverse events are common. Nor is there evidence that the current regulatory framework for notifying and dealing with adverse events is inadequate.

- 218 Angela Pratt, Amanda Biggs and Luke Buckmaster, *How Many Abortions are there in Australia? A Discussion of Abortion Statistics, Their Limitations, and Options for Improved Statistical Collection* (2005) 2.
- 219 For a comprehensive analysis of the limitations see *Ibid*.
- 220 The *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 1996* (SA) contain the notification regime, including penalties for doctors who fail to comply. The *Health Act 1911* (WA) s 335 contains WA’s notification requirements.
- 221 Narelle Grayson, Jenny Hargreaves and Elizabeth Sullivan, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia* (2005) 59. The study is discussed in Chapter 3.
- 222 *Ibid* 59–62.
- 223 *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002* rr 6, 7 and *Health Services Act 1988* s 3.
- 224 *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002* r 47. This was confirmed in consultations 1 (Fertility Control Clinic), 9 (Croydon Day Surgery), 35 (Women’s Clinic Richmond Hill).
- 225 Consultations 19 (Royal Women’s Hospital), 23 (Victorian Women with Disabilities Network), 31 (RANZCOG); submissions 8 (Presbyterian Church of Victoria), 73 (Leo Mahoney), 80 (the Hon Dr Bob Such MP), 90 (Corrina Broomfield), 100 (Rita Joseph), 101 (James Hanrahan), 145 (Roger McVhinney), 148 (Mary Anne Yang), 255 (Waverly Catholic Deanery), 467 (Suryan and Therese Chandrasegaran), 507 (Royal Women’s Hospital).
- 226 *Health Act 1958* s 9.
- 227 Eg, submission 8 (Presbyterian Church of Victoria).
- 228 This policy rationale is consistent with the *NHMRC Ethical Guidelines for the Clinical Practice of Assisted Reproductive Technology*. In ART many techniques are experimental or innovative and patients have a strong interest in success rates. Abortion is a different type of procedure and is less reliant on emergent techniques than ART. Success rates are not an issue in the same way as they are for people contemplating ART.
- 229 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005–06* (2007) 56.
- 230 The expectation to record, monitor, and investigate adverse events as a part of an ongoing quality management system is a general expectation of all health service establishments, not just abortion clinics.
- 231 Confirmed in email from Women’s Clinic on Richmond Hill, 4 December 2007.
- 232 Confirmed in email from Austin Hospital, 4 December 2007.
- 233 *Ibid*.

RECOMMENDATION

- 13. Adverse event reporting and management occur under existing public health protocols and as a condition of registration under the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*. No further legislative requirement is necessary.**

ADDITIONAL CONSENT REQUIREMENTS

Father's Consent

- 8.209 Some people felt that the father should have to give consent before the woman could proceed with an abortion.²³⁴ They cast this as an equality issue.²³⁵
- 8.210 AMA Victoria did not agree, stating: 'The patient, in consultation with her medical practitioner, should be making decisions about their own care. Any third party involvement will have the potential to compromise best patient care'.²³⁶
- 8.211 Although there is not a significant amount of research in this area, the most recent data from the Women's suggests that nearly three-quarters of partners are informed and supportive of the woman's decision. The following table provides information about partner knowledge of abortion.

Table 8²³⁷

Partner Attitude Towards Abortion

Partner in pregnancy aware and supportive	2370	72%
Partner in pregnancy aware and unsupportive	292	9%
Partner in pregnancy aware; attitude unknown	139	4%
Disclosure that partner in pregnancy violent/abusive	83	3%
Partner in pregnancy not aware	368	11%
Separation	27	1%
Total	3279	100%

- 8.212 A father's consent is not required in any other Australian statutory schemes. The issue was considered in the High Court 25 years ago, when an application by a man for an injunction to restrain an abortion was refused.²³⁸ The court found a man cannot compel a woman to continue with a pregnancy; the decision is consistent with cases in other jurisdictions.²³⁹
- 8.213 The commission believes there is no reason to disturb this principle.

Young People and People with Disability

- 8.214 Some people sought additional notification and consent requirements for young people seeking abortion. For example, people who sent pro-forma submissions argued that parents of young people should be required to give consent.²⁴⁰ Some people said the permission of the Family Court should also be required for people 'under age'.²⁴¹
- 8.215 The Endeavour Forum argued that medical practitioners should be required to notify police of all requests for an abortion by young women under 16 years of age.²⁴²
- 8.216 The Youth Affairs Council of Victoria was strongly opposed to mandated parental consent for all young women under 16 years. Along with Family Planning Victoria, it argued that the existing law of consent should apply. It was also concerned that health information privacy principles be observed for competent minors, citing community consultation research indicating that health privacy and confidentiality is a significant concern of young people.²⁴³

Current Law and Practice in Victoria

- 8.217 The law of consent was discussed in Chapter 2. In summary, the legal age of maturity in Victoria is 18. The capacity of a young person below this age to legally consent to medical treatment is determined by applying the **competency** test laid down in *Gillick*²⁴⁴ and confirmed by the High Court in *Marion's Case*.²⁴⁵

8.218 The Medical Practitioners Board of Victoria has published guidelines for practitioners that outline the practical application of the *Gillick* test. The doctor must be satisfied that the young person has the capacity to understand and appreciate the proposed procedure and the consequences of having or not having the treatment.²⁴⁶ These guidelines also set out relevant privacy and confidentiality considerations.

8.219 A young person with an intellectual disability may not be able to consent to medical treatment. In these circumstances, the parent may generally consent.²⁴⁷

Relationship Between Competency and Confidentiality

8.220 Medical practitioners have a legal and ethical duty to maintain the confidentiality of a competent young person. The AMA has adopted the position 'that if a young person is able to make autonomous decisions regarding medical treatment and wishes the treatment to remain confidential, his or her doctor must respect and maintain that confidentiality'.²⁴⁸

8.221 The *Privacy Act 1988* (Cth) does not contain specific provisions for young people but is generally understood to give the same rights and protections to competent young people as those enjoyed by adults.²⁴⁹ The privacy principles contained in the *Health Records Act 2001* are observed for a competent young person.²⁵⁰

8.222 Medicare records can include the type of service received and the medical speciality of the practitioner.²⁵¹ The written consent of a young person aged 14 years and over is required before parents can access their child's Medicare and Pharmaceutical Benefits Scheme records. Parents who cannot gain their child's authorisation may request that Medicare pass on their request to the medical practitioner.²⁵²

Other Jurisdictions

8.223 In NSW, young people aged 14 and over can consent to medical treatment without undergoing a *Gillick* **mature minor** assessment.²⁵³ In South Australia competency to consent to medical treatment, including abortion, occurs at 16 years.²⁵⁴

8.224 In the Northern Territory, a woman must be over 16 years to lawfully consent to an abortion.²⁵⁵

8.225 In Western Australia, a young woman under 16 years is not regarded as having given informed consent to an abortion unless a custodial parent or guardian has been informed that abortion is being considered. The parent or guardian must be given the opportunity to participate in the counselling process and medical consultations.²⁵⁶ If these provisions are met, the young woman may give her consent, even if this is not consistent with the parent or guardian's wishes.²⁵⁷

234 A very small minority of submissions included grandparents, local priests, and others in the class of persons who should give consent.

235 Submission 519 (Mr Chris Whelan). Note also that paternity itself may be contested.

236 Submission 503 (Australian Medical Association Victoria).

237 Information provided at a meeting with Professor Doreen Rosenthal, Dr Heather Rowe, Dr Shelley Mallett, Ms Annarella Hardiman and Dr Maggie Kirkman, 5 December 2007.

238 *Attorney General (ex rel Kerr) v T (Qld)* [1983] 13 Fam LR 189; See also *In the Marriage of F* (1989) 13 Fam LR 189.

239 Eg, *Paton v British Pregnancy Advisory Services Trustees and Another* [1978] 2 ALL ER 987.

240 Eg, submission 39 (Paul Smithers).

241 Consultation 4 (Presbyterian Church of Victoria).

242 They argued that in such cases a statutory rape had occurred. Victorian criminal law does not include an offence of statutory rape; however, there are offences of incest and sexual penetration of children under the age of 16: *Crimes Act 1958* ss 44, 45.

243 Submission 502 (Youth Affairs Council of Victoria) citing Australian Law Reform Commission, *Review of Australian Privacy Law: An Overview* (2007).

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

245 *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

246 Medical Practitioners Board of Victoria, *Consent for Treatment and Confidentiality in Young People* (2004) <www.medicalboardvic.org.au/pdf/ConsentforTreat&ConfinYoungPeople.pdf> at 22 February 2008.

247 See Chapter 2.

248 Australian Medical Association, *Submission to the Office of the Privacy Commissioner Review of the Private Sector Provisions of the Privacy Act 1988* (21 December 2004) 21, cited in Australian Law Reform Commission, *Review of Privacy*, Issues Paper 31 (2006) 467.

249 *Ibid* 461.

250 That is, health information should not be disclosed other than in the circumstances prescribed by the Act. The legislation does not prescribe a fixed age at which a young person is deemed competent; however, the legislation does provide statutory guidance about when people, including young people, are considered incapable of making decisions about their health information: *Health Records Act 2001* s 85(3).

251 Young people aged 15 years and above may apply for their own Medicare card without parental approval.

252 This policy is set out in public information prepared by Medicare. See Medicare Australia, *Information Sheet for Medicare and/or Pharmaceutical Benefits Scheme (PBS) Claims Information for Children* <www.medicare.gov.au/common/utills/files/request-obtaining-medicare-pbs-claims-info-child-under16.pdf> at 22 February 2008.

253 *Minors (Property and Contracts) Act 1970* (NSW) s 49(2).

254 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

255 *Medical Services Act* (NT) s 11(5)(a).

256 *Health Act 1911* (WA) s 334(8). Note, the age provisions only apply to dependant minors, ie young women under 16 years who are being supported by a custodial parent or parents.

257 *Acts Amendment (Abortion) Act 1998* Review Steering Committee [Western Australia] (2002) above n 38, 25.

- 8.226 To vary the parental requirements, a dependent minor must seek the permission of the Children's Court.²⁵⁸ Twenty-six such applications were made between 1998 and 2002. All were approved. Reasons given for granting orders included fears of violence, retribution, cultural and religious reasons.²⁵⁹
- 8.227 Parental notification and consent requirements feature strongly in the US:²⁶⁰ 22 states require parental consent only. By default this includes notifying parents:²⁶¹ 11 states require parental notification only.²⁶²
- 8.228 Six states permit a minor to obtain an abortion if a grandparent or other adult relative is involved in the decision and 14 states allow a minor to obtain an abortion in cases of abuse, assault, incest or neglect.
- 8.229 All of the 35 states have a judicial bypass procedure, which allows young women to obtain approval from a court.

Policy Issues

- 8.230 The *Gillick* principle of the mature minor is the basis for assessing competency for medical procedures in Victoria.²⁶³ To move from this principle would mean that individual determinations of capacity are not made. Instead, a fixed age becomes the proxy for competency. In an area as sensitive as medical treatment for young people, proceeding by way of individual determinations of competency is the preferred approach.²⁶⁴
- 8.231 As discussed in Chapter 2, the commission believes that the current common law rules concerning the competency of minors to consent to medical treatment are appropriate.
- 8.232 Maintaining the confidentiality of a mature minor's medical treatment is essential. 'The provision of confidential medical care goes hand in glove with acknowledging their right to consent to medical treatment: minors mature enough to consent are medico-legally owed the same duty of confidentiality as adults'.²⁶⁵
- 8.233 It is also important not to deny the central role parents play in supporting young women in their decisions, and that most young women turn to their parents for support when dealing with unwanted pregnancy. Overseas studies show that most adolescents turn first to their parents for health care concerns,²⁶⁶ however, mandating parental notification risks some young women not accessing health services out of fears about confidentiality.²⁶⁷
- 8.234 While the Western Australian legislation allows young women to seek an order from the Children's Court, such a process is dependent upon young women knowing the option is available, and the subsequent provision of effective legal advice.²⁶⁸ This is a cumbersome way to deal with circumstances where the young woman wishes her case to be kept confidential. It also undermines the first principle that a mature minor patient's confidentiality is as important as that of an adult.
- 8.235 The commission notes that registered medical practitioners and nurses are under an existing obligation to notify DHS and /or Victoria Police if they believe on reasonable grounds that a person aged under 17 years is in need of protection.²⁶⁹ The commission does not think it necessary that medical practitioners be legally required to notify Victoria Police of all women aged under 16 years seeking abortion.
- 8.236 The Guardianship and Administration Act applies to people with a disability who are not competent to give lawful consent to abortion. No further legislation requirement is necessary.

RECOMMENDATION

- 14. The existing law governing consent and confidentiality for young people is adequate. No further legislative reform is required**
- 15. The *Children, Youth and Families Act 2006* requires registered doctors and nurses to notify the Department of Human Services or Victoria Police if they are of the reasonable belief that a person under 17 years is in need of protection. No further legislative requirement is necessary.**

ANTI-COERCION LEGISLATION

- 8.237 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.'²⁷⁰
- 8.238 There was specific concern that the decision-making capacity of women with a disability be respected.²⁷¹ 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.²⁷² The Victorian Women with Disabilities Network also expressed concern that there may be coercion to continue with a pregnancy from groups opposed to abortion.²⁷³
- 8.239 Some people suggested that partners, parents, and doctors regularly coerce women into abortion.²⁷⁴ Some of these people, while generally supportive of requiring parental consent, were concerned that parents may actively coerce young women into abortions. Some claimed financial inducements were provided by clinics.²⁷⁵ No firm evidence of coercion was provided to the commission.
- 8.240 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.²⁷⁶ This is consistent with the practitioner's existing ethical duty to gain valid consent.
- 8.241 The Endeavour Forum²⁷⁷ recommended the introduction of specific anti-coercion legislation based on draft Bills under consideration in some US states.²⁷⁸ These Bills define specific actions as criminal if they are intended to coerce a pregnant woman into seeking an abortion. They require doctors to screen patients for coercion. They sometimes require signs to be put in waiting rooms explaining that coercion and intimidation is illegal.
- 8.242 Anti-coercion legislation does not exist in any Australian jurisdiction. Nor does it exist in the UK or New Zealand, where the general law of consent applies. In the absence of evidence indicating that coercion is a problem, the commission does not think specific anti-coercion legislation is necessary. The current law governing all medical procedures deals appropriately with issues of consent. No further legislative requirement is necessary.

RECOMMENDATION

- 16. Any new abortion law should not include a specific 'anti-coercion' provision.**

SUBSTANTIVE ISSUES BEYOND THE SCOPE OF THIS REFERENCE

TRUTH IN ADVERTISING

Community Views

- 8.243 Women seeking information and counselling about pregnancy may approach a pregnancy counselling service. These may be telephone services, community health or family planning services, or counsellors linked to hospitals or GPs. Generally, services will provide women with information about all three options: abortion, adoption, or continuing the pregnancy and keeping the child.
- 8.244 Some people expressed concern about the accuracy of information provided by some pregnancy counselling services operating in Victoria. They argued that some counselling advertisements mislead women into believing that they offer abortion advice, when the agency is run by groups that oppose and stigmatise abortion.²⁷⁹
- 8.245 Women's Health and people in regional areas were particularly concerned about this issue.²⁸⁰ They suggested that a law be introduced to ensure transparency in advertising to clearly identify counsellors from particular organisations, or with value systems opposed to abortion.²⁸¹

Current Law and Practice

- 8.246 As noted, anyone may describe themselves as a counsellor, regardless of qualifications or membership of a professional body.

- 258 *Health Act 1911* (WA) s 334(9).
- 259 *Acts Amendment (Abortion) Act 1998* Review Steering Committee [Western Australia] (2002) above n 38, 25–26.
- 260 For a summary see Guttmacher Institute, *Parental Involvement in Minors' Abortions*, State Policies in Brief as of 1 January 2008 (2008).
- 261 Mississippi and North Dakota require both parents' consent.
- 262 In Minnesota both parents must be notified.
- 263 The Summary Offences Amendment (Body Piercing) Bill 2007 requires parental consent for body piercing of people aged under 18 years but does not apply to medical practitioners as it is not a medical procedure.
- 264 The range of ages in other jurisdictions' statutory schemes illustrates the complexity of this task.
- 265 Lena Sancu et al, 'Confidential Health Care for Adolescents: Reconciling Clinical Evidence with Family Values' (2005) 183 (8) *Medical Journal of Australia* 410.
- 266 *Ibid* 413.
- 267 'When adolescents understand a service is confidential, they are more willing to disclose behaviours that entail a health risk, to seek health care and to return for follow up': *ibid* cited in submission 502 (Youth Affairs Council of Victoria).
- 268 Legal Aid is available for this purpose in Western Australia.
- 269 *Children, Youth and Families Act 2005* s 184.
- 270 Fleming and Tonti-Filippini (2007) above n 66, 132.
- 271 Consultation 23 (Victorian Women with Disabilities Network; submission 502 (Youth Affairs Council of Victoria)).
- 272 Consultation 23 (Victorian Women with Disabilities Network).
- 273 *Ibid*.
- 274 Consultation 2 (Endeavour Forum); submission 82 (Women's Forum Australia).
- 275 Right to Life Australia referred to an anecdotal story of a private provider who offered a woman a 'cut price abortion': consultation 7 (Right to Life Australia). See also Melinda Tankard Reist, *Giving Sorrow Words: Women's Stories of Grief after Abortion* (2000).
- 276 Consultation 35 (Women's Clinic Richmond Hill).
- 277 Consultation 2 (Endeavour Forum).
- 278 The Michigan Coercive Abortion Prevention Bill 2006 lapsed in the Senate after amendments making it an offence to coerce a woman not to have an abortion were put. A similar Bill was defeated in Virginia. The Wisconsin Senate has referred a similar Bill to Committee (AB 427).
- 279 Submission 461 (Association for the Legal Right to Abortion).
- 280 Eg, submissions 465 (Women's Health Grampians), 509 (Annarella Hardiman).
- 281 Submission 147 (Dr Leslie Cannold).

8.247 Professional associations such as the Australian Association of Social Workers and the Psychotherapy and Counselling Federation have published standards and ethical codes. These state clearly that a counsellor or agency should accurately describe their service. For example, the Psychotherapy and Counselling Federation of Australia standards state:

*[A]ny publicity material and all written and oral information should reflect accurately the nature of the service offered and the training, qualifications and relevant experience of the counsellor.*²⁸²

8.248 There is no requirement that an individual counsellor or service be a member of an organisation that has standards of this nature.

8.249 The Health Professions Registration Act regulates the practice of health professionals, including nurses, pharmacists, doctors, and Chinese medicine practitioners. The Act prohibits registered health professionals from engaging in false, misleading, or deceptive advertising;²⁸³ however, counselling is not a registered profession for the purposes of the legislation and so is not bound by the prohibition.

8.250 No legislation regulates advertising by counsellors who do not charge for their services. Section 52(1) of the *Trade Practices Act 1974* (Cth) states: 'A corporation shall not, in trade or commerce, engage in conduct that is misleading or deceptive or is likely to mislead or deceive'. The *Fair Trading Act 1999* similarly regulates the conduct of persons other than corporations.²⁸⁴ A service that provides free counselling or information is not engaged in trade or commerce. Consequently, it is not governed by the relevant provisions in the Trade Practices Act or the Fair Trading Act.

Attempts at Federal Reform

8.251 Many people who raised this issue referred to the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005, introduced as a private member's Bill into federal parliament by Senator Stott Despoja.²⁸⁵

8.252 The Bill sought to make pregnancy counselling service providers who are exempt from the Trade Practices Act subject to the same principles as those engaged in trade or commerce. It included significant penalties and required organisations in receipt of Commonwealth funding to comply with the Bill.

8.253 The Bill was referred for inquiry by the Senate Community Affairs Legislative Committee. It reported that it 'received many case studies from people who felt they had been misled by some pregnancy counselling services'.²⁸⁶

8.254 Reporting in August 2006, the committee did not make specific recommendations on the Bill; however, it did acknowledge that transparency in advertising is an important issue. It concluded that 'the community is in favour of transparent advertising but how this is best achieved remains the challenge for policy makers and politicians'.²⁸⁷

8.255 Given the complexities of the issue and its terms of reference, the commission has not had the time or resources to canvass this issue; however, there is community concern about truth in advertising by pregnancy counselling services.

8.256 The commission encourages the Minister for Health to address this issue by considering appropriate regulatory options.

BUBBLE ZONES

Community Views

8.257 During consultations, several people raised the issue of protestors outside abortion clinics. There was concern that the safety and wellbeing of patients and staff were being jeopardised by intimidation and harassment from protestors.²⁸⁸ Several people reminded the commission of the fatal shooting of a security guard at a clinic in 2001.

8.258 The Fertility Control Clinic described the issue as a 'chronic and serious situation of daily harassment'.²⁸⁹ It took the view that no person should be able to obstruct a woman from accessing health care, including abortion.

- 8.259 A woman, who wished to remain anonymous, described her own experience as one where she was in 'no position to defend myself from such a cowardly attack at a vulnerable time in my life'. She felt there was a lack of protection for women and their friends, partners, families, and support people and said this was of 'grave concern'. She submitted that the law should provide protection for workers at and clients of abortion services.²⁹⁰
- 8.260 The Victorian Women with Disabilities Network noted that women with disabilities use clinics for a variety of reproductive health services. It reported that women may be confronted by protestors regardless of their reasons for using the clinic.²⁹¹
- 8.261 A medical practitioner, who claimed to have received a death threat in the past, said one of the reasons for local specialists in regional areas not performing abortions is the 'concern about verbal or physical attacks'. Women's Health Victoria reported similar problems.²⁹²
- 8.262 The Helpers of God's Precious Infants strongly defended their activities outside abortion clinics. They describe their activities as 'encouragement and assistance' and state that they 'always act within the law and we never incite or instigate violence'. They said 'no-one has ever been dissatisfied with the help we have given them'.²⁹³

Current Law and Practice

- 8.263 The Women's has a permanent injunction against Right to Life Victoria and people named in the **schedule** to a Supreme Court of Victoria order made on 20 July 1992. This injunction applies to the hospital's current premises.²⁹⁴
- 8.264 The commission was informed that Victoria Police can issue on-the-spot notices for breaches of Melbourne City Council by-laws for obstruction or public nuisance.²⁹⁵

Examples from Other Jurisdictions

- 8.265 The use of **intervention orders** to stop protestors is seen by some people as a piecemeal approach to what is arguably a broader issue of equitable access to health care. Since no other medical procedure attracts the number and persistence of abortion protestors, some people say that a more comprehensive approach is needed.
- 8.266 Several people suggested 'bubble zone' legislation.²⁹⁶ This is also referred to as 'buffer zone' or 'moving-on' legislation. In contrast to existing Victorian law, which requires a hospital or clinic to seek intervention orders or injunctions against particular people, bubble zone legislation establishes a physical zone around a clinic or hospital that protestors may not enter, and/or where their speech or action is restricted. If they do so, they commit an offence.²⁹⁷
- 8.267 In Canada, the British Columbia buffer zone statute—the *Access to Abortion Services Act 1995*—was established following the shooting of an abortion provider and the bombing of a clinic. It creates access zones around facilities which provide abortion services, homes and offices of doctors who provide abortion services, and the homes of other abortion service staff. Within these access zones, a person may not engage in sidewalk interference; protest; beset; or intimidate or attempt to or physically interfere with staff or patients.²⁹⁸
- 8.268 The legislation has been subject to several constitutional challenges on free speech grounds, none of which have been successful.²⁹⁹
- 8.269 The US *Freedom of Access to Clinic Entrances (FACE) Act 1994* does not automatically create buffer zones around clinics; however, its provisions for granting injunctive relief permit judges to order such exclusion zones under appropriate circumstances.³⁰⁰ Three states, Massachusetts, Montana and Colorado, have specific buffer zone legislation,³⁰¹ all of which have attracted constitutional challenge.³⁰²
- 8.270 There is no bubble zone legislation in the UK or in any Australian state or territory.

Policy Issues

- 8.271 The safety and wellbeing of women using abortion services, and any other medical facilities, is a matter of significant importance.
- 8.272 Bubble zone legislation raises several complex legal and policy issues which fall outside our terms of reference.

- 282 Psychotherapy and Counselling Federation of Australia (2006) above n 68, 11.
- 283 *Health Professions Registration Act 2005* s 94.
- 284 A person must not, in trade or commerce, engage in conduct that is liable to mislead the public as to the nature, the characteristics, the suitability for their purpose or the quantity of any services: *Fair Trading Act 2007* s 11.
- 285 The Bill has not been passed.
- 286 Senate Community Affairs Committee, Commonwealth of Australia, *Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005*, Report (2006) 4.
- 287 Ibid 42–43.
- 288 Eg consultations 3 (Association for the Legal Right to Abortion), 10 (Health Services Commissioner); submissions 134 (Women's Health West), 338 (Dr Sally Cockburn), 384 (Victorian Women with Disabilities Network).
- 289 Submission 1 (Fertility Control Clinic).
- 290 Submission 401 (Anonymous).
- 291 Consultation 23 (Victorian Women with Disabilities Network).
- 292 Submission 451 (Women's Health Victoria).
- 293 Submission 476 (Helpers of God's Precious Infants).
- 294 Information provided by the Women's, 20 February 2008.
- 295 Part 2 of the *Melbourne City Council Activities Local Law 1999* (No1 of 1999) prohibits certain activities, including interference with the personal comfort of another person in a public place. Part 13 sets out enforcement procedures and section 1.3 defines an authorised officer to include any police officer, subject to a notice in the *Government Gazette*.
- 296 Eg, consultations 11 (Family Planning Victoria), 12 (Reproductive Choice Australia); submission 11 (Fertility Control Clinic).
- 297 Rebecca Dean and Susie Allanson, 'Abortion in Australia: Access Versus Protest' (2004) 11 *Journal of Law and Medicine* 510, 20.
- 298 *Access to Abortion Services Act 1995* s 2(1).
- 299 See *R v Lewis* [1997] 1 WLR 496; *R v Demers* 2002 BCCA 28.
- 300 FACE prohibits intentional property damage and the use of 'force or threat of force or ... physical obstruction' to 'injure, intimidate or interfere with' someone obtaining or providing reproductive health services: *Freedom of Access to Clinic Entrances (FACE) Act*, 18 USC § 248.
- 301 Guttmacher Institute, *Protecting Access to Clinics*, State Policies in Brief as of January 1, 2008 (2008) 1.
- 302 See *Madsen v Women's Health Ctr* 512 US 753 (1994); *Schenck v Pro-Choice Network of Western NY* 519 US 357 (1997); *Hill v Colorado et al* 530 US 703 (2000).

Chapter 8

Other Legal and Policy Issues

- 8.273 There is understandable community concern about the safety and wellbeing of staff and patients at the hospitals and clinics where people protest or stage vigils because of their views about abortion. The commission encourages the Attorney-General to consider options for a legislative response to this issue.

Appendices

Background Information

The commission has decided to include four appendices that contain background material and references, which may assist readers who wish to examine a particular issue in further detail. This material is provided for information only and, due to the nature of the terms of reference, did not directly influence the commission's recommendations.

Appendix A contains a brief history of abortion law policy in Australia and the UK. Appendix B contains a summary of some of the major ethical writings about abortion. Appendix C refers to a range of judicial statements about the status at law of a fetus and the nature of the relationship between a pregnant woman and a fetus. Appendix D consider some of the issues that arise in the area when abortion is considered from a human rights perspective.



CONTENTS

- 142 Appendix A: History of Abortion Law Policy
- 148 Appendix B: Ethics of Abortion
- 158 Appendix C: Legal Developments
- 162 Appendix D: Human Rights and Abortion
- 172 Appendix E: Consultations
- 173 Appendix F: Submissions

Appendix A

History of Abortion Law Policy

INTRODUCTION

- A.1 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.¹
- A.2 Grubb has suggested that public policy considerations of abortion have moved through three distinct phases. These phases can be described as the criminalisation of abortion, the acceptance of therapeutic abortion, and the regulation of abortion with the medical profession as gatekeepers.² The policy and ethical considerations of patient autonomy, and in particular women's reproductive autonomy, have recently emerged as policy values informing modern abortion laws.
- A.3 The historical policy framework of abortion law is not lineal. Rather, a series of common themes has emerged over time. The history of abortion policy in Victoria 'suggests a dynamic interplay between protection of women, regulation of abortion practices, and tolerance of abortion'.³ The ebb and flow of different policy considerations in Victoria is not dissimilar to the history of abortion policy and practice in Britain, upon which much of our criminal law is based.
- A.4 This appendix considers the major policy drivers underpinning the development of abortion law in the UK and Australia.

EARLY HISTORY

- A.5 'In most, if not all, the civilisations ... abortion was regarded as contrary to the social ethos: in some it was criminal.'⁴ The earliest surviving record of abortion law is over 3000 years old—Assyrian–Babylonian law provided that a woman who 'cast the fruit of her womb by her own act shall suffer impailment'.⁵
- A.6 The policy basis for these laws, across the various civilisations and as far as they can be ascertained, was the suppression of social evils such as sexual promiscuity, and protection of adult life from the risks of taking **abortifacients** or using dangerous instruments. There appears to have been little concern for the fetus. By Roman times the criminal element of abortion related to depriving the father of his child rather than fetal protection.⁶

19TH CENTURY—CRIMINALISATION OF ABORTION

- A.7 There is conflicting authority about the extent to which abortion was regulated by the common law before 1803.⁷ Abortion was mentioned in Blackstone's *Commentaries on the Law of England* in the 18th century and in Coke before that.⁸
- At common law abortion of a woman quick with child seems to have been a misdemeanour only, unless it resulted in the death of the mother ... before quickening it was not punishable at all.*⁹
- A.8 The development of abortion as a statutory offence in Lord Ellenborough's Act extended the offence to the entire gestational period. It also increased the penalty for post-quickening abortion from a misdemeanour to a capital offence; the pre-quickening offence attracted a penalty of transportation.¹⁰ The 1803 statute did not make specific reference to the woman herself.¹¹
- A.9 Keown argues that parliamentary debate and amendments passed during the Bill's passage suggest that its primary purpose was to clarify the law because there was conflicted authority about the status of the common law offence.¹² A further aim was to punish and prevent what was seen as a too frequent social problem with resultant loss of fetal and maternal life.¹³ A further purpose, according to Brookes, was the desire to protect women from the dangers of forced abortion.¹⁴ Although there does not appear to have been any major public outcry over the issue at the time, there is evidence that the practice of abortion was widespread.¹⁵

A.10 The establishment of a statutory offence may also have enjoyed support from the emerging professionalised medical community. Although many abortions were self-performed, midwives also undertook abortion.¹⁶ The criminalising of abortion may well have assisted in the medical profession's struggle in the 19th century for supremacy over 'irregulars'.¹⁷

A.11 From 1803 to 1861 the offence was gradually extended and attracted 'consistently severe punishment'.¹⁸ The severity of the law was in part due to the generally harsh nature of the criminal law at that time but also reflected the increasing influence of the medical profession.¹⁹ While successive legislative reforms in 1828, 1837, and 1861 were primarily in the interests of consolidating the criminal law, significant changes were made in response to criticisms by the profession.²⁰

A.12 The *Offences Against the Person Act 1837* gave the offence of abortion its modern form.²¹ It removed the distinction around quickening, which had been an irritant to the medical profession.²² It also ended the death penalty for abortion. This was part of a broader intention to improve conviction rates by reducing the number of capital offences as juries were generally reluctant to deliver guilty verdicts when a death penalty applied. In making the law on offences against the person simpler and more lenient there was an expectation that both prosecutors and juries would be more likely to apply it. There was still no express provision regarding the woman; however, that was resolved in the next reform.²³

A.13 The *Offences Against the Person Act 1861* enacted a specific provision to make it clear that the abortion offence applied to the mother. This was in keeping with medico-legal opinion that aborting a fetus was abhorrent to morality and that the woman should be punished.

A.14 The 1861 Act also specified that it was no longer necessary to establish that the woman was in fact pregnant. Throughout the 19th century the medical profession increasingly warned of the life-threatening risks of abortion techniques and this new offence aimed to act as a further deterrent. Thus, the medical profession increasingly characterised the problem of abortion in terms of maternal health.²⁴

*The reason assigned for the punishment of abortion is not that, thereby an embryo human being is destroyed, but that it rarely or never can be [e]ffected by drugs without sacrifice of the mother's life.*²⁵

A.15 Previously, reformers had recommended that the offence of procuring a miscarriage should not be punishable when the act is done in good faith and with the intention of saving the life of the woman.²⁶ This was not acted upon; however, the 1861 Act did

1 Her Majesty's Stationery Office, *Report of the Committee on the Working of the Abortion Act*, Volume 1: Report (1974) 4.

2 Andrew Grubb, 'Abortion Law in England: The Medicalization of a Crime' (1990) 18 *Law, Medicine and Health Care* 146, 147.

3 Robyn Gregory, 'Corrupt Cops, Crooked Docs, Prevaricating Pollies and 'Mad Radicals': A History of Abortion Law Reform in Victoria, 1959–1974' (Unpublished PhD Thesis, RMIT University, 2004) 12.

4 Her Majesty's Stationery Office (1974) above n 1, 192.

5 *Ibid* 190.

6 *Ibid* 192.

7 John Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (1998) 3. See also Ian Kennedy and Andrew Grubb, *Medical Law* (3rd ed, 2000) 860–861.

8 Keown (1998) above n 7, 10.

9 Her Majesty's Stationery Office (1974) above n 1, 196.

10 Barbara Brookes, *Abortion in England 1900–1967* (1988) 24.

11 Some commentators argue that the woman was likely to have been included, see Ian Kennedy and Andrew Grubb, *Medical Law: Text with Materials* (2nd ed, 1994) 862. Cf with Barbara Brookes who argues the Act did not prohibit a woman from procuring self abortion: *ibid* 24.

12 Keown (1998) above n 7, 12.

13 *Ibid* 12.

14 Brookes (1988) above n 10, 24.

15 Keown (1998) above n 7, 21.

16 *Ibid* 24.

17 Grubb (1990) above n 2, 150.

18 Keown (1998) above n 7, 27.

19 *Ibid* 28.

20 Eg, *Lord Landsdowne's Act 1828* made more specific reference to instruments or other means to procure the miscarriage. This followed criticism by the medical profession of a loophole in the 1803 offence: *ibid* 28.

21 D Seaborne Davies, 'The Law of Abortion and Necessity' (1938) *Modern Law Review* 126, 135.

22 Brookes (1988) above n 10, 25.

23 Grubb (1990) above n 2, 148.

24 For discussion see Keown (1998) above n 7, 35–39.

25 'Trial of William Russell for the murder of Mary Wormsley' cited in Keown (1998) above n 7, 38.

26 Second report of Her Majesty's Commissioners Revising and Consolidating the Criminal Law, Parliamentary Papers (1846) 24, 42.

Appendix A

History of Abortion Law Policy

include the term ‘unlawfully’ which was to be used so creatively in *Bourne* some 77 years later. This point was made more explicit in the *Infant Life Preservation Act 1929* which provided a maternal life exception.²⁷

- A.16 These concerns for maternal health, expressed in the strongest of sanctions—the criminal law—also served the interests of medical practitioners keen to consolidate their status as a profession. In criminalising abortion the
- regulars, perceiving a demand for abortion, were concerned that patients might be lost to unqualified competitors unless strict laws were enacted to suppress the practice.*²⁸

Early Abortion Policy in Victoria

- A.17 Here in Australia in the second half of the 19th century, there was a similar cultural shift in the meaning of abortion from a well-utilised means of fertility control to a crime with a moral equivalent of murder.²⁹ Nevertheless, the widespread practice of abortion continued.
- A.18 Throughout the colonial period there were very high rates of illegitimacy and maternal mortality.³⁰ Although Victoria’s illegitimacy rates were lower than NSW, unwanted pregnancy was still a major problem for women.³¹ ‘By the mid 1850’s abortion and advertisements for abortifacients were widespread in Australia ... while chemists were strongly linked to referrals to abortionists.’³²
- A.19 The practice of infanticide also grew in the late 19th century.³³ Indictment rates for abortion and infanticide were much lower in Victoria than NSW, but the conviction rate was higher.³⁴ Of defendants in abortion cases, 92% were unmarried women, the majority of whom were domestic servants or working class women.³⁵
- A.20 Nevertheless, ‘the overall numbers of abortion related convictions were extremely low’ compared to the practice.³⁶ This suggests that the police may have been reluctant to pursue charges, or juries to convict.
- A.21 By 1907 the *Australian Medical Gazette* argued that abortionists were ‘looked upon as a public benefit rather than a common nuisance by juries’.³⁷

20th CENTURY—THERAPEUTIC ABORTION

- A.22 Both in Victoria and the UK, the late 19th and early 20th century saw a stronger focus on maternal health as the policy imperative underpinning abortion law and the emergence of the concept of the therapeutic abortion. While concern for the moral status of the fetus remained, the medical and legal communities increasingly considered notions of preserving the life and health of the mother as central to abortion law. This is given its most significant expression in *Bourne*, however, such concerns were raised before that famous case.³⁸
- A.23 Keown argues that abortion on the grounds of maternal health was more prevalent among the regular medical profession than is often thought. He cites an article in the 1898 *Lancet* which stated ‘[t]he fundamental principle ... is this: when the patient’s life is necessarily exposed to great danger if the pregnancy is allowed to continue it is proper to terminate it after adequate consultation’.³⁹ He argues that by the late 1930s ‘it had become acceptable to preserve not only life but also health, both physical and mental’.⁴⁰
- A.24 In England in 1937 the Birkett Committee enquired into ‘the prevalence of abortion, and the law relating thereto’. The committee was required to ‘consider what steps might be taken by more effective enforcement of the law or otherwise to secure a reduction in maternal mortality and morbidity arising there from’.⁴¹ This places the health of the woman front and centre in the policy-making framework, alongside a developing concern to bring the widespread practice of abortion under control.
- A.25 That committee, reporting after the *Bourne* decision, recommended the law be amended to make it:
- [u]nmistakeably clear that a medical practitioner is acting legally, when in good faith he procures an abortion of a pregnant woman in circumstances which satisfy him that continuance of the pregnancy is likely to endanger her life or seriously to impair her health.*⁴²

- A.26 The case of *Bourne* itself marks the first regulation of lawful abortion and in effect brought the common law into line with the clinical practice of registered practitioners.⁴³ From a policy perspective, Justice Macnaghten drew a clear distinction between ‘the act of the professional abortionist and an operation openly performed by a qualified surgeon’.⁴⁴
- A.27 However, its effect in practice does not appear to have solved the problem of the backyard abortionist, at least for poorer women in England. 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.*⁴⁵
- [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’, wielding a knitting needle, syringe or stick of slippery elm ... Although illegal abortions ran into thousands each year, convictions were comparatively few ...*⁴⁶
- A.28 Glanville Williams was particularly concerned about the inequity that enabled rich women to secure an abortion but poor women to risk the backyard operators. He argued that wherever there was a total prohibition this dilemma remained.⁴⁷
- A.29 A clear distinction also emerged in Victoria between the abortion experiences of the rich, who could access a network of midwives and doctors, and the experiences of the poor.⁴⁸ Both practices operated in the shadow of the law. While the policy aim of the criminal prohibition was to protect women, the effect was to drive the practice underground.⁴⁹
- A.30 At the Women’s Hospital in Melbourne the percentage of patients admitted following abortions trebled between 1910 and 1920.⁵⁰ Between 1930 and 1933, 1069 women were treated at the Women’s Hospital for septic abortion, 136 of whom died. By 1936 abortion-related deaths accounted for 31% of the maternal mortality rate at the hospital, which was the place many women ended up following a botched procedure.⁵¹
- A.31 Robyn Gregory, in her thesis on the history of abortion law reform in Victoria, argues that post war
- although abortion was publicly condemned, behind the façade of respectability there was societal acceptance ... but the continuing illegal status of abortion led to a subculture of corruption and collusion with chemists, taxi drivers, hotel keepers and hired touts forming a network of information for women.*⁵²
- A.32 By the 1950s the demographic profile of those seeking abortion had shifted towards married women.⁵³ Given the general acceptance of the Macnaghten ruling in *Bourne*, medical schools were teaching that an abortion performed in a hospital setting with the agreement of two medical practitioners was lawful. ‘Despite the secrecy surrounding abortion, it played a necessary role in medical practice in 1950’s Australia.’⁵⁴

1960s—REGULATION OF ABORTION

- A.33 Although abortion was almost universally illegal in the first half of the 20th century, laws were liberalised in almost all industrialised countries and several developing nations after the 1960s. In the vast majority of cases, abortion became lawful in some circumstances, with the medical profession performing a gatekeeping role. This served the dual function of regulating therapeutic abortion with subsequent improvements in public health while promoting respect for the rule of law.
- A.34 This policy was given legislative expression in the UK in what has been described as the ‘compromise measure’ of the *Abortion Act 1967*.⁵⁵ This placed therapeutic abortion on a statutory footing and extended the grounds for which abortion is lawful. It maintained professional autonomy and the primacy of clinical decision making. However, ‘... the law provides a special regulatory scheme beyond that pertaining to medical treatment and procedures in general’.⁵⁶
- 27 This suggests parliament may have meant to delegate the determination of the circumstances in which abortion is lawful to the judiciary. See Chapter 7 for further discussion of this as regards the Infant Life Preservation Act.
- 28 Keown (1998) above n 7, 40.
- 29 Lyn Finch and Jon Stratton, ‘The Australian Working Class and the Practice of Abortion 1880–1939’, (1988) 23 *Journal of Australian Studies*, 45–46, cited in Gregory (2004) above n 3, 27.
- 30 From 1788 to 1888 more women died in labour or from its after effects than from any other single cause. Gregory (2004) above n 3, 70.
- 31 Gregory (2004) above n 3, 78–79.
- 32 *Ibid* 79.
- 33 *Ibid* 81.
- 34 *Ibid* 81.
- 35 *Ibid* 81.
- 36 ‘Averaging about one every two to three years in Victoria between 1880 and 1939’: *ibid* 84.
- 37 Editor, ‘The Abortion-monger a Common Nuisance’ (1907) 26(3) *Australian Medical Gazette* 130: cited in *ibid* 84.
- 38 See, eg, *R v Collins* [1898] 2 *British Medical Journal* 59; 122 (Grantham J) cited in Keown (1998) above n 7, 52.
- 39 ‘The Legitimate Induction of Abortion’ [1898] 1 *Lancet* 235 cited in Keown (1998) above n 7, 66.
- 40 Keown (1998) above n 7, 69.
- 41 *Report of the Committee on the Working of the Abortion Act* (1974) cited in Kennedy and Grubb (2000) above n 7, 1418.
- 42 *Ibid*.
- 43 Sally Sheldon, ‘Subject Only to the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion’ (1996) 5 *Social and Legal Studies* 95, 99.
- 44 *Ibid* 98.
- 45 Glanville Williams ‘The Law of Abortion’ (1952) *Current Legal Problems* 128, 156 cited in Kennedy and Grubb (2000) above n 7, 1416.
- 46 Glanville Williams, *Textbook of Criminal Law* (2nd ed, 1983) 296.
- 47 *Ibid* 296.
- 48 It was estimated that about 8000 abortions occurred annually in Victoria in the 1920s and 1930s: Gregory (2004) above n 3, 104–105.
- 49 ‘one, and perhaps the chief evil which the Legislature wished to prevent was the possibility of harm being done to the woman’: *R v Trim* [1943] VLR 109, 115 (Martin J).
- 50 Gregory (2004) above n 3, 92.
- 51 *Ibid* 102.
- 52 *Ibid* 116–117.
- 53 Based on the marital status of women who died from abortion, see *ibid* 123.
- 54 *Ibid* 123.
- 55 Williams (1983) above n 46, 296.
- 56 Kennedy and Grubb (2000) above n 7, 1409–1410.

Appendix A

History of Abortion Law Policy

End of the Backyard Trade

- A.35 The policy aim of the UK legislation was to keep women away from the backyard abortionists and eliminate their practice. By 1975 it was felt this aim had been achieved.⁵⁷
- A.36 By 1960 it was estimated there were 10 000–30 000 abortions each year in Victoria. The introduction of the contraceptive pill in 1961 coalesced with growing calls for reproductive freedom and control by women. The influence of the UK Abortion Act was ‘undeniable’,⁵⁸ as public sympathy for women facing unplanned pregnancy increased.
- A.37 Abortion gained more media attention in the second half of the 1960s when a police crackdown on medical practitioners commenced. After two decades of relative immunity the prosecution rate in 1965 was four times the rate than that in each of the previous six years.⁵⁹ By 1968 a much more zealous approach by the homicide squad had significantly increased the risk to doctors relying on the application of the *Bourne* precedent.
- A.38 At the same time public opinion was moving towards patient autonomy. A Morgan Gallup Poll conducted in October 1967 found 64% in favour of liberalised abortion laws.⁶⁰
- A.39 While there were significant policy pressures, including the prevalence of backyard abortion and the dilemma over the gap between the criminal law and clinical practice, the Victorian Parliament did not amend the Crimes Act.⁶¹ In Victoria, NSW, and Queensland, the courts rather than the parliaments determined the circumstances in which abortion was lawful.⁶²
- A.40 Victorian criminal law had always referred to the notion of ‘unlawful abortion’. It was on this phrase that the Menhennitt ruling would turn, confirming the lawfulness of the practice of therapeutic abortion by a medical practitioner in some broadly defined circumstances.
- A.41 However, ‘in practice, doctors continued to be charged, and women found it just as difficult to access abortion after the ruling as before’.⁶³ Police corruption was subsequently exposed through the Kaye Inquiry.⁶⁴ This inquiry pointed to ‘systemic police corruption, maintained in part, by a struggle for industrial control of a lucrative abortion industry’.⁶⁵
- A.42 It was only after the backyard industry was dismantled through the provision of abortion services in the private and public health sectors that the policy aims of protecting maternal health and safeguarding the rule of law could be realised.
- A.43 By the end of the 20th century, Victoria, NSW, and Queensland had retained criminal laws that regulated abortion. Judicial interpretations of those laws allowed therapeutic abortions in some circumstances. Some states, such as South Australia, reformed their criminal codes broadly in line with the UK Abortion Act. In Western Australia, abortion became primarily a health law issue following law reform in 1998.⁶⁶ A few years ago, the ACT completely decriminalised abortion by removing all references to it from the Crimes Act.

LATE 20TH CENTURY—EMERGENCE OF PATIENT AUTONOMY

- A.44 It has already been noted that the medical profession exerted a significant influence on the development of abortion law in the UK and Victoria, regarding the restriction of the law in the 19th century and in its subsequent relaxation in the late 20th century.⁶⁷ This ‘medicalisation of a crime’ makes doctors the gatekeepers of the law.⁶⁸ Thus ‘a great social responsibility is firmly placed by the law on the shoulders of the medical profession’.⁶⁹
- A.45 Sheldon writes that since the Abortion Act women in Britain generally have access to safe, legal services; however, the legislation itself represents only a partial decriminalisation as decision-making power rests with the doctor rather than the woman:
- In becoming constructed in a medical manner, abortion is removed from the public sphere into a private realm where it can be regulated by experts who can lay claim to specialist medical knowledge.*⁷⁰
- A.46 In Australia the public funding of abortion services meant women could better afford therapeutic abortion but because the approval of abortion remains in the hands of medical practitioners, the diversity of medical attitudes towards abortion has a ‘profound influence’ upon its provision.⁷¹

A.47 Medicalising abortion places it firmly within the general management of pregnancy and, as such, it is governed by ethical medical practice as a whole.⁷² The gatekeeping role brings with it its own set of dilemmas. Kerry Petersen describes a 'wedge' in the therapeutic relationship:

*the ethical values of respect for autonomy and beneficence are undermined when criminal laws require a doctor to make a medical assessment based on legal grounds rather than the needs and best interests of the woman.*⁷³

A.48 In practice, the gatekeeping role allows for wide variation because some doctors may deny abortions on the basis of their personal moral values, while others may perform or refer for abortions on the basis of a woman's decision. Both of these circumvent the original policy intention.⁷⁴

A.49 Medicalisation has particular significance for women, as they tend to use health services more frequently than men. Historically, medical discourse has treated women as biologically unstable, psychologically or socially vulnerable, and therefore in need of protection and control.⁷⁵ The practice of medicine and the ethical principles underlying doctor–patient relationships have moved on considerably in the past few decades.

A.50 The right to self-determination in the medical context is drawn from the broader ethical value of autonomy. Personal autonomy is one of the guiding principles of medical law.⁷⁶ Thus, any competent person has the right to make an informed choice to accept or forego medical treatment.

A.51 Reproductive autonomy has been slower to develop as an accepted ethical principle; however, since the 1970s, as abortion became a mainstream medical procedure rather than an illicit act, community attitudes further shifted towards reproductive autonomy. It is likely that this in turn meant that reproductive autonomy became more institutionalised within the medical profession.

A.52 With patient autonomy in the ascendancy, the past few decades have seen a stronger focus upon shared decisions between doctor and patient.⁷⁷ As Kerridge notes, shared decisions involve a subtle but important shift in the traditional doctor–patient relationship. 'Shared decision-making is difficult. Respect for patients' autonomy does not necessarily imply a value-neutral role for health workers; but it does require a delicate balancing of roles.'⁷⁸

57 United Kingdom, Parliamentary Debates, House of Commons, 7 February 1975, 885, 1763–1764 (David Steele).

58 Gregory (2004) above n 3, 134.

59 Ibid 132.

60 Ibid 158.

61 There was, however, significant support for statutory reform among campaigners and professional bodies. Premier Bolte sent the matter to the Chief Justices Law Reform Committee in July 1968, who declined to report on whether laws should be amended. In November 1968 a private member's Bill, the Jenkins Bill, was introduced but there was no debate on it before parliament rose. For discussion see Gregory (2004) above n 3, 145–148.

62 Kerry Petersen, 'Classifying Abortion as a Health Matter: The Case for De-Criminalising Abortion Laws in Australia' in Sheila McLean (ed) *First Do No Harm: Law Ethics and Healthcare* (2006) 354.

63 Gregory (2004) above n 3, 19.

64 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* (1971).

65 Gregory (2004) above n 3, 14.

66 Talina Drabsch, *Abortion and the Law in New South Wales* (2005) 17–18.

67 Keown (1998) above n 7, 84.

68 Kennedy and Grubb (2000) above n 2, 1405.

69 *R v Smith (John)* [1973] 1 WLR 1510 (Scarman LJ).

70 Sheldon (1996) above n 43, 96.

71 Kerry Petersen, 'Criminal Abortion Laws: An Impediment to Reproductive Health' in Ian Freckleton and Kerry Petersen (eds) *Controversies in Health Law* (1999) 33.

72 John Mason, *The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction* (2007) 26.

73 Petersen (1999) above n 71 39.

74 National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) 28.

75 Sheldon (1996) above n 43, 97.

76 Mason (2007) above n 72, 24.

77 Eg, NHMRC Guidelines on Information to Patients contains the principle that 'patients should be encouraged to make their own decisions': National Health and Medical Research Council, *General Guidelines for Medical Practitioners on Providing Information to Patients* (2004) 9.

78 Ian Kerridge, Michael Lowe and John McPhee, *Ethics and Law for the Health Professions* (2nd ed, 2005) 50.

Appendix B

Ethics of Abortion

REVIEW OF MAJOR PHILOSOPHICAL AND THEOLOGICAL ARGUMENTS

- B.1 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. In Chapter 5 we summarised the various views expressed during our consultations.
- B.2 The commission's task is to provide options to government on the decriminalisation of abortion and in particular the legal consequences of various options for reform. The commission has not been asked to form, and has not formed, its own view about the ethical issues surrounding abortion.
- B.3 The following section describes some of the major philosophical arguments on abortion.¹ The commission has included this review to assist the reader with an overview of the ethical debates that may inform people's views about abortion.
- B.4 The discussion first examines arguments about the ethical status of the fetus. It then discusses ethical views about whether abortion can be ethically justified. It concludes with a description of additional philosophical issues that arise in moving from a discussion about the ethics of abortion to one about the ethics of laws regulating abortion.
- B.5 Some caveats are in order. First, the emphasis is on reporting and marshalling the leading arguments in the contemporary debate, and then identifying the major points of disagreement. The various positions are briefly summarised, an approach that will inevitably not capture all nuances. Secondly, there is a deliberate focus on the best-known analyses.² In a literature as vast as this one, the preference for highly visible scholarship may miss many thoughtful and more recent ethical arguments, including some from women who have experienced abortion directly and some from studies of the relationship between the pregnant woman and the fetus.³
- B.6 Commentary in this area generally uses descriptors such as 'conservative', 'moderate', and 'liberal' to categorise different positions in the debate. We have not used those terms because they are not particularly helpful in a brief review of this nature. Just as the commission does not form any view about the relative 'progressiveness' of any position, it does not judge the merits of the ethical or moral positions discussed. Rather, we acknowledge that a range of views exists.
- B.7 This section outlines a mix of views in that range and describes some of the main arguments that sit behind them.

KEY ETHICAL QUESTIONS

- B.8 No issue in bioethics 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. Three specific questions follow:
1. Is the fetus a person, in the sense of having ethical standing and rights?⁴
 2. If the fetus does have ethical standing, what happens when its survival comes into conflict with the decision of the woman to have an abortion? In short, when is abortion ethically acceptable?
 3. How do we characterise the relationship between a pregnant woman and a fetus?
- B.9 Nearly all the ethical debate on abortion can be distilled into competing answers to those questions, or slight variations on them. Historically, the debate pits opponents of abortion against those who argue that abortion is a personal matter for the woman contemplating it. One line of argument is based on the belief that fetal interests are paramount; the other is based on the view that a woman's autonomy is paramount.
- B.10 Another line of argument seeks to resolve these two, seemingly irreconcilable, views. Positions in this middle ground strive to explain how, if the fetus acquired a right to life at conception, it could ever be acceptable to end its life. Alternatively, if middle-ground arguments are premised on the view that the fetus does not have firm rights, they must attempt to provide a principled basis for justifying situations in which the woman's right to choose may be limited.

- B.11 Some more recent scholarship focuses upon the unique nature of the relationship between the pregnant woman and the fetus. This is examined to find a possible answer to the question of whether abortion is ever ethically justified, and if so, under what circumstances. In particular, the relational approach aims to bridge the gap between maternal autonomy interests and ethical status of the fetus. Its success or otherwise is for others to assess.
- B.12 An additional set of ethical questions concerns the justification for legislative intervention. There is an important distinction between assessments of the morality of abortion as a practice and arguments over the morality of laws that regulate abortion.
- B.13 The ethical question here is: To what extent is it morally acceptable to limit the ability of pregnant women who request abortions to have them?
- B.14 It is at this point that lawmakers confront fundamental policy decisions about the ordering of interests: women's autonomy, maternal-fetal relationships, fetal interests and the role of the State.

IS THE FETUS A PERSON?

- B.15 The first ethical question entails three distinct issues:
- When does human life begin?
 - When does a fetus become a person with all of the rights entailed in that status?
 - Does a fetus acquire legal rights prior to birth?
- B.16 The first is a biological question with ethical overtones. The latter two are ethical questions which may translate into legal policy decisions.

CONCEPTION AS THE PERSON-DEFINING STAGE

- B.17 The Catholic Church has long taken the view that life begins at conception and so abortion is a grave ethical wrong.⁵ A series of pronouncements by Pope John Paul II reinforced this stance: 'Life must be protected with the utmost care from the moment of conception'.⁶ Abortion and infanticide are 'unspeakable crimes' because they are acts that 'violat[e] the integrity of the human person' and are 'hostile to life itself'.⁷
- B.18 A person's religious belief might require them to delve no deeper. Others do not take theological teaching as the final word and take a more secular view. John Noonan, an American lawyer-philosopher, is perhaps the most prominent voice in this regard. In defending conception as the beginning of human life, Noonan sidesteps the contested notion of ensoulment⁸ and opts for more secular logic. The criterion he lays out for humanity is that 'if you are conceived by human parents, you are human'.⁹
- B.19 This assertion leads to the question of why we should regard conception as the decisive, ethically relevant moment at which a human being comes into existence. Noonan's position is rooted in two interrelated arguments. The first argument turns on the notion of the fetus as a potential person. The second claims that conception is a more convincing stage than any other in the continuum from **gamete** to **neonate** at which to draw the personhood line. Outlining these two arguments, and the counter arguments against them, is a useful way to track opposing views of the fetus's ethical status.

Potentiality

- B.20 Although the basic cells and genetic material needed to form a walking, talking, and thinking human being exist at conception, for many, calling the zygote, embryo, or fetus a 'person' at its early stages may obscure the meaning of that word and defy common sense.
- B.21 People who argue conception is the moment at which an ethically relevant person comes into existence tend to point to what the fetus is poised to become, rather than what it actually is, in mind and body. This type of argument is referred to as the 'potentiality' criterion. The substantial weight Noonan places on the first assembly of the genetic code becomes clearer in light of the potentiality criterion:

- 1 Professor David Studdert undertook a review of leading bioethical scholarship that informs this part of the report.
- 2 Much of this comes from American philosophers writing in the 1970s and 1980s, a particularly productive period for abortion scholarship.
- 3 See, eg, Leslie Cannold, *The Abortion Myth: Feminism, Morality, and the Hard Choices Women Make* (2000).
- 4 Having moral standing is different to having legal rights. It is a long-standing legal rule that the fetus does not have legal rights until born. The legal status of the fetus is reviewed in Appendix C. A discussion of human rights law and the fetus, specifically, the right to life of the fetus is in Appendix D.
- 5 Across religions and faiths there is a range of positions, eg, the Anglican Diocese of Melbourne takes a gradualist view, ie, while the fetus is fully human from the time of conception, it accrues moral significance as it develops. For a discussion of the various religious perspectives put to the commission in consultations see Chapter 5.
- 6 Pope John Paul II, *Gospel of Life*, 1995, n 62 cited in submission 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne).
- 7 Pope John Paul II, *Veritatis Splendour: Encyclical Regarding Certain Fundamental Questions of the Church's Moral Teaching* (1993) <www.newadvent.org/library/docs_jp02vs.htm> at 13 February 2008.
- 8 In the 13th century, Aquinas argued that the fetus becomes a human being when ensoulment occurred—40 days after conception for males and 90 days after conception for females. However, there has been debate within the Catholic Church about when this occurs and its significance.
- 9 John T Noonan, 'An Almost Absolute Value in History' (1970) reproduced in James White (ed), *Contemporary Moral Problems* (2nd ed, 1988) [10].

Appendix B

Ethics of Abortion

[I]t is this genetic information which determines [the fetus's] characteristics, which is the biological carrier of the possibility of human wisdom, which makes him a self-evolving being. A being with a human genetic code is man.¹⁰

- B.22 Marquis advances a slightly different version of the potentiality argument—what he calls his ‘future-like-ours’ theory. Marquis condemns abortion because the act deprives the fetus of ‘all those activities, projects, experiences, and enjoyments’ that are commonly the stuff of being human.¹¹ The salient feature of Marquis’s argument is that, by emphasising one’s future as a core element of ethical standing, he is able to appeal to a human characteristic that the fetus has as a *fetus*; his argument does not turn on some person-like characteristic, such as consciousness, that awaits late gestation or birth for its crystallisation.
- B.23 Critics challenge the potentiality criterion on several grounds. First, critiques are levelled at the elastic nature of potentiality. Why stop at conception? this argument suggests; each sperm and ovum is also an organism with the potential for life. Does that mean ending the life of a gamete would be deeply unethical, as is abortion?
- B.24 Noonan and Marquis respond by focusing on probabilities. Each sperm has a minute probability of realising its potential to form a person, whereas a fertilised egg has a much higher probability. In their view, the large leap forward at conception in the chances of producing a person is ethically meaningful, and makes it the correct point at which to define the coming into existence of a human being with much the same right to life as any other human being.
- B.25 A second challenge to the potentiality argument is that it involves an error of logic. What follows from potential personhood, it is argued, is potential rights, not actual rights, and potential rights and actual rights are not equivalent.¹² In this view, potential personhood may give rise to some interests or claims to rights, but these are not fully-fledged rights of the kind we would ascribe to a living person.¹³
- B.26 A third criticism focuses on the implications of the language used. Consider the sequence of logic that underpins the potentiality position: (1) it is wrong to kill an innocent human being; (2) the fetus is an innocent human being; and therefore (3) it is wrong to kill a fetus. Several scholars, most notably Mary Anne Warren, have argued that this equation conflates a physical or genetic human being (in proposition 2) with an ethical being (in proposition 1). This type of human being is a member of a ‘moral community’, someone who exists as a person and carries rights and duties by virtue of that person’s place in society. Warren concludes that it is wrong to regard the fetus as a moral, rights-bearing person of this type.¹⁴

Conception—Better than the Rest?

- B.27 The other main argument for conception as the correct stage at which to affix personhood is that it is a more compelling moment than any other in the continuum from zygote to neonate in which to do this. Governments, courts, and commentators who reject conception as the decisive point have attempted to defend later stages of gestation as ethically significant;¹⁵ however, these positions have their own difficulties. Viability, for example, is a shifting concept that can change with advances in medical technology. It may also vary by place, with premature babies in many developing countries having lower chances of survival because of limitations in the medical care available.¹⁶
- B.28 There is divergence within the medical community about the true meaning of the term ‘viability’. It is used in two ways. First, it is used as a biological criterion. Secondly, it is used as an ethical category.¹⁷ Englehardt argues that the use of viability as an ethical concept expresses the idea that the fetus is of a stage of development that, if brought ex-utero, it could be placed in the ‘social role of a child’.¹⁸
- B.29 Singer, who does not agree with the conception arguments, nonetheless acknowledges that the

search for a morally crucial dividing line between the newborn baby and the fetus has failed to yield any event or stage of development that can bear the weight of separating those with a right to life from those who lack such a right ...¹⁹

B.30 In the absence of such a dividing line, proponents of the conception argument therefore assert that ‘we must either upgrade the status of the earliest embryo to that of the child, or downgrade the status of the child to that of the embryo’.²⁰ They maintain that as the latter makes little sense to most people, conception stands as the natural dividing line.

OTHER APPROACHES TO DEFINING MORAL PERSONHOOD

- B.31 Some philosophers have sought to come up with more nuanced criteria for defining personhood. This enterprise is an important intellectual concern in other realms of bioethics besides abortion, such as end of life care and the status of permanently unconscious patients.
- B.32 In the context of abortion, a range of criteria has been proposed as being decisive in determining ethically relevant personhood. The criteria favoured by various commentators include **segmentation**,²¹ brain functioning,²² rationality,²³ and a conceptual and temporal understanding of one’s self.²⁴
- B.33 Mary Anne Warren has proposed five criteria: consciousness (particularly the capacity to feel pain); reasoning; self-motivated activity (relatively independent of either genetic or direct external control); communication and self-awareness. She acknowledges that there may be reasonable debate about whether all of these traits must exist, or just some, but considers it self-evident that if a being satisfies none then the being cannot be a person. The fetus, she concludes, at least in early life, does not satisfy any of the five criteria.²⁵
- B.34 A common challenge to these formulations of personhood is that the bar they set for ethical personhood is far too high. It is too high, the argument goes, because no neonate and possibly no infant (much less a fetus) could meet the specified criteria, particularly those that require reasoning and temporal understanding. Consequently, strict application of the criteria would lead us to the conclusion that infanticide does not involve the unethical killing of a being with rights to life.²⁶
- B.35 Critics also argue that if the fetus fails the personhood test, then that must mean anything goes.²⁷ Personhood proponents respond in a couple of ways to this challenge. One response is a utilitarian argument that runs as follows: society may be worse off by condoning late abortions that are motivated by inconvenience to the pregnant mother. In these circumstances limits should apply.²⁸

- 10 White (1988) [10].
- 11 Don Marquis, ‘Why Abortion is Immoral’ (1989) 86(4) *The Journal of Philosophy* 183, 189.
- 12 Stanley I Benn, ‘Abortion, Infanticide, and Respect for Persons’, in Joel Feinberg (ed), *The Problem of Abortion* (1973) 102.
- 13 See Joel Feinberg, ‘Chapter 6: Abortion’ in Tom Regan (ed), *Matters of Life and Death* (1980) 183, 193–4.
- 14 Mary Anne Warren, ‘On the Moral and Legal Status of Abortion’ (1973) reproduced in White (ed) (1988) above n 9, 16.
- 15 For defences of viability, see, eg, Justice Blackmun’s decision in *Roe v Wade* 410 US 113 (1973); Alan Zaitchik, ‘Viability and the Morality of Abortion’ (1981) 10(1) *Philosophy and Public Affairs* 18–24.
- 16 Viability is discussed in Chapter 3
- 17 See discussion in Kristin Savell, ‘Is the ‘Born Alive’ Rule Outdated and Indefensible’ (2006) 28 *Sydney Law Review* 625, 643. Some people equate viability with the capacity for any length of survival, or disability; others say viability requires a meaningful life.
- 18 Tristram Englehardt, ‘Viability and the Use of the Fetus’ in William Bondenson et al (eds), *Abortion and the Status of the Fetus* (1984), 196 cited by Savell (2006) above n 17, 644.
- 19 Peter Singer, ‘Chapter 6: Taking Life: The Embryo and the Fetus’ in *Practical Ethics* (2nd ed, 1993) 135, 142.
- 20 *Ibid* 138.
- 21 P Ramsey, ‘Reference points in deciding about abortion’, in JT Noonan (ed), *The Morality of Abortion: Legal and Historical Perspectives* (1970) 60–100.
- 22 Baruch Brody, *Abortion and the Sanctity of Human Life: A Philosophical View* (1975); Kenneth Himma, ‘A dualist analysis of abortion: personhood and the concept of self qua experiential subject’ (2005) 31 *Journal of Medical Ethics* 48.
- 23 See, eg, Singer (1993) above n 19.
- 24 Michael Tooley, ‘A Defense of Abortion and Infanticide’ in Joel Feinberg (ed) *The Problem of Abortion* (1973).
- 25 Mary Anne Warren, ‘On the Moral and Legal Status of Abortion’ (1973) in James White (ed), *Contemporary Moral Problems* (2nd ed, 1988) above n 9, 16.
- 26 The response to this challenge by some defenders of relatively demanding personhood criteria is that infanticide

is wrong because it would have terrible consequences. They argue that such a practice would make society worse off and cause great unhappiness because of the high value most people place on the lives of very young children. This counter is based on consequentialist reasoning; it does not concede the personhood point. Warren adds a postscript accounting for the wrongness of infanticide on consequentialist grounds, eg, the unwanted baby could be adopted. See Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal—Fetal Conflict* (2002) 33.

27 Eg, anything can be done to a fetus or abortion can be allowed for any reason.

28 Critics are quick to label this an evasion. They argue that if a moral case is built on deontological foundations, temporarily applying consequentialist reasoning to fix a weakness in a deontological argument is not acceptable. In response, it might be argued that conception-based proponents make a similar switch in their rationale for why fetal rights to life supersede maternal rights to autonomy.

Appendix B

Ethics of Abortion

- B.36 A second response is to state that it does not follow from classification of the fetus as a non-person that anything goes. Non-persons may still be worth something, especially when they are living things, and cruel, wanton or reckless mistreatment of them can be ethically wrong.²⁹

MIDDLE VIEW ON ETHICAL PERSONHOOD?

- B.37 The descriptions so far have tended to pit those who define ethically relevant personhood at conception or soon thereafter, against those who fix it at late stages of fetal development, birth, or some time after birth. Some philosophers have attempted to situate themselves in the considerable space between these opposing viewpoints.
- B.38 These philosophers criticise the tenor and tactics of the polarised nature of the debate. Jane English, an American philosopher, characterises the debate this way:

[f]oes of abortion propose sufficient conditions for personhood which fetuses satisfy, while friends of abortion counter with necessary conditions for personhood which fetuses lack. But these both presuppose that the concept of a person can be captured in a strait jacket of necessary and/or sufficient conditions. Rather, 'person' is a cluster of features, of which rationality, having a self concept and being conceived of humans are only part.³⁰

- B.39 English goes on to criticise the struggle for binary outcomes in the fetus-as-person debate:

*[T]here is no single core of necessary and sufficient features which we can draw upon with the assurance that they constitute what really makes a person; there are only features that are more or less typical. This is not to say that no necessary or sufficient conditions can be given. Being alive is a necessary condition for being a person, and being a U.S. Senator is sufficient. But rather than falling inside a sufficient condition or outside a necessary one, a foetus lies in the **penumbra** region where our concept of a person is not so simple. For this reason I think a conclusive answer to the question whether a fetus is a person is unattainable.³¹*

- B.40 This argument appears to reflect the views of a large proportion of the general public about the ethical status of the fetus.³² It does not permit any certain resolution of when it is ethically acceptable to end the life of a fetus.

RELATIONAL CONCEPTS OF PERSONHOOD

- B.41 Some look to the unique relationship between the fetus and pregnant woman to answer the fundamental questions about the ethical status of the fetus, and the circumstances in which abortion is ethically acceptable. These approaches may be described as relying on relational concepts of personhood.
- B.42 Savell argues,
- a conception of personhood that pays due regard to the intrinsic and relational aspects of foetal being has greater potential to explain the existing criminal law, and to guide future developments, than does a theory based solely on the intrinsic properties of the foetus.³³*
- B.43 She reviews several approaches to the issue of ethical personhood.
- B.44 Mackenzie argues that in early stages of pregnancy the ethical status of the fetus is defined in relational terms 'because it is a being with moral significance for the woman in whose body it develops and who acts as its moral guardian'.³⁴ As pregnancy develops the fetus becomes more differentiated from the woman. Thus the fetus's ethical standing 'is less and less dependent on its relational properties to the woman in whose body it develops and more and more tied to its own intrinsic value'. The fetus is never the ethical equivalent of the woman.³⁵
- B.45 Sherwin adds another dimension to relational notions of personhood. She sees personhood as a social category.³⁶ On her analysis 'persons are members of a social community that shapes and values them'.³⁷ Thus, in her view, a fetus is different to a newborn and cannot be a person in an ethically relevant sense. She argues that the responsibility for determining a fetus's ethical worth rests with the woman who is carrying it.³⁸

- B.46 Others, such as James, take a broader view of relationships. They look to the potentiality of relationships beyond the mother, identifying a ‘potential web of social relationships prior to birth’ in what is described as the ‘pre-birth space’.³⁹

WHEN IS ABORTION ETHICALLY ACCEPTABLE?

FETAL INTERESTS AS TRUMPS

- B.47 It is a short step from understanding the position of the Catholic Church, and commentators who have a similar view of the ethical status of the fetus, to an understanding of their view about when abortion is permissible. Pope John Paul II wrote that ‘direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave ethical disorder, since it is the deliberate killing of an innocent human being’.⁴⁰ In short, the same degree of moral turpitude that attaches to homicide applies to abortion.
- B.48 Thus, when faced with the first question—What is the ethical standing of a fetus?; the answer—The same right to life as any other living person enjoys—is controlling. This leads inexorably to the answer to the next question—abortion is ethically wrong.
- B.49 Adherents of this view do not necessarily ignore the notion that the abortion decision involves a conflict between fetal and maternal interests. They may even acknowledge that a pregnant woman sometimes has compelling reasons for not carrying her fetus to term. However, the substance of the response is that the woman’s reasons for choosing abortion will rarely, if ever, prevail over the fetus’s ‘presumptively’ strong right to life.⁴¹
- B.50 Sumner characterises the reasoning here succinctly: ‘Life is more basic than, and therefore morally prior to, autonomy. When values conflict, the lesser should be sacrificed’.⁴²

Double Effect and Other Exceptions

- B.51 ‘**Double effect**’ is a term that has a number of uses in bioethics. In the context of abortion, the principle of double effect admits an exception, albeit a very narrow one, that recognises the ethical acceptability of abortion when it is undertaken in circumstances akin to self-defence. In Catholic theology, it refers to a fairly specific formula that enables one, in situations where one action will have both good and bad effects, to determine whether the action constitutes a sin. Four conditions must be met:
1. stripped of its context, the act must be good or, at worst, indifferent
 2. the actor must directly intend only the good effect
 3. the good effect must produce the bad effect, not the reverse
 4. there must be proportionality; the act must serve a sufficiently grave need to warrant the risk of producing the bad effect.⁴³
- B.52 The Catholic Church regards abortion as ethically acceptable when, and only when, all four conditions are satisfied. The principal exonerating factor is that an abortion in those circumstances would not be intended, that is, the saving of a woman’s life is allowed insofar as it does not include the deliberate destruction of the fetus.
- B.53 Double effect is a high hurdle. In practice, only two clinical situations have been held to consistently fit the necessary conditions of double effect. One situation is an ectopic pregnancy, the other is a pregnant woman found to have a malignant uterine tumour, whose fetus is excised as part of a hysterectomy.⁴⁴

MATERNAL INTERESTS

- B.54 Commentators at the other end of the philosophical spectrum concerning the ethical status of the fetus regard abortion as ethically acceptable. As they conclude that the fetus does not possess rights or interests that may override a pregnant woman’s autonomy, there is no conflict between maternal and fetal interests.
- B.55 Sumner captures the essence of the argument: ‘Although abortion results in the death of the fetus, it does no harm or injury because the fetus is not the sort of thing that can be harmed or injured. Abortion therefore lacks a victim’.⁴⁵

- 29 Warren’s ‘anti-cruelty principle’ see Scott (2002) above n 26, 36.
- 30 Jane English, ‘Abortion and the Concept of a Person’ (1975) 5 *Canadian Journal of Philosophy* 233, reproduced in White (1988) above n 9, 36.
- 31 Scott (2002) above n 26, 36–37.
- 32 See the discussion of community attitude survey evidence in Chapter 4.
- 33 Savell (2006) above n 17, 627.
- 34 Catriona Mackenzie ‘Abortion and Embodiment’ (1992) 70 *Australian Journal of Philosophy* 136, 146 cited in Savell (2006) above n 17, 652.
- 35 Ibid.
- 36 Susan Sherwin (1992) *No Longer Patient: Feminist Ethics and Health Care* cited by Ibid 653.
- 37 Ibid.
- 38 Ibid.
- 39 Wendy James, ‘Placing the Unborn: On the Social Recognition of New Life’ (2000) 7 *Anthropology and Medicine* 169, 176 cited by Ibid 654.
- 40 Pope John Paul II, *Evangelium Vitae: Encyclical Letter on the Value and Inviolability of Human Life* (1995) New Advent <www.newadvent.org/library/docs_jp02.ev.htm> at 13 February 2008.
- 41 Marquis (1989) above n 11, 183.
- 42 L Wayne Sumner, *Abortion and Moral Theory* (1981) 18.
- 43 See Kathy Rudy, *Beyond Pro-Life and Pro-Choice* (1996) 24–25.
- 44 Ibid 24.
- 45 Sumner (1981) above n 42, 15.

Appendix B

Ethics of Abortion

Thomson's Famous Violinist

- B.56 In her 1971 essay, *A Defense of Abortion*, Judith Jarvis Thomson argues that there is a difference between the claim that a fetus has a right to life and the claim that another person (the pregnant woman) is ethically obliged to do whatever is necessary to keep it alive.⁴⁶
- B.57 For the purposes of her argument, Thomson concedes that the fetus is an ethically relevant person with a right to life. Using an imaginary scenario, she then seeks to build a case that the ethical legitimacy of abortion survives this concession.
- B.58 Thomson's argument has led to much spirited criticism. A common focus of the critics is the bizarre and dramatic circumstances of the scenario she uses to illustrate her theory.⁴⁷ In particular, because the ethical choice she depicts arises as a result of coercion, it is argued that the ethical relevance of the argument to the abortion context is undermined. Small tweaks to the scenario lead one away from the conclusion she draws. Although Thompson does not dwell on this problem, she does acknowledge in a general way that her argument is not that abortion is always ethically permissible.⁴⁸

MATERNAL–FETAL CONFLICT

- B.59 Presenting views from two ends of the philosophical spectrum throws key points of divergence into sharp relief. These approaches may be seen as simplifications of what is a nuanced and complex issue.
- B.60 Save for an absolutist position, recognition of the fetus's ethical personhood at conception, or shortly thereafter, coexists with a variety of opinions about when abortion is ethically acceptable. The doctrine of double effect's highly circumscribed account of self-defence has been criticised, in relation to both abortion⁴⁹ and other end-of-life situations.⁵⁰
- B.61 Some people reject an approach based upon double effect and accept abortion's moral legitimacy in a broader range of circumstances. Common circumstances are to preserve the pregnant woman's life or health (in situations that extend beyond those that double effect would permit); when the pregnancy results from rape or incest; and when the fetus is known to have catastrophic disabilities.
- B.62 Within autonomy circles, little scholarship would support the ethical legitimacy of abortion at every point up until birth for any reason whatsoever. The next two subsections review a selection of arguments that identify a conflict between a pregnant woman's decision-making autonomy and fetal interests. Some of these arguments consider how that conflict should be properly resolved.

Autonomy and Maternal–Fetal Relations

- B.63 Some commentators' understanding of personal autonomy includes a woman being able to determine whether she will physically carry a fetus for nine months, how her life will be lived, and the social relations she will enter.⁵¹
- B.64 Catriona MacKenzie argues:
- It is because of ... [the] psychic and bodily connectedness between the woman and the fetus that in pregnancy questions about the fate of the fetus cannot be separated from the issue of a woman's right to self-determination. What the abortion decision involves is a decision that this part of herself should not become a being in relation to whom ... questions of parental responsibility and emotional attachment arise.*⁵²
- B.65 Some people argue that the relational interest of a woman in the outcome of her pregnancy may be just as important as her strictly biological interest. A pregnant woman has an emotional interest in the fetus and with the broader community, initially during her pregnancy, and thereafter if a child is born. The relational interest of a woman extends beyond pregnancy because once a woman gives birth to a child she enters a relationship—that of mother and child—which brings with it a large number of socially and individually determined responsibilities and expectations. Requiring a woman to continue with pregnancy forces her to enter and maintain

a relationship that involves those responsibilities and expectations. Cannold has argued that, 'the abortion decision is not essentially about ending a pregnancy but about choosing motherhood'.⁵³

CENTRIST APPROACH

- B.66 Philosophers who reject absolute positions hold a range of views about when and for what reasons abortion is ethically justified. Himma's personhood criteria define a point in the middle stages of pregnancy, but they are linked solely to fetal development.⁵⁴
- B.67 Mackenzie assigns a different ethical status to the late-term fetus. The fetus is never the ethical equivalent of the woman, hence maternal health grounds for abortion are justified.⁵⁵
- B.68 Callahan argues that respect for the sanctity of human life should cause every woman to have a strong moral bias against abortion.⁵⁶ He goes on to acknowledge that there are circumstances in which it is ethically right for a woman to have an abortion because of the responsibilities she believes she owes to herself, her family, or society. Callahan's point is that a narrow focus on protection of the life of the fetus constitutes a blinkered view of the sanctity of life; respect for the sanctity of life also dictates attention to the cost of having a child on the welfare of living children and adults.
- B.69 Sumner is more specific. He advocates a policy that would allow abortion on request up to a specified time limit, and 'only for cause thereafter'.⁵⁷ Just cause may be established on several grounds: therapeutic (threats to maternal life or health), eugenic (risks of serious fetal abnormality), humanitarian (pregnancy due to commission of a crime such as rape or incest), or socioeconomic (poverty, family size).⁵⁸
- B.70 English is even more specific, linking the ethical acceptability of abortion to both fetal development and the woman's reasons for obtaining the abortion.⁵⁹
- B.71 Englehardt sees ethical significance in viability. At the same time, he considers abortion after viability ethically acceptable in some circumstances, including maternal health and fetal abnormality.⁶⁰
- B.72 The structure of each of these arguments highlights the formidable challenge associated with drawing a line. The avoidance of absolutist positions results in considerable complexity (some critics say impossibility) in resolving the overall ethical equation.
- B.73 Many non-absolutist positions bring two inversely-related sliding scales to bear. One is linked to the development of the fetus, the other to the moral legitimacy of the woman's motivation for abortion and concepts of autonomy. On this analysis, at early stages of gestation, weak motivations will suffice. At late stages, when the fetus has moved closer to ethical personhood and has assumed substantive interests in survival, the woman's reasons need to be more compelling.
- B.74 While lamenting the polarisation of the abortion debate, Scott provides the following summary:⁶¹
- [T]he key to the project of reconciliation lies in attention to a woman's reasons for exercising her right, the ways these relate to her underlying interests in bodily integrity and in self-determination, to the moral claims of the fetus and to the values inherent in the right to refuse medical treatment on one hand and to abort on the other.*⁶²
- B.75 Scott highlights the moral and normative importance of viability. She sees this as a manifestation of how maternal and fetal interests interlock. In resolving ethical decisions about abortion she stresses 'the way in which the strength of each must be viewed in relation to and partly determined by the strength of the other, a point inherent in the viability benchmark'.⁶³
- B.76 For Scott, 'the critical issue of justification of harm to the fetus is developed from the woman's perspective by analysing her relationship with the fetus in two ways: first in terms of her rights, and second, in terms of her duties.⁶⁴ At the end of the day, though, because of the interlocking relationship between the woman and the fetus, Scott argues that we 'must place our faith or trust in the moral responsibility of the pregnant woman'.⁶⁵

- 46 Judith Jarvis Thomson, 'A Defense of Abortion' (1971) 1(1) *Philosophy and Public Affairs* 47
- 47 Thomson asks the reader to imagine, 'You wake up in the morning and find yourself back-to-back in bed with a famous unconscious violinist. He has been found to have a fatal kidney ailment and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you and last night the violinist's circulatory system was plugged into yours ... If he is unplugged from you now, he will die; but in nine months he will have recovered from his ailment and can safely be unplugged from you.' Thomson completes the story by imagining that the hospital director says you can't unplug yourself without killing the violinist, and you must remain like that for nine months.
- 48 'It would be indecent', she states, for 'the woman to request an abortion, and indecent in a doctor to perform it, if she is in her seventh month, and wants the abortion just to avoid the nuisance of postponing a trip abroad'. Thomson (1971) above n 46, 65–66.
- 49 Philippa Foot, 'The Problem of Abortion and the Doctrine of Double Effect' (1967) *Oxford Review* 5, 5–15
- 50 Timothy E Quill, Rebecca Dresser and Dan W Brock, 'The role of the double effect—a critique of its role in end-of-life decision making' (1997) *New England Journal of Medicine* 337, 1768–71.
- 51 Reproductive choice can also be examined as an equality issue: see Regina Graycar and Jenny Morgan, *The Hidden Gender of Law* (2nd ed, 2002) 209–210.
- 52 MacKenzie (1992) above n 34, 151–2.
- 53 Cannold (2000) above n 3, 118.
- 54 Himma (2005) above n 22, 48.
- 55 Mackenzie (1992) above n 34, 146.
- 56 Daniel Callahan, 'Abortion Decisions and Personal Morality' (1970) in White (1988) above n 9, 28.
- 57 Sumner (1981) above n 42, 27.
- 58 Ibid 155.
- 59 Jane English, 'Abortion and the Concept of a Person' (1975) 5 *Canadian Journal of Philosophy* 233, reproduced in White (1988) above n 9, 41.
- 60 Tristram Englehardt, 'Viability and the Use of the Fetus' in Bondenson et al (1984), cited in Savell (2006) above n 17, 644.
- 61 Scott is concerned with ethical and legal issues arising from a decision to refuse medical treatment when it may harm the fetus and examines ethical issues around abortion.
- 62 Scott (2002) above n 26, xxxi.
- 63 Ibid 30.
- 64 Ibid xxxii.
- 65 Ibid 102–103.

Appendix B

Ethics of Abortion

ABORTION LAW MAKING

- B.77 The issue of when it is appropriate for the State to intervene in the affairs of citizens is a separate ethical question to the morality of abortion laws. It juxtaposes independent ethical questions about abortion and about legal regulation.
- B.78 The relationship between law and ethics has been a central preoccupation of jurisprudential philosophy. Limitations of space do not permit a discussion of the many schools of thought in this area.
- B.79 In liberal pluralistic societies Australia, there is often a gap between the ethical views of segments, even majorities, of the population, and expressions of law.⁶⁶ Although some activities might be widely disapproved of, the State does not always intervene to prevent people from undertaking them. It permits people to make their own decisions about whether to engage in these activities. Many people, for example, frown upon adultery as an immoral act, but it is not illegal. A defining feature of Western liberal ideology is its willingness to reject certain forms of State interventions despite distaste for the acts those interventions would address.
- B.80 How should the various ethical arguments about abortion be viewed from the perspective of public policy and law making?
- B.81 For some there is fairly straight line between the ethics of abortion and the ethics of public policies toward the abortion. For those who regard abortion as a form of homicide, it is unethical for the State not to intervene to stop and punish people who engage in the behaviour.
- B.82 Proponents of this view argue that it is compatible with fundamental liberal ideals. One circumstance in which it may be just for the government to disrupt a person's freedom is when the exercise of that freedom will adversely affect another person's rights and freedoms.⁶⁷ In the context of abortion, some, particularly those who look to conception as the person-defining moment, regard the fetus as that other person. Thus, in order to protect the fetus, the State is entitled to limit the pregnant woman's autonomy. For those who regard women's interests in autonomy as paramount, it is apparent that the State should not interfere with pregnant women's entitlement to make their own decisions.
- B.83 There are some influential writers who occupy the middle ground. Dworkin argues that many of those who believe that abortion is never or almost never morally acceptable, 'nevertheless think that the law should leave women free to make decisions about abortion for themselves, that it is wrong for the majority or for the government to impose its view upon them'.⁶⁸
- B.84 A similar disjunction between ethical and legal positions may attract support among people who argue for women's unfettered autonomy in the early months of pregnancy, but believe the moral legitimacy of abortion in the later stages of gestation may depend upon the reasons for it. People who hold this view may still resist any law or legal process that would inhibit free choice.
- B.85 A distinction between a person's views about the ethics of a practice and the ethics of making laws with respect to that practice is not necessarily contradictory. Many philosophers have followed in the footsteps of John Stuart Mill in arguing that the government should try, as a rule, to avoid dictating to individuals about matters of personal morality.⁶⁹ For instance, Callahan, although plainly uncomfortable with the ethics of abortion, nevertheless argues that the government should not enact rigid laws to prevent or reduce the practice because such private matters must constitute 'a clear and present danger to the common good' before they are candidates for State action.⁷⁰
- B.86 Thomson argues that while people may confront one another equally in the straight ethics debate, the State-action overlay shifts the burden of proof to those who support an absolute prohibition on abortion. She argues:

[O]ne side says that the fetus has a right to life from the moment of conception, the other side denies this. Neither side is able to prove its case . . . why should the deniers win? Why break the symmetry by letting the deniers win instead of the supporters? The answer is that the situation is not symmetrical. What is in question here is not which of two values

we should promote, the deniers' or the supporters'. What the supporters want is a license to impose force; what the deniers want is a license to be free of it. It is the former that needs the justification.⁷¹

- 66 The term 'liberal' is used several times in this section. It refers to the branch of political philosophy known as liberalism, which prioritises individual rights, applauds pluralism, and demands a high degree of value neutrality from government.
- 67 For discussion of positive and negative freedom see Isaiah Berlin, 'Two Concepts of Liberty' *Four Essays on Liberty* (1969). For discussion of curtailment of liberty see Isaiah Berlin *The Power of Ideas* (2001) 111–114.
- 68 Ronald Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (1995) 24.
- 69 John Stuart Mill, *On Liberty* (1859).
- 70 Daniel Callahan, 'Abortion Decisions and Personal Morality' (1970) in James White (ed) (2nd ed, 1988) above n 9, 29.
- 71 Judith Jarvis Thomson, *Abortion* (Summer 1995) *Boston Review*, <<http://bostonreview.net/BR20.3/thomson.html>> at 15 February 2008.

Appendix C

Legal Developments

INTRODUCTION

- C.1 In Appendix B, the commission described some of the major ethical views about abortion. As part of that exercise, we considered how some prominent commentators have characterised the relationship between a pregnant woman and a fetus. In this part we consider how some senior members of the judiciary have characterised that relationship when it has arisen for determination in different legal contexts. A preliminary issue that emerges when undertaking this task is to consider the legal status of a fetus.

LEGAL STATUS OF A FETUS

- C.2 The legal status of a fetus has been considered by courts on several occasions in a variety of contexts. The nature of the task of characterising the fetus for legal purposes was explained by the Supreme Court of Canada when it considered whether a fetus was a 'human being' for the purposes of the Quebec *Charter of Human Rights and Freedoms*:

[M]etaphysical arguments may be relevant but they are not the primary focus of inquiry. Nor are scientific arguments about the biological status of a foetus determinative in our inquiry. The task of properly classifying a foetus in law and in science are different pursuits. Ascribing personhood to a foetus 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.¹

- C.3 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. In a few areas the common law has acknowledged that a fetus has an interest that merits legal attention, but in those cases the courts made it clear that legal rights do not accrue until birth. These cases have arisen in contexts where there has been no question of separate interests and where the decision reached by the courts has been supported by the pregnant woman in question.
- C.4 Recent legislation, at both Commonwealth and state levels, has acknowledged fetal existence by regulating what may be done to embryos in various scientific contexts. This legislation regulates what may be done to an embryo in a laboratory rather than within a woman's uterus.

LEGAL PERSONHOOD COMMENCES AT BIRTH

- C.5 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.² 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'.³ This rule was recently confirmed by the NSW Court of Criminal Appeal in *R v Iby* when Chief Justice Spigelman stated that 'the common law "born alive" rule is satisfied by any indicia of independent life'.⁴ This rule is discussed in detail in Chapter 7.
- C.6 This approach has been confirmed in different contexts, including in the abortion case of *Attorney General (QLD) (Ex rel Kerr) v T*, where Justice Gibbs stated 'a fetus has no rights of its own until it is born and has a separate existence from its mother'.⁵ Justice Gillard pointed out in a recent case: 'Legal personality begins at birth and ends with death'.⁶

COMMON LAW FICTIONS

- C.7 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.
- C.8 Two clear examples of the fiction arise for injuries sustained by a fetus during pregnancy as a result of negligent conduct by a third party, and the entitlement of a fetus to acquire a contingent interest in property under a will or trust. In both instances the realisation of the fetal interest is dependent upon live birth.

- C.9 Since the Full Court of the Victorian Supreme Court's decision in *Watt v Rama*, it has been clear that a person who sustained injury while still a fetus, as a result of the negligent act of a third person, has a good **cause of action**, upon birth, against the wrongdoer. This is despite the plaintiff not being a person and not having legal rights when the injury actually occurred.⁷ The majority of judges held that even though the plaintiff could not acquire any legal rights or suffer any compensable damage until birth, she had a 'contingent interest' not to be injured by the negligence of another person, which could ripen or crystallise at the time of birth. This fiction permitted the plaintiff in that case to recover damages for the severe injuries she sustained, while still a fetus, when her mother was involved in a car accident. The common law principles that were identified and applied in that case have been followed by other Australian intermediate appellate courts⁸ and were approved by the High Court in 2006.⁹
- C.10 The same fiction has been applied when dealing with the entitlement of a fetus to acquire an interest in property under a will or trust.¹⁰ In a recent Victorian case, *Yunghanns v Candoora No 19 Pty Ltd*, Justice Gillard held that a man could take action, on behalf of his unborn child and with the support of his pregnant wife,¹¹ to prevent the distribution of assets held in trust for the benefit of all his children.¹²

STATUTORY PROVISIONS

- C.11 Some Victorian and Commonwealth statutes recognise the existence of embryos and regulate what may be done to them in the contexts of assisted reproduction, scientific research, and human cloning. The regulation of embryos by these statutes arises when an embryo has a separate existence outside of a woman's uterus.
- C.12 The two major Commonwealth statutes are the *Research Involving Human Embryos Act 2002* (Cth) and the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth). The first Act prohibits the creation of a human embryo for a purpose other than achieving pregnancy. It also regulates the use of 'excess' human embryos created by assisted reproductive technology. Research involving embryos is prohibited unless a scientific body obtains a licence to undertake the limited research permitted by the legislation. As its title implies, the Prohibition of Human Cloning for Reproduction Act prohibits the cloning of human beings. The Victorian *Infertility Treatment Act 1995* contains mirror provisions because the Commonwealth lacks the constitutional power to regulate these activities throughout the entire community.¹³
- C.13 There is one provision in the Victorian legislation that deals with embryos in utero. Section 38K prohibits collecting a viable human embryo from the body of a woman. There is a similar offence in Commonwealth law.¹⁴ The aim of this provision is to prevent the harvesting of embryos from a woman for experimental purposes or for placement in another woman.¹⁵

RELATIONSHIP BETWEEN A PREGNANT WOMAN AND A FETUS

- C.14 On occasions, the courts have sought to describe the relationship between a pregnant woman and a fetus when the issue has arisen in different contexts. Not surprisingly, there has been no consistency of view. There appears to have been a recent evolution of thinking, as the courts have been called upon to consider the issue more commonly than in the past.
- C.15 Courts have sought to deal with the issue of the relationship between a pregnant woman and a fetus in a criminal law context when an assault upon a pregnant woman has caused injury to, or destruction of, a fetus. In some instances the fiction of deeming the physical element of the offence to have occurred at birth, when a child is born with injuries acquired as a result of an assault upon its mother before birth, has been used to ensure that the assailant is culpable. In others, the fiction has not been able to be usefully employed.¹⁶
- C.16 In the course of some of these criminal cases, judges have sought to describe the relationship between a pregnant woman and a fetus. In *Attorney-General's Reference (No 3 of 1994)* Lord Mustill described the relationships as one of 'bond, not identity'.¹⁷ He went on to suggest that a fetus was neither a person nor an adjunct of the mother but '[t]he mother and the foetus were

- 1 *Tremblay v Daigle* [1989] 2 SCR 530, 557.
- 2 *R v Hutty* [1953] VLR 338, 339.
- 3 *R v Hutty* [1953] VLR 338, 339.
- 4 (2005) 63 NSWLR 278, [56].
- 5 (1983) 46 ALR 275, 277.
- 6 *Yunghanns v Candoora No 19 Pty Ltd* [1999] VSC 524, [82].
- 7 *Watt v Rama* [1972] VLR 353.
- 8 See, eg, *X&Y v Pal* (1991) 23 NSWLR 26; *Lynch v Lynch* (1991) 25 NSWLR 411.
- 9 *Harriton v Stephens* (2006) 226 CLR 52, [245].
- 10 See, eg, *Yunghanns v Candoora No 19 Pty Ltd* [1999] VSC 524 (Gillard J).
- 11 The court accepted evidence that the plaintiff's wife was five months pregnant when the proceedings were heard.
- 12 The plaintiff asserted that the company, which was the trustee of a discretionary family trust, which he no longer controlled, might distribute the trust's assets to his existing adult children before the birth of his unborn child, thereby defeating its interest.
- 13 *Infertility Treatment Act 1995* pt 2A.
- 14 A person commits an offence if the person removes a human embryo from the body of a woman, with the intention of collecting a viable human embryo: *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) s 16.
- 15 Explanatory Memorandum, *Infertility Treatment Amendment Bill 2007* 18.
- 16 The relevant cases are considered in Bernadette McSherry, 'Homicide and Antenatal Injury' (1998) 5 *Journal of Law and Medicine* 204.
- 17 [1998] AC 245, 255.

Appendix C

Legal Developments

two distinct organisms living symbiotically'.¹⁸ According to Lord Musthill, a fetus is 'a unique organism' and '[t]o apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead'.¹⁹

- C.17 In *R v King*,²⁰ the NSW Court of Criminal Appeal considered whether an attack upon a pregnant woman by the father of the unborn child, which was designed to terminate the pregnancy, and resulted in the stillbirth of the fetus, could amount to grievous bodily harm to the woman. After referring to judicial statements which suggested that a fetus was, for various purposes, part of its mother, Chief Justice Spigelman stated:

I find this approach compelling for the law of assault and in particular for the forms of aggravated assault requiring as an element of the offence actual bodily harm, grievous bodily harm or wounding. The close physical bond between the mother and the foetus is of such a character that, for the purposes of offences such as this, the foetus should be regarded as part of the mother ...

Where such enhanced injury is inflicted on a foetus only, I can see no reason why the aggravated form of offence should depend on whether the foetus is born alive. The purpose of the law is best served by acknowledging that, relevantly, the foetus is part of the mother.²¹

- C.18 The Canadian Supreme Court reached a similar conclusion in *R v Sullivan*.²² That case involved criminal charges against two midwives who had allegedly been negligent when assisting at a home birth which resulted in the stillbirth of the fetus. The midwives were charged with negligently causing death to another person and negligently causing grievous bodily harm to another person. The Supreme Court held that the death charge could not be maintained because a fetus was not a person; however, it held that the death of the fetus could constitute grievous bodily harm to the pregnant woman because of her connectedness with the fetus.
- C.19 During the 1990s a number of so-called forced caesarean cases were decided by British courts.²³ In all of these cases court orders were sought because pregnant women refused to give birth by caesarean section against medical advice. In all of these cases it was held that a woman could not be forced to have a caesarean. When reaching these decisions the courts considered the relationship between a pregnant woman and a fetus.
- C.20 In *In Re MB*²⁴ the Court of Appeal held:

[A] competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though, as we have already stated, the consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anaesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.²⁵

- C.21 The relationship between a pregnant woman and a fetus arose for consideration in broadly similar circumstances in *St George's Healthcare NHS Trust v S*.²⁶ The English Court of Appeal was asked to consider whether a woman who was 36 weeks pregnant could be forced to undergo a caesarean section because her own health, as well as the life of her fetus, was endangered by her refusal of medical treatment.²⁷ The Court of Appeal stated:

*[I]n our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways set out in the judgment in *In re MB (An Adult: Medical Treatment) [1997] 2 FCR 541*, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally*

repugnant. The declaration in this case involved the removal of the baby from within the body of her mother under physical compulsion. Unless lawfully justified this constituted an infringement of the mother's autonomy. Of themselves the perceived needs of the foetus did not provide the necessary justification.²⁸

- C.22 The interconnectedness of the maternal–fetal relationship was also emphasised by the Canadian Supreme Court in a case regarding glue sniffing by the pregnant woman.²⁹ The majority of the Canadian Supreme Court stated:

*[T]o permit an unborn child to sue its pregnant mother-to-be would introduce a radically new conception into the law; the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation. Such a legal conception, moreover, is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by birth.*³⁰

NEW APPROACHES

- C.23 Traditionally, some commentators characterised abortion as an instance of maternal–fetal conflict because a pregnant woman and her fetus were seen as having separate interests, which could form the basis of that conflict.³¹ Recent judicial statements and theoretical writings have suggested that this characterisation may not be useful or accurate.³²
- C.24 Some legal scholars and courts have recently explored a different approach. This focuses upon the interconnectedness of the relationship between the woman and the fetus, rather than upon maternal–fetal conflict. For example, Seymour has proposed an approach which 'seeks to combine a recognition of the potentiality of the fetus with an acknowledgment that the woman and her fetus are indivisibly linked'.³³ He describes this as the 'not-one-but-not-two' model.
- C.25 On this view, the fetus does not have a uniform value or character in the eyes of the law. The law makes choices about the situations in which it will take account of actual or threatened antenatal harm.³⁴ Seymour argues that sensitivity to the not-one-but-two relationship better allows for 'discriminating answers to questions as to when the law should intervene to protect a fetus'.³⁵
- C.26 He uses the examples of assault upon a pregnant woman and abortion to illustrate this, arguing that the issues to be considered are fundamentally different because the context of the relationship is different when a woman chooses to have an abortion.³⁶ Seymour concludes that acceptance of the State punishing a person who assaults a pregnant woman causing harm to a fetus 'does not mean that the state should punish a person who performs an abortion with the woman's consent'.³⁷

18 [1998] AC 245, 255.

19 [1998] AC 256.

20 (2003) 59 NSWLR 472.

21 (2003) 59 NSWLR 472, 491. This case is discussed further in Chapter 7.

22 [1991] 1 SCR 489.

23 *Re S (Adult: Surgical Treatment)* [1993] 1 FLR 26; *Re MB* [1997] 2 FLR 426; *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936.

24 [1997] 2 FLR 426.

25 [1997] 2 FLR 426, [60].

26 [1998] 3 WLR 936.

27 The fetus had in fact been delivered by caesarean section because a judge had earlier made an ex parte declaration authorising the operation without the woman's consent. The case in the Court of Appeal, in which various declarations were sought, was effectively an appeal against the original ex parte declaration.

28 [1998] 3 WLR 936, 957.

29 *Winnipeg Child and Family Services (Northwest Area) v DFG* [1997] 3 SCR 925.

30 [1997] 3 SCR 925, [29].

31 See description of ethical debates in Appendix B.

32 See John Seymour, 'The Legal Status of the Fetus: An International Review' (2002) 10 *Journal of Law and Medicine* 28. See also Pam Stewart and Anita Stuhmcke, 'Legal Pragmatism and the Pre-Birth Continuum: An Absence of Unifying Principle' (2007) 15 *Journal of Law and Medicine* 272. For discussion of implications of abandoning the 'born alive rule' see Kristin Savell, 'The Legal Significance of Birth' (2006) 29 (2) *UNSW Law Journal* 200–6.

33 John Seymour, 'The Legal Status of the Fetus: An International Review' (2002) 10 *Journal of Law and Medicine* 28.

34 *Ibid* 39–40.

35 *Ibid* 38.

36 In the case of assault the State's interests are in protecting the woman and fetus from the wrongdoing of a third party. In the case of abortion, the State must consider whether it is justified or interferes with the woman's autonomy: *ibid* 39.

37 *Ibid* 38.

Appendix D

Human Rights and Abortion

INTRODUCTION

- D.1 Many of the submissions received by the commission applied a human rights perspective to the question of abortion law reform. People mainly talked about the right to life, freedom from discrimination, and respect for privacy.
- D.2 The abortion debate has the capacity to conflate two important sets of considerations that inform people's views about human rights. The first of these relates to ethical issues concerning abortion, including the moral status of the fetus and the freedom of action of the mother. These are discussed in Appendix B. The second involves the question of when legal personhood begins. This is discussed in Appendix C.
- D.3 In this Appendix, we set out information about domestic **human rights instruments**, including the *Victorian Charter of Human Rights and Responsibilities Act 2006*. Australia's obligations under international human rights instruments are reviewed and implications for abortion law reform considered. Relevant case law from Australian and other jurisdictions is discussed, along with statements from United Nations human rights committees.

CURRENT VICTORIAN LAW

CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

- D.4 The Charter of Human Rights and Responsibilities Act established a legislative framework for the protection and promotion of human rights in Victoria. The charter includes a series of rights based largely upon the *International Covenant on Civil and Political Rights 1966* (ICCPR). Australia ratified this treaty in 1980.
- D.5 The human rights potentially engaged by abortion include the right to life, privacy, and security of the person.¹ The Charter contains a section which specifically provides that it has no operation for current and future Victorian law concerning abortion and child destruction. This provision is intended to encompass statute law, judicial interpretation of statute law and the common law. Section 48 states: '(N)othing in this Charter affects any law applicable to abortion or child destruction, whether before or after the commencement of Part 2'.²
- D.6 The Charter, therefore, has no effect upon the law of abortion in Victoria, and the rights contained in the Charter are not applicable in abortion cases.

OTHER DOMESTIC HUMAN RIGHTS PROTECTIONS

- D.7 Australia's Constitution does not contain a Bill of Rights;³ however, it does explicitly protect some human rights and has been found to contain some implied rights.⁴ None of those rights are of direct relevance to abortion law reform.
- D.8 At a domestic level, several human rights are recognised or protected, to varying degrees, by common law principles. These include the right not to incriminate one's self, the onus on the prosecution to prove a criminal offence, and principles of natural justice.⁵
- D.9 The Australian Parliament has incorporated some aspects of international human rights instruments, such as the ICCPR, into domestic legislation. An example is the *Disability Discrimination Act 1992*.⁶

INTERNATIONAL HUMAN RIGHTS FRAMEWORK

GENERAL PRINCIPLES

- D.10 International human rights are entitlements that belong to every human being. They are protected by international human rights treaties and long established principles of international law.⁷ In Australia, human rights treaties do not create rights enforceable by individuals in domestic courts until they are incorporated directly into domestic law.⁸
- D.11 The *Universal Declaration of Human Rights* (UDHR) sets out human rights as 'a common standard of achievement for all peoples and all nations'.⁹ It is regarded as 'the modern genesis of international human rights law'.¹⁰

D.12 Australia has ratified several international treaties that aim to identify and protect human rights. These include the ICCPR; the *International Covenant on Economic, Social and Cultural Rights* (CESCR); the *Convention on the Rights of the Child* (CRC); and the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW).¹¹

D.13 People need to be aware of international human rights standards 'because those norms ... establish legal obligations for the government ...'¹² Ratifying a treaty requires a government¹³ to implement in good faith all the obligations in the treaty. Some obligations require immediate implementation; others are to be implemented by 'progressive realisation'.¹⁴ Domestic laws are subject to scrutiny by the relevant UN human rights committees.¹⁵

INTERNATIONAL HUMAN RIGHTS POTENTIALLY ENGAGED

D.14 In this appendix we examine the rights potentially engaged by any law that regulates abortion.

RIGHT TO LIFE

D.15 The right to life has been described as 'the supreme right'.¹⁶ It is guaranteed in major international human rights instruments, including the UDHR and the ICCPR. It is duplicated in many national bills of rights and in regional human rights instruments such as the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.

D.16 The right to life is often invoked to support opposing claims about abortion. Some people argue that the right to life applies to both the fetus and the woman. This argument featured heavily in our consultations. The Catholic Archbishop of Melbourne, Denis J Hart, stated in his submission:

*Declaring that unborn children are not legal persons does not change the reality that they are human beings endowed with a rational nature and inherent inviolable worth. They are natural persons in virtue of their rational human nature and also subjects of basic human rights.*¹⁷

D.17 Others say the scope of the right is limited to people after birth.¹⁸ Responding to the argument that the right to life applies to the fetus, the Castan Centre for Human Rights Law stated:

*Such an interpretation of the Covenant is not apparent from its wording and not supported by the Human Rights Committee's findings and conclusions. It is also contrary to the wording and jurisprudence of other key international human rights treaties.*¹⁹

1 *Charter of Human Rights and Responsibilities Act 2006* ss 9, 13, 21.

2 The inclusion of the **savings clause** in the Charter is significant. It contrasts with the ACT human rights legislation, which states that the right to life applies to a person from the time of birth.

3 Australia is the only Western democracy without a national Bill of Rights.

4 Rights protected by the Australian Constitution include the requirement that an acquisition of property by the Commonwealth must be on just terms: s 51(xxxi), and the right of individuals who believe that the federal government has acted unlawfully to seek review of such actions in the High Court: s 75(v). Under the Constitution, the Commonwealth cannot 'make any law for establishing any religion', impose 'any religious observance' or prohibit 'the free exercise of any religion': s 116. For discussion of implied constitutional rights see Tony Blackshield, Michael Coper and George Williams (eds) *The Oxford Companion to the High Court of Australia* (2001) 335–336.

5 For discussion of common law and human rights see Nick O'Neill, Simon Rice, and Roger Douglas, *Retreat from Injustice: Human Rights Law in Australia* (2nd ed, 2004) 106–114.

6 Human rights are defined in the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) to include the rights and freedoms in the ICCPR. The Human Rights and Equal Opportunity Commission may therefore undertake inquiries into systemic human rights issues. HREOC may also resolve complaints of discrimination or breaches of human rights under federal laws.

7 In addition to various human rights treaties, customary international human rights law also applies; however, the status of international customary law within Australian law is not settled.

8 Alison Duxbury and Christopher Ward, 'The International Law Implications of Australian Abortion Law' (2000) 23(2) *University of New South Wales Law Journal* 1, 9.

9 *Universal Declaration of Human Rights* (10 December 1948) UNGA Res 217A (III) (1948).

10 Andrew Butler and Petra Butler, *The New Zealand Bill of Rights Act: A Commentary* (2005) xiii.

11 Australia has signed, but not yet ratified, the *Convention on the Rights of Persons with Disabilities*. Australia has not signed or ratified the *Declaration on the Rights of Indigenous Peoples*.

12 Martin Flynn, *Human Rights in Australia: Treaties, Statutes and Cases* (2003) 5.

13 The term used in UN treaties and human rights discourse is 'state parties' in recognition that not all signatories to a convention are governments, eg, the Holy See.

14 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3, art 2(1) (entered into force 3 January 1976).

15 The UN treaty system establishes two main accountability functions: individual complaints and country reports. An individual complaint can only be made when the person has exhausted all domestic remedies and the State party has ratified the Optional Protocol attached to the convention. Australia has ratified the First Optional Protocol to the ICCPR; it has not ratified the Optional Protocol to CEDAW.

16 Human Rights Committee General Comment 06, Article 6: The Right to Life, 16th sess 1982, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HR/GEN/1/Rev.6 at 127 (2003).

17 Submission 67 (Archbishop Denis J Hart, Catholic Archdiocese of Melbourne).

18 The right to life of the mother is not usually contested in the abortion debate. Very few people suggest that a woman's life should be sacrificed to preserve the fetus. Regardless, under international law it is very clear that the woman's right to life must be observed. There is debate about whether the right to life includes a positive duty to promote life, eg, by advancing safe and dignified motherhood. Under this 'positive duty' analysis, where states do not provide the means necessary to prevent women from dying of pregnancy-related causes, including access to safe abortion services, the right to life may be breached. See Rebecca Cook and Bernard Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25 *Human Rights Quarterly* 1, 29.

19 Submission 383 (Castan Centre for Human Rights Law).

Appendix D

Human Rights and Abortion

- D.18 These are hotly contested principles within the context of the abortion debate. However, decisions of the domestic courts and international human rights bodies provide guidance about the legal status of the fetus.

DOES THE FETUS HAVE A RIGHT TO LIFE UNDER INTERNATIONAL LAW?

Article 3—Universal Declaration of Human Rights

- D.19 Article 3 of the UDHR states that ‘everyone has the right to life’. It does not specifically mention the fetus and it does not define ‘everyone’.
- D.20 When the Commission on Human Rights was drafting this provision, several proposals to provide explicit protection for the fetus from the moment of conception were put forward. Although debated, these did not go to a vote, and were not included in the final text.²⁰
- D.21 Some commentators, including Fleming and Harris, argue that the UDHR nevertheless provides protection for the fetus because the term ‘everyone’ includes ‘every member of the human family, that is, all human beings’.²¹ They argue:
- there is no agreed basis for dividing up the human family into persons and non-persons, but there is agreement from science that from fertilisation we all share a common humanity, that we are all members of the ‘human family’.*²²
- D.22 Similar arguments were put forward in submissions to the commission.²³ Joseph Santamaria wrote: ‘the unborn child or foetus is no less a human individual than someone who has been born’.²⁴
- D.23 The debate about the scope of the term ‘everyone’ and its specific application to the fetus also applies to other human rights instruments to which Australia is a party, including the ICCPR.

Articles 6 (1) and 6(5)—International Covenant on Civil and Political Rights

- D.24 The right to life is protected by Article 6(1) of the ICCPR. This right is absolute and cannot be derogated. It is generally recognised that Article 6 is not applicable before birth.²⁵
- D.25 During preparatory debates on the ICCPR, proposals to include the words ‘from the moment of conception’ were rejected.²⁶ Since then, the right of every ‘human being’ has generally been seen to apply from birth. This is not to say there is no ethical interest in the fetus, but rather the rights arising under the treaty do not attach until birth. As noted by Liberty Victoria, this is consistent with the general approach domestic law takes to fetal rights.²⁷
- D.26 Article 6(5) of the ICCPR contains a prohibition on the death penalty for pregnant women. Rita Joseph argues the principal reason for this prohibition is to ‘protect the child’s inherent right to life’. She draws a corollary between the death penalty and abortion, which she considers a ‘form of death penalty imposed on the unborn child’.²⁸
- D.27 The Castan Centre for Human Rights Law submitted that Article 6(5) was drafted to protect pregnant women in countries that have not abolished the death penalty.²⁹ They argued that human rights law does not recognise abortion as a form of the death penalty.³⁰

Convention on the Rights of the Child

- D.28 There are various provisions in the CRC that relate to the right to life. These include the preamble, Article 1 defining a child as aged up to 18 years, and Article 6, the right to life.
- D.29 The preamble to the convention states: ‘[T]he child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth ...’
- D.30 Abortion opponents cite this preamble³¹ to support their argument that international human rights protection applies to the fetus. For example, the Catholic Justice Agency states ‘unquestionably those who developed, and those who adopted this Declaration ... had an understanding of a “child” which included the unborn child’.³²
- D.31 Some also argue that Australia did not make a reservation on the preamble to protect current abortion laws, and so this represents Australia’s acceptance that the CRC provides protection to the fetus.³³ However, a preamble alone does not create an obligation and so a **reservation** would not be appropriate.³⁴

D.32 Examination of the debate over the wording of the preamble suggests that the preamble does not establish a positive obligation to extend rights to the fetus. For the preamble to equate to such recognition, it would have to revise the usual legal understanding of the term child. The drafters rejected such a revision. Former Chairperson of the United Nations Committee on Economic, Social, and Cultural Rights, Professor Phillip Alston,³⁵ concludes:

*[W]hile the pre-ambular paragraph can be considered to form one part of the basis for the interpretation of the treaty, there is no obvious reason why the preamble would be resorted to in order to interpret what would otherwise be a natural and ordinary meaning of the term 'child' in international law. In international law, at least, there is no precedent for interpreting that term, or others such as 'human being' or 'human person' as including a fetus.*³⁶

D.33 Alston points out that even if the preamble were binding, one needs to look at the wording, which includes 'appropriate legal protection, before and after birth'. He argues there is neither an explicit nor implicit assumption that this includes an absolute right to life: 'What is "appropriate" in that regard is for each state to determine for itself'.³⁷

D.34 It is also important to note that the operative part of the convention applies exclusively to children from birth up to 18 years (articles 1 and 6). If such a major revision of the definition of a child were envisaged then those articles would have included a clear statement to that effect.³⁸

D.35 Some States have chosen to go down the path of either specifically protecting the fetus in domestic law³⁹ or making a reservation against Article 1 of the CRC.⁴⁰ Australia has not opted for either of these alternatives.

RIGHT TO LIFE, FETAL RIGHTS, AND ABORTION CASES

D.36 The Castan Centre for Human Rights Law notes

*liberal abortion laws in France, Austria and the Netherlands have been subject to domestic challenges on the basis of alleged inconsistency with the right to life in article 2 of the European Convention. These challenges have all been unsuccessful.*⁴¹

D.37 Courts in the UK, Canada, and South Africa have also held that fetuses are not protected by right to life guarantees in human rights instruments because they lack legal personhood.⁴²

20 Philip Alston, 'The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child' (1990) 12 *Human Rights Quarterly* 156, 157.

21 John Fleming and Michael Hains, Rights of the Unborn under International Law, Priests for Life <<http://priestsforlife.org/articles/flemingpage2.htm>> at 19 October 2007.

22 Ibid.

23 Eg, submission 100 (Rita Joseph).

24 Submission 516 (Joseph Santamaria).

25 'It would appear that international law ... protects the child from the moment of birth, but without an express provision to the contrary, it does not provide the fetus with an absolute right to life': Duxbury and Ward (2000) above n 8, 20.

26 Fleming argues that toleration of abortion played no part in the debate over the words 'from the moment of conception' during negotiations over ICCPR. He argues that the reason it was rejected was because it was too hard to determine the moment of conception and it would involve impacting on the rights and duties of medical profession: Fleming and Hains, above n 21, at 19 October 2007.

27 Submission 501 (Liberty Victoria).

28 Submission 100 (Rita Joseph).

29 One of the aims of Article 6 is the abolition of the death penalty, however, this has not been achieved in all States: Human Rights Committee General Comment 06, Article 6: The Right to Life, 16th sess 1982, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HR/GEN/1/Rev.6 at 127 (2003).

30 Submission 383 (Castan Centre for Human Rights Law).

31 They also cite the preamble to its precursor, the 1959 *Declaration on the Rights of the Child*.

32 Submission 452 (Catholic Justice Agency).

33 Fleming and Hains also argue that both the *Declaration of Rights of the Child* (1959) and the CRC confer rights upon the fetus. Both contain the words 'before as well as after birth' in their preambles. The 1959 declaration was attached as a schedule to the *HREOC Act 1986* following discussions with the Right to Life Association. Fleming and Hains contend that as a consequence the declaration is part of Australian municipal law; however, the High Court has held that 'The ICCPR is now contained in Sch 2 of the HREOC Act. While the Act confers power on the Human Rights and Equal Opportunity Commission to investigate and conciliate alleged breaches of rights contained in the ICCPR, it does not create justiciable rights for individuals': *Dietrich v R* (1992) 177 CLR 292, 359-60 (Toohey J).

34 International declarations generally are not binding, nor are the preamble statements of treaties (conventions). but they contain important human rights principles and may be referred to when interpreting human rights treaties. In contrast, the articles (main text) of conventions are binding on State parties as these contain the substantive rights. For discussion of the non-binding nature of the CRC preamble see Duxbury and Ward (2000) above n 8, 16; Cook and Dickens (2003) above n 18, 24.

35 Professor Alston was UNICEF's legal adviser throughout the period of the drafting of the CRC.

36 Alston (1990) above n 20, 170.

37 Ibid 172.

38 Ibid 172.

39 Eg, Irish Constitution, art 40.3.

40 Eg, Argentina has lodged a declaration that Article 1 should be interpreted to mean a child is a human being from conception.

41 Submission 383 (Castan Centre for Human Rights Law).

42 In *Christian Lawyers Association of SA and Others v Minister of Health and Others 1998* (11) BCLR 1434(T) it was held that the task of properly classifying a fetus in law and in science were different pursuits. Ascribing personhood to a fetus in law was a fundamentally normative task, resulting in a recognition of rights and duties, a matter which fell outside the realm of scientific classification. See also *Tremblay v Daigle* [1989] 2 SCR 530.

Appendix D

Human Rights and Abortion

- D.38 These courts, in common with Australian courts,⁴³ have held that fetuses do not have legally enforceable rights until they are born alive. Examples include: *Burton v Islington Health Authority*,⁴⁴ and *Paton v British Pregnancy Advisory Service Trustees*.⁴⁵
- D.39 In *Paton v British Pregnancy Advisory Service Trustees* the European Commission discussed the definition of ‘everyone’ and the right to life and said that all of the limitations contained in Article 2 ‘by their nature concern persons already born and cannot be applied to the fetus’.⁴⁶ The commission found that a termination at 10 weeks on physical and mental health grounds did not breach the right to life article.
- D.40 In *Vo v France*, after reviewing previous decisions, the European Court of Human Rights found that the unborn child is ‘not regarded as a “person” directly protected by Article 2 of the Convention, and that if the unborn child does have a “right” to “life”, it is implicitly limited by the mother’s rights and interests’.⁴⁷

FREEDOM FROM DISCRIMINATION AND RIGHT TO EQUALITY BEFORE THE LAW

- D.41 ‘Non-discrimination is a fundamental principle of international human rights law.’⁴⁸ Prohibitions on sex and disability discrimination are therefore included in the ICCPR and the CESC. CEDAW defines what constitutes discrimination against women and establishes an agenda for action by States to end such discrimination.⁴⁹

Prohibitions on Discrimination in the ICCPR and CESC

- D.42 Article 2 of the ICCPR and CESC are general non-discrimination articles.⁵⁰
- D.43 Article 26 of the ICCPR establishes the right to equality before the law.⁵¹ Equality principles include positive rights, as well as the freedom from discrimination.
- D.44 The CESC rights are particularly relevant to abortion, especially the right to health, including reproductive health.⁵² **Reproductive rights** are illuminated further in CEDAW.
- D.45 It should also be noted that specific age discrimination rights arise from the CESC and CRC.⁵³ For example, mature adolescents suffer unjust discrimination when they are not able to obtain reproductive health counselling and services with the same confidentiality as adults.⁵⁴

Definition of Discrimination

- D.46 Article 1 of CEDAW defines sex discrimination as: ‘Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women ... of human rights and fundamental freedoms’.⁵⁵ Non-discrimination does not simply mean equal treatment. It also requires that different cases be treated according to those differences, recognising that discrimination may be multi-layered and intersectional.
- D.47 Substantive equality means that differentiation must not be arbitrary. Therefore one must look to see if men and women are treated differently, and if so, why. Duxbury and Ward note that one example would be if laws criminalised abortion in all cases.⁵⁶ In this scenario, women making reproductive decisions would face criminal sanctions, while men exercising their rights over the number and spacing of children, or seeking a medical procedure,⁵⁷ would not face criminal penalties.⁵⁸

Right to Equality—Transformative Equality, Autonomy, Women as Moral Agents

- D.48 Some people argue that ‘women’s reproductive autonomy is inextricably linked with their ability to enjoy a range of human rights’.⁵⁹ Cook and Howard argue that ‘transformative’ equality requires that women are able to make their own reproductive decisions with dignity, free from stigma and stereotypes.⁶⁰ From this perspective, equality is not consistent with either forced abortion or compelling women to continue with a pregnancy. Instead:

*[T]ransformative equality requires rethinking unintended pregnancy from the perspective of the woman affected, recognizing and remedying the disadvantages women face in making decisions to terminate or continue pregnancy, and removing barriers faced in seeking services.*⁶¹

D.49 This approach places abortion within a spectrum of health and support services to which women should have access. It views women as competent and conscientious decision makers in their own lives.⁶² Liberty Victoria, among others, put forward this position in its submission.⁶³ It argued that women, in common with men, possess ethical agency, that is, the capacity to make and execute decisions about their own life.⁶⁴

RIGHT TO HEALTH

D.50 Article 12(1) of the CESCR recognises the right of 'everyone to the enjoyment of the highest attainable standard of physical and mental health'.⁶⁵ This right, in common with all other obligations under the convention, is to be 'progressively' realised, in recognition of resource capacity and constraints.

Are Reproductive Health Rights Guaranteed by International Law?

D.51 The right to health, including reproductive health, is central to human rights protection and promotion.⁶⁶ The Beijing Platform for Action, arising from the United Nations Fourth World Conference on Women held in 1995, observed that the 'ability of women to control their own fertility forms an important basis for the enjoyment of other rights'.⁶⁷

D.52 The United Nations Committee on Economic, Social and Cultural Rights has issued General Comments⁶⁸ on access to reproductive health services.⁶⁹ To fulfil the obligations, health services need to be available, accessible, acceptable, and adequate. Cook and Dickens suggest that laws and policies that unreasonably restrict safe abortion services would be unlikely to meet this standard.⁷⁰

RIGHTS UNDER CEDAW

D.53 Australia ratified CEDAW in 1983. CEDAW is the only human rights treaty which specifically affirms the reproductive rights of women. In addition to its general non-discrimination provisions, several articles relate directly to reproductive rights. These include:

- Article 5, which examines maternity as a social function⁷¹
- Article 12(1) regarding elimination of discrimination against women in health care, including equality in access to health services relating to family planning
- Article 14, which contains the right to adequate health services, including family planning for rural women
- Article 16(1)(e), which affirms on the basis of equality with men 'the right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights'.

43 *In the Marriage of F* (1989) 13 Fam LR 189, 194 (Lindenmayer J).

44 [1993] QB 204.

45 [1979] 1 QB 276. A similar approach was taken in *Re F (in utero)* [1988] 2 All ER 193, where the English Court of Appeal held that it had no jurisdiction to make an unborn child a ward of the court because of the born alive rule. Cf with *Heath J* in *Re an Unborn Child* [2003] 1 NZLR 115, where the court held it could apply its *parens patriae* jurisdiction to a child in utero. The court held that having regard to the CRC and other provisions of New Zealand law which support the interests of the unborn child, the term 'child' in s 2(1) of the Guardianship Act could include an unborn child.

46 *Paton v United Kingdom* (1980) 3 EHRR 408, 415.

47 The court noted that the question of when the right to life begins comes within the margin of appreciation that States enjoy: *Vo v France* 53924/00 ECHR 326 (8 July 2004).

48 *Duxbury and Ward* (2000) above n 8, 14.

49 The CRPWD, although not yet ratified by Australia, contains specific protections for individual autonomy for women with disabilities. It does not establish any additional rights, but aims to ensure people with disabilities enjoy human rights on an equal basis with others: Convention on the Rights of Persons with Disabilities, United Nations <www.un.org/disabilities> at 1 November 2007.

50 People are entitled to the rights and freedoms within the covenant 'without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.

51 This broad norm extends beyond the treaty. Thus, all people have a right to equality before the law in all matters, not just the specific rights contained in the ICCPR.

52 Even in jurisdictions where abortion laws have been liberalised (eg, Canada) there remain significant barriers to accessing services.

53 Some people argue this age-based, non-discrimination principle applies to gestational status, thus conferring rights upon the fetus; however, in international and Australian law the fetus has no substantive rights until birth.

54 Cook and Dickens (2003) above n 18, 41.

55 This definition has also been adopted by the Human Rights Committee, see Human Rights Committee General Comment 18, Non-discrimination (Thirty-seventh session, 1989), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc HRI/GEN/1/Rev.6 at 146 (2003).

56 For discussion see *Duxbury and Ward* (2000) above n 8, 16.

57 Eg, vasectomy.

58 Unless they were charged as an accessory to the abortion, procuring, or performing an abortion.

59 Submission 383 (Castan Centre for Human Rights Law).

60 Rebecca Cook and Susannah Howard, 'Accommodating Women's Differences Under the Women's Anti-Discrimination Convention' (2007) 56 *Emory Law Journal* 1039, 1045.

61 *Ibid* 1045.

62 Cook and Dickens (2003) above n 18, 5.

63 Submission 501 (Liberty Victoria).

64 Thus, the right to equality is not seen as an absolute right to have a baby or an abortion, but rather the right to have those decisions respected: Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (2001) 9.

65 The UDHR also refers to health. Article 25.1 affirms that: 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services'.

66 Cook and Dickens (2003) above n 18, 21.

67 The United Nations Fourth World Conference on Women, Beijing, China, September 1995 Action for Equality, Development and Peace, Platform for Action; Part C Women and Health A/ CONF.177/20, para 97 (1995): <www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en> at 13 February 2008.

68 A General Comment is an authoritative summary of the views of a human rights treaty body. General Comments amplify the meaning of the right and give guidance to State parties as to the implementation of the right.

69 Eg, the right to health specifically includes the 'right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference'. It also sets out the obligation to implement policies 'to provide access to a full range of high quality and affordable health care, including sexual and reproductive services': Committee on Economic, Social and Cultural Rights, General Comment No 14: The right to the highest attainable standard of health, 13th sess 1995, UN Doc E/1996/22 at 20 (1996).

70 'A law or policy requiring unnecessarily high qualifications for health service providers will limit the availability of safe abortion services. Such policies may be proposed in good faith to ensure excellence in health care. However, it is poor public health policy, and may be a human rights violation, to jeopardise health care by requiring standards that prevent delivery of medically indicated services': Cook and Dickens (2003) above n 18, 16.

71 That is, the role of motherhood and the impact it has upon women.

Appendix D

Human Rights and Abortion

- D.54 CEDAW obliges governments to achieve formal and substantive equality through elimination of **direct** and **indirect discrimination**. The particular needs of women with disabilities are also addressed.⁷²
- D.55 The CEDAW Committee has made **general recommendations** regarding reproductive rights. These include recommendations that State parties take measures to prevent coercion in reproduction and to ensure women are not forced to seek unsafe abortion because of lack of appropriate services.⁷³ Central to the reproductive rights enshrined in CEDAW is the corresponding right of a pregnant woman to choose to continue with a pregnancy.⁷⁴
- D.56 The committee has explained the reasoning behind women's autonomy regarding the numbers and spacing of children. It requires 'all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice ...'⁷⁵
- D.57 General Recommendation 24 explains in some detail the positive obligation to ensure, on a basis of equality between men and women, access to reproductive health care services.⁷⁶ This includes refraining from criminalising medical procedures only needed by women.⁷⁷
- D.58 The CEDAW Committee has criticised legal systems where abortion is subject to spousal, parent, or partner approval.⁷⁸ Governments may risk noncompliance when abortion provision is subject to excessively burdensome requirements.⁷⁹

RIGHT TO PRIVACY

- D.59 Privacy rights arise from traditional concerns about State interference with individual liberty. 'Any interference with privacy must be proportional to the end sought and be necessary in the circumstance of any given case.'⁸⁰

International Instruments

- D.60 Article 17 of the ICCPR protects the right to privacy. While Article 17 has not been interpreted specifically on the issue of abortion, a similar right contained in Article 8 of the European convention has been subject to judicial consideration.⁸¹ In the most recent case, *Tysiaogonc v Poland*,⁸² the European Court of Human Rights found a breach of Article 8 when a woman was denied an abortion within the lawful grounds for abortion in Poland. The European Commission previously held that not every restriction on abortion constitutes an interference with the right.⁸³
- D.61 The UN Human Rights Committee has confirmed that privacy includes autonomy over one's body.⁸⁴ The committee has specifically identified requirements for compulsory reporting of identifiable abortion information to authorities by medical practitioners as breaches of privacy.⁸⁵
- D.62 Privacy includes freedom from interference and a positive right.⁸⁶ Thus, 'the law must promote rather than hinder the right to privacy of a woman, including her right to a realm of protection in respect of her body'.⁸⁷
- D.63 The central question is, therefore, whether and when it is appropriate for the State to intervene in the private decision of a woman to have an abortion.
- D.64 Some people argue that the State has no role beyond regulating the health system to ensure medical standards. This view assumes that reproductive decisions are best made by 'the person whose conscience is most directly connected to the choice and who has the greatest stake in it'.⁸⁸
- D.65 A majority of the people participating in this reference who were in favour of decriminalisation took this position. It was summed up by Reproductive Choice Australia in its submission:
- [G]ranteeing women the right to decide in law does not deny that abortion is one of a number of medical procedures that also have moral implications. Instead it simply rejects the claim that anyone other than the woman ... (is) better placed than the woman herself to negotiate the moral aspects of the decision well.*
- D.66 Another view is that the legitimate role of government is to set the standards of justification 'that a woman is expected to interpret and define for herself as an exercise of personal responsibility'⁸⁹ and beyond which it is reasonable for the law to intervene. This approach has loomed large in the US.⁹⁰

- D.67 Others argue that the State has a clear role in setting moral standards, protecting the fetus, and regulating women's decisions by prohibiting abortion because the right to privacy is a qualified right.⁹¹
- D.68 Australian courts, have suggested there are limits to which the law should intrude upon a woman's autonomy in pursuit of moral and religious aims.⁹²

RIGHT TO LIBERTY AND SECURITY OF THE PERSON

International Instruments

- D.69 Everyone has the right to liberty and security of person under Article 9(1) of the ICCPR. Generally, liberty has been treated as freedom from physical restraint, such as detention, while security of the person has been connected with freedom from interference with bodily integrity.⁹³

International Cases

- D.70 Article 9's equivalent in the Canadian *Charter of Rights and Freedoms* has been found to be contravened by criminal laws restricting access to abortion. These laws contained requirements of designated facilities and therapeutic committees to approve abortion.⁹⁴
- D.71 In *Morgentaler*⁹⁵ the Supreme Court of Canada struck down such provisions for failing to conform with principles of fundamental justice. Chief Justice Dickson stated:
- [F]orcing a woman, by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus an infringement of security of the person.*⁹⁶
- D.72 In her concurring decision, Justice Wilson explicitly stated that requiring a woman to obtain a certificate from the therapeutic abortion committee violated the woman's right to liberty by 'deciding for her something that she has the right to decide for herself'.⁹⁷ She went on to state that 'liberty does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to protect them'.⁹⁸
- D.73 The case of *Morgentaler* has not been directly followed in any other jurisdiction but the Columbian Constitutional Court recently stated: '[A] woman's right to dignity prohibits her treatment as a mere instrument for reproduction. Her consent is essential to the fundamental life changing decision of giving birth to another person'.⁹⁹

- 72 'States parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.' : Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, 20th sess, 1999, UN Doc A/54/38 at 5 (1999).
- 73 Committee on the Elimination of Discrimination against Women, General Recommendation 19: Violence against Women, 11th sess 1992, UN Doc A/47/38 at 1 (1993).
- 74 These standards also link to other CEDAW articles protecting the rights of women who face particular disadvantage. Eg, art 14(2)(b), which requires State parties to ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning.
- 75 Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, 20th sess, 1999, UN Doc A/54/38 at 5 (1999).
- 76 This duty includes the obligation to respect, protect, and fulfil women's rights to health care and to ensure that law, policy and executive action comply with this duty.
- 77 The committee specifically mentions 'acceptable' services as those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives': Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, 20th sess, 1999, UN Doc A/54/38 at 5 (1999).
- 78 General Recommendation 21: Equality in marriage and family relations, 13th sess 1992, UN Doc A/49/38 at 1 (1994); Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, 20th sess, 1999, UN Doc A/54/38 at 5 (1999).
- 79 This may include mandating 'bureaucratic approval procedures, such as medical specialist therapeutic abortion committees'. Cook and Howard (2007) above n 60, 1055.
- 80 *Toonen v Australia* (1994) UN Doc CCPR/C/50/D/488/1992 (4 April 1994).
- 81 *European Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221, art 8 (entered into force 3 June 1952).
- 82 *Tysiaogonc v Poland* (2007) 45 EHRR 42 ECHR.
- 83 *Bruggemann and Scheuten v Federal Republic of Germany* (1981) 3 EHRR 244.
- 84 Sarah Joseph, Jenny Schultz and Melissa Castan, *The International Covenant on Civil and Political Rights: Cases and Commentary* (2nd ed, 2004) 480.
- 85 Human Rights Committee, General Comment 28, Article 3: Equality of Rights between Men and Women, 68th sess, 2000, UN Doc CCPR/C/21/Rev 1/Add 10 (2000).
- 86 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171, art 17(1) (entered into force 23 March 1976).
- 87 Duxbury and Ward (2000) above n 8, 22.
- 88 Ronald Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (1995) 15.
- 89 *Ibid* 64.
- 90 US cases were discussed in Chapter 2.
- 91 Submission 100 (Rita Joseph).
- 92 See Gibbs CJ in *Attorney-General (Qld) (ex rel Kerr) v T* (1983) 46 ALR 275, 277: 'There are limits to the extent to which the law should intrude upon personal liberty and personal privacy in the pursuit of moral and religious aims. Those limits would be overstepped if an injunction were to be granted in the present case'. This case dealt with an application for an injunction restraining a woman from having an abortion. The injunction was refused.
- 93 Lord Lester and David Pannick (eds) *Human Rights Law and Practice* (2nd ed, 2004) 528.
- 94 Canadian Charter of Rights and Freedoms s 7.
- 95 *Morgentaler et al* [1988] 1 SCR 30.
- 96 *R v Morgentaler et al* [1988] 1 SCR 30, [22] (Dickson CJ).
- 97 *R v Morgentaler, et al* [1988] 1 SCR 30, [241] (Wilson J).
- 98 *R v Morgentaler, et al* [1988] 1 SCR 30, [229] (Wilson J).
- 99 Sentecia C-355/06, Corte Constitucional (10 May 2006) (Columb).

Appendix D

Human Rights and Abortion

Australian Law

- D.74 The principle of autonomy is a basic feature of modern health law.¹⁰⁰ The concept of bodily integrity is central to self-determination.¹⁰¹ This concerns a 'person's interest and right, derived from the value of autonomy, in reflectively making significant personal choices'.¹⁰²
- D.75 While Australian courts have not dealt directly with *Morgentaler*, there have been several cases where paternal applications for an injunction to prevent a proposed abortion have been refused as an unreasonable interference with the woman's 'liberty of action'. Thus, in Australian law, a husband or partner cannot legally stop a woman from proceeding with an abortion.¹⁰³

FREEDOM OF THOUGHT, CONSCIENCE, AND RELIGION

- D.76 This freedom is recognised in the UDHR and the ICCPR. It is 'far-reaching and profound',¹⁰⁴ encompassing freedom of thought on all matters. The right includes a freedom to hold a belief and to manifest that belief in public and in private.¹⁰⁵ It is recognised to include both freedom of, and freedom from, religion.
- D.77 This freedom arises when medical practitioners refuse to perform an abortion due to religious or moral beliefs. It is expressed in medical ethics codes but with some limitations, for example life saving interventions, and a requirement that alternative care be available.¹⁰⁶
- D.78 The CEDAW Committee has recommended: 'if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers'.¹⁰⁷
- D.79 Some health care organisations make a claim for protection of conscientious objection to providing abortion, or other reproductive health services, for the organisation as a whole. This argument was strongly put in submissions from the Ambrose Centre for Religious Liberty, along with several Catholic organisations and individual submissions,¹⁰⁸ but human rights are generally regarded as residing in individuals rather than organisations.¹⁰⁹
- D.80 We consider conscience clauses in more detail in Chapter 8.

FREEDOM OF EXPRESSION

- D.81 This well-known human right is contained in Article 19 of the ICCPR and other major human rights instruments. It includes the right to receive information, including medical information.¹¹⁰
- D.82 A detailed review of freedom of expression is not possible here; however the freedom does touch on abortion law in two ways. First, some people claim this freedom and an associated right to freedom of conscience in the context of protesting outside abortion clinics. This was discussed in detail in Chapter 8.
- D.83 Freedom of expression also relates to abortion in the context of women having access to information about abortion services.¹¹¹ This in turn relates to the operation of any proposed conscience clause and the obligation to make an effective referral. This was discussed in Chapter 8.
- D.84 Freedom of expression is usually read widely by the courts. In a recent United Kingdom case, the High Court held that a woman who sent pamphlets containing images of aborted 21-week old fetuses to three pharmacists selling the morning-after pill could not manifest her religious beliefs (or freedom of expression) over the rights of people who did not wish to receive the material.¹¹²

FREEDOM FROM CRUEL AND DEGRADING TREATMENT

- D.85 Various human rights instruments contain a right to freedom from cruel and degrading treatment.¹¹³ It is a **non-derogating right**, also protected by **customary international law**.
- D.86 In the European case of *H v Norway*¹¹⁴ the applicant argued that during an abortion no measures were taken to prevent pain to a fetus of 14 weeks gestation, amounting to a violation of the (fetal) right to freedom from cruel and degrading treatment. The European Commission rejected this argument on the basis that there was no material evidence of fetal pain upon which to base it.

D.87 The Human Rights Committee considered the issue in 2003.¹¹⁵ A Peruvian woman argued that her freedom from cruel and degrading treatment had been violated when she was refused an abortion after discovering that the fetus had anencephaly.¹¹⁶ The committee found that the Peruvian prohibition on abortion in these circumstances did amount to foreseeable, cruel and degrading treatment.¹¹⁷

SPECIAL PROTECTION FOR MOTHERS BEFORE AND AFTER CHILDBIRTH

D.88 Article 10 of the CESCR provides that special protection should be accorded to mothers during a reasonable period before and after childbirth. This includes practical assistance such as paid maternity leave and adequate income support through the social security system. This article is aimed at protecting the mother, rather than affording specific rights to the fetus.

RIGHT TO FOUND A FAMILY

D.89 Article 23 (2) of the ICCPR (the right to marry and found a family) has been interpreted by the Human Rights Committee to prohibit coercive methods of family planning.¹¹⁸ There is a similar provision in the European Convention.¹¹⁹ However, in European law 'it is firmly established that Article 12 does not create an absolute right to procreate descendents'.¹²⁰ This suggests that a husband or partner cannot force a woman to continue with a pregnancy.

CONCLUSIONS

D.90 We have discussed how human rights law treats the issue of abortion. We have examined the various treaties, general comments of UN committees and leading cases to identify what impact, if any, international law has on domestic abortion laws.

D.91 In summary, the Charter of Human Rights and Responsibilities has no specific application to the law of abortion or child destruction in Victoria. Charter rights cannot be relied upon in legal cases about abortion in Victoria.

D.92 International human rights law does not preclude abortion, and does not establish a right to life of the fetus.¹²¹ Nor does it guarantee a right to provision of abortion services beyond the general right to health which can be realised progressively.¹²²

100 Eg, the right to refuse treatment.

101 Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (2002) 15.

102 Ibid 13.

103 See *In the Marriage of F* (1989) 13 Fam LR 189; *Attorney General (ex rel Kerr) v T (Qld)* [1983] 13 Fam LR 189.

104 Human Rights Committee, General Comment No 22, Article 18: The right to freedom of thought, conscience and religion, 48th sess, 1993, UN Doc CCPR/C/21/Rev 1/Add 4 (1993).

105 This right to manifest one's beliefs in public can only be limited by law and insofar as it is necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others: Article 18 (3) ICCPR.

106 See, eg, Australian Medical Association, *Code of Ethics* (May 2003).

107 Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, 20th sess, 1999, UN Doc A/54/38 at 5 (1999).

108 Submission 444 (Ambrose Centre for Religious Liberty).

109 Cook and Dickens (2003) above n 18, 50.

110 Article 10(h) CEDAW states that all women shall have 'access to specific educational information to help ensure the health and well-being of families including information and advice on family planning'.

111 *Open Door and Dublin Well Woman v Ireland* [1992] ECHR 68.

112 *Connelly v Director of Public Prosecutions* [2007] EWHC 237 (Admin).

113 See, eg, Article 7 ICCPR; Article 3 European Convention.

114 *H v Norway* Application No 17004/90 (1992).

115 *Karen Noelia Llanto Huamán v Peru*, Communication No 1153/2003, UN Doc ICCPR/C/85/D/1153/2003 (2005). Case cited in submission 383 (Castan Centre for Human Rights Law).

116 The 17-year-old woman gave birth to a child with anencephaly, ie, a condition where part or all of the brain is missing. The child survived for four days, during which the mother was required to breastfeed her. It was alleged in the complaint that the distress of being obliged to continue with the pregnancy, of witnessing the baby's disability, and knowing the child would not survive precipitated the mother's depression.

117 The cruel and degrading treatment was also raised in argument in *Mortengaler* but was not considered by the majority decision. Justice McIntyre specifically rejected the argument in his dissenting judgment.

118 Human Rights Committee General 19, Article 23, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, 39th sess 1990, UN Doc HRI/GEN/1/Rev 6 at 149 (2003).

119 *European Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221, art 12 (entered into force 3 June 1952).

120 David Hart, *The Impact of Human Rights on Medical Law* (21 October 2002) Human Rights Update <www.humanrights.org.uk/686> at 10 October 2007.

121 Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code, Chapter 5, Non Fatal Offences Against the Person*, Discussion Paper (1996) 160.

122 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 Dec 1966, 993 UNTS 3, art 2(1) (entered into force 3 January 1976).

Appendix E

Consultations

NO	PARTICIPANTS	DATE (2007)
1	Fertility Control Clinic	1 October
2	Endeavour Forum Inc.	2 October
3	Association for the Legal Right to Abortion	3 October
4	Presbyterian Church of Victoria	4 October
5	Australian Christian Lobby	4 October
6	Women's Health Victoria	4 October
7	Right to Life Australia	5 October
8	Choices Clinic—Royal Women's Hospital	8 October
9	Croydon Day Surgery	9 October
10	Health Services Commissioner	9 October
11	Family Planning Victoria	10 October
12	Reproductive Choice Australia	10 October
13	Medical Indemnity Protection Society	11 October
14	Marie Stopes International	11 October
15	Dr Ian Freckleton	11 October
16	Women's Health Goulburn North East Region	12 October
17	Victorian Women's Trust	15 October
18	Dr Nicholas Tonti-Filippini	15 October
19	Royal Women's Hospital	16 October
20	Australian Family Association Victoria	16 October
21	Women's Electoral Lobby	16 October
22	Associate Professor Kerry Petersen	17 October
23	Victorian Women With Disabilities Network	18 October
24	Fetal Management Unit—Royal Women's Hospital	18 October
25	Respect Life Office, Catholic Archdiocese of Melbourne	18 October
26	Professor David Healy	19 October
27	Associate Professor Ian Pettigrew	22 October
28	Anglican Diocese of Melbourne	22 October
29	Youth Affairs Council of Victoria	22 October
30	Australian Medical Association Victoria	22 October
31	Royal Australian and New Zealand College of Obstetricians and Gynaecologists fellows	23 October
32	Associate Professor Lynn Gillam	24 October
33	Dr Lachlan de Crespigny	30 October
34	Jewish Community Council of Victoria and Rabbi Aviva Kipen	7 November
35	Women's Clinic on Richmond Hill	12 November
36	Jewish Community Council of Victoria and Rabbi Feitel Levin	13 November

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
1	Fertility Control Clinic	22 August 2007
2	Mr David Kumnick	06 September 2007
3	Ms Margaret Ryan	24 September 2007
4	Ms Mary Doohan	02 October 2007
5	Mr Peter Robertson	02 October 2007
6	Endeavour Forum Inc.	02 October 2007
7	Anonymous	04 October 2007
8	Presbyterian Church of Victoria	04 October 2007
9	Mr Charles Francis AM, QC, RFD	05 October 2007
10	Mrs CD Crosbie Goold	05 October 2007
11	Ms Kate A Oldaker	09 October 2007
12	Mr Paul Johnson	09 October 2007
13	Mrs P Oldham	10 October 2007
14	Anonymous	10 October 2007
15	Dr Nicholas Tonti-Filippini	11 October 2007
16	Mr Mario Farrugia	12 October 2007
17	Ms Liz Olle	12 October 2007
18	Ms Dalrene Pompeus	12 October 2007
19	Mr Maurice White	15 October 2007
20	Ms Natasha Hamilton	15 October 2007
21	Mr Tony Howe	16 October 2007
22	Mr Michael W Houlihan	16 October 2007
23	Mary Smith	17 October 2007
24	Humanist Society Of Victoria Inc.	17 October 2007
25	Mr and Mrs Sinclair	23 October 2007
26	Coalition for the Defence of Human Life	23 October 2007
27	Mr Frank Gashumba	23 October 2007
28	Mr John Carter	23 October 2008
29	Ms Zoe Mathews	23 October 2007
30	Mr Paul Manser	23 October 2007
31	Ms Anne Webster	23 October 2007
32	Ms Jo-An M Partridge	23 October 2007
33	Dr D Ciarnette	23 October 2007
34	Mr Matthew Soo	23 October 2007
35	Mr Dennis and Mrs Cheryl Harold	23 October 2007
36	Ms Piera Cerantola	23 October 2007
37	Mr David and Mrs Ruth Cummings	23 October 2007
38	Festival of Light Australia	23 October 2007
39	Mr Paul Smithers	23 October 2007
40	Ms Gabrielle Cranny	23 October 2007
41	Mr Kevin McCormack	23 October 2007
42	EL Hyde	24 October 2007
43	Confidential	24 October 2007
44	Victims of Abortion Trauma Counselling & Info Services	24 October 2007
45	Confidential	25 October 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
46	Anonymous	25 October 2007
47	Mrs Joan Rigoni	25 October 2007
48	Anonymous	25 October 2007
49	Anonymous	25 October 2007
50	Anonymous	25 October 2007
51	Anonymous	25 October 2007
52	Anonymous	25 October 2007
53	Mr and Mrs Paton	25 October 2007
54	Mr and Mrs Scully	25 October 2007
55	Miss Maroa Shelton	25 October 2007
56	Ms Mary Fitzgibbon	26 October 2007
57	Mr Brian Tierney	26 October 2007
58	Mr and Mrs D'Souza	26 October 2007
59	Ms Karena Calpakam	26 October 2007
60	Mr D McMahan	26 October 2007
61	JD Reazy	26 October 2007
62	DC Coyne	26 October 2007
63	Fr S Arokiyadoss	26 October 2007
64	Ms Dorothy Moore	26 October 2007
65	Rev Dr Robert C Weatherlake	26 October 2007
66	Mr Greg Byrne	26 October 2007
67	Denis J Hart Archbishop of Melbourne—Catholic Archdiocese of Melbourne	26 October 2007
68	Les and Bev Jones	26 October 2007
69	Mr and Mrs Webber	26 October 2007
70	Mr and Mrs Pryor	26 October 2007
71	Unknown	26 October 2007
72	Mr and Mrs Calilhanna	26 October 2007
73	Mr Leo D Mahoney	26 October 2007
74	Mr Mark Simmonds	28 October 2007
75	Ms Jodie Simmonds	28 October 2007
76	Ms Tracey Lamprecht	29 October 2007
77	AH Griffiths FCPA	29 October 2007
78	Mornington Social Justice Group	29 October 2007
79	Confidential	29 October 2007
80	Hon Dr Bob Such MP	29 October 2007
81	Fr Joachim O'Brien OFM	29 October 2007
82	Women's Forum Australia	29 October 2007
83	Mr George Simpson	30 October 2007
84	Ms Rosemary Brown	30 October 2007
85	Mrs C Coleman	30 October 2007
86	Mrs Maria McCarthy	30 October 2007
87	Ms Carmel Collis	30 October 2007
88	Mr Paul Hayhoe	30 October 2007
89	Mrs Patricia	30 October 2007
90	Mrs Corrina Broomfield	30 October 2007

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
91	Mrs A Denbrok	30 October 2007
92	Mrs Catherina A Schelling	30 October 2007
93	Leo Morrissey and Moya Morrissey	30 October 2007
94	Women's Health Goulburn North East	30 October 2007
95	Ms Hilarie Roseman	31 October 2007
96	Ms Catherine Ludeman	31 October 2007
97	Mr Des O'Callaghan	31 October 2007
98	Mrs Marcia Wilkinson	31 October 2007
99	Anonymous	08 November 2007
100	Ms Rita M Joseph	01 November 2007
101	Mr James Hanrahan	01 November 2007
102	Mr Tom Scully	01 November 2007
103	Ms Florence McMahan	01 November 2007
104	Ms Margaret Butts	01 November 2007
105	Mrs Mary Harkin	01 November 2007
106	Mr Nicholas Joseph Sorenson	01 November 2007
107	Ms Joan McGrath	01 November 2007
108	VW Hickey	01 November 2007
109	Mrs Eileen V Hanrahan	01 November 2007
110	Ms Maureen Jongebloed	01 November 2007
111	Ms Margaret Noonan	01 November 2007
112	Ms Val Heltham	02 November 2007
113	Desmond and Josephine Kenneally	01 November 2007
114	Mr John and Ms Cheryl Hackett	02 November 2007
115	Mr Kevin Shannahan	02 November 2007
116	Canterbury Christadelphian Ecclesia	05 November 2007
117	Mr John Purcell	05 November 2007
118	Anonymous	05 November 2007
119	Ms Rebecca Carey	05 November 2007
120	Anonymous	05 November 2007
121	Mr Barry and Mrs Helen Lauritz	05 November 2007
122	Mrs Sandra Johnson	05 November 2007
123	Mr Richard Earle	03 November 2007
124	Catholic Women's League of Victoria Inc.	05 November 2007
125	Fr John Quinn	05 November 2007
126	Ashley Hughes	05 November 2007
127	Mrs Jackie Vandeligt	05 November 2007
128	Confidential	05 November 2007
129	Mr John Box	05 November 2007
130	Mrs Mary Flanagan	05 November 2007
131	Ms Mary McCormack	05 November 2007
132	Rev Stan and Mrs Katherine Fishley	02 November 2007
133	Mr Jerome Brown	02 November 2007
134	Women's Health West	02 November 2007
135	Dr Pieter Mourik	02 November 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
136	EMILY's List Australia	02 November 2007
137	Mr Ronald Berchy	03 November 2007
138	Anonymous	04 November 2007
139	Mr Michael and Mrs Josephine Renehan	04 November 2007
140	Ms Michelle White	04 November 2007
141	Medicine with Morality	04 November 2007
142	M O'Rielly	05 November 2007
143	Ms Allana Moorse	02 November 2007
144	Mr Peter Olney	31 October 2007
145	Mr Roger McWhinney	31 October 2007
146	Ms Maria Anna Taylor	30 October 2007
147	Dr Leslie Cannold	30 October 2007
148	Mary-Anne Yang	02 November 2007
149	Michael Keane and Barbara Keane	03 November 2007
150	Frances B Ritchie	03 November 2007
151	Catholic Women's League of Victoria and Wagga Wagga, Social Questions Committee	05 November 2007
152	Professor Rebecca Albury	05 November 2007
153	Mr James Ward	05 November 2007
154	Ms Maryse Usher	05 November 2007
155	Mr David J Perrin	05 November 2007
156	Anonymous	05 November 2007
157	Mr Doug Felton	05 November 2007
158	Mr Matt Ritchie	06 November 2007
159	Ms Annette McDonald	06 November 2007
160	Mr Peter McDonald	06 November 2007
161	R Hill	07 November 2007
162	Mr Michael Casanova	06 November 2007
163	Ms Jennifer McDonald	06 November 2007
164	Ms Clare Power	06 November 2007
165	Mr Michael and Mrs Joan Cutajar	06 November 2007
166	Mr Peter Baker	07 November 2007
167	Mr John van Heuzen	07 November 2007
168	Pastor Noel Uebergang and Mrs Ros Uebergang	07 November 2007
169	Ms Diane Tay	07 November 2007
170	Rev Frank C Lees	07 November 2007
171	Ms Margaret Green	07 November 2007
172	Ms Gillian Taylor	07 November 2007
173	Mr Craig Manners	07 November 2007
174	Ms Erundina Fernandez	07 November 2007
175	Anonymous	07 November 2007
176	Ms Erica Grace	07 November 2007
177	Ms Christine Beveridge	07 November 2007
178	Anonymous	07 November 2007
179	Mr David Bernard	07 November 2007
180	Mr Jeremy Peet	07 November 2007

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
181	Mr Peter Kavanagh	07 November 2007
182	Anonymous	07 November 2007
183	Australian Education Union Victoria	07 November 2007
184	Mr Ron Edmonds	07 November 2007
185	Associate Professor Kerry Petersen	07 November 2007
186	Mr Christian Duin	07 November 2007
187	Mr John H Cooney	07 November 2007
188	Mr David Forster	07 November 2007
189	Dr Paul Egan	07 November 2007
190	Dr Peter McCleave	07 November 2007
191	Mr Anthony G Wright	07 November 2007
192	Ms Tess Natoli	07 November 2007
193	Confidential	07 November 2007
194	Ms Katie Lindorff	07 November 2007
195	Mr Simon Millie	07 November 2007
196	Confidential	07 November 2007
197	Professor Caroline deCosta	07 November 2007
198	Mr Patrick Sibly	07 November 2007
199	Anonymous	07 November 2007
200	Mr Kevin Guinane	07 November 2007
201	Parishoners of St Kevin's Templestowe Lower	07 November 2007
202	Mr James Jackson	07 November 2007
203	Anonymous	07 November 2007
204	Mrs Mary Jenkins	07 November 2007
205	Mrs Margaret Morrison	07 November 2007
206	Pat and Betty Bourke	07 November 2007
207	Mrs Catherine Ley	07 November 2007
208	Mrs MA van Dyk	07 November 2007
209	Mrs ML Rowlinson	07 November 2007
210	Mr Eric Neill Harvey	07 November 2007
211	Mrs Leanne Casanova	07 November 2007
212	Mrs Joan Drago	07 November 2007
213	Ms Josephine Kelly	07 November 2007
214	Ms Elizabeth McNamara	07 November 2007
215	Elwyn Sheppard	07 November 2007
216	Confidential	07 November 2007
217	Parish of St Fidelis	07 November 2007
218	Mr John A Gill	07 November 2007
219	Mr James Duggan	07 November 2007
220	Mr Michael Smith	07 November 2007
221	Anonymous	07 November 2007
222	Mrs Ann Fowles	07 November 2007
223	Mrs Connie Mirabella	07 November 2007
224	Ms Kathleen Richards	07 November 2007
225	Tangambalanga Catholic Women's League	07 November 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
226	Women's Health Association of Victoria	07 November 2007
227	Reproductive Choice Australia	07 November 2007
228	Mr John S Parker	08 November 2007
229	Mr Bruce Bennett	08 November 2007
230	Mr Richard Grant	09 November 2007
231	Public Health Association of Australia Women's Health Special Interest Group	09 November 2007
232	Mrs Lucia Morham	09 November 2007
233	Mr Brendan Griffin	09 November 2007
234	Anonymous	09 November 2007
235	Youthlaw	09 November 2007
236	Mr Peter McGlade	09 November 2007
237	Ms Patricia M Guinan	09 November 2007
238	Anonymous	09 November 2007
239	Mrs Patricia Patton	09 November 2007
240	DA Cook, ET Cook, JM Cook	09 November 2007
241	Mr Phil Brabin and Mrs Susan Brabin	09 November 2007
242	Mr James Stiffle and Ms Dolly Stiffle	09 November 2007
243	Anonymous	09 November 2007
244	Ms Joan McKenna	09 November 2007
245	Ms Kath Andraczke	09 November 2007
246	Mr John Abraham	09 November 2007
247	Ms Kathleen M Chosich	09 November 2007
248	Pregnancy Counselling Australia	09 November 2007
249	Ms Anges-Mary Hanna	9 November 2007
250	Mr Peter Beriman	09 November 2007
251	Ms Anne B Buchan	09 November 2007
252	National Civic Council	09 November 2007
253	Mrs Mary Sayers	09 November 2007
254	Anonymous	09 November 2007
255	Waverley Catholic Deanery	09 November 2007
256	Redemptorist Community	09 November 2007
257	Mr and Mrs Birch	09 November 2007
258	Confidential	09 November 2007
259	Mr Michael Anstis	09 November 2007
260	Anonymous	09 November 2007
261	Gippsland Women's Health Service	09 November 2007
262	Victorian Women Lawyers	09 November 2007
263	Antony O'Brien	09 November 2007
264	Mr Ray Rus	09 November 2007
265	Dr JN Santamaria	09 November 2007
266	Mr Alan A Hoysted	09 November 2007
267	Anonymous	09 November 2007
268	Peter Rice for Anglicare South East	09 November 2007
269	Ms Stef Puszka	09 November 2007
270	Anonymous	09 November 2007

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
271	Anonymous	09 November 2007
272	Ms Desmond J Kelly	09 November 2007
273	Law Institute of Victoria	09 November 2007
274	Mr Justin Tan	09 November 2007
275	Ms Susan Juhas	09 November 2007
276	Family Council of Victoria	09 November 2007
277	Mrs Alison Stanley	09 November 2007
278	Mr Nathan Keen	09 November 2007
279	Ms Elyse Brown	09 November 2007
280	Mrs Fiona Roberts	09 November 2007
281	Ms Rhiannon Platt	09 November 2007
282	Women's Health in the North	09 November 2007
283	Mr Peter Phillips	09 November 2007
284	Fr John O'Connor	09 November 2007
285	Anonymous	09 November 2007
286	Anonymous	09 November 2007
287	Mr Peter Coventry	09 November 2007
288	Anonymous	09 November 2007
289	Victorian Centres Against Sexual Assault Forum	09 November 2007
290	Professor Loane Skene	09 November 2007
291	Ms Annaliese Wursthorn	09 November 2007
292	Mr Timothy Ginnane SC	09 November 2007
293	Ms Marita Gill	09 November 2007
294	Anonymous	09 November 2007
295	K and A Huggett	09 November 2007
296	AX Lyons	09 November 2007
297	Mr David Millie	09 November 2007
298	Anonymous	09 November 2007
299	Caroline Chisholm Centre for Health Ethics	09 November 2007
300	Mr Bryan Roberts	09 November 2007
301	Spero Katos	09 November 2007
302	Mr John McClelland	09 November 2007
303	Fr Brendan Lane	09 November 2007
304	Mr Alexander White	09 November 2007
305	Mr K and Mrs H Harwood	09 November 2007
306	Mrs Atala Ladd	09 November 2007
307	Mr David Briggs	09 November 2007
308	Anonymous	09 November 2007
309	Ms Margaret Rush	09 November 2007
310	Mr Daniel Briggs	09 November 2007
311	Mr Matthew Briggs	09 November 2007
312	Mr Ivor Briggs	09 November 2007
313	Ms Naomi Briggs	09 November 2007
314	South West Community Legal Centre	09 November 2007
315	Confidential	09 November 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
316	Westgate Catholic Deanery Social Justice Group	09 November 2007
317	Confidential	09 November 2007
318	Mrs Frances Dunlop	09 November 2007
319	Ms Tanya Mammone	09 November 2007
320	Ms Janice Adams	09 November 2007
321	Confidential	09 November 2007
322	Confidential	09 November 2007
323	Confidential	09 November 2007
324	Mr Rodney Schneider	09 November 2007
325	Anonymous	09 November 2007
326	Dr Ann Robertson	09 November 2007
327	Children by Choice	09 November 2007
328	Confidential	09 November 2007
329	Family Life International (Aust)	09 November 2007
330	Ms Maureen Jones	09 November 2007
331	Mr Matthew Grinter	09 November 2007
332	Pat Healy	09 November 2007
333	Ms Pauline Stoll	09 November 2007
334	Mr Anthony Krohn	09 November 2007
335	Mr Robert and Mrs June Mears	09 November 2007
336	World Federation of Doctors who Respect Human Life	09 November 2007
337	Confidential	09 November 2007
338	Dr Sally Cockburn	09 November 2007
339	Dr Lachlan de Crespigny	09 November 2007
340	ALP Brunswick	08 November 2007
341	Keith and Shirley Jeans	09 November 2007
342	Mr Graham Beasy	09 November 2007
343	Mrs Therese Parker	07 November 2007
344	Rev Dr Peter Barnes	08 November 2007
345	Mr David and Mrs Rebecca Field	07 November 2007
346	Ms Lynn Tan	07 November 2007
347	Mr Ivor Jenkins	08 November 2007
348	Anonymous	08 November 2007
349	Mr Michael Ryan	08 November 2007
350	Ms Joanne Switserloot	08 November 2007
351	Mr John Brancatisano and Miss Rosa Brancatisano	08 November 2007
352	Ms Patrica Costin	08 November 2007
353	Mrs Cathy Smit	08 November 2007
354	Radical Women	08 November 2007
355	Sacred Heart Newport and St Margaret Mary's Spotswood	08 November 2007
356	Dr Peter Ferwerda	08 November 2007
357	Anonymous	08 November 2007
358	Mrs Ann Hancock	08 November 2007
359	Mrs Anita M Toner	08 November 2007
360	Mr John F Hennessy	08 November 2007

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
361	Anonymous	08 November 2007
362	Mrs Rosaria M Righela	08 November 2007
363	Anonymous	08 November 2007
364	Ms Moya O'Keefe	08 November 2007
365	Echuca Branch—Catholic Women's League of Victoria & Wagga Wagga	08 November 2007
366	Mrs Win Kelly	08 November 2007
367	Anonymous	08 November 2007
368	Mr Des Ryan	08 November 2007
369	Fr Peter Carrucan	08 November 2007
370	Ms Cambria M Parkinson	08 November 2007
371	H Breach	08 November 2007
372	Ms Mary B McInerney	08 November 2007
373	Mr Peter Hancock	08 November 2007
374	Mr John Burke	08 November 2007
375	Mrs Julia Conlon	08 November 2007
376	Anonymous	08 November 2007
377	Mrs Maureen Federico	08 November 2007
378	Ms Mary Kirk	08 November 2007
379	Mr Patrick Jackson	08 November 2007
380	Ms Jane Munro	08 November 2007
381	Pastor Steve McNeilly	08 November 2007
382	Mr Richard J Reardon	08 November 2007
383	Castan Centre for Human Rights Law	08 November 2007
384	Victorian Women with Disabilities Network	08 November 2007
385	Mr Michael Twigg	08 November 2007
386	Mr Robin J Johnson	08 November 2007
387	Mr Damien Spillane	08 November 2007
388	Barbara Tregonning	08 November 2007
389	Dr Mark Jones	08 November 2007
390	Mrs Claire McManus	08 November 2007
391	Dr Mary Lewis	08 November 2007
392	Anonymous	08 November 2007
393	Ms Mary Schulberg	08 November 2007
394	Mrs Joan-Eileen Spee	08 November 2007
395	City Life Church	08 November 2007
396	Mr Mark Godfree	08 November 2007
397	Mr Steven Tudor and Ms Alison King	08 November 2007
398	Anonymous	08 November 2007
399	Confidential	08 November 2007
400	Mrs Lisa Brick	08 November 2007
401	Anonymous	08 November 2007
402	Mr John Breheney and Mrs Anna Breheney	08 November 2007
403	Mr Jose Morel	08 November 2007
404	Anonymous	08 November 2007
405	Mr Geoff and Mrs Helen Wells	08 November 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
406	Ms Maria Lusby	08 November 2007
407	Mr John Keble	08 November 2007
408	Ms Natalie Grima and Ms Marlene Grima	08 November 2007
409	Anonymous	08 November 2007
410	The Key Centre for Women's Health in Society	08 November 2007
411	Right to Life Australia	08 November 2007
412	Anonymous	08 November 2007
413	Steven, Myrna and Tania Hengeveld	08 November 2007
414	Anonymous	08 November 2007
415	Dr FP Denton	08 November 2007
416	Mr DG Condon	08 November 2007
417	Anonymous	08 November 2007
418	Ms Monica Clark	08 November 2007
419	Mr John Casanova	08 November 2007
420	Ms Betty Gough	08 November 2007
421	Mr Alan and Mrs Lyn Manson	08 November 2007
422	Mr James and Mrs Aileen Hewat	08 November 2007
423	Mrs Adrian Micallef	08 November 2007
424	Mr GJ Keane	08 November 2007
425	Mr Garry Webb	08 November 2007
426	Anglican Diocese of Melbourne	08 November 2007
427	Ms Sally Jensen	05 November 2007
428	Jaime Jensen	07 November 2007
429	Mr Chris Jensen	05 November 2007
430	Pat P	31 October 2007
431	CB McAteer	21 November 2007
432	Mr John Rouse	08 November 2007
433	Irene Flanily	09 November 2007
434	Mr Laurence Winkle	09 November 2007
435	Mr Brian Gleeson	09 November 2007
436	Ad Hoc Interfaith Committee	09 November 2007
437	Christian City Church Whitehorse	09 November 2007
438	Ms Hazel Sessarego	08 November 2007
439	Henricke	09 November 2007
440	Ms Marie McKinley	07 November 2007
441	Mr Peter O'Callaghan	31 October 2007
442	Mrs Sharon Duiker	10 November 2007
443	Mr Erik Werps and Mrs Elizabeth Werps	10 November 2007
444	Ambrose Centre for Religious Liberty	10 November 2007
445	Mrs Pauline Smit	10 November 2007
446	Shop, Distributive and Allied Employees Association	09 November 2007
447	Mr Maurie Conry	08 November 2007
448	M Buckley	31 October 2007
449	YWCA Victoria	09 November 2007
450	Victorian Young Labor	09 November 2007

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
451	Women's Health Victoria	09 November 2007
452	Catholic Justice Agency of the Archdiocese of Melbourne	09 November 2007
453	Young Labor Left Victoria	09 November 2007
454	Australian Christian Lobby	09 November 2007
455	Mr Peter Newland	11 November 2007
456	Mr Gerard McKernan	11 November 2007
457	Mr Peter Evans	12 November 2007
458	Caroline Chisholm Society	12 November 2007
459	Pro-Life Victoria	12 November 2007
460	Health Services Commissioner	13 November 2007
461	Association for the Legal Right to Abortion	12 November 2007
462	Family Planning Australia	12 November 2007
463	Fr Max Polak	12 November 2007
464	Anonymous	12 November 2007
465	Women's Health Grampians	12 November 2007
466	Mrs A Ogden	12 November 2007
467	Mr Suryan Chandrasegaran and Mrs Therese Chandrasegaran	12 November 2007
468	Anonymous	12 November 2007
469	Mrs Clare Snell	12 November 2007
470	Mr Francis Dwyer	12 November 2007
471	Mrs Josephine A Fogarty	12 November 2007
472	Confidential	12 November 2007
473	Ms Trudi Aiashi	12 November 2007
474	Mr Tony Hrkac	13 November 2007
475	Dr Katrina Haller	13 November 2007
476	Helpers of God's Precious Infants	14 November 2007
477	Mr Kevin James Brown	14 November 2007
478	Mario and Helena Hrkac	14 November 2007
479	Ms J Cushing	13 November 2007
480	Mrs Geraldine Scholter	15 November 2007
481	E Opray	16 November 2007
482	Ms Josephine Jones	16 November 2007
483	Ms Margaret Pekin	10 November 2007
484	Dr Philomene Joshua Tenni	12 November 2007
485	Ms Helen Wursthorn	12 November 2007
486	Mr Noel and Mrs Catharine Carpenter	12 November 2007
487	The Victorian Women's Trust	07 November 2007
488	Mr Peter Longshaw	31 October 2007
489	Mr Frank Maher	31 October 2007
490	Mr Robert Hamilton	31 October 2007
491	Mr Gordon Borlow	31 October 2007
492	Mr Paul Bak	31 October 2007
493	Mr William Curry	31 October 2007
494	Mr Ralph Cleary	31 October 2007
495	Mr Bernie Conroy	31 October 2007

Appendix F

Submissions

NO	SUBMITTER / ORGANISATION	DATE RECEIVED
496	Mr Ron A Coban	31 October 2007
497	Campaign for Women's Reproductive Rights	09 November 2007
498	Union of Australian Women Vic	09 November 2007
499	Knights of the Southern Cross Victoria	09 November 2007
500	Mr Scott Bloodworth	09 November 2007
501	Liberty Victoria—Victorian Council for Civil Liberties Inc.	09 November 2007
502	Youth Affairs Council of Victoria	09 November 2007
503	Australian Medical Association (Victoria)	09 November 2007
504	Fitzroy Legal Service	09 November 2007
505	Victoria Legal Aid	09 November 2007
506	Salt Shakers	09 November 2007
507	Royal Women's Hospital	09 November 2007
508	Ms Catherine Mayes	14 November 2007
509	Ms Annarella Hardiman	20 November 2007
510	Confidential	23 November 2007
511	Anonymous	26 November 2007
512	Marianne Glowe	27 November 2007
513	St John's Presbyterian Church Bendigo	1 November 2007
514	Baptist Fellowship Warragul	29 October 2007
515	Disability Discrimination Legal Service	27 November 2007
516	Joseph Santamaria	03 December 2007
517	Paediatric State Committee—Royal Australasian College of Physicians	10 December 2007
518	Anonymous	30 January 2008
519	Mr Chris Whelan	31 January 2008

Glossary

Abortifacient describes something used to produce abortion. It includes a drug or device.

Access and equity describes an approach to planning and delivering services. It strives to ensure people can use services regardless of their age, gender, disability, ethnicity, cultural background, religion, sexuality, socioeconomic background, or geographical location. Equity is a broad concept referring to the ability to access, participate and get results from a service. It requires services to be inclusive and respectful of diversity.

Adverse events are incidents which result in harm to a person receiving health care.

Antenatal means during pregnancy before childbirth. It is the same as prenatal.

Assisted reproductive technology (ART) facilitates the conception of children using laboratory or clinical technology. It includes techniques such as in-vitro fertilisation and assisted insemination and may involve the use of donated sperm, eggs, or embryos.

Autonomy is a principle in medical ethics that any competent person has the right to make an informed choice to accept or forego medical treatment. In human rights law it is the principle that a person has a right to control his or her own life and destiny.

Bioethics is the study of ethical choices faced in medical research and treatment of patients.

Born alive rule concerns proof of life and states that any sign of life after birth is sufficient.

Bubble zone laws establish a physical zone around an abortion clinic or hospital which protestors may not enter, and/or where their speech or action are restricted.

Care pathway describes the patient's journey through the health system, including all aspects of care (eg, seeing a doctor and then seeing a counsellor).

Cause of action refers to the legal rule that gives rise to a claim for redress.

Cognitive impairment includes, but is not limited to, impairment of mental functioning due to intellectual disability, mental illness, dementia, and acquired brain injury.

Common law is law created by decisions of the courts, rather than law created by parliament through legislation.

A common law offence is conduct treated as criminal by the common law instead of legislation.

Competency (or capacity) refers to a person's ability to understand and give legal consent (eg, consent to medical treatment).

Conscientious objection is the unwillingness to meet an obligation on the basis of deeply held beliefs, religious or ethical conviction.

Cooling-off period is a period of time or enforced delay between deciding to act and legally being allowed to do so.

Customary international law refers to legal standards that have become settled practice in international law even though they have not been written down in treaties. To amount to customary law it must be widely practised and countries must follow the legal standard in a way that shows they consider it to be obligatory.

Demographic characteristics is a term often used in statistics to describe features of the population or group of people (eg, age and gender).

Denominational hospitals are hospitals funded by the Department of Human Services under Health Service Agreements that are run by faith-based organisations. A list of denominational hospitals can be found in Schedule 2 of the *Health Services Act 1988*.

Diagnostic tests include tests such as amniocentesis.

Direct discrimination occurs when a person with a particular attribute is treated (or is proposed to be treated) less favourably than another person because of that particular attribute. Attributes are listed in legislation and include gender, disability, age, pregnancy, religious belief, sexuality, etc.

Double effect is an ethical doctrine that allows for circumstances where a fetus may die as an unintended consequence of a medical intervention aimed at saving the life of the mother.

Duty of care refers to the obligation of a person within a particular relationship to take reasonable care in their conduct towards others in that relationship. If they fail in that duty and it causes harm, a claim for negligence may arise.

Encephalitis is an inflammation of the brain.

Ectopic pregnancy is one outside the womb (eg, in a fallopian tube).

Fetal screening refers to a range of tests that take place during pregnancy to identify possible conditions or fetal disability. Screening includes ultrasound and maternal serum samples.

Glossary

Framing bias occurs when the design or wording of survey questions may influence the answer a survey participant gives to the question.

Gametes are cells involved in reproduction. The male sperm and the female ovum (egg) are gametes that unite to produce a cell zygote that may develop into an embryo and then a fetus.

General recommendations are guidelines issued by United Nations human rights committees which explain the meaning of rights contained in international human rights treaties or conventions.

Gestational limits are sometimes included in abortion laws. They set a fixed point in the pregnancy after which abortion is either prohibited or subject to specific legal rules or conditions.

Human rights instruments is the general term for laws that contain human rights. They include international treaties (sometimes called covenants) and declarations. At a national or state level they may be called a charter, a human rights Act or a bill of rights.

Hydrocephalus means an increase in fluid around the brain which may cause an enlargement in the skull and compression of the brain.

Indictable offences are the more serious criminal offences, sometimes dealt with by a judge and jury.

Indirect discrimination occurs when a specific requirement, condition, or practice that applies to everyone results in it being harder for a person with a particular attribute (ie disability) to meet the requirement and it is not reasonable. For example, a height requirement may indirectly discriminate against women or ethnic groups who tend to be shorter, unless being that height is necessary to perform the job.

Infanticide is an offence where a woman kills her child and her state of mind was so disturbed by the effect of giving birth to that child within the previous two years or from a disorder following birth within the previous two years, that the law treats her as if she were guilty of manslaughter rather than murder. Infanticide is an alternative verdict to murder. In a trial for murder, the jury may therefore give a verdict of infanticide.

Intervention orders restrain the behaviour of a person in some way, usually for a set period, though sometimes indefinitely. Breaching an intervention order is a criminal offence.

Jurisprudence generally refers to the philosophy of law or legal theory.

Legal personhood refers to the time when a person has rights and duties under the law. Human beings do not have legal personhood until birth.

Mature minor is a legal principle used to describe a young person aged under 18 years who has sufficient understanding and intelligence to understand what is proposed and so can give valid, lawful consent to medical treatment.

Medical abortion is where drugs are used to induce abortion instead of having surgery.

Neonates are newborn children.

Non-derogating rights are human rights that must be fully met, they cannot be watered down or avoided. An example is freedom from torture.

Non-response bias refers to a problem with using results from a small and possibly unrepresentative sample of people surveyed to generalise to the wider population.

Notification schemes are sometimes included in abortion laws. They require medical practitioners or other health professionals to send information or data about abortions to the government, usually the health department.

Onus of proof refers to the responsibility of proving a case or argument to the court. It is the obligation to prove what is alleged.

Parens patriae jurisdiction refers to the power of a superior court to make a decision for a person who is unable to make the decision for themselves because of lack of capacity. For example, decisions about medical treatment for people who are unable to make their own decisions because of disability or age.

Penalty units. Many offences are punishable by a fine. Rather than setting a monetary amount, laws refer to numbers of penalty units. The unit is an amount of money, set by the government each year and published in the *Government Gazette*. To calculate the fine, you multiply the number of penalty units by the value of the unit (one penalty unit is currently worth \$110.12).

Penumbra refers to something being uncertain or unclear, in partial shadow.

Prenatal means during pregnancy but before childbirth. It is the same as antenatal.

Prima facie is a Latin term meaning at first appearance, before investigation.

Proximity refers to people being so closely and directly involved in an act that they are part of it. For example, a nurse is part of the medical team in abortion but a hospital receptionist is not. Proximity also relates to the law of negligence but has a different meaning in that context.

Quickening is an old word used to describe the stage of pregnancy when the fetus begins to be felt moving in the womb.

Recall (or reporting) bias occurs when the way a survey respondent answers a question is affected by the gap in time between the event they are being asked to recall and the time of the survey question.

Regulatory framework is used to describe the total set of laws, rules, policies, and institutions that organise or control an activity.

Reproductive rights is used in human rights law to describe rights that relate to people's ability to control their fertility and reproductive health.

Reservation can be made by a country on an international treaty when it wishes to excuse itself from meeting the obligation created by the treaty.

Sampling is the statistical process of selecting a group of people to be used as a representative or random example of the wider population.

Savings clause is a provision in legislation which preserves a legal rule or right existing before the legislation. For example, the Charter of Human Rights and Responsibilities Act includes a savings provision that means the Charter does not affect the existing law of abortion.

Schedules are located at the back of an Act of Parliament.

Segmentation is the point at which it is no longer possible for a single fertilised egg to divide and create identical twins.

Substitute decision making is a means of making decisions on behalf of other people who are unable to make decisions for themselves.

Surgical abortion ends a pregnancy by surgically removing the contents of the uterus, most commonly by suction and curettage.

Therapeutic abortion is an abortion within the law, performed by or under the supervision of a registered medical practitioner.

Truth in advertising refers to a legal requirement that when people advertise their services the advertising is not misleading or deceptive.

Zygote is the cell that is produced when an egg (ovum) is fertilised by a sperm.

Bibliography

- Adelson, Pamela, Frommer, Michael and Weisberget, Edith, 'A Survey of Women Seeking Termination of Pregnancy in New South Wales' (1995) 163 *The Medical Journal of Australia* 419
- Allanson, Susie, 'Pregnancy/Abortion Counselling: False Providers, Mandatory Counselling, Ultrasound & "Cooling Off"' (2007) 19 *Women Against Violence* 5
- Australian Association of Social Workers, *Code of Ethics* (1999) <www.aasw.asn.au/adobe/about/AASW_Code_Of_Ethics-2004.pdf> at 9 January 2008
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005–06* (2007)
- Australian Law Reform Commission, *Review of Privacy Issues Paper 31* (2006)
- Australian Medical Association, *Code of Ethics* (2004) <www.ama.com.au/web/nsf/tag/amacodeofethics> at 18 February 2008
- Baker, Philip (ed), *Obstetrics by Ten Teachers* (18th ed, Hodder Arnold, 2006)
- Betts, Katherine, 'Attitudes to Abortion in Australia: 1972 to 2003' (2004) 12(4) *People and Place* 22
- Bonevski, Billie and Adams, Jane, *Psychological Effects of Termination of Pregnancy: A Summary of the Literature: 1970–2000* (Newcastle Institute of Public Health, 2001)
- British Columbia Women's Hospital and Health Service and Provincial Health Services, *Best Practice in Abortion Care: Guidelines for British Columbia* (2004)
- British Medical Association, *Abortion Time Limits: A Briefing Paper from the BMA May 2005: Part Two—Factors Influencing Views on Abortion Time Limits: Fetal Viability* <www.bma.org.uk/ap.nsf/Content/AbortionTimeLimits~Factors~viability> at 14 September 2007
- Calo, Brooke, 'The Violence of Misinformation: Compulsory Independent Counselling and the Current Abortion Debate' (2007) 19 *Women Against Violence* 10
- Capper, David, 'The Condition of Abortion Law in Northern Ireland' (2003) 54(3) *Northern Ireland Legal Quarterly* 320
- Cica, Natasha, 'The Inadequacies of Australian Abortion Law' (1991) 5 *Australian Journal of Family Law* 37
- Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the Year 2005* Victorian Perinatal Data Collection Unit, *Victorian Birth Defects Bulletin No 4* (2007) <www.health.vic.gov.au/perinatal/downloads/bdr_bulletindec07.pdf> at 12 February 2008
- Criminal Law Review Division, NSW Attorney General's Department, *Review of the Law of Manslaughter in New South Wales* (2003)
- Davies, Julie-Anne, '32 Weeks: 5½ Years' *The Bulletin* (Australia) 8 January 2008, 42
- Dean, Rebecca and Allanson, Susie, 'Abortion in Australia: Access Versus Protest' (2004) 11 *Journal of Law and Medicine* 510
- De Costa, Caroline, 'Medical Abortion for Australian Women: It's Time' (2005) 183(7) *Medical Journal of Australia* 378
- 'Early Medical Abortion in Australia: More Common than Statistics Suggest?' (2006) 185(6) *Medical Journal of Australia* 341
- De Crespigny, Lachlan, 'Australian Abortion Laws: Do They Pose a "Health Hazard"?' (2005) 7(1) *O & G* 52
- De Crespigny, Lachlan and Savulescu, Julian, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201
- Department of Health [NSW], *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations*, Policy Directive PD2005_587 (25 May 2005)
- Department of Health [Western Australia], *Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term/Guidelines for Counselling* <www.health.wa.gov.au/publications/subject_index/a/abortion.cfm> at 21 February 2008
- Dickinson, Jan, 'Late Pregnancy Termination with a Legislated Medical Environment' (2004) 44 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 337
- Drabsch, Talina, *Abortion and the Law in New South Wales* (NSW Parliamentary Library Research Service, 2005)
- Duvnjak, Angella and Buttfield, Barbara, 'Ignorant Fools: The Construction of Women's Decision-Making in Recent Abortion Debates in Australia' (2007) 19 *Women Against Violence* 20
- Ellwood, David, 'Is There a "Borderline of Viability"?' (2007) 47 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 261
- Ewing, Selena, *Women & Abortion: An Evidence Based Review* (Women's Forum Australia, 2005)
- Faunce, Thomas, 'The Carhart Case and Late-Term Abortions—What's Next in Australia?' (2007) 15 *Journal of Law and Medicine* 23
- Fergusson, David, Horwood, John and Rider, Elizabeth, 'Abortion in Young Women and Subsequent Mental Health' (2006) 47(1) *Journal of Child Psychology and Psychiatry* 16
- Fleming, John and Tonti-Filippini, Nicholas (eds), *Common Ground? Seeking an Australian Consensus on Abortion and Sex Education* (St Paul's Publications, 2007)
- Freckelton, Ian, '12 Into One: Regulation of Health Practitioners' (2007) 81(10) *Law Institute Journal* 39
- Gabriel, Stephen, 'Child Destruction: A Prosecution Anomaly Under Both the Common Law and the Criminal Codes' (1997) 21 *Criminal Law Journal* 32
- Gee, Graham, 'Regulating Abortion in the United States after *Gonzales v Carhart*' (2007) 70(6) *Modern Law Review* 979
- Gold, Rachel Benson and Nash, Elizabeth, 'State Abortion Counseling Policies and the Fundamental Principles of Informed Consent' (2007) 10(4) *Policy Review* 6

- Grayson, Narelle, Hargreaves, Jenny and Sullivan, Elizabeth, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia*, Perinatal statistics series no 17 AIWH cat no PER 34 (AIHW National Perinatal Statistics Unit, 2005)
- Gregory, Robyn, "Corrupt Cops, Crooked Docs, Prevaricating Pollies and 'Mad Radicals': A History of Abortion Law Reform in Victoria", 1959–1974 (Unpublished PhD Thesis, RMIT University, 2004)
- Grenache, DG and Gronowski, AM, 'Fetal Lung Maturity' (2006) 39(1) *Clinical Biochemistry* 1
- Guttmacher Institute, *Parental Involvement in Minors' Abortions, State Policies in Brief as of 1 January 2008* (2008a) *State Policies in Brief: Mandatory Counseling and Waiting Periods for Abortion* (2008b) <www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf> at 14 January 2008
- Her Majesty's Stationery Office, *Select Committee on the Infant Life (Preservation) Bill [HL] Special Report with Evidence*, House of Lords: Session 1986–1987 (1987) *Report of the Select Committee on the Infant Life (Preservation) Bill [HL] with Evidence*, House of Lords: Session 1987–1988 (1988)
- House of Commons, Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07: Volume 1*, HC 1045–1 (2007)
- Jones, Rachel and Henshaw, Stanley, 'Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden' (2002) 34(3) *Perspectives on Sexual and Reproductive Health* 154
- Kennedy, Ian and Grubb, Andrew, *Medical Law: Text with Materials* (2nd ed, Butterworths, 1994) *Medical Law* (3rd ed, Butterworths, 2000)
- Keogh, J, et al, 'Delivery in the "Grey Zone": Collaborative Approach to Extremely Preterm Birth' (2007) 47 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 273
- Keown, JJ, 'The Scope of the Offence of Child Destruction' (1988) 104 *Law Quarterly Review* 120
- Laing, Jacqueline, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 12(1) *University of New South Wales Law Journal Forum* 42
- Lastman, Anne, *Redeeming Grief: Abortion and its Pain* (Victims of Abortion, 2007)
- Laws, Paula, Grayson, Narelle and Sullivan, Elizabeth, *Australia's Mothers and Babies 2004*, Perinatal statistics series no 18 AIHW cat no PER 34 (AIHW National Perinatal Statistics, 2006)
- Llewellyn-Jones, Derek, Oats, Jeremy and Abraham, Suzanne, *Llewellyn-Jones Fundamentals of Obstetrics and Gynaecology* (8th ed, Mosby, 2005)
- Marie Stopes International, *Late Abortion: A Research Study of Women Undergoing Abortion between 19 and 24 Weeks Gestation* <www.mariestopes.org.uk/documents/Late%20abortion.pdf> at 7 January 2008
- Mackay, RD, 'The Relationship between Abortion and Child Destruction in English Law' (1988) 7(2) *Medicine and Law* 177
- Market Facts (Qld), *What Australians Really Think About Abortion: A Report on Comprehensive Independent Market Research* (Australian Federation of Right to Life Associations, 2006)
- Mason, JK and Laurie, GT, *Mason and McCall Smith's Law and Medical Ethics* (7th ed, Oxford University Press, 2006)
- McCalman, Janet, *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856–1996* (Melbourne University Press, 1998)
- Medical Practitioners Board of Victoria, *Report on Late Term Terminations of Pregnancy* (1998)
- Middleton, Sarah, Pearce, Thomas and Buist, Michael, 'The Rights and Interests of Doctors and Patients: Does the New Victorian Health Professions Registrations Act 2005 Strike a Fair Balance?' (2007) 186(4) *Medical Journal of Australia* 192
- National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia* (1996) *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2007)
- Nickson, Carolyn, Smith, Anthony and Shelly, Julia, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329
- Nuffield Council on Bioethics, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues* (2006)
- Parliamentary Library, Parliament of Australia, *Abortion Law in Australia*, Research Paper 1 1998–99 (1998)
- Petersen, Kerry, *Abortion Regimes* (Dartmouth Publishing, 1993)
- Pratt, Angela, Biggs, Amanda and Buckmaster, Luke, *How Many Abortions are there in Australia? A Discussion of Abortion Statistics, their Limitations, and Options for Improved Statistical Collection*, Research Brief no 9 2004–05 (Parliamentary Library, Parliament of Australia, 2005)
- Pringle, Helen, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal* 207
- Pro-Choice Forum, *Late Abortion: A Review of the Evidence—A Briefing Compiled by Pro-Choice Forum* (2004)
- Psychotherapy & Counselling Federation of Australia, *Professional Standards* (2006) <www.pacfa.org.au/files/PACFA_Professional_Standards_0906.pdf> at 18 February 2008
- Reproductive Choice Australia, *RU 4861 Mifepristone: A Factual Guide to the Issues in the Australian Debate* <www.reproductivechoiceaustralia.org.au/Articles/RU486_final-Feb06.pdf> at 8 February 2008

Bibliography

- Acts Amendment (Abortion) Act 1998* Review Steering Committee [Western Australia], *Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code Relating to Abortion* (2002) Rhoden, Nancy, 'The New Neonatal Dilemma: Live Births from Late Abortions' (1984) 72 *Georgetown Law Journal* 1451
- Rice, Kerrilie, *Difficulties in Access to Termination of Pregnancy Services* (Women's Health Victoria, 2007)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005)
College Statement No C-Gyn: Mifepristone (RU486) (2005) <www.ranzcog.edu.au/publications/statements/C-gyn14.pdf> at 18 September 2007
- Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion*, Evidence-Based Clinical Guideline No 7 (2004)
- 'Abortion—A Women's Health Issue: Joint Statement by the Royal Women's Hospital, Royal Children's Hospital Centre for Adolescent Health, Family Planning Victoria & Women's Health Victoria' (2007) 19 *Women Against Violence* 75
- Royal Women's Hospital, *Clinical Report 2007* (2008) <www.thewomens.org.au/uploads/downloads/HealthProfessionals/Publications/ClinicalReport/Clinical_Report.2007.pdf> at 28 February 2008
- Sanci, Lena, et al, 'Confidential Health Care for Adolescents: Reconciling Clinical Evidence with Family Values' (2005) 183(8) *Medical Journal of Australia* 410
- Savell, Kristin, 'Is the "Born Alive" Rule Outdated and Indefensible' (2006) 28 *Sydney Law Review* 625
'Turning Mothers Into Bioethicists: Late Abortion & Disability' in Bennett, Belinda, et al (eds) *The Brave New World of Health* (Federation Press, forthcoming in 2008)
- Seaborne Davies, D, 'Child-Killing in English Law' (1937) *Modern Law Review* 203
- Sedgh, Gilda, et al, 'Induced Abortion: Estimated Rates and Trends Worldwide' (2007a) 370 *The Lancet* 1338
'Legal Abortion Worldwide: Incidence and Recent Trends' (2007b) 33(3) *International Family Planning Perspectives* 106
- Senate Community Affairs Committee, Commonwealth of Australia, *Inquiry into Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005* (2006)
- Skegg, P, *Law, Ethics, and Medicine: Studies in Medical Law* (Clarendon Press Oxford, 1988)
- Skene, Loane, *Law & Medical Practice: Rights, Duties, Claims & Defences* (2nd ed, LexisNexis, 2004)
- Southern Health, *A Guide to Tests and Investigations for Uncomplicated Pregnancies* (2003)
- Stone, Peter, 'Late Termination of Pregnancy' (2007) 9(4) *O & G* 31
- Straton, J, et al, *Induced Abortion in Western Australian 1999–2005: Report of the WA Abortion Notification System* (Department of Health, Western Australia, 2006)
- Taft, Angela and Watson, Lyndsey, 'Termination of Pregnancy: Associations with Partner Violence and Other Factors in a National Cohort of Young Australian Women' (2007) 31(2) *Australian and New Zealand Journal of Public Health* 135
- Tankard Reist, Melinda, *Giving Sorrow Words: Women's Stories of Grief after Abortion* (Duffy & Snellgrove, 2000)
- Taylor, Elly, 'The Difficulties Young Rural Women Face in Trying to Obtain Surgical Terminations of Pregnancy' (Unpublished Postgraduate Diploma in Gender Studies Thesis, University of Melbourne, 2007)
- Wainer, Jo, 'Abortion and the Full Humanity of Women: Nearly There' (2007) 4 *Sexual Health* 219
- Waller, Louis, 'Any Reasonable Creature in Being' (1987) 13 *Monash University Law Review* 37
- Websurvey, *What Women Want: When Faced with an Unplanned Pregnancy: Key Findings* (Marie Stopes International, 2006)
- Williams, Clare, et al, 'Women as Moral Pioneers? Experiences of First Trimester Antenatal Screening' (2005) 61 *Social Science & Medicine* 1983
- Williams, Glanville, *The Sanctity of Life and the Criminal Law* (Faber and Faber, 1958)
- Wilson, Shaun, et al (eds), *Australian Social Attitudes: the First Report* (UNSW Press, 2005)
- Woodrow, Nicole, 'Termination Review Committees: Are they Necessary?' (2003) 179(2) *Australian Medical Journal* 92
- World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003)

Other VLRC Publications

Disputes Between Co-owners: Discussion Paper (June 2001)

Privacy Law: Options for Reform—Information Paper (July 2001)

Sexual Offences: Law and Procedure—Discussion Paper (September 2001)
(Outline also available)

Failure to Appear in Court in Response to Bail: Draft Recommendation Paper (January 2002)

Disputes Between Co-owners: Report (March 2002)

Criminal Liability for Workplace Death and Serious Injury in the Public Sector: Report (May 2002)

Failure to Appear in Court in Response to Bail: Report (June 2002)

People with Intellectual Disabilities at Risk—A Legal Framework for Compulsory Care: Discussion Paper (June 2002)

What Should the Law Say About People with Intellectual Disabilities Who are at Risk of Hurting Themselves or Other People? Discussion Paper in Easy English (June 2002)

Defences to Homicide: Issues Paper (June 2002)

Who Kills Whom and Why: Looking Beyond Legal Categories by Associate Professor Jenny Morgan (June 2002)

Workplace Privacy: Issues Paper (October 2002)

Defining Privacy: Occasional Paper (October 2002)

Sexual Offences: Interim Report (June 2003)

Defences to Homicide: Options Paper (September 2003)

People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care (November 2003)

Assisted Reproductive Technology & Adoption: Should the Current Eligibility Criteria in Victoria be Changed? Consultation Paper (December 2003)

People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care: Report in Easy English (July 2004)

Sexual Offences: Final Report (August 2004)

The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction: Occasional Paper by John Tobin (September 2004)

A.R.T., Surrogacy and Legal Parentage: A Comparative Legislative Review: Occasional Paper by Adjunct Professor John Seymour and Ms Sonia Magri (September 2004)

Outcomes of Children Born of A.R.T. in a Diverse Range of Families by Dr Ruth McNair (September 2004)

Workplace Privacy: Options Paper (September 2004)

Defences to Homicide: Final Report (October 2004)

Review of Family Violence Laws: Consultation Paper (November 2004)

Review of the Laws of Evidence: Information Paper (February 2005)

Assisted Reproductive Technology Position Paper One: Access (May 2005)

Assisted Reproductive Technology Position Paper Two: Parentage (July 2005)

Family Violence Police Holding Powers: Interim Report (September 2005)

Workplace Privacy: Final Report (October 2005)

Review of the Bail Act: Consultation Paper (November 2005)

Have Your Say About Bail Law (November 2005)

Assisted Reproductive Technology Position Paper Three: Surrogacy (November 2005)

Implementing the Uniform Evidence Act: Report (February 2006)

Uniform Evidence Law: Final Report (February 2006)

Review of Family Violence Laws: Report (March 2006)

Review of Family Violence Laws: Final Report Summary (March 2006)

Residential Tenancy Databases: Report (April 2006)

Civil Justice Review Consultation Paper (September 2006)

Assisted Reproductive Technology & Adoption: Final Report (June 2007)

Review of the Bail Act: Final Report (October 2007)



Victorian
Law Reform
Commission

GPO Box 4637
Melbourne Victoria 3001 Australia
DX 144 Melbourne, Vic

Level 10, 10–16 Queen Street
Melbourne Victoria 3000 Australia

Telephone +61 3 8619 8619
Facsimile +61 3 8619 8600
1300 666 555 (within Victoria)
TTY 1300 666 557
law.reform@lawreform.vic.gov.au
www.lawreform.vic.gov.au

Printed on 100% recycled paper