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South Australian Law Reform Institute
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Submission: SA Abortion Law and Practice

Background:

I am a Lecturer in Crime, Justice and Legal Studies at La Trobe University, Melbourne. I have spent the last decade researching in the area of abortion; through this research I have developed an unequivocal pro-choice position and I strongly believe that abortion should be fully decriminalised and regulated like all other health procedures. My position on abortion is shared by the majority of Australians and professional health bodies. Surveys of public opinion on abortion, for example, consistently show overwhelming support for the decriminalisation of abortion and women's right to choose (VLRC 2008: 66; Barratt 2018). Abortion law reform needs to be considered from the perspective of the woman who is seeking an abortion. Laws that obstruct and, at worst, prevent women from accessing abortions on request compel women to continue with pregnancies unwillingly.

Summary:

Abortion should be fully decriminalised and integrated into existing health law. Abortion is an essential and routine component of reproductive healthcare. Women have been controlling their fertility through abortion since ancient times (Riddle 1999).[i] Abortion was only criminalised in the nineteenth century, and, since that time, the criminalisation of abortion has existed alongside the widespread practice of

abortion (Brookes 1988). Restrictive laws on abortion do not impact on the prevalence of abortion but they do impact on the safety of abortion and the equality of access to abortion care (WHO 2012; Sedgh et al. 2016). The decriminalisation of abortion is a realistic reflection of the fact that women have always, and will always, require access to abortion. One in three to one in four Australian women will have an abortion over their lifetime (Pregnancy Outcome in South Australia 2016), a rate on par with the USA (Jones and Kavanaugh 2011), Canada (Norman 2012) and the UK (Royal College of Obstetricians & Gynaecologists 2011). The decriminalisation of abortion would modernise the law and bring it into line with public opinion (VLRC 2008: 66; Barratt et al. 2018) and the opinion of the health professionals involved in providing this essential health service (Quantum Market Research 2004; De Costa et al. 2010; RANZCOG 2019). The decriminalisation of abortion would enable health professionals to provide women with the best possible care and would pave the way for equality of access to abortion in South Australia.

SALRI has been asked to consider a range of measures that prevent the full incorporation of abortion into existing health law. These measures include the continued criminalisation of abortions performed by unqualified or unlicensed persons, the inclusion of different laws for abortions performed at different gestations, the specification that abortion must only be performed by medical practitioners, grounds for conscientious objection, and requirements to offer women counselling. Many of these inclusions appear, on the surface, to be motivated to protect women's health and wellbeing and to ensure that health professionals are not forced to perform procedures to which they conscientiously object. Women and medical professionals are, however, already protected under existing laws and professional codes of conduct. When given its own specific forms of regulation, abortion is isolated from, and positioned as an exception to, other aspects of healthcare. This is out of step with the reality of abortion, which is common, routine and incredibly safe. The exceptional status that abortion occupies under the law increases abortion stigma, which can deleteriously impact on the health and wellbeing of women who have abortions as well as the health professionals who provide this essential health service (Kumar, Hessini and Mitchell 2009; Steinberg et al. 2016). Abortion stigma is also implicated in the shortage of health professionals who are trained to provide abortion services (Harris et al. 2011; Norris et al. 2011).

Legislation that opens up women's access to medical abortion via telemedicine, GPs, nurse practitioners and Aboriginal health workers (amongst other suitably-trained health professionals) would greatly benefit women, especially those living outside of Adelaide. Medical abortion has been slowly rolled out throughout Australia since legal and policy restrictions on the import of mifepristone were lifted in 2012 (Baird 2015). About one in three Australian women opt for medical abortion (Shankar et al. 2017). In England and Wales, where medical abortion has been available to women since 1991, 80 percent of abortions under 10 weeks and 66 per cent of all abortions were medical abortions in 2017. A recent government report notes that 'The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall percentage of abortions performed at under ten weeks gestation' (Department of Health and Social Care 2018: 15).

Laws that differentiate 'early' from 'late' abortions are incredibly problematic. Gestational cut-off points are arbitrary and are, as such, vulnerable to further review (VLRC 2008: 79-80). The Canadian example proves that the full integration of abortion into existing health law does not lead to an increase in second and third trimester abortions (Abortion Rights Coalition of Canada 2019). Rather, ensuring that abortions throughout a women's pregnancy are fully integrated into existing health law affords women and their partners time to receive the best possible diagnoses, the best quality information, and to fully consider their options before being rushed into a decision with profound implications for their future lives. The health professionals who provide women with later abortions are unequivocal: they do not want the law to intervene in their ability to provide their patients with the best quality care (de Crespigny and Savulescu 2008; RANZCOG 2016a).

RESPONSE TO CONSULTATION QUESTIONS

The role of the Criminal Law (questions 1-4)

Abortion should be fully decriminalised and there should be no criminal offence for abortions that are not performed by an appropriate healthcare professional.

Abortion is an essential health service and, as such, should be recognised by the law as a health rather than criminal law issue. This approach would bring South Australian law into line with other Australian jurisdictions that have already undergone the law reform process (ACT, Victoria, Tasmania, NT and QLD). The decriminalisation of abortion would bring SA law into line with public opinion, which is overwhelmingly supportive of decriminalisation and women's choice (VLRC 2008; Barratt et al. 2018). Leading health bodies also support the decriminalisation of abortion, with the Royal Australian and New Zealand College of Gynaecologists (2019) recently stating that 'abortion is an essential aspect of safe healthcare delivery and that it should be removed from the Criminal Code.'

Abortion should be regulated like all other medical procedures. There is no need to have a specific criminal offence for abortions that are not performed by an appropriate health practitioner because the provision of healthcare is already tightly regulated at state and federal levels. Unqualified or unlicensed persons who perform abortions commit an offence under the *Health Practitioner Regulation National Law (South Australia) Act 2010*. A raft of other state and federal statutes (for example, the *Therapeutic Goods Act 1989* (Cth)), professional codes of conduct, and institutional policies and procedures further ensure that abortion is only performed by qualified medical professionals.

The health and safety of women seeking abortions is guaranteed within protections that already exist in South Australian and Commonwealth Law. Any additions to legislation are unnecessary from a legal standpoint. They also serve to regulate a practice that does not exist: women do not seek abortions from unqualified practitioners when they have access to safe and legal procedures (Yusuf and Siedlecky 2002). The inclusion of additional regulations pertaining to abortion in the criminal law thus serves to reinforce the exceptional status of abortion, preventing abortion's full integration into health law. As mentioned above, the exceptional status of abortion reinforces abortion stigma, which can have deleterious consequences for the health of women who have abortions and their healthcare providers.

Who should be able to perform or assist in performing terminations (question 5)

All health practitioners (not just medical practitioners) should be authorised to perform and assist in performing lawful terminations. This would bring SA law into line with global guidelines. The World Health Organisation stipulates that 'abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers' and that such a regime for provision is 'safe, and minimizes costs while maximizing the convenience and timeliness of care for the woman' (2012: 65). Expanding the provision of abortion to all suitably trained and accredited health practitioners would help address the shortage of abortion providers in South Australia, particularly in rural and regional areas. The careful regulation of healthcare provision in South Australia (as outlined in response to questions 1-4) would ensure that abortions remain safe.

Gestational limits and grounds for Termination of Pregnancy (questions 6-11)

There should be no gestational limit for the lawful termination of pregnancy. Such legislation would bring abortion into line with public opinion (Barratt et al. 2018) and the views of leading professional health bodies, including the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG 2016b), the Royal Australasian College of Physicians, the Australian Phycological Society Limited (QLRC 2018: 67-8), and the Public Health Association of Australia (2018).

In 2016, the majority of abortions performed in in SA (90.6%) occurred within the first fourteen weeks of pregnancy. 2.8 per cent occurred beyond 20 weeks, of which 43.3 per cent were performed for foetal abnormalities, 48.5 per cent for the mental health of the mother, and 8.3 per cent for specified medical conditions of the pregnant woman (Pregnancy Outcome in South Australia 2016: 49).

<u>Arbitrary cut off point</u>

South Australia should follow the ACT when it comes to legislating around gestational limits. With the exception of the ACT, other Australian states and territories that have reformed their abortion laws have adopted a two-staged model, with a line determined by gestational age demarcating 'early' from 'later' abortions. This line ranges from 14

weeks in the Northern Territory to 24 weeks in Victoria, a range that testifies to the arbitrary nature of such a delineation (also see VLRC 2008; RANZCOG 2016b). The 24-week limit in place in Victoria was adopted from UK law and is based on foetal viability. Viability is subject to medical technologies that are constantly evolving. 22-26 weeks' gestation is considered a 'grey zone', where some foetuses have survived with major medical intervention, mostly with ongoing disabilities (Keogh et al. 2007). De Crespigny and Savulescu report that paediatricians recommend that the parents of babies born at 24-26 weeks should decide whether or not they receive treatment, even if there is a chance of survival; the discrepancy between this practice and gestational limits on abortion grants 'the fetus *inside* a woman's body … a higher moral status than a newborn infant of the same gestation *outside* the woman's body' (2008: 102).

Because gestational cut-off points are arbitrary and problematic, if applied, they will be subject to judicial review in the future (VLRC 2008: 79-80). This has been the case in the UK, for example (Franklin 2014). The incredibly volatile and politicised nature of gestational cut-off points is evinced in the recent spate of bills in US states that prohibit abortion after six weeks' gestation, before many women even know they are pregnant.

Forced pregnancy and motherhood

Even if viability could be assessed with accuracy, and gestational limits fixed accordingly, state restrictions on abortion compel women to undergo pregnancy and birth unwillingly and to form a maternal relationship with a child they did not want. Compelling women to undergo a pregnancy unwillingly has deleterious effects on their health, and the health of the children born, in the immediate and long term. Childbirth is more dangerous than abortion at any point in a woman's pregnancy (Raymond and Grimes 2012), and women who are pregnant unwillingly are less likely to follow guidelines relating to prenatal care (Cheng et al. 2009). There are also emotional and psychological penalties attached to becoming mothers unwillingly and being born unwanted (David 2011; McCrorry and McNally 2012; Russo 2014; Guterman 2015).

Anti-choice activists look at adoption as an alternative to abortion. This proposed solution sidesteps the ethical issue of forced pregnancy and birth. Local adoption is very rare in Australia and the open adoption practiced in Australia today encourages

ongoing relationships between birth parents and their adopted children (Australian Institute of Health and Welfare 2018). Thus a maternal relationship is established even when the child is adopted.

Gestational limits serve no practice purpose

The inclusion of gestational limits for abortion is viewed as a 'middle ground' (VLRC 2008: 91), balancing the pro-choice concern with a woman's bodily autonomy with anti-choice focus on foetal life. A compromise between permissive and prohibitive views on abortion is, however, a significant move away from the middle-ground towards the position of a vocal and well-financed minority. According to the most recent major study of public opinion towards abortion in Australia, for example, 73 per cent of respondents believed that abortion should be fully decriminalised and regulated as a healthcare service; 85 per cent of respondents were broadly 'pro-choice', with 57.9 per cent agreeing with the statement that 'Women should be able to obtain an abortion readily when they want one'. Only 5.6 per cent of respondents were opposed to abortion regardless of circumstance (Barratt et al. 2018). An earlier study also concluded that 'a majority of Australians support laws which enable women to access abortion services after 24 weeks' gestation' and there 'was little support for professional sanctions against doctors for providing terminations after 24 weeks' gestation' (de Crespigny and Savulescu 2008: 9, 11).

There is a fiction circulating that an absence of legal restrictions on abortion would force doctors to perform abortion 'until birth'. This fiction relies on spurious claims that women would be willing to terminate pregnancies they have carried to near term and that highly trained doctors would be willing to perform such procedures. Both these claims are clearly untrue. Legal restrictions on second and third trimester abortions do not reduce the number of abortions that occur later in pregnancy. In Canada, which in 1988 became the first jurisdiction to decriminalise abortion throughout a woman's pregnancy, 0.66 per cent of abortions occur after 20 weeks, which is well under half the current rate in South Australia (Abortion Rights Coalition of Canada 2019).[ii]

The absence of legal restrictions on abortion would enable doctors to act according to the needs of their individual patients—who each face unique medical and/or social

circumstances when they present for abortion—and they will not compel doctors to perform abortions to which they conscientiously object (see response to questions 15-17).

Makes for rushed decisions with limited information

RANZCOG (2016a) states that in some circumstances 'it is clinically unreasonable to compel decisions around termination at an earlier gestation'. Second trimester ultrasounds are generally performed between 19-20 weeks' gestation, even though their accuracy is enhanced when performed at 22-24 weeks (de Crespigny and Savulescu 2008: 100). When anomalies are detected, further testing is required. Some abnormalities (such with cytomegalovirus infection and severe hydrocephalus) are not diagnosable until much later in a woman's pregnancy (VLRC 2008: 44; RANZCOG 2016a). De Crespigny and Savulescu note that 'When a major fetal abnormality is diagnosed, clinical experience shows that even women who consider themselves antichoice commonly re-evaluate their in-principle opposition to abortion' (2008: 101).

Gestational cut-offs prevent women from deep reflection in consultation with an appropriate range of healthcare professionals (de Crespigny and Savlulescu 2008; RANZCOG 2016a). Gestational cut-offs compel women and their partners to make decisions without the necessary time or information to understand complex medical conditions and contemplate the wellbeing of their potential child and the consequences for their own lives of raising a child with a disability. As a result of gestational cut-offs, women can terminate pregnancies they would otherwise keep; they can keep pregnancies they would have otherwise terminated; and they can be forced to terminate a pregnancy before they are emotionally and psychologically prepared to end a pregnancy that was, until that time, wanted.

Discriminates against the most marginalised

Restrictions on abortion past 20 weeks' gestation disproportionately impact on the most marginalised members of the community (RANZCOG 2016a). Limited data on the Australian context exists. The largest study conducted about women who present for abortion after 20 weeks' gestation in the USA for reasons other than foetal abnormality or life endangerment concluded that restrictions on later abortions

'disproportionately affect young women and women with limited financial resources' (Foster and Kimport 2013: 217). Women who present for abortions after 20 weeks' gestation were likely to fit into one of five profiles: they were single parents; they were depressed or using illicit substances; they had trouble deciding and then had access problems; they were young and nulliparous; they were experiencing conflict with their male partners and/or domestic violence. Other studies, including a recent study on the QLD context, have confirmed links between reproductive coercion and the late presentation for abortion (Colarossi and Dean 2014; Price et al. 2019).

Women who have been denied abortion in South Australia because of gestational cut-offs have travelled interstate or overseas to obtain abortions. Thus gestational cut-offs produce a two-tiered system, where women with financial resources have access to more choices. Gestational cut-offs also impact more significantly on women who face language or socio-cultural barriers to accessing health care and those who live in rural and remote communities, who need to travel for abortions and who do not have ready access to the medical expertise required for the testing and diagnosis of foetal abnormalities (RANZCOG 2016a).

Foetal personhood

Two-staged laws on abortion embed the notion of foetal personhood into the law (albeit only from a certain gestational age). When outlining the model for law reform that was adopted in Victoria, the Victorian Law Reform Association stated that a two-staged model of law reform meant that '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' and that this 'exception exists because there are other matters which must be taken into consideration … such as the potential life of the fetus and the role of the state in safeguarding that potential life' (VLRC 2008: 89).

The view that fetuses are separate entities that require legal protection rests on the assumption that there is an objective and scientific basis to foetal personhood. Professor Sarah Franklin from Cambridge University has charted how anti-abortionists have 'harnessed … the power of "objective" biological models of human life' in its broader 'shift away from traditional religious language toward modern

medical imagery', calling this shift both a political strategy and 'form of political camouflage' (2014: 111). Aware that it is politically untenable to re-criminalize abortion in all circumstances, anti-abortionists have increasingly focused their attention on challenging the upper limit of abortion. The focus on later abortions misrepresents the practice of abortion (only 2-3 per cent of which occur after 20 weeks) and furthers the anti-abortion aim of transforming foetuses into autonomous entities to be protected under the law.

Discussion of foetuses as independent, biogenetic entities has emerged alongside the increasingly visible presence of foetuses, depicted as though they are separate from the women whose bodies sustain and nourish them. In a classic essay on the topic of foetal imagery, renowned US scholar of reproductive justice, Professor Rosalind Petchesky, argues that 'we have to restore women to a central place in the pregnancy scene. To do this, we must create new images that recontextualize the fetus, that place it back into the uterus, and the uterus back into the woman's body and her body back into social space' (1987: 287). Foetuses always exist within a woman's body, and a woman always exists within her specific social space, a space that is not necessarily hospitable to pregnancy, birth, and the establishment of a new maternal relationship.

Consultation by a medical practitioner (questions 12-14)

A medical practitioner should not be required to consult with one or more others before performing a termination of pregnancy. Abortion should be available upon a woman's request. South Australia is the only Australian jurisdiction where two doctors must agree before a termination is performed at any gestation. This has obvious implications for the capacity of women to make decisions with profound consequences for their bodies and future lives. It discriminates most acutely against women living in remote and regional communities, who find it more difficult to access two doctors to approve of their abortions.

Conscientious objection (questions 15-17)

Abortion should be treated like all other medical procedures under the law. As such, there is no need for specific measures for conscientious objection in the case of abortion. The AMA Code of Ethics and mandatory national codes of conduct for

doctors, nurses and midwives provide for conscientious objection and oblige health professionals to refer patients to alternative sources of care.

Counselling (question 18)

Abortion should be treated like all other medical procedures under the law. There should not be any requirement in relation to offering counselling for women. Directive counselling has been a key strategy of the anti-abortion movement since the 1980s, and the idea that women should receive counselling before their abortions relies on several value-laden assumptions (Millar 2016). Firstly, it presumes that women are uncertain about their decision, when health professionals and researchers note that the vast majority of women have a very high level of decisional certainty as they approach abortion and, afterwards, feel that abortion was the right decision for them in the short- and long-term (VLRC 2008: 120; Rocca et al. 2015). Secondly, requiring health professionals to offer women counselling for decisions pertaining to termination, and not for continuing with a pregnancy, establishes abortion as a problematic choice, which increases abortion stigma. Thirdly, the idea that health professionals should refer women seeking abortion to counselling feeds into the idea that abortion is emotionally and psychologically harmful to women. This anti-abortion claim contradicts scholarship on abortion and mental health. There is broad consensus that abortion is not associated with any profound or long-lasting effects. The most common emotional response from abortion is relief (NCCMH 2011).

Women who want to discuss their decision to terminate a pregnancy can already access federally-funded counselling and phone support services. Counselling is also integrated into existing abortion services (VLRC 2008: 119-20).

Protection of women and service providers and safe access zones

Safe access zones should be created around premises that provide abortion services and advice. The most recent public opinion poll in Australia showed that 81 per cent of respondents supported the creation of safe access zones (Barratt et al. 2018). Safe access zones have been introduced in Victoria, Tasmania, the ACT, the NT and QLD and they are currently being considered in WA. In April 2019 the High Court unanimously affirmed that safe access zones comply with the constitution and affirmed the importance of such laws. Justice Nettle, for example, said that

'women seeking an abortion … are entitled to do so safely, privately and with dignity, without haranguing or molestation' (*Clubb v Edwards & Anor; Preston v Avery & Anor* [2019] HCA 11 [258]).

Safe access zones should be automatically established (and not established by the responsible Minister). This would prevent individual Ministers from obstructing women's access to abortion care. South Australia should model its law on other jurisdictions, which prohibit any conduct that interferes with a person who is attempting to access or leave a premise that provides abortion, any form of communication that is reasonably likely to cause distress or anxiety, and the intentional recording, by any means, of another person who is accessing, attempting to access or leaving a place at which abortions are provided. Such prohibitions should apply at all times to avoid confusion and protect staff that work outside of normal business hours.

Collection of data about terminations of pregnancy (question 25)

Abortion should be regulated like all other health procedures. Specific data on abortion should not be collected, as it is under existing law. The de-identified collection of data relating to medical procedures is currently permissible after a rigorous application process. The same process should be applied to the collection of data relating to the termination of pregnancy.

Rural and Regional Access (questions 26-28)

Abortion should be regulated under the law like all other medical procedures. There should not be separate laws governing the regulation of abortion for women in rural and urban areas. Legislation that enables women to access abortion via telehealth and all suitably trained medical professionals would help alleviate some of the current inequalities of access.

The current law impedes women's access to abortion in rural areas. In 2016, only 12.2 per cent of rural women who had an abortion did so in a country hospital; the vast majority were required to travel to Adelaide at their own expense, which includes costs such as travel, accommodation, time off work and childcare (Pregnancy Outcome in South Australia 2016: 47). The discrimination against women living outside of

Adelaide is built into two specifications of the current criminal law: the requirement that two medical practitioners must assess and approve of an abortion; and the requirement for abortion to be 'carried out in a hospital'. Women who are living in rural and remote communities do not always have ready access to two doctors, let alone two doctors who would support their decision to terminate their pregnancy.

Incidental

In response to **question 29**, there should be no residency requirement to access a lawful abortion in South Australia. The residency requirement in the current law is outdated, based as it is on the concern in 1969 that South Australia would become the 'abortion capital' of Australia. The residency requirement for abortion is out of step with normal medical practice, whereby people from interstate (for example Broken Hill and remote communities in the Northern Territory) are brought to Adelaide to receive care that is not available to them in their local communities. The clause also prevents international students who are newly arrived in South Australia from obtaining an abortion in the state.

In relation to **question 30** and **31**, in order to ensure equality of access, it is critical that abortion remains funded under the public health system in South Australia. In other parts of Australia, the vast majority of abortions are performed in private clinics. The average Medicare rebated cost of early abortions (at or before 9 weeks) is $570 (for medical procedures) and $470 (for surgical procedures), with costs rising significantly after 12 weeks' gestation. A recent Australian survey found that one in three women found it difficult or very difficult to finance their abortion. Two thirds of women obtained financial assistance from others to cover the cost of their abortion, and 62.5 per cent of women had to forgo a regular payment (such as utility bills, food and groceries) in order to cover the cost of their abortion (Shankar et al. 2017). This is clearly discriminatory: women are left to foot the bill for the consequences of a pregnancy they did not create by themselves, and this financial penalty is felt most severely by those with less financial resources.

The hospital requirement in the current law should be removed. It is also outdated because it does not account for the development of medical abortion, which is less invasive than surgical abortion and does not require the use of anaesthetics. This

requirement has also led to a gross inequality of access to abortion services between women living in Adelaide and those living in rural and regional communities. It is essential that the law in South Australia allow for the provision of abortion by telemedicine and all suitably trained and accredited health professionals in order to ensure equality of access to this essential health service.

[i] Women are not the only people who require abortions. Trans men and non-binary people also have abortions.
[ii] The Canadian Institute for Health Information collects data on abortions performed in public hospitals (excluding those in Quebec). In 2017, 3.2 per cent of abortions performed in hospitals were at 21 + weeks (Canadian Institute for Health Information 2017). The figure of 0.66 per cent accounts for the inclusion of data from standalone clinics, very few of which perform abortions at 21 + weeks.

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