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# RESPONSE TO SOUTH AUSTRALIA'S ABORTION LAW REFORM CONSULTATION

## SUBMISSION TO THE SOUTH AUSTRALIAN LAW REFORM INSTITUTE


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## I. PREFACE

As recognised by the South Australian Law Reform Institute ("**SALRI**"), abortion is a "*sensitive topic that gives rise to sincere, strong and often competing views*". SALRI also recognises that, because abortion raises particular ethical, social, legal and health issues, it is quite different to any other medical procedure.

The views expressed in this submission represent those of its signatories, supported by testimonies and evidence from a collective of women affected by abortion, doctors, lawyers, politicians and academics grappling to develop best practice.

There are a range of moral and ethical issues raised by abortion, responses to which will vary based on an individual's personal values. The authors readily acknowledge these contrasting views, as well as the genuine compassion and regard for human dignity that typically motivates those who hold them.

Abortion is known as a silent issue, about which discussion is frequently stifled due to strong differences of opinion, shame, guilt, fear or anger. The opportunity for respectful, considered discussion afforded by SALRI's submission process is a valuable one, and the authors extend gratitude to those who provided the opportunity and who will objectively consider each submission.

**NB: This submission is not to be construed as supporting abortion in any form, but is written according to the terms of reference of SALRI, particularly to the openness to international excellence.**

**Personal testimonies used throughout this submission are available in their entirety at https://spaces.hightail.com/space/T0camnp5Rb for SALRI's reference.**

## II. EXECUTIVE SUMMARY

This submission has been prepared on the basis of testimonials and evidence from a collective of women affected by abortion, doctors, lawyers, politicians and academics in response to SALRI's request for input into its examination of South Australia's abortion laws. The response has been based on an approach informed by five principles ("**5C**"):

1. Care for women;
2. Care for babies;
3. Care for children in the womb;
4. Care for families; and
5. Care for life.

The five principles are submitted as foundational to the development of best practice legislative reform and have served as a compass in considering the questions posed by SALRI in light of international benchmarks.

### 1. *Care for women*

The need to provide the best possible care for women considering, undergoing or recovering from abortion is generally acknowledged, although less frequently is it adequately addressed with regard to its medical, social or legislative aspects. In his textbook on abortion, Hern acknowledges that "*there are few surgical procedures given so little attention and so underrated in [their] potential hazard as abortion*."[1] Further to immediate surgical hazards, the long term impacts of abortion on the welfare of the woman warrants attention. In contrast to the prevailing view, research demonstrates that 30% of women undergoing abortion suffer from long term health and emotional consequences.[2]

> *After the abortion, I felt so much darkness, hopelessness, shame and guilt. My self-esteem was destroyed and I became involved in abusive relationships, and substance and alcohol abuse became a constant part of my life. I would do anything to try and feel better. Instead, I spiralled out of control.*
>
> \- Ruth McLemore

Given the physical and emotional risks associated with abortion, recommendations are made with a view to best practice. These recommendations reflect the importance of fully informed and voluntary consent consistent with the objects of the *Consent to Medical Treatment and Palliative Care Act* 1995 (SA) and the National Health and Medical Research Council ("**NHMRC**") guidelines. Fully informed consent can only be given if the woman contemplating an abortion has been fully advised of all her options reasonably available to her. Consent must also be voluntary, which is to say that it must be given in the absence of pressures such as partner coercion, mental disturbance or certain external circumstances. Fully informed and voluntary consent is critical to protecting women's rights and making them informed decision-makers about their personal health care.

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[1] Warren M. Hern, *Abortion Practice* (1990).
[2] DM Fergusson, LJ Horwood and JM Boden, 'Abortion and mental health disorders: evidence from a 30-year longitudinal study (2008) *British Journal of Psychiatry* 193(6): 444-451.

*All my abortions were results of pressure by the father or a family member. I chose abortions because I was afraid, unsupported and felt like I had no other choice but to sacrifice my children.*

- Marina Velasco

A woman should have access to the best available healthcare when considering an abortion. In exercising its mandate to care for women, the government should take all measures to discourage action outside of the best possible medical care. Legislative offences currently in place in this regard should be retained.

A requirement for consultation with a second medical practitioner is an implementation of the best medical care principle. However, this should not override section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) for women under the age of 16 years, as this applies to every other medical procedure. Similarly, a medical practitioner should be required to refer a woman to an independent and non-directive counsellor for the purposes of identifying coercion and intimate partner violence, offering women with an unplanned pregnancy community-based alternatives to abortion, and screening for women who are at higher risk of subsequent mental health problems.

Women should have access to pregnancy support services and support in the vicinity of a clinic without physical impediment to entering the clinic. The choice available to women must include the option to receive advice, information and prayer in a polite and respectful manner, up until the conclusion of the matter. Although unnecessary in South Australia, a safe access zone of 6 metres around public entrances and exits is sufficient, commensurate with Australian Electoral Commission guidelines for safety and wellbeing concerns during elections, noting that the significantly larger zones implemented in other States make pregnancy support services unlawful within the zones, and deny potential support to vulnerable women who have been coerced or are ambivalent about undergoing an abortion.

## 2. *Care for babies*

It has become apparent that babies born alive as a result of a failed abortion are being denied life-sustaining treatment and thus being left alone to die, both in Australia and internationally. Based on the foundational principle of care for babies, this submission outlines the legislative and ethical implications associated with an attempted abortion which results in the delivery of a living baby. The South Australian standard can be none other than that all medical providers be required to do everything necessary to sustain the life of a child who is born alive.

Survival of extremely premature infants has improved dramatically since the gestational limit for abortion in South Australia was set at 28 weeks in 1969. A child in the womb at 22 weeks after the last menstrual period ("**LMP**") of the woman (approximately 20 weeks after fertilisation) is capable of surviving ex-utero.[3] It is recommended that the viability of the child in the womb be considered in setting term limits on abortion, and that abortion for an unwanted but otherwise healthy baby capable of surviving outside the womb be prohibited. The submission notes that, in the case of a viable child in the womb who might otherwise be aborted, a Caesarean section is both the fastest method of delivery and the safest for the woman and for the baby. With regard to available options for a child delivered under these

[3] American Association of Pro-Life Obstetricians & Gynecologists, 'AAPLOG Statement on Post-Viability Abortion Bans' (2019) see https://aaplog.org/wp-content/uploads 019/02/AAPLOG-Statement-on-Post-Viability-Abortion-bans.pdf.

circumstances, adoption laws should be reworked to assist in providing an alternative that serves the child's best interests.

### 3. *Care for children in the womb*

> *What I heard was the sound of the suction machine as they tore my baby to pieces inside of me. Lying on the bed paralysed, unable to move, I thought I heard my baby scream. This is when the mother in me woke up. This is the moment I knew this was a baby, my baby. I remember screaming for them to "Stop!" To this day, I don't know if they heard me or if it was all in my mind. Too late, I learned what an abortion really is.*
>
> \- Mayela Banks

There is considerable evidence that the child in the womb is sentient and therefore experiences pain as early as 15 weeks[4] and possibly earlier still.[5] As such, there is an ethical obligation to provide care regarding potentially painful procedures during in-utero life. Few countries in the world allow the abortion after the first trimester, beyond which the child in the womb begins to feel pain.[6] Furthermore, the procedure also becomes more dangerous for the woman. Abortion after the first trimester should be prohibited.

Although much of the western world has adopted a liberal attitude towards the legality of the abortion (with the notable exception of recent developments in the US), there are still general restrictions that have been observed in most places, the retention of which are recommended for South Australia. These restrictions include abortion on the basis of sex-selection or disability, partial birth abortion, dismemberment of a living child in the womb and harvesting of foetal tissues. Relatedly, certain offences should exist relating to qualified health practitioners conducting abortions, as discussed below.

### 4. *Care for families*

The *Universal Declaration of Human Rights* recognises that the family is the natural and fundamental group unit of society and is entitled to protection by society and the state.[7] As the fundamental unit of society, the family is a source of belonging and identity, in addition to care for the needs of those unable to care for themselves. Further, in the family is found financial security and support for physical and emotional health. The protection and support of the family unit therefore underlies the recommendations set out within this submission.

It should be acknowledged that while a decision regarding abortion may be undertaken by a woman acting independently, in reality it rarely occurs outside of the context of some degree of present (or future) familial relationships. For example, the long term health and emotional consequences of abortion on a woman have implications for her partner and other familial relationships. Furthermore, abortion carries certain risks that affect subsequent pregnancies, and therefore the health and well-being of the future children.

> *After my abortion, I spiralled into self-destructive behaviours… I attempted suicide, and married an abusive man. The abortion ruined all chances of having children. I*

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[4] S Sekulic *et al.*, 'Appearance of fetal pain could be associated with maturation of the mesodiencephalic structures' (2016) *J Pain Res* 11(9): 1031-1038.
[5] American Association of Pro-Life Obstetricians and Gynecologists, 'AAPLOG Fact Sheet Fetal Pain' (2019) see https://aaplog.org/wp-content/uploads/2019/02/2019-02-13-AAPLOG-FACT-SHEET-FETAL-PAIN.pdf.
[6] A Baglini, 'Gestational Limits on Abortion in the United States Compared to International Norms' (2014) *American Reports Series:* Charlotte Lozier Institute, 6, see https://lozierinstitute.org/internationalabortionnorms/.
[7] *Universal Declaration of Human Rights*, Article 16(3).

*suffered 5 miscarriages during my marriage of 18 years, which resulted in divorce… Abortion was the most selfish decision I ever made. It affected everyone in my life and caused devastation to my mind, soul and body.*

- Nona Ellington

Therefore, women and their partners should be made aware of family-related risks. Counselling and other forms of assistance should be holistic in their approach, with an awareness of interpersonal familial dynamics (both positive and negative) and the value of supporting families towards healthy functioning.

**5.** ***Care for life***

The prioritisation of care for women, children in the womb, babies and families stems from a personal conviction of each signatory: that human life is invaluable. Every person possesses inherent dignity and immeasurable worth. As such, respect for human life, compassion for human suffering and an ethical obligation for providing best practice emotional and physical care are fundamental to the recommendations made.

## III. INTRODUCTION

On 26 February 2019, the State Attorney-General, the Hon Vickie Chapman, requested that the SARLI examine the State's abortion laws with a stated intention to improve access, modernise practice, and treat abortion as a health issue rather than a criminal one.[8] This request arose in the context of a proposal for broad legislative changes which have been criticised as lacking in adequate regulation.[9] Instead, noting that there have been significant advancements in medical technology and shifts in community attitudes since the current legislation was enacted in 1969, SALRI has been asked to consider a legislative framework that adopts best practice reforms as a matter of healthcare.[10]

As recognised by SALRI, abortion is a "*sensitive topic that gives rise to sincere, strong and often competing views.*"[11] However, it must be remembered that when a woman considers an abortion, it is not a theoretical or academic decision. Rather, the decision is often made in circumstances where the woman is highly vulnerable, perhaps due to some combination of a lack of familial support, poor economic position, pressure from the father of the child or the prospect of change to long term plans and priorities. At such a vulnerable time, the woman must be accorded the best possible supports, which will be set out in detail below.

SALRI's terms of reference do not extend to the prevention of abortion in South Australia.[12] However, despite the difficulty in finding an accurate assessment of the numbers of abortions in Australia each year, estimates around 80,000 have been made[13] involving approximately one in every three Australian women over their lifetime.[14] In that context, this submission sets out substantial medical information, much of which was unavailable or unknown when the current law was enacted, and examines several aspects of community attitudes to abortion. Drawing upon the review of medical advances and community attitudes, three principles will be identified, namely:

### 1. *Best medical care*

A woman should have access to the best available healthcare when considering an abortion. The government has a duty to protect the people for whom it is responsible, and should ensure the best medical care if any woman proceeds with an abortion.

### 2. *Fully informed and voluntary consent*

An abortion should only take place where the woman has voluntarily consented to the procedure and has received information on all material risks associated with, and alternatives to, the proposed treatment.

### 3. *Maintenance of general restrictions*

Abortion should not simply be made available for any gestational age or for each and every reason. Appropriate restrictions should remain in place. These will be discussed below.

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[8] SALRI Fact Sheet 1 – Background Information, pp. 4-5.
[9] Attorney-General's Department, 'Law Reform Institute to consider abortion law reform' (Press Release, 26 February 2019), see https://www.agd.sa.gov.au/newsroom/law-reform-institute-consider-abortion-law-reform.
[10] *Ibid.* and SALRI Fact Sheet 1 – Background Information, p. 1.
[11] SALRI Fact Sheet 1 – Background Information, p. 1.
[12] SALRI Fact Sheet 1 – Background Information, p. 2.
[13] A Pratt *et al.,* (2005) 'How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection'. Parliament of Australia, Department of Parliamentary Services, Research Brief No. 9.
[14] Family Planning Victoria, *Abortion Overview* (2018), see https://www.fpv.org.au/for-you/abortion/abortion-overview.

These principles will be applied to answer the specific questions posed by SALRI, with the intention that alternatives to abortion be facilitated, and that a shared hope for a reduction in the frequency of abortion in South Australia be achieved.

## IV. MEDICAL INFORMATION

### 1. *Methods of terminating a pregnancy*

There are two methods of terminating a pregnancy which are clinically and ethically distinct. The first is abortion, where the primary aim is to end the life of the child in the womb. The second is delivery, where the primary aim is to separate the woman and the child in the womb as safely as possible. The ideal is that a pregnancy should proceed along its natural course to delivery, even if the child in the womb is not born alive, or dies soon after birth.

#### *(a) Early Medication Abortion ("EMA")*

##### *(i) Description of procedure*

EMA involves taking two different medications two days apart.[15] The first, mifepristone (also known as "**RU-486**"), blocks the action of progesterone, a hormone essential for pregnancy. This changes the lining of the uterus to prevent the pregnancy from continuing. It also opens the cervix and increases the sensitivity of the uterus to the second medication, misoprostol. Misoprostol is taken up to 48 hours after the first medication, causing the uterus to contract, assisting the expulsion of the pregnancy tissue. These two medications will not bring about the abortion of an ectopic pregnancy where the chid is growing outside of the womb, such as in a fallopian tube. An ultrasound and a blood test are essential to exclude ectopic pregnancy prior to an early medication abortion.

Whilst EMA does not require a hospital setting for commencement, it does require pre-treatment assessment relying on pathology testing (swabs, cervical screening test, blood tests) and ultrasound, and for the patient to be within ready reach of a hospital to manage potential complications which may require emergency surgical evacuation of the uterus. For rural and regional women in particular, all these requirements can only be met in a hospital setting. Hence, for the safety reasons explained below, the pre- and post-treatment requirements mandate all women, and rural and regional women especially, to be within 30 minutes of a hospital or purpose built facility of prescribed class. This same safety standard applies to the medical management of miscarriage as per the SA Perinatal Practice Guideline which lists no immediate access (>30 minutes) to emergency facilities as an exclusion criteria. On page 12, the guideline further stipulates: "*Access to 24-hour telephone advice and emergency facilities within 30 minutes of a woman's place of residence including O negative blood and surgical management are conditions of undertaking medical treatment of miscarriage*."[16]

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[15] Please note SA Health material refers to 'Early Medication Abortion' as opposed to 'Early Medical Abortion'; see for example https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions

[16] Department for Health and Wellbeing, Government of South Australia, 'Bleeding & Pain in Early Pregnancy: Ectopic Pregnancy, Miscarriage & PUL' (2019) *South Australian Perinatal Practice Guideline,* see https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/bleeding+and+pain+in+early+pregnancy+-+sa+perinatal+practice+guidelines.

### *(ii) Immediate risks*

If 'safety' is defined in terms of maternal mortality (death rate) and morbidity (the complication rate), then EMA is less safe than early surgical abortion. For this reason, retired Canberra academic and prochoice activist, Renata Klein, was a staunch opponent of EMA, describing it as 'a return to backyard abortion'.[17] Up to eleven times as many women die from EMA compared with early surgical abortion.[18] The first Australian fatality from EMA arose from an associated infection and occurred at a Marie Stopes International Australia clinic in 2010.[19]

The latest Pregnancy Outcome in SA report (2016) notes that, on page 51, EMA failed to empty the uterus at a rate of 9.8% compared with 0.8% for surgical abortion (vacuum aspiration). Of 1,455 women who had an initial EMA, 122 progressed to a surgical procedure. In this regard, EMA was 12 times more likely to fail than surgical abortion. In 2009, Niinimaki *et al.* reported a four-fold higher overall complication rate [haemorrhage, infection, incomplete abortion, need for surgical re-evacuation] for medical [20%] vs surgical abortion [5.6%].[20]

Even the RU-486 drug manufacturer has admitted that: "*[n]early all of the women who receive [RU-486] will report adverse reactions, and many can be expected to report more than one such reaction."*[21] These adverse reactions include abdominal pain, cramping, vomiting, headache, fatigue, uterine haemorrhage, viral infections, and pelvic inflammatory disease.[22] These effects are demonstrated in that for every death from EMA there are 70 reported (and up to 700 unreported) severe and life-threatening adverse events from complications such as severe bleeding, serious infection (including Clostridium Sordellii) and ruptured ectopic pregnancy. Whilst surgical abortion facilitates the early diagnosis of ectopic pregnancy, medication abortion masks it, creating the potential for delayed diagnosis and higher maternal morbidity and mortality.[23] In July 2011, the United States Food and Drug Administration ("**FDA**") reported adverse events after women used RU-486, including 14 deaths, 612 hospitalisations, 339 blood transfusions and 256 infections, including 48 severe infections.[24]

Further evidence of the risk is found in the guidelines approved by the Therapeutic Goods Administration ("**TGA**") in relation to mifepristone and misoprostol, including that a woman being treated with those drugs must have access to 24-hour emergency care.[25] That position is supported by the Royal Australian and New Zealand College of Obstetricians and

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[17] R Klein, Letter to All Members of the Australian Parliament and selected press (2005).
[18] MF Greene, Fatal infections associated with Mifepristone-induced abortion (2005) *New England J Med* 353(22): 2317-2318.
[19] P Goldstone *et al.*, Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study (2012) *Medical Journal of Australia* 197:282-286.
[20] M Niinimaki, A Pouta, A Bloigu *et al.,* 'Immediate complications of medical compared with surgical termination of pregnancy' *Obstet Gynecol* (2009) 114(4): 795-804.
[21] Mifeprex (RU-486) Final Printed Labeling, see http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/020687s013lbl.pdf (last visited August 31, 2017); FDA, Mifeprex (mifepristone) Information (July 19, 2011), see http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm111323.htm (last visited August 31, 2017).
[22] Mifeprex (RU-486) Final Printed Labeling, *op. cit.* at p.12 (Table 3).
[23] M Gary and D Harrison, 'Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient' (2006)The *Annals of Pharmacotherapy* 40(2):191-197.
[24] Americans United for Life, *Abortion-Inducing Drugs Information and Reporting Act: Model Legislation and Policy Guide for the 2018 Election Year*, (2017) p. 3.
[25] Department of Health (NT), 'Termination of Pregnancy Law Reform: Discussion Paper: Improving access by Northern Territory women to safe termination of pregnancy service' (2016) see https://digitallibrary.health.nt.gov.au/prodjspui/handle/10137/931.

Gynaecologists ("**RANZCOG**") which requires that arrangements for abortion by way of mifepristone and misoprostol must include 24 hour access to telephone advice, and 24 hour access to surgical uterine evacuation, such as through on call arrangements or in an emergency department.[26] RANZCOG further directs that medical abortions should not be performed in remote places which lack access to suitable emergency care, which is supported by the advice of the Australian Medical Association Northern Territory that a woman be within two hours of a hospital when she takes mifepristone and misoprostol.[27]

### *(b) Surgical abortion in the first trimester*

#### *(i) Description of procedure*

A surgical abortion in the first trimester involves placing the woman under general anaesthesia, after which the cervix is dilated or stretched. A sterile suction tube is introduced to completely remove the contents of the womb in a piecemeal fashion. The contents include the baby, the amniotic fluid, the placenta and membranes.

#### *(ii) Immediate Risks*

The common side effects of surgical abortion include nausea, vomiting, bleeding, cramping and pain. The specific risks of surgical abortion include infection and potential complications such as adhesions inside the uterus, the tubes or ovaries, chronic pain, infertility,[28] and future ectopic pregnancy. There is also a risk that the procedure is incomplete, such that parts of the baby are left within the woman. There can be injury to organs, including a tear of the cervix, perforation of the uterus or injury to nearby organs such as the bowel, bladder and blood vessels. These procedures can also fail to terminate the pregnancy, or fail to address an ectopic pregnancy.

Excessive bleeding can arise due to injury, poor uterine tone, and a coagulopathy (bleeding disorder) such as Disseminated Intravascular Coagulation, and lead to haematometra, which involves blood and clots collecting in the uterus. Although rare, the woman may require a hysterectomy to control bleeding with a risk of death.

### *(c) Later term (2nd and 3rd trimester) abortion*

#### *(i) Description of procedure*

Later term abortions are usually undertaken by Dilatation and Evacuation ("**D&E**"). This procedure involves cervical preparation by special dilators or drugs that may take days to reach their full effect, followed by a combination of vacuum suction and surgical instrumentation to remove the child in the womb, placenta and other tissues. Sometimes a lethal injection is used to kill the child in the womb before evacuation occurs. Some later term abortions proceed by induction, which involves the use of drugs to cause uterine contractions to expel the baby in a manner similar to labour.

#### *(ii) Immediate risks*

Late term abortions carry greater risk of long term complications than abortions performed earlier in the pregnancy.[29] Examples of increased risk include increased risk of preterm birth

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[26] Department of Health (NT), (2016) *op. cit.*
[27] *Ibid.*
[28] Y Wang *et al.*, 'Association between induced abortion history and later in vitro fertilization outcomes' *Int J Gynecol Obstet* (2018) 141:321-326.
[29] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit.*

in subsequent pregnancies, increased risk of adverse psychological outcomes such as depression, substance abuse and suicide and increased risk of subsequent breast cancer if the late term abortion occurs before 32 weeks, if the woman had not brought a previous pregnancy to term, and if the woman subsequently delays bringing another child to term.

## 2. *Development of the child in utero (from LMP)*

Information on the development of the unborn child is a critical part of understanding what an abortion is actually doing to human life. Since the SALRI review seeks to consider what might be permitted at different gestational ages, knowledge of development is crucial.

The advent of pre-natal scanning and pre-natal surgery has provided to modern medical science substantially more information regarding the development of an unborn child than was available in 1970. In short, it is now possible to accurately identify numerous characteristics of an unborn child at various stages of development. Characteristics will be divided into the following categories:

### *(a) 6 weeks*

At 6 weeks from LMP the heartbeat can be detected upon ultrasound.

### *(b) 11 Weeks*

Although there is always some variation between each child, the face of an unborn child at approximately eleven weeks from LMP will be slowly forming. The eyes of that child are developing and there will be some colour in them. The mouth and tongue have developed, and the unborn child will have tiny taste buds. Hands and feet will also develop, with ridges where fingers and toes will grow. The development of the major internal organs, such as heart, brain, lungs, kidneys, and gut has commenced. Around this time, an unborn child is typically about 22 mm long from the head to the bottom.

### *(c) 16 Weeks*

At this stage of development the unborn child is, from head to bottom, about 85 mm in length and the child's ovaries or testes are fully developed within the body. At the same time, external genitals are beginning to form and the identification of the unborn child's gender is usually possible. The unborn child will also begin to swallow some amniotic fluid, which will progress through the stomach and kidney and be passed back into the amniotic fluid as urine.

It is also important to note that in this stage of development, roughly after the first trimester, an unborn child can feel pain.[30]

### *(d) 23 to 26 Weeks*

At about 23 weeks, the unborn child will usually weigh about 350 grams, and will soon move into a pattern of wakefulness and sleep, though that pattern may differ from the mother's sleeping pattern. This leads to the sensation of the unborn child moving while the mother may be trying to sleep. The unborn child's lungs do not yet work properly, however he or she will be practicing breathing movements in preparation for life after birth.

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[30] Sekulic *et al.,* (2016) *op. cit.*

## 3. *The stage of development when an unborn child can be born alive*

Children in the womb at 22 weeks by LMP (20 weeks post fertilisation) are human beings who feel and react to the pain of abortion procedures and are capable of surviving ex-utero.[31] In fact, evidence exists that children in the womb feel and react to pain even in the first trimester of pregnancy. Dr Bernard Nathanson, an abortion physician in America in the 1960s and 1970s, had the chance to observe a child in the womb reacting to his own abortion procedure through recently developed ultrasound technology. Nathanson saw the first trimester infant struggling, distressed and appearing to scream. Speaking of himself in his film, '*The Silent Scream*', Nathanson recounts:

> *The physician who performed the abortion was a young man who… had already done close to 10,000 abortions in his young life. When he was asked to attend the editing session of the film, he was so appalled at what he was done, that… he never again did another abortion.*[32]

There is considerable evidence that the child in the womb experiences pain.[33] For instance, during foetal surgery there is an ethical obligation to provide foetal anaesthesia and analgesia, and it has also been shown that pain and stress may affect foetal survival and neurodevelopment.[34] It is therefore recommended to provide adequate pain relief during potentially painful procedures during in utero life.[35]

Survival of extremely premature infants has improved dramatically since the gestational limit for abortion in SA was set at 28 weeks in 1969, to the point where survival of infants is possible at 22 weeks gestation.[36] The ability of extremely preterm infants to survive depends on the amount of expert care received when they are separated from their mother's womb and underscores the fact that these infants are complete, separate human beings.[37]

In the case of a viable child in the womb, the most rapid and safest delivery for both the woman and the child is Caesarean section, which can be accomplished in 30 minutes from decision to separation as standard obstetrical procedures require.[38] In contrast, most elective abortion procedures performed after 22 weeks require days to accomplish and carry a greater risk of immediate maternal death than vaginal birth or Caesarean section.[39]

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[31] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit.*
[32] D Smith & J Dabner, *The Silent Scream* (1984) available at: https://www.youtube.com/watch?v=gON-8PP6zgQ&feature=youtu.be&has_verified=1.
[33] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit.*
[34] *Ibid.*
[35] *Ibid.*
[36] *Ibid.*
[37] *Ibid.*
[38] *Ibid.*
[39] L Bartlett, C Berg, H Shulman, S Zane, C Green, S Whitehead, and H Atrash, 'Risk factors for legal induced abortion-related mortality in the United States' *Obstet Gynecol* (2004) 103:729-737.

## V. LEGAL ISSUES

### 1. *Consent*

It is a precondition to interference with a person's body that the person has given consent to that interference. This proposition is the foundation of the law of assault. In the context of medical treatment, horrific abuses have arisen where a person has been subjected to medical treatment without their consent. No mentally competent adult should be subjected to medical treatment unless they have provided voluntary and informed consent to that treatment. Further, where a person is a child or subject to mental difficulty such that effective consent cannot be given, there are mechanisms to ensure that those who have the guardianship of that person exercise that power in their best interests, ultimately subject to the Supreme Court.

#### *(a) Consent that is Fully Informed*

##### *(i) The Medical Practitioner's Duty*

In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) deals with the need for consent to medical treatment. One of the objects of the Act (at section 3) is to make reforms to the law relating to consent to medical treatment to allow persons aged 16 or over to decide freely for themselves on an informed basis whether or not to undergo medical treatment.

The Act requires (at section 15) that a medical practitioner explain to a patient (or a patient's representative), so far as may be practicable and reasonable in the circumstances-

(a) the nature, consequences and risks of proposed medical treatment; and

(b) the likely consequences of not undertaking the treatment; and

(c) any alternative treatment or courses of action that might be reasonably considered in the circumstances of the particular case.

This duty mirrors the common law duty. A failure to comply with this duty can result in liability for loss or damage to a patient who suffers injury either during or as a result of medical treatment.

In 2003, the US State of Texas enacted the 'Woman's Right to Know Act'. Under this law, a doctor or abortion provider must provide a woman with a special 23-page information booklet from the Texas Department of Health entitled *A Woman's Right to Know*. The booklet describes the methods of abortion, medical and psychological risks, sources of support and counselling and assistance available before, during and after childbirth. The Act has been credited with the reduction of abortions in Texas to their lowest level since 1978.[40]

The provision of a publication in similar terms to women considering an abortion would go some way to ensuring fully informed consent and demonstrating that the medical practitioner has satisfied the duty to explain.

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[40] J Ballantyne, 'Suffering in silence no more', *News Weekly,* January 7 200, see http://newsweekly.com.au/article.php?id=2964.

The practical requirements of obtaining fully informed consent are further developed in the NHMRC guidelines.[41] The process of obtaining informed consent requires a medical practitioner to give the patient information about:

a) the possible or likely nature of the condition;

b) the proposed approach to management;

c) what the proposed approach entails;

d) the expected benefits;

e) common side effects and material risks;

f) whether the intervention is experimental or conventional;

g) other options for management;

h) the degree of uncertainty of the outcome;

i) the likely consequences of not choosing the proposed procedure, or of not having any procedure at all;

j) any significant long term physical, emotional, mental, social, sexual or other outcome that may be associated with the proposed procedure;

k) the time involved; and

l) the cost involved, including out of pocket costs.

We now discuss how each of the points in the NHMRC guidelines should be applied in relation to an abortion. Different considerations apply at different gestations in relation to surgical abortion and abortion by medication. The example below relates to a woman consenting to an abortion at eight weeks from her LMP, but similar considerations apply across the spectrum.

### *A. The possible or likely nature of the condition (i.e. pregnancy)*

This can be demonstrated to the patient by ultrasound (showing foetal parts, movements and heart activity), or by using foetal models or pictures. Numerous resources are available[42]. To ensure that women are properly informed about their pregnancy prior to abortion, some US states have enacted Ultrasound Before Abortion bills, which give women 2 opportunities to see their baby beforehand.[43]

[41] NHMRC, 'General guidelines for medical practitioners on providing information to patients' (1993) Copyright: Commonwealth of Australia.
[42] See for example, https://www.babycentre.co.uk/8-weeks-pregnant.
[43] Bioethics Defense Fund, 'Ultrasound Before Abortion Model Legislation' (2016) see http://bdfund.org/stories/ultrasound-abortion-model-legislation/

*I listened to the story that the abortionist told me, that my baby was just a blob of cells and felt no pain… [Later I] found a pro-life site that showed the perfectly formed feet of a 10-week-old foetus; this was how far along I was before I ended my child's life. I knew then that I had been lied to. My child was not a blob of cells but a perfectly formed human with feet. Depression and grief overwhelmed me.*

- Jeannie Guinther

At least 24 hours before an abortion, the woman must receive from the abortion provider a list of places that offer free ultrasound services. If the woman returns, the abortion provider must perform an ultrasound at least 2 hours before the abortion to determine foetal viability and issues related to the woman's health. At that ultrasound, the woman must be read a script that gives her three options: to view the ultrasound screen; to hear an explanation of the images; or to get a print out of the image of her child in the womb. There is no such legal requirement in Australia.

It is necessary that the mother and, if present, the father should understand that they have a live baby in the womb and the intention of the procedure is to remove the baby from the womb and end its life.

### *B. The proposed approach to management (i.e. abortion)*

There needs to be a discussion about the methods of surgical and medication abortion relevant to the stage of pregnancy (8 weeks), i.e. EMA vs. surgical abortion under general anaesthesia by vacuum (suction) aspiration. The discussion needs to highlight that the 2 procedures are very different in terms of the steps involved, time line (several days with EMA vs. day surgery) and risks: EMA appears not to increase the risk of preterm birth in a subsequent pregnancy, but when it comes to the overall incidence of complications (haemorrhage, infection, incomplete abortion and need for surgical re-evacuation), medical abortions outstrip surgical ones by a factor of at least four.[44] Eight weeks is below the cut off for EMA (63 days), above which there is a higher complication and failure rate.[45,46] Also, EMA is potentially reversible after the first of 2 abortion drugs is given (but not after the second has been administered) and avoids surgery under a general anaesthetic in most cases.[47]

Whilst maternal death from abortion at 8 weeks is rare, it happens up to 11 times more often after EMA.[48]

### *C. What the proposed approach entails*

Here, a step-by-step account of what the surgical or medication method involves is presented orally and with written information.

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[44] G Pike, *Abortion and the Physical and Mental Health of Women: A review of the evidence for health professionals* (2018), Family First NZ see https://www.familyfirst.org.nz/research/abortion-health-of-women-2018/.
[45] *Ibid.*
[46] G Papaioannou, A Syngelaki, L Poon, J Ross and K Nicolaides, 'Normal Ranges of Embryonic Length, Embryonic Heart Rate, Gestational Sac Diameter and Yolk Sac Diameter at 6-10 Weeks' (2010) *Fetal Diagn Ther* 28: 207-219, see https://www.fetalmedicine.com/synced/fmf/2010_27.pdf.
[47] G Delgado *et al*., 'A Case Series Detailing the Successful Reversal of the Effects of Mifepristone Using Progesterone' (2018) *Issues in Law & Medicine* 33(1): 3-14.
[48] Greene, (2005) *op. cit.*

### *D. The expected benefits*

Surgical abortion has a high success rate (empties the uterus in over 99% of cases) and has a low risk of complications in particular, haemorrhage, infection, incomplete abortion and need for surgical re-evacuation.[49] EMA fails to empty the uterus more often (up to 12 times) and the overall complication rate is at least 4 times higher.[50,51]

### *E. Common side effects and material risks*

> *They didn't discuss any other options. They didn't help me understand the risks and possible complications, or what the procedure consisted of. I wasn't told that there was a risk of infertility or trauma since I was already 19 weeks pregnant. They never said the word "baby" and when they did the ultrasound I asked if they could see anything, they promptly turned the screen away and refused to answer my question, "Is it a boy or girl?"*
>
> \- Christina Wong

International experience is that medical practitioners do not always warn of the risks associated with abortion. For example, the FDA approved RU-486 in September 2000.[52] Providers of this drug ignored the protocol, and provided RU-486 to vulnerable women in a manner that conflicted with the standard of practice prescribed by the FDA.[53] In Australia, the High Court has held that to obtain fully informed consent, it is incumbent on medical practitioners to warn of the risks associated with the procedures:

> *The law should recognise that a doctor has a duty to warn a patient of the material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.*[54]

Furthermore, when obtaining consent, the discussion on risk needs to cover general risks (common risks of the procedure), risks specific to the procedure, and particular risks (material risks for this particular patient). Under material risks, the Avant guidelines state:

> *Doctors have a legal obligation to inform patients of the important or 'material' risks inherent in a proposed procedure or treatment. The emphasis is on the particular and inherent in a proposed procedure or treatment. The emphasis is on the particular and the individual – what is material to one patient may not be to another. The particular circumstances of the individual patient will ultimately determine which risks are considered to be material by the patient (and ultimately, by the medical*

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[49] SA Health, *Pregnancy Outcome in South Australia 2016,* (2018) see https://www.sahealth.sa.gov.au/wps/wcm/connect/4ccbba85-14c6-4b39-a19e-4e8cd54e9ea1/Pregnancy+Outcome+in+South+Australia+2016.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4ccbba85-14c6-4b39-a19e-4e8cd54e9ea1-mFIF14U

[50] *Ibid.*

[51] Niinimaki *et al.,* (2009) *op. cit.*

[52] Americans United for Life, *Abortion-Inducing Drugs Information and Reporting Act: Model Legislation and Policy Guide for the 2018 Election Year*, (2017), p 2.

[53] *Ibid.*

[54] *Rogers v Whitaker (*1992) 175 CLR 479.

*practitioner). Asking patients: "What is the one thing you're worried about?" and other open questions will assist you in identifying risks material to the patient.*[55]

The common side effects of surgical abortion are nausea, vomiting, bleeding, cramping and pain.[56] With EMA, these side effects occur more commonly, are more severe and last longer, resulting in more visits to the doctor and emergency department.[57]

The specific risks of surgical abortion are infection (and its sequelae, like adhesions inside the uterus or of the tubes and ovaries, chronic pain, infertility, future ectopic pregnancy), excessive bleeding (due to injury, poor uterine tone, and coagulopathy like DIC), haematometra (blood and clot collecting in the uterus), incomplete abortion with retained pregnancy tissue, organ injury (including cervical tear, perforation of the uterus, and injury to nearby bowel, bladder and blood vessels), and ongoing pregnancy (due to failure to end a pregnancy in the womb or failure to treat an ectopic pregnancy).[58] With EMA, the specific risks of haemorrhage, infection, incomplete abortion and need for surgical re-evacuation occur at least 4 times as often, and contribute up to an 11 times higher death rate (1/100,000).[59,60]

The significant differences in safety and complications are not mentioned in the SA Health online information sheet, copied below.[61]

Using definitions determined by the Council for International Organizations of Medical Sciences ("**CIOMS**"), complications occur commonly (1-10%) after surgical abortion, but very commonly (>10%) after EMA.[62] The need for surgical evacuation after EMA is common, but uncommon (0.1-1%) after surgical abortion. Overall, maternal death from EMA at 8 weeks is very rare (0.01-0.001%); however, it happens up to 11 times more often than after surgical abortion.[63] This risk becomes clinically significant when a procedure is performed very commonly, as in the case of abortion.

| Medication abortions | Surgical abortions |
|---|---|
| **Can be used from 4 weeks after last period** | May not be available before 6 weeks from last period |
| **For a pregnancy of less than 9 weeks** | For a pregnancy of more than 7 weeks |

[55] Avant Mutual, 'Consent Essentials' (2016) See https://www.avant.org.au/Resources/Public/consent-essentials/.
[56] British Pregnancy Advisory Service, 'Caring for yourself after your abortion' see https://www.bpas.org/abortion-care/abortion-aftercare/
[57] E Mulligan and H Messenger, 'Mifepristone in South Australia' (2011) *Australian Family Physician* 40(5): 342-345, see https://www.racgp.org.au/afp/2011/may/mifepristone-in-south-australia/.
[58] Royal College of Obstetricians & Gynaecologist 'Abortion Care', (2012), see https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-abortion-care.pdf.
[59] Niinimaki *et al.*, (2009) *op. cit.*
[60] Greene, (2005) *op. cit.*
[61] SA Health, 'Medication or surgical abortion' Government of South Australia see https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/medication+or+surgical+abortion
[62] These definitions have been determined by the Council for International Organizations of Medical Sciences (CIOMS), an organisation established by WHO and UNESCO. They are described in the CIOMS training manual, which can be found at http://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf
[63] Greene, (2005) *op. cit.*

| | |
|---|---|
| **Resembles a natural miscarriage** | Involves inserting a tube into the uterus to remove the contents |
| **Abortion process lasts one to two days** | The operation procedure is completed within 10 to 15 minutes |
| **Women can expect to be at the centre for 2 hours on one day but only 10 to 20 minutes on return visit** | Women can expect to be having two clinic visits and be at the health facility for up to five hours on the day of operation procedure |
| **The abortion usually happens at home and support is required** | The abortion operation happens in a health facility. Overnight support is advised after an anaesthetic. A support person is welcome to attend with you. |
| **May be painful for 2 to 3 hours or more after taking the medication** | May be mildly painful afterwards when the uterus contracts |
| **Longer period of bleeding up to several weeks** | Shorter period of bleeding |
| **Anaesthesia is not needed. Pain medication will be provided for you** | Pain medication, light sedation and anaesthesia are required for the procedure |
| **Severe complications are rare** | Severe complications are rare |

### *F. Whether the intervention is experimental or conventional*

Early surgical abortion and EMA are regarded as conventional interventions.

### *G. Other options for management*

This refers to alternatives to abortion. As recommended in the June 2018 White Paper entitled Abortion Reform in Australia,[64] women considering abortion should be referred to an independent counsellor to screen them for coercion and intimate partner violence, to discern their true feelings with respect to the pregnancy and offer community-based alternatives to abortion, such as the Crisis Pregnancy Service model of Hassan *et al.*,[65] and to screen for those who are at higher risk for mental health problems after abortion. The mental health risk factors are a previous history of mental health problems, undertaking an abortion for foetal abnormality, women who become distressed at the time of their abortion, and those who react negatively to abortion. At risk women should be counselled to consider options other than abortion and/or seek post-abortion counselling early.[66,67] The pregnancy support

[64] T Legge, 'Abortion Reform in Australia: A White Paper' (2018) Women and Babies Support (WOMBS) International Ltd, 'Abortion Rethink'.
[65] J Hassan, C Hassan, and W Joyes, 'Evaluating a New Primary Care initiative – A Crisis Pregnancy Service within a General Practice Setting in New Zealand: Letter to the editor' (2014) *Journal of Primary Health Care* 6: 350-351.
[66] Legge, (2018) *op. cit.*
[67] Pike, (2018) *op. cit.*

services available in SA are Birthline Pregnancy Inc., Genesis Pregnancy Support Inc., Pregnancy Help SA, and Mothers Without Medicare.

Abortion consent forms should include the following statement:

> "*I understand that the alternatives to abortion are to carry this pregnancy to term, have a child and parent, or carry the pregnancy to term and make an adoption plan. I have considered these alternatives and the counsellor has offered to make referrals to appropriate agencies for financial assistance, antenatal care and adoption. I decline these alternatives and request that the abortion procedure be performed to end my pregnancy.*"

### *H. The degree of uncertainty of the outcome*

The rate of ongoing pregnancy for surgical abortion is less than 1% and for EMA is 1%.[68,69]

### *I. The likely consequences of not choosing the proposed procedure, or of not having any procedure at all*

Proceeding with the pregnancy gives a high chance of delivering a healthy baby at term, and may lower the woman's future risk of mental health problems, preterm birth, and breast cancer (see section J below).

### *J. Any significant long term physical, emotional, mental, social, sexual or other outcome that may be associated with the proposed procedure*

The long term effects of abortion can include a higher risk of (a) mental health problems, (b) preterm birth, and (c) breast cancer. Providing antibiotics are given, infection and infertility are prevented in most women.

Unfortunately, the politicization of science about abortion harm has produced a culture of dismissal within the medical profession with regards to potential long term complications of abortion i.e. preterm birth, mental ill health and breast cancer.[70] This phenomenon is a barrier to patient consent and care, and is analogous to a situation in the 1960's when the American Medical Association and the US National Cancer Institute denied the causal link between smoking and lung cancer, and opposed the Surgeon General's 1964 warning on cigarette packs.[71,72]

#### *i. Mental health risks*

In his 2018 review, "Abortion and the Physical and Mental Health of Women," Pike observed that reviews on the psychological effects of abortion have arrived at disparate conclusions, highlighting that the field is riven with disagreement, and making the provision of guidance to physicians difficult.[73] A 2013 review by Bellieni and Buonocore concluded that abortion is

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[68] Royal College of Obstetricians & Gynaecologists (2012) *op. cit.*
[69] SA Health, 'Early medication abortions' Government of South Australia, see *https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/abortions/early+medication+abortions*.
[70] A Lanfranchi, I Gentles, and E Ring-Cassidy E. 'Biology and Epidemiology Confirm the Abortion-Breast Cancer Link' (Chapter 7). *Complications: Abortion's Impact on Women* (2013), p. 140.
[71] *Ibid.*
[72] A Lanfranchi, 'The Federal Government and Academic Texts as Barriers to Informed Consent', *Journal of American Physicians & Surgeons* (2008)13(1):12-15.
[73] Pike (2018) *op. cit.*

linked to a variety of adverse mental health outcomes, arguing that foetal loss is traumatic, whether by miscarriage, induced abortion, or stillbirth.[74] Pike points out that some reviews advance a very strong view that there is no link, unprepared to even acknowledge controversy in the field. While some researchers acknowledge an effect on some women, they can be quick to blame social mores as the cause of mental harm.

Pike notes that women are reported to experience a range of emotions after abortion, including sadness, loneliness, shame, guilt, grief, doubt and regret. However, some studies also identify positive reactions like relief, happiness and satisfaction. In the longer term, some women exhibit cognitive dissonance.

A long term New Zealand study which followed over 500 women for 30 years found that women who had abortions had a 30% increased rate of mental disorders (including depression, anxiety and substance abuse) compared to women who had not had an abortion.[75] In most cases, these women had no problems before their abortion. Also, no increase of mental health problems was evident for those having unwanted pregnancy that came to term. The authors commented that no study has shown a reduction in risk of mental health disorder from abortion, some studies have been 'neutral', and others have shown an increased risk.

A 2009 study from the same group found that women who showed signs of distress at the time of their abortion were at significantly more risk of long term depression.[76] Those having an abortion and reporting negative reactions had rates of mental health disorders that were approximately 1.4-1.8 times higher than those not having an abortion.

> *Over the next 25 years, I experienced depression, overwhelming feelings of worthlessness, guilt, shame, and intense fear of being found out. My coping mechanisms were numbness, partying, promiscuity, drugs and alcohol. Anything to keep my mind off what I'd done.*
>
> \- Christina Wong

In a 2016, well-controlled study of 8005 American women, which attempted to replicate work by the New Zealand group, Sullins found a 30% elevated risk of depression and a 25% elevated risk of anxiety. Sullins, like Coleman *et al.*, estimates that approximately 10% of the prevalence of mental health disorders comes from induced abortion.[77,78]

When deaths from all causes are examined in the first year following an abortion, several large studies have identified an increased risk compared either to giving birth or never being pregnant. Causality has not been confirmed.[79] Pike points out that the overall evidence points to common risk factors for both death and abortion, and that an abortion request should be viewed as a flag for women who might need assistance in various areas of their

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[74] CV Bellieni and G Buonocore, 'Abortion and subsequent mental health: Review of the literature' *Psychiatry and Clinical Neurosciences* (2013) 67:301-310.
[75] Fergusson *et al.*, (2008) *op. cit.*
[76] DM Fergusson, LJ Horwood and JM Boden 'Reactions to Abortion and Subsequent Mental Health' (2009) *British Journal of Psychiatry* 195(5): 420-426.
[77] DP Sullins, 'Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States' *SAGE Open Med (*2016) 4:1-11.
[78] PK Coleman, 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009' *The British Journal of Psychiatry* (2011) 199(3): 180-186.
[79] Pike (2018) *op. cit.*

lives.[14] The Finnish government has acted upon this and achieved a small reduction in post-abortion mortality by providing such post-abortion support.[80,81]

When abortion is undertaken for foetal abnormality, the evidence is clearer – that abortion results in significant mental harm, including persistent grief, depression and post-traumatic stress.[82]

Clinical experience of women post-abortion is consistent with the literature quoted above; that is, that a significant proportion suffer long term mental ill health, and some, like Australian TV personality, Charlotte Dawson, will suicide.[83] Ms Dawson, who suicided in 2014, stated in her 2012 memoir titled Air Kiss and Tell, that abortion was the catalyst for her depression.

Women with an unwanted pregnancy who progress to term have a lower chance of mental health problems than those who abort.[84,85,86]

Summary: After abortion, a range of positive and/or negative emotions may occur, including relief, satisfaction, happiness, loneliness, sadness, grief and regret. Some women will go on to develop depression, anxiety, alcohol and drug abuse. Women with a past history of mental health problems, those who are distressed at the time of their abortion, women who react negatively to abortion, or those whose abortion is undertaken for foetal abnormality, are at higher risk for mental health problems and should seek medical help early. Women with an unwanted pregnancy who progress to term have a lower chance of mental health problems than those who abort.

### *ii. Preterm birth risk*

The physical effects of surgical abortion include an increased risk of preterm birth in subsequent pregnancies. This risk is specified in the Pregnancy Care Guidelines of the Australian Government Department of Health website and quotes the 2016 systematic review and meta-analysis of Sassone *et al.*, published in the American Journal of Obstetrics and Gynecology.[87,88] The risk of preterm birth was increased 52% (Odds Ratio 1.52) among women with a history of surgically induced abortion. The risk of preterm birth was increased to a lesser degree (19%) among women with surgically managed miscarriage (OR 1.19). Other studies have also shown that the risk of preterm birth increases as the number of surgical abortions increases.[89,90,91] Consequently, in 2003, Rooney and Calhoun stated,

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[80] M Gissler *et al.*, 'Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000' *American Journal of Obstetrics and Gynecology* (2004) 190(2): 422-7.
[81] M Gissler, E Karalis, and VM Ulander, 'Decreased suicide rate after induced abortion, after the Current Care Guidelines in Finland 1987 – 2012' *Scandinavian Journal of Public Health* (2015) 43: 99-101.
[82] Pike (2018) *op. cit.*
[83] Personal communication, Dr Elvis Šeman.
[84] DC Reardon, 'The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities' *SAGE Open Medicin*e (2018) 6: 1–38.
[85] Fergusson *et al.*, (2008) *op. cit.*
[86] Fergusson *et al.*, (2009) *op. cit.*
[87] Australian Government Department of Health, 'Risk of preterm birth' *Pregnancy Care Guidelines,* see https://beta.health.gov.au/resources/pregnancy-care-guidelines/part-d-clinical-assessments/risk-of-preterm-birth.
[88] G Saccone, L Perriera, and V Berghella, 'Prior uterine evacuation of pregnancy as independent risk factor for preterm birth: a systematic review and meta-analysis' *Am J Obstet Gynecol* (2016) 214: 572-591.
[89] B Rooney and BC Calhoun, 'Induced abortion and risk of later preterm births' *J American Physicians Surgeons* (2003) 8: 46-49.
[90] P Shah *et al.*, 'Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta–analysis' *BJOG* (2009) 116: 1425-1442.

"*Women contemplating surgical abortion should be counselled about the potential risk to subsequent pregnancies – Low Birth Weight & Preterm Birth are risk factors for infant mortality (death) and disabilities, including cognitive and behavioural problems, epilepsy, autism, mental retardation and cerebral palsy.*"[92]

A large analysis presented to the annual meeting of the European Society of Human Reproduction and Embryology in Lisbon, 2015, assessed 21 cohort studies including nearly two million women.[93] The reviewers reported that the use of Dilatation and Curettage ("**D&C**") for miscarriage or abortion increased preterm birth in subsequent pregnancies by 29%, and very preterm birth by 69%. The risk was highest for women who had several abortions. The authors urge the prevention of preterm labour by minimising the use of D&C.

These findings align with a large 2012 Scottish record linkage study indicating that surgical but not medical abortion increases the risk of spontaneous premature birth in a second pregnancy.[94] A similar Scottish record linkage study from 2013 showed that the association of preterm birth with abortion declined over the study period (1980 to 2008). The authors propose that the decline is due to the increasing use of medical abortion (from 18 to 68%) and pre-treatment of the cervix prior to surgical abortion (from 69 to 99.6%).[95]

Only 3 studies have not found any association between abortion and subsequent premature birth.[96]

Summary: Women undergoing surgical abortion are at increased risk of preterm birth in a subsequent pregnancy. They should be warned about this possibility and given the option of cervical pre-treatment with Misoprostol.

### *iii. Breast cancer risk*

There are 3 potential mechanisms by which induced abortion increases the risk of breast cancer:

- Delaying or eliminating a full term pregnancy (undisputed)
- Causing preterm birth prior to 32 weeks (undisputed)
- As an independent risk factor (disputed)

Abortion removes the protective effect of a full term pregnancy and delays the age at which many women have their first or subsequent child, thus contributing to an increase in their breast cancer risk.

Full□term pregnancy is protective against breast cancer; hence, a woman who procures an induced abortion only after she has given birth is at a lower risk of breast cancer than a

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[91] HM Swingle, TT Colaizy, MB Zimmerman, and FH Moriss, 'Abortion and the risk of subsequent preterm birth: A systematic review and meta-analysis' *J Reproductive Medicine* (2009) 54: 95-108.
[92] Rooney & Calhoun, (2003) *op. cit.*
[93] Z Kmietowicz, 'Dilatation and curettage procedure raises risk of premature birth in subsequent pregnancies, study finds' *BMJ News (2015)* 350: h3261.
[94] S Bhattacharya *et al.*, 'Reproductive outcomes following induced abortion: a national register-based cohort study in Scotland' *BMJ Open (*2012) 2: e000911.
[95] C Oliver-Williams C *et al.*, 'Changes in association between previous therapeutic abortion and preterm birth in Scotland, 1980 to 2008: A historical cohort study' *PLOS Medicine* (2013) 10(7): e1001481.
[96] Pike, (2018) *op. cit*.

woman who has an induced abortion before giving birth.[97,98] Furthermore, with each term pregnancy after her first, a woman reduces her risk of breast cancer by 10 percent.[99]

However, a woman's breast cancer risk increases 0.7 percent for each year subsequent births are delayed after the first time she gives birth.[100]

A woman who has her first full□term pregnancy at age 20 has a 90 percent lower risk of breast cancer than a woman who remains childless or waits until she is 30 for her first full□ term pregnancy.[101] Each year a woman delays pregnancy after age 20, her risk of premenopausal breast cancer increases 5 percent and her risk of postmenopausal breast cancer increases 3 percent.[102] This results from the lengthening of the "susceptibility window," the period between menarche and a first full□term pregnancy, when the breast is most susceptible to carcinogenesis. It is the time when the breast is composed solely of cancer□vulnerable Type 1 and Type 2 lobules. However, if a woman delays her first pregnancy until after age 30, she will have a transient (but statistically significant) increased risk of breast cancer for 10 to 15 years before she gains the risk□lowering benefit of pregnancy.[103]

If, due to premature delivery, a pregnancy does not continue past 32 weeks, the woman will not get the protective effect of pregnancy against breast cancer. This is because her breast tissue will not have developed enough Type 4 cancer□resistant lobules. This is supported by studies show a doubling in breast cancer risk when preterm birth occurs before 32 weeks.[104,105]

The "independent risk" is disputed by many authors. However, most published studies since the first in 1959, including a 2018 systematic review and meta-analysis of studies on South Asian women, support abortion being an independent risk factor for breast cancer.[106] Furthermore, the epidemiologic studies showing the abortion/breast cancer link satisfy the nine Bradford Hill criteria for causality.[107,108]

Summary: Abortion has the potential to increase a woman's risk of breast cancer in three ways, whilst a pregnancy going to term protects against breast cancer.

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[97] L Lipworth *et al.,* 'Abortion and the Risk of Breast Cancer: A Case□Control Study in Greece' *International Journal of Cancer (*1995) 61: 183.
[98] MA Rookus *et al.,* 'Induced Abortion and Risk for Breast Cancer: Reporting (Recall) Bias in a Dutch Case□ Control Study' *Journal of the National Cancer Institute* (1996) 88: 1762.
[99] M Lambe *et al,* 'Parity, Age at First and Last Birth, and Risk of Breast Cancer: A Population□Based Study in Sweden' *Breast Cancer Research and Treatment (*1996) 38: 305□311.
[100] Adriano Decarli, Carlo La Vecchia, Eva Negri, and Silvia Franceschi, 'Age at Any Birth and Breast Cancer in Italy' *International Journal of Cancer (*1996) 67:187□189.
[101] Mats Lambe, 'Chapter Six: Reproductive Factors' in *Breast Cancer Epidemiology*, ed. Christopher I. Li. New York: Springer (2009) 129□136.
[102] Françoise□Chapelon and Mariette Gerber, 'Reproductive Factors and Breast Cancer Risk' *Breast Cancer Research and Treatment (*2002) 72: 107□115.
[103] Mats Lambe *et al.*, 'Transient increase in the risk of breast cancer after giving birth' *New England Journal of Medicine (*1994) 331: 5□9.
[104] M Melbye *et al.*, 'Preterm Delivery and Risk of Breast Cancer' *British Journal of* Cancer (1999) 80: 609.
[105] CC Hsieh *et al.*, 'Delivery of Premature Newborns and Maternal Breast Cancer Risk' *The Lancet* (1999) 353: 1239.
[106] J Brind, S Condly, A Lanfranchi and B Rooney, 'Induced Abortion as an Independent Risk Factor for Breast Cancer: A Systematic Review and Meta-analysis of Studies on South Asian Women (2018) see https://www.bcpinstitute.org/uploads/1/1/5/1/115111905/brind_final_corrected_proof__021118.pdf.
[107] A Lanfranchi, 'The breast: physiology and the epidemiology of the abortion breast cancer link' *Imago Hominis (*2005) 3: 228-236.
[108] AB Hill, 'Presidential address' *Proc Royal Soc Med (1965)* 58: 295-300.

### *iv. Infertility risk*

> *I remember the day that I met my current husband and, before I would let us get close in our relationship, I had to tell him that I would be unable to have children with him and why. I had to ask him if he still wanted a life with me*
>
> - Jeannie Guinther

Research from the 80s and 90s appeared to show that there is no long term association between abortion and infertility. However, recent research has shown a clear link between the two.[109] Anecdotally, cases of infertility have been observed after induced abortion resulting from post-infective adhesions of the tubes and ovaries (tubal factor infertility), Asherman's syndrome (a rare condition of adhesions inside the uterus), anovulatory disorder, and as a direct result of hysterectomy performed to control abortion-induced haemorrhage.[110]

Pelvic infection has been identified as a complication of up to 12% of induced abortions and, therefore, potentially cause tubal factor infertility, ectopic pregnancy, chronic pelvic pain and tubo-ovarian abscess (TOA). Universal antibiotic prophylaxis has been recommended over "screen and treat," as it halves the rate of post-abortal sepsis.[111,112] Thus, most, but not all, sepsis and its sequelae can be prevented.

Summary: Antibiotics should be given routinely when a pregnancy is terminated because, in most women, they prevent infection and potential complications like infertility.

### *K. The time involved*

Surgical abortion involves less time and is more predicable than EMA, which may occur anytime and anywhere. Women can return to work and normal activities sooner after surgical abortion.

### *L. The cost involved, including out-of pocket costs*

For public patients, these are covered by SA Health. Women having an abortion performed by a private practitioner may incur gap fees. For rural and regional women accessing the pregnancy advisory centre ("**PAC**") Central Adelaide Local Health Network, travel and accommodation expenses are covered by the patient assistance transport scheme ("**PATS**").[113]

### *(ii) Duty of a Counsellor*

In addition to the obligations upon a medical practitioner, a woman contemplating an abortion should be referred to a counsellor as a component of ensuring that if the woman proceeds with an abortion, the consent she provides is fully informed and voluntary. That counsellor must be completely independent, in that he or she must not have any pecuniary

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[109] Wang, (2018) *op. cit.*
[110] Personal communication, Dr Elvis Šeman.
[111] GC Penney, 'Preventing infective sequelae of abortion' *Hum Reprod* (1997) 12 (11 Suppl): 107-112.
[112] Centres for Disease Control and Prevention, 'Pelvic Inflammatory Disease (PID)' (2017) see https://www.cdc.gov/std/pid/stdfact-pid-detailed.htm.
[113] SA Health, *Patient Assistance Transport Scheme (PATS) Guidelines for Assessment* (2018) CHSA Local Health Network p. 13, See https://www.sahealth.sa.gov.au/wps/wcm/connect/1e7c6c804d48bcb581dafb4c56539eed/CHSALHN+PATS+Guidelines+for+Assessment+Dec+2018+FINAL.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-1e7c6c804d48bcb581dafb4c56539eed-mHt8mKg.

or other interest in a health service which provides abortion, just as a solicitor presenting legal advice in relation to retirement village contracts cannot have a pecuniary interest in the retirement village.

> *He never offered me [the chance] to have another opinion or to try and save the baby I wanted. I felt hopeless and trapped like an animal in a snare. I didn't know he was lying to me. I didn't know I could go elsewhere for help.*
>
> - Molly White

In addition to ensuring voluntariness, which will be explored in further detail below, an independent counsellor has a role in ensuring that a woman is aware of alternatives to abortion, prior to undergoing the procedure. Unless a woman is aware of the alternatives to abortion, the woman cannot give fully informed consent.

### *A. Adoption*

Where adoption was once considered a method of dealing with a pregnancy that results in an unwanted child, the incidence of adoption has reduced significantly in South Australia. Instead, the adoption process has become unwieldy and expensive.

Adoption laws should be reviewed with the intention of making the process easier for both people who wish to adopt and women who may wish to deliver a child and relinquish the child rather than submit themselves to the medical risks associated with any type of abortion. Facilitating this alternative, and ensuring that women are aware of this alternative, ensures that a woman contemplating an abortion is fully informed of relevant matters prior to giving consent. Excellent work is being done by 'Adopt Change', founded by Debora Lee Furness, wife of Hugh Jackman, and can be accessed at www.adoptchange.org.au.

### *B. Safe Haven or "Baby Moses" Laws*

Some jurisdictions, particularly in the United States of America, have enacted 'safe haven laws' in order to provide an alternative to a woman who is unwilling or unable to care for a baby, but does not wish to undergo an abortion. These laws allow for a baby, under a certain age, to be handed over to nominated persons at a hospital or similar institution without question.[114]

Safe haven laws should be introduced in South Australia to ensure that women contemplating an abortion have a further alternative to undergoing the risks of abortion. Providing this further alternative, and ensuring that women contemplating an abortion are aware of the alternative, ensures that any consent is given in full knowledge of all alternatives.

### *C. Pregnancy Crisis Centres*

A woman may seek an abortion not because it is her preferred resolution to a pregnancy, but rather because she lacks sufficient support to either care for a child or manage until delivery where adoption or safe havens provide other options. Pregnancy crisis centres provide support to women in these circumstances, ranging from ongoing counselling to baby clothes, depending on need.

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[114] More information regarding safe haven laws can be found at https://www.nationalsafehavenalliance.org/.

The American experience has noted the value that pregnancy centres provide to pregnant women, whether or not they ultimately proceed to terminate their child.[115] In the United States of America, there are thousands of these centres and in 2010, they supported over 2.3 million people.[116] That support has included emotional and financial support.[117]

The role of pregnancy crisis centres in South Australia should be encouraged and expanded in order to ensure there are options available for pregnant women who might be contemplating an abortion. Further, for such a woman to give fully informed consent, counsellors must ensure that women are aware of the services provided by pregnancy crisis centres.

### *(b) Consent that is Voluntary*

As set out above, the consent necessary for any interference with the body, including medical treatment, must be given in circumstances where the person providing that consent does so on a voluntary basis. For consent to be given voluntarily, the woman must not be subjected to circumstances which impair her freedom to choose from all of the available options.

#### *(iii) Coercion by a person*

> *I didn't want this. But I made the choice my boyfriend wanted me to make so I wouldn't lose him.*
>
> - Jaime Bates

While the conversation regarding abortion focuses upon a woman, a woman does not become pregnant in isolation, and the father may encourage the woman to undertake an abortion. That encouragement ceases to be the promotion of one option and becomes coercion when emotional manipulation, financial pressure, threats or actual violence is applied to secure the woman's decision to undergo an abortion. Coercion might also arise from family members of the woman who, even if well meaning, nevertheless utilise their relationship or financial support in order to secure the woman's decision to undergo an abortion.

In either of these scenarios, the nature of the coercion applied to the woman deprives any consent she gives of its voluntary nature. To ensure that consent is voluntary, a woman contemplating an abortion should be required to engage with an independent counsellor who is trained to identify coercion. Further, given that such coercion prevents consent from being voluntary, and the effect of consent is to subject the woman to the risks associated with abortion, such coercion should be recognised as a form of domestic violence.

Louisiana's 'Signs of Hope' Bill (HB 636) has been cited as a potential model for legislation in Australian States.[118] Enacted in July 2011, the Bill requires full colour signs to be posted in abortion clinic waiting areas and patient rooms, informing women that they cannot be forced to abort against their will, and detailing basic rights and available resources.

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[115] Americans United for Life, *Joint Resolution Honoring Pregnancy Centers, Model Legislation and Policy Guide, for the 2018 Legislative Year* (2017), p 2.
[116] *Ibid.* p. 3.
[117] *Ibid.*
[118] B Francis, 'Pro-life, pro-women laws enacted in Louisiana' *News Weekly,* September 3 2011.

#### *(iv) Coercion by circumstance*

Even where no person is actively pressuring a woman to undergo an abortion, a woman may be motivated due to the circumstances in which she lives, be they social or economic circumstances. However, if those circumstances are the basis for the decision to undergo an abortion, then the woman has not given voluntary consent to the procedure because of the pressures against choosing an alternative.

In this scenario, an independent counsellor will be able to advise the woman of options such as pregnancy crisis support to deal with the immediate circumstances, and adoption or safe-haven laws to deal with ongoing circumstances. Without the involvement of an independent counsellor who is in a position to ensure the woman is aware of those options, the consent provided by the woman will be motivated not by free choice but by circumstance, and will therefore not be voluntary.

### *(c) Consent unaffected by mental disturbance*

Section 269C of the *Criminal Law Consolidation Act 1935* (SA) ("**CLCA**") provides that a person does not have the mental competence to commit an offence if, at the time of the conduct alleged to give rise to the offence, they were suffering from a mental impairment which left them unaware of the nature and quality of their conduct or unaware that the conduct is wrong.[119] The principle underlying this section is that a person can only be responsible when they know what they are doing.

In the same manner, consent to undergo an abortion can only be voluntary when it is given with an appreciation of what that consent means. This is also relevant to the question of whether a woman is giving fully informed consent. Given the risks inherent in abortion, no woman should undergo the procedure on the basis of a consent given at a time when she could not fully comprehend the nature of the consent she provided. Both independent counsellors and medical practitioners should be alert to the risk of mental disturbance and take steps to ensure they do not rely upon a consent given by a woman in those circumstances.

## 2. *General restrictions*

Although many jurisdictions have adopted a liberal attitude towards the legality of abortion, there are still general restrictions which have been observed in most places. Even if abortion is to remain lawful, there are some restrictions which should remain in place. Some examples include abortion in order to harvest organs or foetal tissue (for any reason other than pathological testing), abortion on the basis of foetal disability and sex-selective abortion.

In relation to sex- selective abortion, while Victorian legislation prohibits the choice of sex as a basis for abortion, distinct trends have been identified between different communities. Specifically, 100 boys to every 100 girls were born to an Australian-born woman, while 125 boys to every 100 girls were born to women from certain migrant communities. This gender bias suggests women in those communities are undergoing abortion at a higher rate if it is determined they would deliver a female child.[120] Further, Dr Mark Hobart, a medical practitioner who previously operated in Victoria, has been subject to disciplinary action

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[119] *Criminal Law Consolidation Act 1935* (SA) s 269C.
[120] La Trobe University, 'Gender bias leads to more male births' (Media Release, 12 August 2018) see https://www.latrobe.edu.au/news/articles/2018/release/gender-bias-leads-to-more-male-births

because he refused to refer a couple for an abortion, when their stated reason was their child in the womb was a girl and they wanted a son.[121]

Internationally, on 4 November 2014, the UK Parliament voted 181 to 1 to ban sex-selective abortion.[122] Finally, the *United Nations Committee on the Rights of the Child* asserted that selective abortion is discrimination against girl children and is a serious violation of rights affecting their survival, noting specifically "[*t]hey may be victims of selective abortion…*"[123]

### 3. *Medical care for babies born alive*

It has become apparent that babies who are born alive as a result of a failed abortion are being denied life-sustaining treatment and thus being left alone to die, both in Australia,[124] and internationally.[125] Despite a common law principle that a child is a distinct legal person when they are born and have taken their first breath, as the children in this case have done, there have also been cases where prosecutorial officials have refused to take action.[126]

In the United States of America, agitation upon this issue led to the passage of the federal *Born-Alive Infants Protection Act*, which has become a model for similar state legislation.[127] In 2018, a majority of the states had some form of this legislation, and 26 have enacted a specific affirmative duty upon physicians to provide medical care and treatment to infants who are born alive at any stage of development.[128] These laws do not infringe upon laws which provide for abortion, but rather require that all efforts be made to maintain the life of the child when the child is unconnected to the woman.[129] Best medical care for everyone requires that the medical practitioners should be required to provide life-sustaining care to a child who is born alive, or that the child should be transferred to a hospital willing to do so.[130]

### 4. *Legal recognition of personhood of child in the womb*

SALRI has sought information regarding community attitudes as they have developed since the enactment of the current legal regime. While there is a legal avenue to obtain abortion in all Australian states and territories, other legislation represents a significant development of societal expectation in the unique treatment of children in the womb.

#### *(a) Unlawful killing of a human being*

##### *(i) Common law*

The criminal law of every Australian jurisdiction includes offences such as "murder" and "manslaughter", which prohibit the unlawful killing of a human being. For the purpose of

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[121] M Devine, 'Doctor risks his career after refusing abortion referral', *Herald Sun* (Melbourne), 5 October 2013, see https://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5.

[122] S Parmar, 'MPs back ban on sex-selective abortion, *BBC News*, 4 November 2014, see https://www.bbc.com/news/uk-politics-29891005.

[123] United Nations, Committee for the Rights of the Child, 40th Session, September 2005, para 11(b)(i).

[124] Per data available on request from SA Health: SA Health stats for babies born alive and left to die; 2008 aborted, born alive and left to die; 2019 aborted, born alive and left to die; and Joint Medical Statement on Born Alive Abortion Survivors Protection Act 13 Feb, 2019.

[125] Americans United for Life, *Born-Alive Infant Protection Act, Model Legislation and Policy Guide for the 2018 Legislative Year* (2017), p. 2.

[126] *Ibid.*

[127] *Ibid.* p. 3.

[128] *Ibid.*

[129] *Ibid.*

[130] Americans United for Life, *Life-Sustaining Care Act, Model Legislation and Policy Guide for the 2018 Legislative Year* (2018) p. 2.

these laws, a child in the womb is only capable of dying as a result of murder or manslaughter once he or she is 'born alive', that is completely extruded from the body of the pregnant woman, though it is not necessary for the umbilical cord, placenta or afterbirth to have fully extruded from the woman's body. It is also unnecessary to establish that the child has the capacity to stay alive, though some jurisdictions require the child to have taken a breath before a murder charge could be brought. Therefore no murder or manslaughter charge can be brought for an abortion in utero.

However, it would be inaccurate to suggest that child in the womb is treated as either property or a mere appendage of the mother until he or she is born alive. In *R v Castles,*[131] a woman injected warm water into her uterus with the intention of terminating her pregnancy. The woman gave birth two days later and, as there was some suggestion that the child had taken a breath prior to death, the woman was charged with manslaughter. Lucas J conceded that based on the evidence presented, it was possible for a verdict of guilty to be returned, however the matter was eventually determined on the basis of reasonable doubt as to whether the child had taken a breath prior to dying. Yet it would only be possible for a guilty verdict to be returned if it is accepted that a person can die from injuries inflicted before they are accepted as a person at law. If this position does not contradict the need to be 'born alive' before a child can die from murder or manslaughter, then it at least creates a unique legal recognition at law which applies only to children in the womb.

Further support for the unique recognition is found in English case of *Attorney General's Reference (No 3 of 1994)*,[132] which dealt with a man who stabbed his girlfriend in the lower abdomen while she was between 24 and 26 weeks' pregnant and thus caused her to go into premature labour.[133] The woman gave birth to a child who lived for four months and then died as a result of injuries from the stab wounds received in utero.[134] The Court of Appeal held that both murder and manslaughter could be committed where a child's death resulted from injury to the mother during pregnancy.[135] The Court of Appeal did however state, though not as part of the judgment, that a doctor performing an abortion would not be guilty of murder if the abortion caused the child in the womb to be born alive and then die, provided the procedure was otherwise lawfully performed.[136] A further example is found in *Martin v The Queen,*[137] where the appellant had stabbed his 28 week pregnant partner in the lower back, causing foetal brain damage which caused the child's death after he was born alive.[138] The appellant was convicted for manslaughter and the Western Australian Court of Criminal Appeal held that a prosecution could be brought in respect of injuries inflicted on a child before his or her birth which ultimately led to his or her death, provided the child were born alive.[139] In reaching this decision, the court relied upon section 271 of the *Criminal Code* (WA), which provides that:

> *When a child dies in consequence of an act done or omitted to be done by any person before or during its birth, the person who did or omitted to do such act is deemed to have killed the child.*

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[131] [1969] QWN 36.
[132] [1996] 2 WLR 412
[133] Natasha Cica, Law and Bills Digest Group, *Abortion Law in Australia*, Research Paper No. 1 of 1998-99 (1998) p. 38.
[134] *Ibid.*
[135] *Ibid. p. 39.*
[136] *Ibid.*
[137] WA Court of Criminal Appeal, 4 April 1996, unreported.
[138] Cica, (1998) *op. cit.* p. 39.
[139] *Ibid.* p. 40.

Although the matter was not addressed, *Martin v. R* suggests consistency with the proposition that liability for homicide can attach to the death of a child which results from injuries caused by an otherwise lawful abortion.[140] This reasoning is consistent with decisions in other Australian jurisdictions that if a child is born alive, he or she can bring a civil action in respect of negligent actions which took place before his or her birth.[141]

#### *(ii) Legislation*

The *Criminal Code* (NT) contains two provisions relevant to this discussion. The first is section 170, which provides that:

> *Any person who, when a woman or girl is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of an offence and is liable to imprisonment for life.*

The second is section 317, which provides that:

> *Upon an indictment charging a person with murder or manslaughter, if it appears that the person alleged to have been killed was a child of which a woman had recently been delivered, the accused person may be found guilty alternatively of the offence of preventing the child from being born alive by an act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, or of the offence of disposing of the dead body of a child with the intention of concealing the child's birth.*

Each of these offences point to a recognition of the humanity of the child in the womb, which is distinct from the born child only in that there is a legal avenue for abortion. This is not a position unique to Australian law for, in addition to the English law set out above, the majority of the states of the United States of America have laws which allow for the possibility of an child in the womb being the victim of a crime.

### *(b) Assault laws*

The previous section dealt with laws regarding the taking of life, which are limited by the requirement that a child be born alive. However, some Australian laws already grant a unique form of recognition to a child in the womb for the purpose of assault law. An example is found in the definition of "Grievous Bodily Harm" in the *Crimes Act 1900* (NSW), which includes:

> *the destruction (other than in the course of a medical procedure) of the pre-born baby of a pregnant woman, whether or not the woman suffers any other harm.*[142]

This definition creates a separate offence which deals with actions that result in the death of a child in the womb. This law represents a societal expectation that the loss of a child in the womb in certain circumstances be dealt with under the laws regarding an offence against a person. While this law does allow for the destruction of a child in the womb in the course of a medical procedure, the New South Wales parliament has still elected to grant some unique recognition to a child in the womb, apart from his or her mother. Further, the laws relating to destruction cannot be said to treat the child in the womb as property, as the offence

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[140] Cica, (1998) *op. cit.* p. 40
[141] *Ibid.*
[142] *Crime Act 1900* (NSW), s 4.

"Grievous Bodily Harm" is a species of assault, which is an unlawful interference with a person and not the destruction of property.

### *(c) Child protection laws*

Notwithstanding the limits upon recognition of a child in the womb as a person, Victorian child protection legislation provides that a person can make a child protection report regarding a child in the womb if that person had concerns for the child after his or her birth.[143] There are similar provisions in child protection legislation in New South Wales,[144] and the Queensland child protection department is specifically empowered to offer support to reduce the likelihood that a child in the womb will be in need of protection after the child is born.[145]

### *(d) Registration of births*

Each state and territory of Australia has legislation that deals with the registration of births, deaths and marriages, usually by the giving of a prescribed form of notice to the established Registrar or Registrar-General. In the Australian Capital Territory, that notice must be provided in relation to any child born alive, or any stillbirth,[146] and for the purpose of that legislation, "child" includes a "stillborn child".[147] Similar provisions are enacted by the *Births, Deaths and Marriages Registration Act 1995* (NSW).

In the Northern Territory, section 12 of the *Births, Deaths and Marriages Registration Act* (NT) provides that notice must be given to the Registrar in the event of any child born alive, or of any stillbirth. Section 12(3) of the same legislation provides that when notice of a stillbirth is given, that notice must include a doctor's certificate which certifies "the cause of foetal death".

### *(e) International Law*

There is also recognition at international law that "*the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.*"[148] It was on the basis of this statement in the preamble that, during discussions about the *Convention on the Rights of the Child*, representatives from Malta and Senegal were satisfied that it was not necessary to include the words "from conception" in Article 1's definition of a child.[149]

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[143] *Child, Youth and Families Act 2005* (Vic), s 29.
[144] *Children and Young Persons (Care and Protection) Act 1988* (NSW), s 25.
[145] *Child Protection Act 199* (Qld), s 21A.
[146] *Births, Deaths and Marriages Registration Act 1997* (ACD), s 5.
[147] *Births, Deaths and Marriages Registration Act 1997* (ACD), s 4.
[148] *Convention on the Rights of the Child, Preamble* (ratified by Australia on 17 December 1990).
[149] 1989 Report of the Working Group to the Commission on Human Rights, E/CN.4/1989/48, paras 76-77.

## VI. QUESTIONS POSED BY SALRI

### The Role of the Criminal Law

**1. *Should there be offences relating to qualified health practitioners performing abortions in the Criminal Law Consolidation Act 1935 (SA)?***

Sections 81 and 82 of the CLCA out a general prohibition on abortion in South Australia. That general prohibition is subject to the exception found in section 82A of the CLCA which provides for a medical abortion. That exception requires the concurrence of two doctors except where a single legally qualified medical practitioner has formed an opinion in good faith "*that the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman*".[150] Further, abortion must take place within a hospital of a prescribed class, or a purpose built medical facility.[151]

Best medical care requires that 'backyard' abortion (abortion without medical care) be prohibited, and discouraged under the threat of criminal sanction. Given the risks of abortion, as outlined above, those sanctions should be applied to anyone who participates in an abortion in the absence of qualified medical practitioners and appropriate facilities.

In the 50 years since the CLCA was amended to allow for the lawful abortion in South Australia, there is no evidence that any health practitioners have been prosecuted for terminating a pregnancy. However, the absence of any offence in relation to a qualified health practitioner performing an abortion would establish that a health practitioner can never act improperly in this area. 'Health practitioner' is a broad term which includes pharmacists, nurses and others who have neither the qualifications nor the equipment necessary to advise upon, or minimise the risks involved in, an abortion. Accordingly, there should be a general prohibition upon health practitioners providing abortion.

Yet even qualified medical practitioners could act so improperly in this area that they should be charged with a criminal offence. While each case would need to be considered in its unique circumstances, a medical practitioner who fails to provide the best medical care for the woman to the extent that the woman is harmed should be charged with a criminal offence. Further, a medical practitioner who terminates the pregnancy of a woman who has advised that she does not wish to continue with the procedure should be charged with a criminal offence due to the absence of consent. Finally, a medical practitioner who performs an abortion on grounds subject to general restriction, or who deals with foetal tissue in a prohibited manner, should be charged with a criminal offence.

> *I knew I needed help so in tremendous pain I drove myself to the hospital to find out, in the words of my doctor, "the abortion doctor had just scrambled up the foetus inside of me and left it.*
>
> \- Jeannie Guinther

***Recommendations:***

*(1) The current legislative provisions in the CLCA addressing abortion should either:*

*(a) be retained in the CLCA; or*

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[150] *Criminal Law Consolidation Act 1935* (SA), s 82A(1)(b).
[151] *Criminal Law Consolidation Act 1935* (SA), s 82A(1)(a).

*(b) enacted in the same terms in healthcare legislation.*

*(2) To ensure that a woman undergoing an abortion receives the best medical care by qualified medical practitioners, healthcare legislation should prescribe general criminal offences in relation to abortion in the same terms as sections 81 and 82 of the CLCA.*

*(3) Healthcare legislation should prescribe criminal offences for medical practitioners who fail to obtain fully informed and voluntary consent (based upon a recorded, evidence based, medical opinion) from a woman for the abortion.*

*(4) Healthcare legislation should prescribe criminal offences for medical practitioners who fail to provide the best medical care for women in the course of an abortion.*[152]

*(5) Healthcare legislation should prescribe criminal offences for medical practitioners, and anyone else, who engages in the following procedures or practices:*

*(a) Failing to take all necessary steps to sustain the life of a child who is physically separate from the woman, regardless of whether the child was separated as a result of an attempted abortion,*[153] *or whether the child has taken his or her first breath, or any other reason.*

*Note: Data available on request from SA Health indicates that from 2000-2009 there were 72 live-born abortions, i.e. 72 babies were born alive and left to die.*[154]

*(b) Second and third trimester abortion by intact D & E, also known as "partial birth abortion", and non-intact D & E (dismemberment abortion) on a living child in the womb;*[155]

*(c) The harvesting, removal and use of foetal organs and/or tissue from aborted babies for sale, or purpose other than pathological diagnosis.*

*Note: The combination of repealing section 82A(4) (no reporting) together with 83(1) and (2) (concealment) allows for the selling foetal body parts as in the recent Planned Parenthood scandal*

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[152] See e.g. Americans United for Life, *Enforcement Module for State Abortion Laws: Model Legislation & Policy Guide for the 2018 Legislative Year* (2017).
[153] See Americans United for Life, *Life-Sustaining Care Act: Model Legislation & Policy Guide for the 2018 Legislative Year* (2018).
[154] Per data available on request from SA Health: SA Health stats for babies born alive and left to die; 2008 aborted, born alive and left to die; 2019 aborted, born alive and left to die; and Joint Medical Statement on Born Alive Abortion Survivors Protection Act 13 Feb, 2019.
[155] American Association of Pro-Life Obstetricians and Gynecologists, 'AAPLOG Statement on Dismemberment Abortion Bans (2019) see https://aaplog.org/wp-content/uploads/2019/02/AAPLOG-Statement-on-DE-bans.pdf.

*in USA. These sections should remain in the CLCA or be transferred to health care legislation.*

*(d) Modification of the technique of abortion so as to harvest foetal organs for sale or any other purpose.*

*(e) Abortion for the purpose of selecting the preferred sex of the baby for social reasons. i.e. gender-selective abortion of a healthy baby.*

*(f) Abortion for an unwanted but otherwise healthy baby capable of surviving outside the womb.*[156]

*(g) Performance of medical or surgical abortion without RANZCOG approved training and accreditation.*

*Note: Other matters which should be subject to general restriction will be set out in answers to subsequent questions.*

**2. *Should there be offences relating to the woman procuring an abortion in the Criminal Law Consolidation Act 1935 (SA)?***

Section 81 the CLCA provides that it is a criminal offence either for a woman to terminate her own pregnancy, or for any other person to take an unlawful action to cause her miscarriage. Section 82 of the CLCA provides that it is a criminal offence to provide drugs or other things with the knowledge that the intent is to procure a woman's miscarriage. There is no evidence to suggest that any woman has been prosecuted for abortion, or been denied access to an abortion procedure. The current legal restrictions are therefore not a barrier to women accessing abortion. Further, there is no reason for a woman in South Australia to procure her own abortion in any scenario arising in this inquiry, as it is not open to SALRI to consider a general prohibition on access to abortion.

However, it is important to understand the two key reasons which underlie these offences. The first is that taking of the life of the child in the womb is a serious and intentional act against innocent human life, and the magnitude of the potential penalty (keeping in mind that the law takes into account mitigating factors such as coercion) allows for the possibility that such an offence could occur after the child could be delivered and born-alive, or up until the time of birth, or even during birth (which is the definition of partial birth abortion). The second reason is that a woman who procures her own abortion does so outside of the best medical care and places herself at risk of very serious and life-threatening consequences. Repeal of these sections would reduce the relevant penalties and potentially encourage the practice of self-administered abortions – effectively a return to 'backyard' abortions.

The best medical care requires that any significant medical or surgical procedure takes place under the care of qualified medical practitioners, after the patient having given fully informed and voluntary consent. Given that the risks involved in an abortion are magnified in the absence of qualified medical practitioners, women should be protected by maintaining the current offences relating to terminating a pregnancy outside of the best medical care. It is therefore important that a criminal penalty still exists that may be applied for certain cases, as well as to act as discouragement for self-administered abortions.

[156] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit.*

***Recommendations:***

*(6) Procuring an abortion by a woman should remain an offence in order to discourage backyard abortion and to ensure that the woman receives the best medical care.*

**3. *Should a woman ever be criminally responsible for the termination of her own pregnancy?***

As set out above, section 81 the CLCA provides that it is a criminal offence for a woman to terminate her own pregnancy, and that this law has not prevented women from accessing a procedure for abortion in South Australia, nor has it resulted in any criminal charges. However, even in the absence of criminal charges in specific cases, this prohibition still serves an instructive purpose, specifically that an abortion is serious and can only be undertaken in a prescribed manner.

If women are to be afforded the best medical care, then any attempt to terminate a pregnancy in the absence of qualified medical practitioners in a suitable environment must be prohibited. That prohibition should extend to, and perhaps especially extend to, the woman who would be utterly unable to address any complication. Best medical care requires qualified medical practitioners in a suitable environment because of the gravity of any complications, as described above.

***Recommendations:***

*(7) It should remain an offence for a woman to terminate her own pregnancy in order to ensure that the woman receives the best medical care.*

**4. *Should South Australia have criminal offences for abortions not performed by an appropriate health practitioner?***

Section 82 of the CLCA criminalises the unlawful supply of any substance with the knowledge of intention to procure the miscarriage of any woman, and imposes a penalty of three years in prison. Repeal of this section would permit the black market sale of abortion-related products and lead to the conduct of abortion in circumstances other than the best medical care.

Section 82A of the CLCA provides for a lawful medical abortion, based upon the involvement of legally qualified medical practitioners. Given the risk of complications described above, an abortion not performed by an appropriate medical practitioner places the woman at risk of serious complications, and thus denies the woman the best medical care. A medical practitioner who does not have the appropriate skills, training and facilities will be able to offer little more assistance to a woman, especially in the event of complications, than a layperson.

A system which is serious about delivering the best possible medical care to a woman in relation to an abortion must require that the medical care be provided by an appropriate medical practitioner. In this sense, 'qualified' or 'appropriate' medical practitioner means not a 'health professional' of some description, but rather a medical practitioner who has the appropriate skills, training and facilities in order to provide the best medical care to the woman. Further, such a medical practitioner will be able to ensure that the woman has given fully informed and voluntary consent. Another person (even if some other type of health professional) will not be qualified to either manage the care of the woman or provide the information necessary for a woman to give informed consent to the procedure.

Allowing the abortion to be performed by someone other than an appropriate medical practitioner violates the principle that the best medical care should be made available. Further, it violates the principle that consent should be fully informed and then voluntary. The current criminal offences should be retained for anyone else who attempts to terminate a pregnancy.

***Recommendations:***

*(8) Abortion by someone other than an appropriate medical practitioner should remain an offence in order to ensure that the woman receives the best medical care, and fully informed and voluntary consent is obtained.*

**Who should be permitted to perform or assist in performing terminations?**

**5. *Should health practitioners (other than medical practitioners) be permitted to authorise or perform, or assist in performing, lawful terminations of pregnancy in South Australia?***

Surgical abortion is an inpatient procedure, which requires general anaesthetic and nursing staff. Early medication abortion is an outpatient procedure. Beyond the first trimester, medication abortion requires inpatient management with medical and midwifery assistance. Each type of abortion is a medical procedure which requires thorough medical management of all aspects, and consent that is both fully informed and voluntary, noting that fully informed consent can only be obtained by a qualified medical practitioner.

Based on NHMRC guidelines, in order to obtain fully informed consent a medical practitioner is required to provide patients with information in 12 domains, including complications.[157] Only an appropriately trained, accredited and indemnified medical practitioner is able to adequately set out the potential complications, the likelihood of those complications, what measures should be taken to reduce the risk of complications and how to manage those complications. Therefore informed consent can only be obtained by a medical practitioner.[158]

Best medical care requires a qualified medical practitioner with the appropriate skills and facilities because only such a person will be able to address any complications arising from an abortion. Allowing any lower standard in South Australia will necessarily mean offering something less than the best medical care, which should be rejected.

***Recommendations:***

*(9) A medical practitioner should bear the responsibility for advising a woman contemplating an abortion about all relevant risks of an abortion procedure based on appropriate medical evidence regarding those risks.[159]*

[157] NHMRC (1993) *op. cit*.
[158] *Ibid.*
[159] See e.g. Missouri Prevention of Coerced and Unsafe Abortions Act (2008), Model Bill can be found at https://stopforcedabortions.com/initiative.htm.

## Gestational Limits and Grounds for Termination of Pregnancy

### 6. *Should a woman be allowed to access lawful abortion on request at any stage of a pregnancy?*

Even in a society which accepts that a woman should be able to undergo an abortion there is general opposition to abortion occurring at all gestational ages or for any reason at all. If this question were answered in the affirmative, then it would be an authorisation of practices such as partial birth abortion and abortion up until the child has taken his or her first breath outside of the womb. Accordingly, there should be restrictions upon access to lawful abortion based on the stage of that pregnancy.

***Recommendations:***

*(10) As set out in Recommendation (5) above, there are a series of abortion procedures which should not be lawful in any circumstances. Accordingly, a woman should not be allowed to access lawful abortion on request at each and every stage of her pregnancy.*

### 7. *Should there be a gestational limit or limits for a lawful termination of pregnancy in South Australia?*

The absence of any gestational limit would allow for the lawful abortion up until the child is born alive, including until natural birth. Given the current state of medical practice, it would lead to abortions taking place at a later stage of pregnancy in one ward, while pregnancies at an earlier stage are delivering born alive children in the next ward. There should be general restrictions which place limitations upon the gestational limit at which an abortion can occur.

***Recommendations:***

*(11) There should be a gestational limit for lawful abortion in South Australia.*

### 8. *If there is a gestational limit for a lawful termination should it be related to:*

#### *(a) The first trimester of pregnancy;*

After the first trimester, most abortions occur for elective reasons and the abortion procedure becomes more dangerous for the woman. This increased level of risk is unnecessary when women have already had the opportunity to terminate their pregnancy at an earlier stage. Further, into the second trimester (and late in the first), a child in the womb feels pain and if abortion is to occur, it should occur prior to that point. Few countries in the world allow abortion after the first trimester,[160] and such a limit should be made a general restriction in South Australia.

***Recommendations:***

*(12) There should be a prohibition on lawful abortion after the first trimester.*

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[160] Baglini, (2014) *op. cit.*

### *(b) Viability of the pre-born baby (approximately 22 – 24 weeks);*

It is important to differentiate between two ways of terminating a pregnancy, which are clinically and ethically distinct. The first is abortion, where mother and baby are separated with the intention that the child in the womb not be born-alive. The second is delivery, where mother and child in the womb are separated with the intention that the child in the womb be born alive.

If Recommendation (12) is not accepted, then the gestational limit should be based around the capacity of the child to be born alive. At that point, if a woman decides to terminate her pregnancy, that can occur by way of delivery which allows the child to be born alive.[161] While this process would end the pregnancy, it is clinically and ethically distinct from abortion as it allows a viable child the best chance of survival.[162]

Further, beyond 20 weeks of gestation, the immediate risk of death to the woman from elective abortion procedures exceeds the woman's risk of death from delivery.[163] One study has shown that, compared to abortions performed at eight weeks gestation, the risk of death increases exponentially by 38% for each additional week of gestation.[164]

***Recommendations:***

*(13) If Recommendation (12) is not accepted, then there should be a prohibition on lawful abortion after a child in the womb is sufficiently developed to be delivered and born alive.*

## 9. *Should there be a specific ground or grounds for the lawful termination of pregnancy?*

The CLCA currently sets out a general prohibition and then provides for lawful abortion in certain circumstances. That scheme is consistent with providing the best medical care as it requires the involvement of qualified medical practitioners who are in a position to provide that standard of care and ensure that a woman is giving consent that is both fully informed and voluntary.

However, section 82A(1)(a) only requires that medical practitioners form a view as to the risks involved on a good faith basis, which is inconsistent with best medical care. Best medical care requires that medical practitioners form a view, record that view and tender their advice on the basis of evidence particular to the woman and the continually developing state of medical knowledge. This requirement should be legislated in order to provide best medical care to the woman.

***Recommendations:***

*(14) In order to provide best medical care, the requirement for medical practitioners to form and record their view on the basis of evidence should be enacted in either section 82A(1)(a) of the CLCA, or in any healthcare legislation which replaces that section.*

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[161] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit.*
[162] *Ibid.*
[163] Bartlett *et al.*, (2004) *op. cit.*
[164] *Ibid.*

**10.** ***If there is a specific ground or grounds for a lawful termination should they include:***

***(a) All relevant medical circumstances;***

Any medical decision must be made in the context of all relevant medical circumstances, with the exclusion of those circumstances which should be subject to general restriction. Any exclusion of medical circumstances from consideration (subject to general restrictions) would mean that the woman is receiving something less than the best medical care. Further, the woman may not have been provided with all the information necessary to give fully informed consent.

***Recommendations:***

*(15) Specific grounds for lawful abortion should include all medical circumstances in order to provide best medical care, excluding those which are subject to general restriction.*

***(b) Professional standards and guidelines;***

Professional standards and guidelines are continually developed in order to ensure that best medical practice is not a static concept, but rather is always improving in response to new medical evidence. The protection of women by way of the provision of best medical care requires that all medical practice, including abortion, be conducted according to continuously updated professional standards and guidelines. Further, the latest professional standards and guidelines will support a medical practitioner to inform a woman of those matters which must be raised in order to ensure that a woman has given consent which is both fully informed and voluntary.

***Recommendations:***

*(16) Specific grounds for lawful abortion should include compliance with professional standards and guidelines in order to provide best medical care.*

***(c) That it is necessary to preserve the life of the woman;***

When circumstances arise in which the life of a pregnant woman is at risk by the continuing pregnancy, all necessary steps must be undertaken to preserve her life. However, it is not the case that such an action is to be understood as a lawful abortion. There is a longstanding and well-developed standard of ethical guidance in cases such as these based upon the principle of 'double effect'.

This principle allows for accepting the foreseen but unintended death of the child as a secondary consequence of saving the life of the woman. The death of a child in the womb is bad but accepted in such extraordinary circumstances. However, it is never directly intended.

***Recommendations:***

*(17) The legal framework should incorporate a section that permits a medical practitioner to act to save the life of the woman in good faith without intending the death of the child the womb.*

***(d) That it is necessary to protect the physical or mental health of the woman;***

If the woman's physical health is at serious risk of harm, and the only foreseeable option is to separate the child in the womb from her, then such actions would fall under the principle of double effect as described above. However, since the principle requires that actions be proportionate, the risk of harm must be serious and with no other option available that would avoid also endangering the life of the child in the womb.

Of the hundreds of studies on abortion and the mental health of women, not one has shown abortion to have a positive effect on mental health. These studies have been summarised by Fergusson *et al*.[165] Accordingly, abortion cannot be a therapeutic action to protect a woman's mental health.

***Recommendations:***

*(18) Healthcare legislation should permit a medical practitioner to act to protect the woman from the risk of serious harm to her physical health in good faith without intending the death of the child.*

*(19) Due to the lack of any evidence supporting the proposition that abortion positively impacts a woman's mental health, there should be no provision for abortion for this purpose.*

***(e) That it is necessary or appropriate having regard to the woman's social or economic circumstances;***

The medical treatment received by a woman, or anyone else, should not be deemed necessary or appropriate based on social or economic circumstances. In order for consent to an abortion to be voluntary, the woman must be able to give or withhold that consent irrespective of social or economic circumstances. If either circumstance were to become a basis for abortion, the likely outcome is that abortion would be concentrated among the poor or minority communities, each of which is less able to access the best medical care due to those circumstances. Thus, if either social or economic circumstances become the basis for necessity or appropriateness, then the choice of the woman is supplanted and her consent is not voluntary.

***Recommendations:***

*(20) In order to provide best medical care and ensure a woman's consent is voluntary, specific grounds for lawful abortion should not include regard to the woman's social or economic circumstances.*

***(f) That the pregnancy is the result of rape or another coerced or unlawful act;***

While this is an extremely difficult matter because of the terrible wrong done to the woman, aborting the life of an innocent child in the womb cannot undo that wrong. The abortion constitutes a second act of violence which exposes the woman to the risks which arise from the procedure. In considering the three lives involved (perpetrator, woman, child in the

[165] Fergusson *et al.*, (2008) *op. cit.*

womb), the most innocent party should not receive the most severe treatment. In a powerful account, Ryan Bomberger argues for the protection of people, who like himself, were conceived by rape.[166]

Where a pregnancy is the result of rape, coercion or other unlawful acts, additional steps must be taken to protect a woman who does not seek an abortion. For example, a woman who is found to have conceived as a result of an unlawful act should not need to fear the involvement of the perpetrator in the life of any child. For this reason, any parental rights of the perpetrator should be terminated, while parental responsibilities such as child support should be provided. Further, whatever financial assistance is available for a woman as a victim of crime should be increased with respect to the impact upon her.

***Recommendations:***

*(21) There should be no specific exception for rape or another coerced or unlawful act.*

*(22) The parental rights of a perpetrator of an unlawful act that gives rise to pregnancy should be terminated in order to ensure that the voluntariness of the woman's consent is not compromised by fear of future involvement with the perpetrator.*

*(23) Where pregnancy has arisen as a result of an unlawful act, the woman should be able to receive compensation as a victim of crime. In order to ensure that any consent for the abortion is voluntary, the level of compensation should be greater if the woman elects not to terminate her pregnancy in consideration of increased financial burdens.*

*(24) A perpetrator of an unlawful act that gives rise to pregnancy should be liable to reimburse the state for any victims of crime compensation paid to the woman.*

***(g) That there is a risk of serious or fatal foetal abnormality (drawing on the terminology from the present law);***

The definition of a foetal abnormality as 'serious' or 'fatal' is a moveable standard as improvements in medical information and practice allow for the treatment or correction of conditions which were once fatal. For example, the advent of neonatal surgery allows for the correction of some medical conditions prior to birth which would have at one time constituted a serious foetal abnormality.

As noted above, in cases where there is a life-limiting foetal condition ("**LLFC**"), or where perinatal palliative care ("**PPC**") may be required, there are options available where good results have been achieved in terms of survival, function, and in the case of a LLFC, resolution of grief. Concerning advances in prenatal therapy as well as PPC, Noia notes:

> "*Scientific progress allows us to intervene on pathologies and conditions on which, until a few decades ago, any medical procedure was unthinkable.*"[167]

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[166] R Bomberger, 'I was conceived in rape. I'm the 1% which excuses 100% of abortions. *MercatorNet*, May 30 2019, see https://www.mercatornet.com/features/view/i-was-conceived-in-rape.-im-the-1-which-excuses-100-of-abortions/22512.

[167] Noia G. 'The value of life and the maternal-fetal symbiosis'

There are now options available that were not there just a few years ago. The following table from Noia's paper highlights the results that have been achieved with specific conditions.

| 10 SEVERE PATHOLOGIES AND RESULTS AT LONG FOLLOW UP | |
|---|---|
| **PATHOLOGIES DESCRIBED** | **EVOLUTION** |
| HYPOPLASTIC LEFT HEART | 73% Technical success<br>84% Survival after prenatal palliative and therapeutical treatments and postnatal surgery |
| VENTRICULOMEGALY | On 334 patients:<br>90,7% good outcome in mild pathologies<br>65,9% good outcome in severe pathologies<br>43,8% prenatal resolution of ventriculomegaly |
| SPINA BIFIDA | On 220 patients:<br>81% survival<br>77,7% normal intellectual ability<br>61,7% normal walking<br>71,3% diminished sfinteric compromission |
| RUBELLA IN PREGNANCY | On 284 (100%) patients:<br>209 (73.5%) not at risk of congenital rubella syndrome<br>75 (26.5%) theoric risk<br>of which:<br>12 (16%) real fetal-maternal transmission |
| CYSTIC HYGROMA | On 310 patients:<br>72% good evolution<br>at 25 years of follow up |
| SEVERE Rh ISOIMMUNIZATION | 90% survival with intrauterine intravascular fetal transfusion |
| CCAM | 64,3% Prenatal resolution of volume reduction<br>42,9% Postnatal resolution<br>28,6% Postnatal surgery |
| DIAPHRAGMATIC HERNIA | 44,6% Survival postnatal surgery |
| SACRO - COCCIGEAL TERATOMA | 71% Survival after prenatal palliative and therapeutical treatments and postnatal surgery |
| MEGACYSTIS | 82,3% Survival after prenatal palliative and therapeutical treatments and postnatal surgery |

With particular reference to the resolution of grief, Noia refers to the work of Heidi Cope *et al.*[168] concluding that "*the continuation of the pregnancy decreased the psychological suffering of the loss of the foetus incompatible with extrauterine life.*"

[168] Heidi Cope *et al.,* 'Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated with improved psychological outcome', *Prenat Diagn (2015)* 35(8): 761-768.

In keeping with the views of many with a disability, Noia also points to the changes needed in our health and social system with respect to how disability is seen. He notes that for many families there is "*suffering induced by a health and social system that sets up large barriers in the face of the choice to carry on a pathological pregnancy …*"

With all the advances of modern medicine we can do much better today than ever before both in terms of treating prenatal pathology and caring for children with a LLFC and their families. PPC enables parents to continue the pregnancy so as to purposefully cherish the limited time they have and to reframe their parenting goals so that they will "have no regrets".[169] When available, 37-87% of couples will choose PPC.[170] Further research is needed to identify the best model of care.[171] Literature comparing outcomes of delivery and PPC with abortion in cases of anencephaly shows significantly better mental health outcomes for women who do not abort.[172,173,174]

> *"Some months ago one of my daughters-in-law, Tania, announced at the dinner table that she was expecting again, but with a tone that caused me to look up, then to my son, and back and forth. Something was not right. "There is something wrong. They say he has trisomy 13. Do you know much about that?" I am a paediatrician who has specialised in care of very sick babies. I know a lot about trisomies, but how to share that knowledge? With tears, I am afraid.*
>
> *…*
>
> *The child was born alive in April 2013 by elective caesarean section because of previous similar deliveries. Tania was conscious. The father was present. The baby was limp and blue but breathed, and was able to be introduced to his family.*
>
> *Tania eulogised, "There was so much love in the [delivery] room. I had the privilege of holding you on my skin for 18 and a half hours. Thank you for trying your hardest to stay with us. I hope you felt and knew, while you grew inside me, and when you were born and with us, that you were and still are loved as unconditionally, as completely, and as fiercely in that short time as anyone could hope to be loved in a lifetime."*[175]

It is counterintuitive to liberalise the abortion on such grounds when the trend in medical advancements is to reduce the incidence of those grounds. This is an area which should be subject to general restrictions, lest South Australia find itself in a similar situation to Iceland which has proclaimed the end of Down Syndrome, by terminating all pregnancies that test positive for the condition.[176]

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[169] R Limbo & C Wool, 'Perinatal Palliative Care' *J Obstet Gynecol Neonatal Nurs* (2016) 45(5): 611-613.
[170] A Balaguer *et al.,* 'The model of palliative care in the perinatal setting: a review of the literature' *BMC Pediatr* (2012) 12: 25.
[171] *Ibid.*
[172] Cope *et al.*, (2015) *op. cit.*
[173] BC Calhoun, JS Reitman, and NJ Hoeldtke, 'Perinatal Hospice: A Response to Partial Birth Abortion for Infants with Congenital Defects' *Issues in Law and Medicine* (1997) 13: 125-143
[174] BC Calhoun, NJ Hoeldtke, RM Hinson, and KM Judge, 'Perinatal Hospice: Should all centers have this service?' *Neonatal Network* (1997) 16: 101-102.
[175] JS Whitehall, 'The power of 13' *Medical Journal of Australia* (2013) 199(11): 798-799.
[176] S Camarata, 'Iceland "Cures" Down Syndrome: Should America Do the Same?' *Psychology Today,* January 2 2018, see https://www.psychologytoday.com/us/blog/the-intuitive-parent/201801/iceland-cures-down-syndrome-should-america-do-the-same.

***Recommendations:***

*(25) Abortion for foetal disability or LLFC (such as anencephaly), should be prohibited.*

*(26) Expert and independent counselling about all relevant treatment options (such as intrauterine or neonatal surgery) and PPC, must be provided.*

*(27) All relevant treatment options (such as intrauterine or neonatal surgery) and PPC must be available to the woman.*

**11. *Should different considerations apply at different stages of pregnancy?***

The answers to questions 7 and 8 above are repeated.

***Recommendations:***

*(28) Recommendations (11), (12), and (13) are repeated.*

**Consultation by the medical practitioner**

**12. *Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), before performing a termination of pregnancy?***

Best medical care requires acknowledgement that medical practitioners, like anyone else, are at risk of error. Given the risks involved in an abortion procedure, and the need to ensure fully informed and voluntary consent, a medical practitioner should be required to consult with another medical practitioner prior to any abortion.

***Recommendations:***

*(29) To ensure best medical care, and that fully informed and voluntary consent has been given, a medical practitioner should be required to consult with another medical practitioner before undertaking an abortion.*

**13. *If a consultation is required, should it include:***
- ***(a) Another medical practitioner; or***
- ***(b) A specialist obstetrician or gynaecologist; or***
- ***(c) A health practitioner whose speciality is relevant to the circumstances of the case; or***
- ***(d) Referral to an appropriate counsellor; or***
- ***(e) Referral to a specialist committee?***

As set out in the answers to question 5 above, the best medical care requires a qualified medical practitioner with the appropriate skills if there is to be an abortion. As set out in the answers to question 12 above, for a consultation to have any value as an independent check to ensure that best medical care is provided to the woman, the consultation must involve a second qualified medical practitioner.

However, in order to ensure that the woman's consent is voluntary and fully informed as regards to options, a medical practitioner should also be required to refer a woman

contemplating an abortion to an independent counsellor.[177] The role of an independent counsellor would be to screen women for signs of intimate partner violence, to ensure women are aware of community based alternatives to abortion,[178] and to identify women who are at a higher risk of mental health issues post-abortion so they can be counselled in relation to options and referred to post-abortion counselling.[179] The counsellor must be independent of any abortion provider to ensure the counsellor's advice is not tainted by pecuniary interest in a health service that has as its primary or substantial purpose the provision of abortion services.

***Recommendations:***

*(30) Recommendation (29) is repeated.*

*(31) A medical practitioner should be required to refer a woman contemplating an abortion to an independent non-directive counsellor to ensure that the woman's consent is fully informed and voluntary.*

**14. *If there was a referral requirement should it apply:***
***(a) For all terminations, except in an emergency;***
***(b) For terminations to be performed after a relevant gestational limit or on specific grounds?***

The answer to question 12 above sets out that a referral should be required to a second medical practitioner in order to ensure the woman receives best medical care and provides fully informed consent. The answer to question 13 above sets out that a referral should be required to a non-directive independent counsellor to ensure any consent provided by the woman is voluntary, in the knowledge of alternatives to an abortion.

Any reduction in the standard of medical care means that a woman is not receiving the best medical care. Any reduction in the steps taken to ensure a woman is giving fully informed and voluntary consent increases the risk that any consent is not informed or voluntary. Any departure from these requirements in the case of an emergency should not be a consideration in an abortion, but rather arise from the general law which permits a medical practitioner to take certain actions in the case of an emergency.

***Recommendations:***

*(32) Best medical care and ensuring that a woman is giving fully informed and voluntary consent requires that Recommendations (29) and (31) are repeated.*

**Conscientious objection**

**15. *Should there be provisions for health practitioners in South Australia to decline to provide an abortion related service for conscientious objection?***

The preceding discussion of fully informed and voluntary consent has focused upon the woman who is contemplating an abortion. However, the issue of voluntariness must also extend to a medical or other health practitioner who engages in his or her profession in the context of his or her own thoughts and beliefs.

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[177] Legge, (2018) *op. cit.*
[178] See for example New Zealand Crisis Pregnancy Service model of Hassan *et al.,* (2014) *op. cit.*[20]
[179] I.e. counsel them to consider options other than abortion and/or seek post-abortion counselling early.

Forcing a health practitioner to participate in a procedure which he or she considers wrongful does not prohibit negative behaviour, but rather prohibits the inaction necessary for the practitioner to abide by his or her own conscience. Forcing the practitioner to participate violates his or her conscience and contradicts the protections for conscience contained in the *Universal Declaration of Human Rights*,[180] and the *International Covenant on Civil and Political Rights*,[181] both of which Australia has ratified.

***Recommendations:***

*(33) Any legislation governing abortion must protect the conscience of medical or other health practitioners by allowing them to refuse to be involved in any way in an abortion.*[182]

**16. *If a medical practitioner had a conscientious objection are there circumstances where this objection should be overridden, such as:***

***(a) In an emergency;***

***(b) The absence of another health practitioner or termination of pregnancy service within a reasonable geographic proximity.***

There has been an avenue for medical practitioners to lawfully terminate a pregnancy in South Australia for over four decades. Nevertheless, there are also medical practitioners (and others) who consider abortion to involve the killing of a child in the womb. Not a potential life, nor a mere foetus, but a human child who is entitled to live, regardless of the circumstances identified in the question.

Where a medical practitioner believes that abortion involves killing a child, it would be a gross violation of conscience to force him or her to be involved in any way.

***Recommendations:***

*(34) Any legislation governing abortion must protect the conscience of medical practitioners by allowing them to refuse to be involved, in any circumstances, in abortion.*

**17. *Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?***

For the reasons set out in the answers to questions 15 and 16 above, health practitioners who have a conscientious objection to abortion should not be required to refer a patient to a health practitioner who does not have such an objection. Further to those reasons, compulsory referral contravenes the ethical principle of cooperation and mandates the punishment, by way of deregistration, of conscientious objectors.[183]

In any event, a formal referral is not required for any medical treatment, including an abortion. South Australian clinics which provide abortion procedures accept women without a medical referral, and most such clinics are staffed by General Practitioners for whom a referral is not required. Referrals only provide for the transfer of medical information and to allow the patient to make a claim under Medicare.

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[180] See Article 18(1): "*Everyone has the right to freedom of thought, conscience and religion;…*".
[181] *Ibid.*
[182] See e.g. Americans United for Life, *Healthcare Freedom of Conscience Act: Model Legislation & Policy Guide for the 2018 Legislative Year* (2017).
[183] For example Dr Mark Hobart in Victoria, above n 121.

Finally, even among medical practitioners who will perform an abortion, there is a spectrum with regards to conscientious objection. For example, some medical practitioners will only perform an abortion for foetal abnormality, and never for social reasons. Other medical practitioners will only perform an abortion in the first trimester, and most would refuse sex-selective abortions at any stage of pregnancy. The vast majority of medical practitioners would refuse to perform a late term abortion for any reason.

***Recommendations:***

*(35) To protect the conscience of health practitioners, healthcare legislation should only require that objecting health practitioners honestly and respectfully inform patients about their conscientious objection and inability to refer for abortion or to be directly involved the abortion procedures.*

*(36) To protect the conscience of health practitioners, healthcare legislation should require that health practitioners not be professionally disadvantaged because of their objection to performing abortions.*

*(37) To protect the conscience of health practitioners and to support best medical practice through the collegial development of medical knowledge, healthcare legislation should require that health practitioners be free to discuss with others the rationale for their objection to performing abortions.*

**Counselling**

**18. *Should there be any requirements in relation to offering counselling for the woman?***

*Referral to Counselling*

Fully informed and voluntary consent can only be given for abortion where the woman is able to make that decision free from coercion, mental distress and other pressures. Just as a bank or a retirement village requires a certificate that a person has received legal advice regarding a proposed transaction from an independent solicitor, an abortion provider must require evidence that a woman has received independent and non-directive advice regarding the procedure. This requirement upholds the principle of voluntary consent.

*The Counsellor*

As set out in the answer to question 13 above, a counsellor should screen women for signs of intimate partner violence, ensure women are aware of alternatives to abortion and identify women who are at a high risk of mental health issues. Given the gravity of the matters the counselling role must address, there should be requirements in qualifications and experience in order to provide this counselling, and at present there are none. Inadequate counselling prior to a procedure is a risk factor for negative mental health effects after an abortion.

To ensure that the consent provided by the woman is voluntary, a counsellor must be independent of the health service which provides the abortion procedure. Further, a counsellor must not be concerned with promoting a particular outcome, but rather ensuring that the woman understands what is involved and has given voluntary consent. Australia's

Medicare system already provides for non-directive counselling, and audits should be conducted on a regular basis.[184]

***Recommendations:***

*(38) It should be mandated that women are offered and can receive adequate non-directive counselling through referral to an independent counsellor. Time to make a considered decision prior to an abortion should be provided for.*

*(39) Counsellors should be required to meet minimum standards of qualifications and experience to ensure they can establish that a woman is providing voluntary consent.*

*(40) Counsellors must be completely independent of services which provide for abortion.*

*(41) Counsellors must be non-directive in dealing with a woman, instead concerning themselves with the provision of information and ensuring that any consent is voluntary.*

*(42) The definition of domestic violence should be amended to include coercing a woman to have an abortion.*

*(43) Adoption laws should be reviewed to create a practical alternative to abortion. Counsellors should be required to advised a woman contemplating an abortion of adoption options.*

*(44) Healthcare legislation should require medical practitioners to obtain and show an ultrasound of the child in the womb to the woman, as a precondition to fully informed consent.*

*(45) Healthcare legislation should compel medical practitioners to advise of the risks of abortion by way of drugs.[185]*

*(46) Independent counsellors might be assisted by implementing some form of a self-evaluation for women contemplating the termination of pregnancy.*

**Protection of women and service providers and safe access zones**

**19. *Should South Australia provide for safe access zones in the area around premises where termination of pregnancy services are provided?***

***(a) Safe Access Zones are unnecessary***

Although there will remain a method by which abortion can lawfully be performed in South Australia, the practice remains a contentious issue. As with any contentious issue, the interests of those undertaking lawful behaviour and the interests of those discouraging

[184] Legge, (2018) *op. cit.* p.19.
[185] See e.g. Americans United for Life, *Abortion-Inducing Drugs Information and Reporting Act: Model Legislation and Policy Guide for the 2018 Election Year*, (2017).

behaviour they sincerely believe is harmful and should be unlawful must be carefully balanced.

Safe access zones have been implemented in other States with the intention of creating protection for women accessing abortion clinics.[186] However, there is no evidence of entrenched conflict around abortion clinics in South Australia. Rather, the main example of a presence which might be considered 'protesting' is the *40 Days for Life* campaign, whose members do not approach women entering the clinic and only provide material upon request. However, peaceful prayer is not 'protesting' for it does not involve the characteristics of political action. Rather, those offering peaceful prayers are most frequently harassed and threatened near abortion clinics, despite participants in the 40 Days for Life prayer vigil being required to sign a peace pledge.[187] Far from a problem which needs to be managed by the enactment of law, this type of activity upholds the freedom of individuals to take a reasonable non-threatening action against a practice they consider to be wrongful (despite the practice being lawful in some circumstances).

Further, such practice also supports the principle of fully informed and voluntary consent by making available to women, should they wish it, information regarding alternatives to abortion. In the absence of a requirement for non-directive independent counselling, this might be the only chance that women have to receive information from someone who does not have a pecuniary interest in an abortion clinic.

Finally, there are already laws in South Australia which address harassment. This will be considered in the answer to question 21 below.

***Recommendations:***

*(47) Safe access zones around abortion clinics should not be enacted in South Australia as they are unnecessary.*

### *(b) Difficulties with Safe Access Zones*

Interstate jurisdictions have enacted zones of a 150 metre circumference around a location providing abortion services, and prohibited a variety of activities within that zone.[188] The nature of that restriction is subject to several defects.

Firstly, the distance is far greater than is necessary to ensure a person can engage in the lawful behaviour of entering a clinic. By way of analogy, section 340 of the *Commonwealth Electoral Act 1918* (Cth) provides a limitation on certain behaviour within six metres of a polling booth.[189] This distance prohibits interference with the lawful activity of entering a polling booth with a minimal restriction upon where a person is able to express their views on a subject.

Secondly, the range of 150 metres does not consider what else might be located within that range. It is conceivable that a 150 metre zone, which imposes broad prohibitions on the distribution of information or publications about abortion, would restrict what a person could do and say within their own home if that home happened to be located near an abortion clinic. This proposal denies protection to the persons who are most frequently harassed and threatened near abortion clinics, who are people peacefully offering counsel and prayer for

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[186] SALRI Factsheet 10 – Safe Access Zones.
[187] 40 Days for Life, *Statement for Peace,* see https://40daysforlife.com/media/statement-of-peace.pdf.
[188] SALRI Factsheet 10 – Safe Access Zones and SALRI Factsheet 6 – Termination and the law in Australia: Table 1 – Regulatory approaches to termination in Australian jurisdictions.
[189] *Commonwealth Electoral Act 1918* (Cth), s 340.

the women entering an abortion clinic. The enactment of a more limited zone preserves the rights of both sides.

***Recommendations:***

*(48) If Recommendation (47) is rejected:*

*(a) safe access zones should be enacted at 6 metres in order to balance two types of lawful behaviour, being entering an abortion clinic, and*

*(b) safe access zones should only apply to public spaces, and not private property.*

**20. *If a safe zone was established should it:***
***(a) automatically establish an area around the premises as a safe access zone?; or***
***(b) empower the responsible Minister to make a declaration establishing the area of each safe access zone?***

If a safe zone is established, it should be established automatically. The alternative is to grant and non-reviewable power to a Minister to nominate zones where people's behaviour is restricted. This is an unreasonable grant of power and is easily open to abuse, such as by manipulation of the areas to silence people who hold different political views to the Minister.

Further to establishment by law rather than ministerial fiat, there must be a requirement to provide notice that the zone is in operation. Just as areas are marked where smoking is prohibited, so to should the restriction, if imposed, be clear to allow the public to comply.

***Recommendations:***

*(49) If Recommendation (47) is rejected, a safe access zone should be an area which is*

*(a) defined by legislation so that its meaning is unambiguous at law; and*

*(b) marked in public such that its presence is unambiguous to the public, to help them comply with the law.*

**21. *What types of behaviour or conduct should be prohibited in a safe access zone?***

***(a) Excluded Behaviour***

Laws in some Australian jurisdictions that make it illegal for people to offer information on the support available to women while within broad geographical zones around abortion clinics, even when that offer is made without any sort of physical or emotional harassment. It should not be a crime to offer information to people if it is done in a polite and respectful manner. Some women and couples, who were supported after contact with volunteers near an abortion clinic, have reported this was the only time they were offered a real option to continue their pregnancy.[190] The absence of this support increases the vulnerability of women to coercion to undergo an abortion, especially in the absence of a requirement for

[190]As cited in Legge, (2018) *op. cit.* p. 53 (n 85).

non-directive and independent counselling. Rather than an imposition, the principle of fully informed and voluntary consent requires that women are able to receive advice and information, and prayer, up until the conclusion of the matter.

Given the dispute regarding the role of people who offer assistance around abortion clinics, it is essential that if any behaviour is prohibited, that behaviour should be clearly defined. Further, the behaviour should only be restricted in the event that it might reasonable cause some harm recognisable to the law. The sufficiency of the offences in the *Summary Offences Act 1953* (SA) and the CLCA is a further reason that safe access zones are not required in South Australia. However, if safe access zones are enacted, then prohibited behaviour should be limited to the terms found within that legislation, as those terms have been subject to common law articulation and therefore a higher degree of objectivity in meaning.

***Recommendations:***

*(50) Recommendation (47) is repeated, as existing legislation provides sufficient criminal offences to address undesirable behaviour in this context.*

*(51) If Recommendation (47) is rejected, then prohibited behaviour within a safe access zone should be limited to those matters already defined under existing legislation, such as the Summary Offences Act 1953 (SA) and the CLCA.*

### *(b) Included behaviour*

People who offer pregnancy support to women outside of abortion clinics in a manner that is not harassing or intimidating are supporting the principle of fully informed and voluntary consent. They should not be subject to criminal penalty for mere communication of information different to that provided by the abortion clinic. As set out above, it is essential that any articulation of prohibited behaviour within a safe access zone be in a sufficiently clear and objective manner that people are aware of their obligations. Further, such prohibitions need to be limited so as to achieve their purpose, which may extend to prohibiting intimidation, but should never extend to mere communication of different information.

However, articulating in law only excluded behaviour allows for the expansion of what constitutes that behaviour. In order to ensure that there is no unreasonable imposition upon people who feel morally compelled to offer alternatives to women seeking out abortion clinics, there should be a legislatively defined list of behaviour that does not infringe any prohibitions.

For example, if safe access zones are enforced around abortion clinics, then the same legislation should articulate that offers of pregnancy support within these zones are not prohibited.

Further, legislation should identify particular “inclusion zones” (meaning ‘inclusion of choice’) where advice can be offered, to ensure all women considering an abortion have a choice right up until the time of the procedure, particularly for women who go directly to a clinic without having the opportunity to see a non-directive independent counsellor. Inclusion zones or ‘exemptions’ would be safe places for women to access independent counselling and available pregnancy support services. For example, this could be at or around a pregnancy support centre within an exclusion zone.

***Recommendations:***

*(52) If Recommendation (47) is rejected, the ''inclusion zones' or areas of exemption within these zones, should also be mandated to ensure that women are able to receive information necessary to make a fully informed and voluntary choice.*

*(53) If Recommendation (47) is rejected, the legislation should contain definitions that 'include but are not limited to' behaviour which 'for the avoidance of doubt', does not constitute prohibited behaviour, such as:*

*(a) praying;*

*(b) offering leaflets;*

*(c) asking politely and respectfully if any help is needed.*

**22. *Should the prohibition on behaviours in a safe access zone apply only during periods of operation?***

SALRI has recognised that abortion is a contentious issue. In a democratic society, people must be free to publicly discuss contentious issues without fearing that a statement made at the wrong time and place will lead to criminal sanctions. Accordingly, any restriction on what a person can communicate should be limited to achieve its purpose.

The purpose of a safe access zone relates to ensuring that woman can enter and leave an abortion clinic. There is no justification for a safe access zone to restrict any behaviour when access is not an issue. Accordingly, if safe access zone laws are enacted, it cannot apply to a particular area at all times because that would be a level of restriction unnecessary to protect the behaviour that has been declared lawful. However, it is fundamental to a fair and just society that the laws should be easy to determine, so that people can comply with them. Therefore, if safe access zone laws are enacted, it must be obvious when they are in operation, just as traffic signs make it clear to motorists when particular behaviours will be penalised.

***Recommendations:***

*(54) Laws should only restrict behaviour to the extent necessary to perform their purpose. Any safe access zone law should only apply:*

*(a) during periods when abortions are being provided; and*

*(b) when it is apparent that the restriction is in force.*

**23. *Should it be an offence in South Australia to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?***

If abortion is provided as a form of healthcare, then the law should treat this procedure in the same manner as any other medical procedure. Legal restrictions on the recording or publication of a recording the circumstances described in the question should be identical to the legal provisions applying to a person entering a hospital for any other medical procedure.

***Recommendations:***

*(55) The legal standard applicable to making or publishing a recording of a person entering or leaving any place where medical services are provided, without consent, should apply to location the premises where abortions take place. There should be no specific law in relation to this matter.*

**24. *Should it be unlawful to harass, intimidate or obstruct:***

***(a) a woman who is considering, or who has undergone, a termination of pregnancy;***

There already exist legal prohibitions upon unlawful threats,[191] unlawful stalking,[192] and causing physical or mental harm.[193] Further, there already exist legal prohibitions relating to the obstruction of public places.[194] Accordingly, every person in South Australia is already subject to laws that prevent harassment, intimidation or obstruction.

The existing offences are already subject to legal definition and refinement by way of common law. There is no need for the implementation of further legal restrictions as women, including everyone else in South Australia, are already adequately protected from these provisions in existing law.

***Recommendations:***

*(56) There exist laws to protect persons from threats and stalking for any reason. There should be no specific law enacted for this purpose as it is unnecessary.*

***(b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?***

As with the previous section, there is no reason to create a special class of laws to address this matter as existing South Australian law already addresses unlawful threats, unlawful stalking and causing physical or mental harm. There is no reason to enact specific laws to address this behaviour in relation to abortion.

Further, if there is a deficit in the current laws, there is no reason to suggest that a new law to prohibit these behaviours in relation to abortion would address that defect. It is far more likely that a specific law would be used to threaten those who oppose abortion with criminal sanction.

***Recommendations:***

*(57) As with Recommendation (56), there exist laws to protect persons from threats and stalking for any reason. There is no need to, and Parliament should not, enact a specific law in relation to this matter.*

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[191] *Criminal Law Consolidation Act 1935* (SA), s 19.
[192] *Criminal Law Consolidation Act 1935* (SA), s 19AA.
[193] *Criminal Law Consolidation Act 1935* (SA), Div 7A.
[194] *Summary Offences Act 1953* (SA), s 58.

## Collection of data about terminations of pregnancy

### 25. *Should data about terminations of pregnancy in South Australia be reportable?*

Collection of data about abortions is essential for clinical audit and practice improvement. For instance, the 2016 SA Pregnancy Outcome data showed EMA is failing to empty the uterus twelves times more often than early surgical abortion.

This is just one example of a substantial difference in outcome and relative risks of the procedures. It should inform the ongoing improvement of clinical practice. The provision of best medical care requires data to be recorded to facilitate the continual improvement of clinical practice.

***Recommendations:***

*(58) Medical practitioners should be required to report the types of risk factors which are being identified in women who are seeking an abortion, and those which have undergone an abortion, perhaps by way of a standard, state-wide, pre-abortion screening form for inclusion in the patient's file and for a de-identified version to be provided to the government to support ongoing best medical care.*[195]

*(59) Medical practitioners who fail to report proper screening should be subject to professional monitoring.*

*(60) Procedures should be adopted to hear from women who have experienced harm as a result of abortion.*[196]

## Rural and Regional Access

### 26. *Given the difficulties of access to medical services in rural areas of South Australia should there be different laws to facilitate access in rural and regional areas?*

Many rural women prefer to come to Adelaide in order to remain anonymous when terminating a pregnancy, just as some women resident in Adelaide will drive past several Adelaide hospitals in order to undergo an abortion in the Copper Triangle. The accessibility of city based abortion services for rural women is greatly increased by the PATS, which includes accommodation, and because they are given priority and same-day service at the PAC, Woodville Park.[197] Increasing the availability of abortion services to rural women primarily refers to increasing their access to Early Medication Abortion.

However, greater caution is needed when EMA is administered to remote and isolated women. Women in rural and remote areas are at greater risk of complications from EMA due to non-availability of either pre- or post-medication abortion care, or both. Pre-medication abortion care includes blood tests, clinical examination for a smear test and STI swabs, and pelvic ultrasound (to confirm viability and dates, and to exclude multiple

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[195] See e.g. Missouri Abortion Risk Factor Evaluation and Reporting Bill (HB 540) Text 1335H.01I, see https://www.house.mo.gov/billtracking/bills191/hlrbillspdf/1335H.01I.pdf.

[196] See e.g. Operation Outcry, Suggestions for Listening Session with Women Hurt by Abortion, see http://www.operationoutcry.org/2019/02/06/listening-session-information/suggestions-for-listening-session-with-women-hurt-by-abortion/.

[197] SA Health, *Patient Assistance Transport Scheme (PATS) Guidelines for Assessment* (2018) *op. cit.*

pregnancy, molar pregnancy and an ectopic pregnancy). Post-medication abortion care refers to access to 24-hour telephone advice and emergency facilities within 30 minutes of a woman's place of residence, including O negative blood (as this blood type is a universal red cell donor), and surgical management to complete the abortion or for the control of haemorrhage. The workload and stress of doctors providing EMA in rural SA will increase due to the increased number of consultations required and the need to provide emergency care for up to 2 weeks after commencing EMA. A South Australian study by Mulligan and Messenger found that women undergoing medication abortion had more symptoms (side effects) and had higher rates of emergency admissions.[198] Furthermore, offering EMA via telemedicine, so-called tele-abortion, to geographically isolated women who can't access adequate pre- and post- abortion care, is unsafe.[199]

Given the potentially fatal consequences, any derogation of the law to apply to rural and regional areas can only occur when the best medical practices are compromised.

***Recommendations:***

*(61) EMA should only be available where the woman has access to 24-hour telephone advice and will reside physically within a 30 minute drive to a site which has available:*

*(a) O negative blood; and*

*(b) surgical management of any post-EMA complications.*

*(62) There should be no difference in laws applicable to rural woman as any difference will necessarily offer rural women less than best medical practice.*

**27. *Should women be permitted to use telehealth or other electronic services to consult with medical and/or health practitioners?***

Access to information by electronic means should be allowed, but only in compliance with the best medical practice outlined above, and in ensuring that there is fully informed and voluntary consent.

Best practice is compromised in tele-medicine, as can be demonstrated from international experience, such as abortion services in Iowa in the United States of America, which have commenced this practice.[200] EMA drugs have been provided without examination or relationship with physician and usually no follow-up.[201] This is also noted to achieve more for the financial interests of abortion providers, than the interests of women.[202]

***Recommendations:***

*(63) Tele-abortion should only be available where the woman has access to adequate pre- and post-medication abortion care as described above.*

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[198] E Mulligan and H Messenger, (2011) *op. cit.*
[199] Marie Stopes Australia, 'Medical abortion by phone (teleabortion), see https://www.mariestopes.org.au/abortion/home-abortion/.
[200] Americans United for Life, *Abortion-Inducing Drugs Information and Reporting Act: Model Legislation and Policy Guide for the 2018 Election Year*, (2017) p 3.
[201] Americans United for Life, *Abortion-Inducing Drugs Information and Reporting Act: Model Legislation and Policy Guide for the 2018 Election Year*, (2017), p. 3.
[202] *Ibid.*

**28.** ***Where a woman would otherwise be able to have a termination but does not have local access to clinics able to do so (such as in rural South Australia), should another qualified health practitioner (such as a registered nurse or pharmacist) be permitted to undertake this procedure?***

Any derogation of the law to apply to rural and regional areas can only occur when the best medical practices are compromised. That would be a violation of the best medical practice principle.

***Recommendations:***

*(64) Recommendation (63) is repeated.*

**Incidental**

**29.** ***Should there be a residency requirement to access a lawful abortion in South Australia?***

A component of the best medical practice principle includes the need for follow up care. That cannot be allowed without sacrificing after care, which is a violation of the best medical practice principle.

***Recommendations:***

*(65) Given the risks of different types of abortion, as set out above, best medical care requires that if abortion is to be available, then it only be provided where it can be preceded by pre-abortion care and followed by post-abortion care.*

**30.** ***Do you have any suggestions for incidental law changes to present law and/or practice in South Australia in relation to abortion?***

***(a) Practice Improvement Mandate***

Informed consent for abortion should be obtained as per NHMRC guidelines,[203] so as to ensure that women are fully informed about the nature of their pregnancy, all of their options, and all potential complications of the procedure.

***Recommendations:***

*(66) SA Health abortion consent forms should be urgently updated to recognise the different considerations relevant to medication and surgical abortion at various gestations.[204]*

***(b) Domestic violence legislation to include coercion to terminate a pregnancy***

A woman should not be able to access a lawful abortion unless she has given voluntary consent. Where that consent has been given due to coercion from another person, the consent has not been voluntary.

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[203] NHMRC, (1993) *op. cit.*

[204] See e.g. the Southern Adelaide Local Health Network Consent to Medical Treatment form for Termination of Pregnancy.

***Recommendations:***

*(67) Domestic violence legislation should be amended to recognise that a woman who consents to an abortion under coercion from another person is a form of domestic violence.*

### *(c) Regular Audits on All Practices in Relation to Termination of Pregnancy*

Government performance audits should be conducted regularly, in relation to all practices around abortion specifically, whether performed through government health departments or in private practice. These should include an assessment against best practice guidelines and standards of care. In particular, controls should be examined around pre-abortion counselling at practices with a pecuniary interest in providing abortions. These controls should ensure independent counselling can be obtained by all women pre and post-abortion and that this meets minimum time and quality requirements. The South Australian Health Minister should work with NGOs concerned with this area of women's health to review all practices in relation to abortion.

***Recommendations:***

*(68) Government performance audits should be conducted regularly, in relation to all practices around abortion.*

### *(d) New Medicare Items for Pregnancy Support Services that provide Case-based Ongoing Care for Women encountering Problems in Pregnancy*

***Recommendations:***

*(69) That new MBS (Medicare) items be introduced for options with unexpected or problematic pregnancies, other than abortion, i.e. one-stop support services in pregnancy.*

### *(e) Review of Training of Abortion Providers to ensure Best Practice particularly in Pre-Decision Protocols and Post Abortion Follow-up*

The SA government should review the education of abortion providers (in training programs across medical colleges and in undergraduate and graduate degree curriculum) and abortion service practice models, particularly pre-decision protocols. Models should include identification and guides on ambivalence in decision-making, coercion and the process to enable informed consent - e.g. the adequacy of information provided to women on human development within the womb.

***Recommendations:***

*(70) The SA government should review the education of abortion providers (in training programs across medical colleges and in undergraduate and graduate degree curriculum) and abortion service practice models, particularly pre-decision protocols.*

*(71) Health care legislation should include 'safe-haven' laws to increase the options, other than abortion, available to a woman.*

## 31. *Are there any other comments you would like to make in relation to this reference?*

No further comment.

## VII. CONCLUSION

> *"For 45 years Robin Millhouse has carried a growing burden. It is not a secret but isn't something he talks much about. In 1969, as Liberal Attorney-General, Millhouse was the architect of radical abortion-reform laws in South Australia.*
>
> *'I deeply regret that the medical profession – and the lawyers – interpreted the law too widely,' Millhouse says today. 'It has become abortion on demand. I did not intend it to be that.'"*[205]

In the 50 years since it was enacted, South Australia's abortion law has been applied far more widely than intended. In seeking best practice legislative reform, it is critical to consider this history, the reasons for Justice Millhouse's "deep regret" and the implications of legislative reform for the wellbeing of South Australians.

This submission has been prepared on the basis of testimonials and evidence from a collective of women affected by abortion, doctors, lawyers, politicians and academics, and is based on an approach informed by the '5C' principles:

1. Care for women;
2. Care for babies;
3. Care for children in the womb;
4. Care for families; and
5. Care for life.

The five principles are considered foundational to the development of best practice legislative reform and have served as a compass in considering the questions posed by SALRI in light of international benchmarks.

### 1. *Care for women*

The need to provide the best possible care for women considering, undergoing or recovering from abortion is generally acknowledged, although less frequently is it adequately addressed with regard to its medical, social or legislative aspects. In his textbook on abortion, Hern acknowledges that "*there are few surgical procedures given so little attention and so underrated in [their] potential hazard as abortion*."[206] Further to immediate surgical hazards, research demonstrates that 30% of women undergoing abortion suffer from long term health and emotional consequences.[207]

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[205] R Jory, 'Robin Millhouse's regret', *The Advertiser* (Adelaide), August 15 2014, see https://www.adelaidenow.com.au/lifestyle/sa-weekend/robin-millhouses-regret/news-story/6b33f9d5a98843cfa747587ffb13e8b5

[206] Hern, (1990) *op. cit.*

[207] Fergusson *et al.*, (2008) *op. cit*.

*The aftermath was a numbness I hadn't anticipated. I was numb, hollow, dead, and so very heavy with sorrow. The feelings didn't 'go with time' as my delighted mother assured me they would. I grew morose, bitter, very sad, so heavy with sadness, I can't describe it… For ten years this went on. I cried every day, I stayed as drunk as I could for as long as I could, and I hated myself and everyone else.*

- *Elizabeth*[208]

Given the physical and emotional risks associated with abortion, recommendations are made with a view to best practice. These recommendations reflect the importance of fully informed consent commensurate with NHMRC guidelines, noting that informed consent could not be reasonably considered to be given unless the woman contemplating an abortion has been fully advised of all her options. Consent must also be voluntary, which is to say that it must be given in the absence of pressures such as partner coercion, mental disturbance or certain external circumstances. Fully informed and voluntary consent is critical to protecting women's rights and making them informed decision-makers about their personal health care.

*I wish I had done what I wanted to do about my pregnancy, not what everyone else wanted me to do… Now I have to live with this guilt for the rest of my life.*

- Jane[209]

A woman should have access to the best available healthcare when considering an abortion. In exercising its mandate to care for women, the government should take all measures to discourage action outside of the best possible medical care. Legislative offences currently in place in this regard should be retained.

A requirement for consultation with a second medical practitioner is an implementation of the best medical care principle. However, this should not override the need for parental consent for women under the age of 16 years, as this applies to every other medical procedure.

*At 15 years old, I was allowed to make a decision that would affect me the rest of my life. Imagine that. I couldn't drive yet, vote yet, even buy a cigarette or a lottery ticket, but I could kill my baby.*

- Christina Wong

Similarly, a medical practitioner should be required to refer a woman to an independent and non-directive counsellor for the purposes of identifying coercion and intimate partner violence, offering women with an unplanned pregnancy community-based alternatives to abortion, and screening for women who are at higher risk of subsequent mental health problems.

Women should have access to pregnancy support services and support in the vicinity of a clinic without physical impediment to entering the clinic. The choice available to women must include the option to receive advice, information and prayer in a polite and respectful manner, up until the conclusion of the matter. Although unnecessary in South Australia, a safe access zone of 6 metres around public entrances and exits is sufficient, commensurate with Australian Electoral Commission guidelines for safety and wellbeing concerns during elections, noting that the significantly larger zones implemented in other States make

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[208] M Tankard Reist, *Giving Sorrow Words: Women's Stories of Grief After Abortion* (2000) Sydney: Duffy & Snellgrove).
[209] *Ibid.*

pregnancy support services unlawful within the zones, and deny potential support to vulnerable women who have been coerced or are ambivalent about undergoing an abortion.

### 2. *Care for babies*

It has become apparent that babies born alive as a result of a failed abortion are being denied life-sustaining treatment and thus being left alone to die, both in Australia and internationally. Based on the foundational principle of care for babies, the submission outlines the legislative and ethical implications associated with an attempted abortion which results in the delivery of a living baby. The South Australian standard can be none other than that all medical providers be required to do everything necessary to sustain the life of a child who is born alive.

Survival of extremely premature infants has improved dramatically since the gestational limit for abortion in South Australia was set at 28 weeks in 1969. A child in the womb at 22 weeks after LMP of the woman (approximately 20 weeks after fertilisation) is capable of surviving ex-utero.[210] It is recommended that the viability of the child in the womb be considered in setting term limits on abortion, and that abortion for an unwanted but otherwise healthy baby capable of surviving outside the womb be prohibited. The submission notes that, in the case of a viable child in the womb who might otherwise be aborted, a Caesarean section is both the fastest method of delivery and the safest for the woman and for the baby.

> *We live in a society today where these children can be wanted children. Even if you don't want to keep this child after you've had it, there's plenty of young couples out there that want children.*
>
> - Norma McCorvey ('Roe' of *Roe v. Wade*)

With regard to available options for a child delivered under these circumstances, adoption laws should be reworked to assist in providing an alternative that serves the child's best interests. Extensive consultation should be made with 'Adopt Change' and similar organisations.

### 3. *Care for children in the womb*

> *I was quite gullible when the abortion clinic worker assured me I was not carrying a baby, but a glob of tissue. If I "took care of it," early enough, the procedure would be no different than removing a cyst, she assured me… [Later] I began to research the development of babies in the womb and what the abortion procedure actually did to them. I was horrified.*
>
> - Carmen Pate

There is considerable evidence that the child in the womb is sentient and therefore experiences pain as early as 15 weeks[211] and likely earlier still.[212,213] As such, there is an ethical obligation to provide care regarding potentially painful procedures during in-utero life. Few countries in the world allow the abortion after the first trimester, beyond which the child in the womb begins to feel pain.[214] Furthermore, most abortions occur for elective reasons

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[210] AAPLOG Statement on Post-Viability Abortion Bans (2019) *op. cit*.
[211] Sekulic *et al.,* (2016) *op. cit.*
[212] AAPLOG Fact Sheet Fetal Pain (2019) *op. cit*.
[213] D Smith & J Dabner, (1984) *op. cit*.
[214] Baglini, (2014) *op. cit*.

and the procedure also becomes more dangerous for the woman. Abortion after the first trimester should be prohibited.

Although much of the western world has adopted a liberal attitude towards the legality of the abortion (with the notable exception of recent developments in the US), there are still general restrictions that have been observed in most places, the retention of which are recommended for South Australia. These restrictions include abortion on the basis of sex-selection or disability, partial birth abortion, dismemberment of a living child in the womb and harvesting of foetal tissues. Relatedly, certain offences should exist relating to qualified health practitioners conducting abortions, given the absence of such offences would establish that a practitioner could never act improperly in this area.

### 4. *Care for family*

The *Universal Declaration of Human Rights* recognises that the family is the natural and fundamental group unit of society and is entitled to protection by society and the state.[215] As the fundamental unit of society, the family is a source of belonging and identity, in addition to care for the needs of those unable to care for themselves. Further, in the family is found financial security and support for physical and emotional health. The protection and support of the family unit therefore underlies the recommendations set out within the submission.

> *As the man in this, I felt disconnected from my wife and the pain she was going through. I didn't realize that the pill she was given was going to cause her to go into labour, the pain she would feel in the bathroom while I slept that night. The loneliness she would feel after that painful night passed and then the regret that we would both feel shortly after making this choice to end the life of our baby.*
>
> \- Manny Bello

It should be acknowledged that while a decision regarding abortion be undertaken by a woman acting independently, in reality it rarely occurs outside of the context of some degree of present (or future) familial relationships. For example, the long term health and emotional consequences of abortion on a woman have implications for her partner and other familial relationships. Furthermore, abortion carries certain risks that affect subsequent pregnancies, and therefore the health and well-being of the children who may be born.

> *The devastation and darkness of abortion stole my baby's life, my life, my joy, the health of our marriage and my mind, and a sibling from my children… The unspoken consequences of abortion are far greater than I ever could have imagined.*
>
> \- Marnie Bello

Women and their partners should be made aware of family-related risks. Counselling and other forms of assistance should be holistic in their approach, with an awareness of interpersonal familial dynamics (both positive and negative) and the value of supporting families towards healthy functioning.

### 5. *Care for life*

The prioritisation of care for women, children in the womb, babies and families stems from a personal conviction of each signatory: that human life is invaluable. Every person possesses inherent dignity and immeasurable worth. As such, respect for human life,

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[215] *Universal Declaration of Human Rights*, Article 16(3).

compassion for human suffering and an ethical obligation for providing best practice emotional and physical care are fundamental to the recommendations made.

Robin Millhouse, the Attorney-General behind South Australia's abortion reform of 1969, was not the only one to deeply regret his role in abortion legislation. Norma McCorvey, formerly known as Jane Roe, is the woman whose 1970 Supreme Court case first legalised abortion in the United States (*Roe v. Wade*). Assisted by her notoriety, Norma obtained work in abortion clinics after her Court case. Based on her learnings about the nature of abortion and its impact on women, Norma subsequently fought to reverse the result of *Roe v. Wade*.

> *At that time, I was an uninformed young woman. Today, I am a fifty-five year old woman who knows the tragedy that arose from my unsuspecting acquiescence in allowing my life to be used to legalise abortion. My personal experience with this three-decade abortion experiment has compelled me to come forward, not only for myself and the women I represented then, but for those women who I now represent.*
>
> *Working in the abortion clinics forced me to accept what abortion really is. It is a violent act which… destroys the peace and real interests of the women involved.*
>
> \- Norma McCorvey[216]

The deep regret of Norma McCorvey and Justice Millhouse serves as a sobering appeal to South Australia in considering legislative reform, and cries out for detailed consideration of the nature of 'best possible care' for women, babies, children in the womb, families and life.

[216] *Roe v Wade*, United States District Court for the Northern District of Texas, Dallas Division, Civil Action No 3.03690B and No. 3-3691C, McCorvey (aka Roe) Aff. 11 June 2003.

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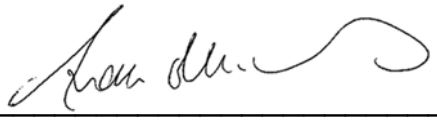

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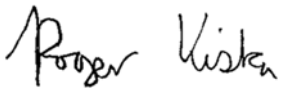

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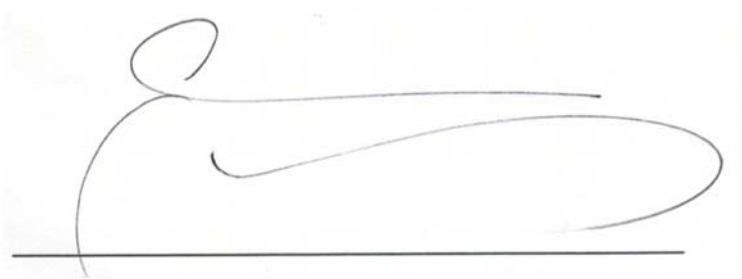

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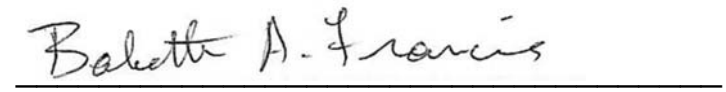

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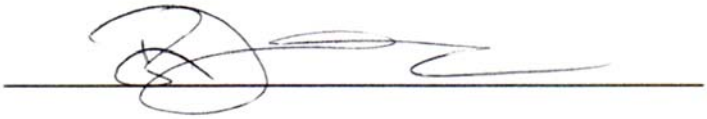

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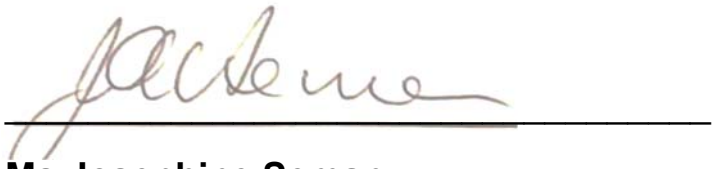

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