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Submission to the South Australian Law Reform Institute

Abortion: A Review of South Australian Law and Practice[1]

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[1] Large parts of this submission are drawn from the authors' Submission to the Tasmanian Legislative Council, Committee Government Administration A, *Reproductive Health (Access to Terminations) Bill 2013* as well as the authors' Submission to the Queensland Law Reform Commission's Review of Termination of Pregnancy Laws (February 2018).

Introduction

Abortion is the only medical procedure that is a subject of the criminal law yet is widely legally available. Although abortion is widely available, women seeking abortions face a range of barriers to access. These include financial barriers, inaccessibility and inadequacy of services, anti-abortion picketing and barriers inherent in the legislative framework. Abortion is also a medical procedure required only by women, rendering the impact of criminalisation and other barriers to access discriminatory. South Australia is to be commended for reviewing its law relating abortion.

This submission is based on research into the operation of abortion law in Australia. This includes empirical research into barriers to access to abortion and, in particular, the effect of safe access zones. In this submission, we comment on the following issues:

- The role of the criminal law
- Who should be permitted to perform or assist in performing terminations
- Early medication abortion and current medical practices
- Gestational limits and grounds
- Consultation by the medical practitioner
- Conscientious objection
- Protection of women and service providers and safe access zones
- Rural and Regional Access
- Maintaining abortion services within the public health system.

The role of the criminal law

The debate around access to abortion remains coloured by intractable and passionately held views. Yet abortions are a fact of human existence. And while for many people the morality of abortion may be shrouded in shades of grey, from a public health perspective the issue is black and white – the accessibility of abortion is a precondition to securing women's right to health. After all,

> *[w]omen have always had abortions and will always continue to do so, irrespective of prevailing laws, religious proscriptions, or social norms. Although the ethical debate over abortion will continue, the public-health record is clear and incontrovertible: access to safe, legal abortion on request improves health.*[2]

While the number of unwanted pregnancies can be reduced through education and access to sexual health services, restrictive abortion laws do not erase the universal reality that a large number of women seek to terminate pregnancies every year. Unsafe abortion accounts for 13% of maternal deaths worldwide, with some 47,000 deaths annually.[3] Women living in countries in which abortion is prohibited or available on the most narrow grounds have statistically lower levels of sexual and reproductive health and are in greater danger of complications resulting from unsafe or self-induced abortions.[4] A majority of unsafe abortions are performed in developing countries with restrictive abortion laws and a lack of quality abortion services. The World Health Organisation has observed that

[2] D A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, 1917 (citations omitted).
[3] World Health Organization, *Facts on induced abortion worldwide,* January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html
[4] D A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908.

unsafe abortion is the cause of serious complications and disability for millions of women each year and a major public health concern which has grown in urgency and significance.[5]

South Australia's health system may appear far removed from the developing countries in which the majority of unsafe abortions take place. Yet maternal mortality and morbidity resulting from unsafe abortions flows from the 'universal risk factor' which is 'simply the fact of being female.'[6] The maintenance of unclear and uncertain criminal provisions criminalises and stigmatises women and doctors and compromises access to health services. Unsafe abortion is no longer commonplace in Australia, but a study of Australian history a mere 40 years ago reveals a very disturbing picture of systemic failure to deliver fundamental rights to women.[7] As long as abortion remains within the ambit of the criminal law, the health and rights of women will remain vulnerable.

It should be noted that the decriminalisation of abortion will not result in an increase in the number of abortions. The World Health Organisation has found that restrictive abortion laws are not associated with lower abortion rates. In contrast with Western Europe where abortion is permitted on broad grounds and the abortion rate is low, Latin American countries tend to have highly restrictive abortion laws and a relatively high number of abortions.[8] The liberalisation of abortion law has furthermore been associated with significant advances in health and well-being.[9]

Reproductive health is fundamental to women's health and wellbeing. With reference to a study published in The Lancet in January 2012,[10] the journal's editor, Dr Richard Horton made the following observation:

> *Abortion is a subject nobody wants to talk about... abortion is ignored, marginalised, stigmatised, and yet it is absolutely central to the health of women worldwide… It's time for a public health approach that emphasises reducing harm, and that means more liberal abortion laws.'* [11]

In Australia, recent years have seen a widespread acceptance of the view that abortion should be decriminalised, with decriminalisation legislation being passed in the ACT, Victoria, Tasmania, Northern Territory and Queensland. By keeping abortion within the purview of the criminal law, South Australia is out of step with this move towards classifying abortion as a health issue rather than an issue for the criminal law.

Access to reproductive health services is fundamental to women's health and in the 21st century should be regulated as a health matter and not as a matter of criminal law. Therefore, **we submit that abortion should be decriminalised and that a woman should not be criminally responsible for the**

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[5] WHO, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, Sixth Edition, 2011 at 31.
[6] R Cook, 'International Protection of Women's Reproductive Rights' (1992) 24 *NYU International Journal of Law and Politics* 545- 727 at 647.
[7] J Wainer (ed) *Lost: Illegal Abortion Stories* (Melbourne University Press, Melbourne, 2006).
[8] World Health Organization, *Facts on induced abortion worldwide,* January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html
[9] World Health Organization, *Facts on induced abortion worldwide,* January 2012 at http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion_facts/en/index.html
[10] G Sedghet al, 'Induced abortion: incidence and trends worldwide from 1995 to 2008' (2012) 379 *The Lancet* 625.
[11] ABC News, A Simmons 'Rise of unsafe abortions 'deeply disturbing', 19 January 2012 at http://www.abc.net.au/news/2012-01-19/rise-of-unsafe-abortions-27deeply-disturbing27/3782702

termination of her own pregnancy. Abortion should be treated by law as a health issue and not a criminal justice issue.

Who should be permitted to perform or assist in performing terminations[12]

We submit that the increase in early medication abortion necessitates expansion of acceptable providers.

The availability of early medication abortion in Australia has a convoluted and controversial history. The drug Mifepristone, also known as the abortion pill RU486, has been available in France since 1988 and has subsequently been registered in around 50 countries. It is also on the World Health Organisation's list of essential medicines.[7] Nevertheless, its availability in Australia has been slow and incremental.

It was not until recently when a company established by Marie Stopes International Australia applied to the Therapeutic Goods Administration (TGA) seeking registration of RU486, and seeking permission to sponsor the drug, that early medication abortion became more widely available to Australian women. Finally, in August 2012, the TGA approved the Marie Stopes application and included Mifepristone on the Australian Register of Therapeutic Goods. This decision means that RU486 can be prescribed in Australia by registered medical practitioners in general, as opposed to only those who have been authorised to prescribe the drug through the Authorised Prescriber process. In June 2013, RU486 was included in the Pharmaceutical Benefits Scheme, enhancing its affordability.

The increasing acceptance of early medication abortion amongst the medical and general community has meant that a growing number of General Practitioners are willing to prescribe the drugs and assist their patients through the process. Therefore, **we submit that when considering who should be permitted to perform or assist in performing terminations, reference be made to appropriately qualified practitioners with a view that different qualifications will be required for the administration of early medication abortion as against a surgical abortion.**

Early medication abortion and current medical practices

South Australia's laws pre-date the developments outlined above concerning the availability of early medication abortion and are inconsistent with current medical practice. While early medication abortion provides an important alternative to surgical abortion, it is (like surgical abortion) subject to the requirements that it be 'carried out in a hospital' and assessed and approved by two medical practitioners.

Early medication abortion requires the administration of mifepristone and misoprostol over a period of around 48 hours. The current law operates as a significant barrier to access, particularly for women in rural and regional areas. A consequence of the 48 hour period over which the medication is administered is that women must present for two hospital visits. This is a significant challenge for women living outside metropolitan areas who must travel significant distances to access hospitals. Therefore, these requirements raise concerns about accessibility, cost and safety.

[12] This section is in part drawn from: R Sifris, 'The Legal and Factual Status of Abortion in Australia' (2013) 38(2) *Alternative Law Journal* 108.

In other jurisdictions, early medication abortion has been carried out safely by general practitioners and via telemedicine. The current legislation imposes requirements which serve no legitimate purpose and operate to limit access to early medication abortion. **We submit that the legislation should be amended to remove the requirement that early medication abortion by carried out in a hospital and approved by two doctors.**

Gestational limits and grounds

Abortion is available "on request" in a number of Australian jurisdictions: In Victoria up to 24 weeks gestation;[13] in Western Australia up to 20 weeks gestation;[14] in Tasmania up to 16 weeks gestation,[15] in the Northern Territory up to 14 weeks gestation[16] and in Queensland up to 22 weeks gestation.[17] Only the ACT imposes no gestational limit on a woman's ability to access abortion services without seeking the approval of a medical practitioner. This is because the ACT, after decriminalising abortion in 2002, included the regulation of abortion in the *Health Act 1993* (ACT) and in doing so reframed the lens through which abortion is viewed from a criminal offence to a health issue.[18] Therefore, as with other forms of medical treatment, the specific approval of a medical practitioner is not required for a termination of pregnancy to be performed and "abortion on request" is theoretically legally available with no gestational limit.

We urge South Australia to follow the example of the ACT and to refrain from imposing a gestational limit or specific grounds for abortion. Such an approach would enable abortion to be managed in the same way as any other medical procedure – with informed consent and professional willingness rather than period of gestation being the primary consideration. Period of gestation is in itself a somewhat arbitrary means of regulating access to abortion as 'measures of gestational age are at best professional estimates, and are routinely off by one or two weeks, especially later in pregnancy.'[19] In addition, many temporal restrictions on access to abortion which are ostensibly based on health and safety concerns for the woman are arbitrary and do not withstand an evidence-based approach.[20]

Further, when the law treats abortion differently to other medical procedures by imposing gestational limits and grounds, it essentially stigmatises abortion by casting such procedures in a deviant light. Brenda Major and Richard Gramzow researched the effect of the stigmatising aspect of abortion. They found that women who felt stigmatised by abortion were more likely to feel a need to keep it a secret from family and friends. Secrecy was related positively to suppressing thoughts of the abortion, and negatively to disclosing abortion-related emotions to others. Greater thought suppression was associated with experiencing more intrusive thoughts of the abortion. Both suppression and intrusive

[13] *Abortion Law Reform Act 2008* (Vic) s 4.
[14] *Health Act 1911* (WA) s 334.
[15] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4.
[16] *Termination of Pregnancy Law Reform Act 2017* (NT).
[17] *Termination of Pregnancy Act 2018* (Qld) s 5.
[18] See above discussion regarding the need to approach abortion as a health issue and not a criminal justice issue.
[19] J N Erdman, 'Theorizing Time in Abortion Law and Human Rights' (2017) 19(1) *Health and Human Rights Journal* 29 at 32.
[20] J N Erdman, 'Theorizing Time in Abortion Law and Human Rights' (2017) 19(1) *Health and Human Rights Journal* 29 at 34.

thoughts, in turn, were positively related to increases in psychological distress over time.[21] In general, it seems that stigmatisation gives rise to increased risk of numerous health problems, including depression, hypertension, coronary heart disease, and stroke.[22] Consequently, if it is accepted that the law plays a role in exacerbating or removing social stigma, then it must be accepted that the creation of a different regulatory regime for abortion as compared with any other medical procedure exacerbates the stigma attached to abortion. Further, if it is accepted that individuals who feel stigmatised suffer negative health consequences as a result of such stigmatisation, then it must be accepted that there is a connection between legal restrictions on accessing abortion and negative health sequelae. It should be noted that such stigma and its negative health consequences attach not only to patients but also to clinicians who participate in pregnancy terminations; thus Joanna Erdman notes that such clinicians may feel 'professionally marginalized and socially isolated'.[23]

We therefore believe that the South Australian legislature should follow the approach of the ACT and remove any gestational limit for "abortion on request". At the very least, we recommend that South Australia bring its legislation in line with that of Victoria which imposes a gestational limit of 24 weeks for "abortion on request".[24]

Consultation by the medical practitioner

It is submitted that the decision to terminate a pregnancy should rest with the woman alone – it should be the woman's decision and not that of her doctors. Therefore, a medical practitioner should not be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy.

The current law requires that surgical or medical abortion may only be conducted in a prescribed hospital after examination and certification by two legally qualified medical practitioners.

Consultation requirements create a situation in which the medical profession is empowered to determine whether an individual woman is able to access abortion services. By adopting such an approach, doctors become the gatekeepers to legal abortion; it is doctors rather than pregnant women who are empowered to determine whether a pregnancy may be terminated. Such an approach entrenches the power imbalance between women and their doctors, removes from women the ability to decide what is in their own best interests, and renders women beholden to the medical profession for allowing them to access abortion services. Thus Sally Sheldon makes the point that, by giving such power to the medical profession, the law constructs 'women seeking abortion as supplicants, who must go cap in hand to request permission to terminate their pregnancies. Refusals

[21] B Major and R H Gramzow, 'Abortion as Stigma: Cognitive and Emotional Implications of Concealment' (1999) 77(4) *Journal of Personality and Social Psychology* 735. See also D A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, 1914 on the link between stigma related to abortion and negative health consequences.
[22] B Major and L T O'Brien, 'The Social Psychology of Stigma' (2005) 56 *Annual Review of Psychology* 393.
[23] J N Erdman, 'Theorizing Time in Abortion Law and Human Rights' (2017) 19(1) *Health and Human Rights Journal* 29 at 36.
[24] *Abortion Law Reform Act 2008* (Vic) s 4.

may result in women carrying unwanted pregnancies to term; they will certainly result in later terminations'.[25]

Further, a requirement for consultation may exacerbate the challenges already faced by women who live in rural and remote areas. For such women, it may be difficult to find one doctor willing to assist with a termination of pregnancy; finding more than one doctor may prove practically impossible and therefore may pose a significant barrier to access.

Conscientious objection[26]

In Tasmania, Victoria, the Northern Territory and Queensland, doctors with a conscientious objection may refuse to participate in an abortion but the law imposes what has become known as an "obligation to refer" to a doctor without such a conscientious objection.[27] The one exception to the provisions allowing a doctor with a conscientious objection to refuse to participate in an abortion involves emergency circumstances.[28] This specific issue was propelled into the global spotlight in October 2012 when a 31-year-old dentist who was 17 weeks pregnant, sought treatment at a hospital in Ireland. Despite the fact that she was having a miscarriage and the foetus had no chance of survival, the hospital refused to terminate the pregnancy while a foetal heartbeat remained. By the time the abortion was eventually performed, days after she presented to the hospital, she had contracted septicaemia and died as a result.[29] This tragedy demonstrates that in the year 2012 it was possible for a woman to walk into a first-world hospital in Western Europe and be denied a potentially lifesaving abortion. It demonstrates the importance of abortion legislation containing a provision which requires doctors to perform an abortion in an emergency situation.[30] **We submit that conscientious objection should not be permissible in an emergency situation.**

It is clear that many doctors who conscientiously object to abortions possess a sincere, deeply held belief in the immorality of abortion. In Australia, provision for doctors to conscientiously object to participating in an abortion has been relatively uncontroversial. The lion's share of the controversy that has arisen in connection with the issue of conscientious objection has stemmed from laws imposing what has become known as an "obligation to refer". This issue raises the question of how, in a democratic society, a doctor's right to conscientious objection should be balanced against a

[25] S Sheldon, 'The Law of Abortion and the Politics of Medicalisation' in J Bridgeman and S Millns (eds), *Law and Body Politics* (Dartmouth Publishing Company Limited, Hants, 1995) 105 at 119.

[26] This section is drawn from: R Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act* 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900.

[27] *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6-7; *Abortion Law Reform Act 2008* (Vic) s 8; *Termination of Pregnancy Law Reform Act 2017* (NT) s 11; *Termination of Pregnancy Act 2018* (Qld) s 8.

[28] See *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6 (where emergency includes threat to life or risk of serious physical injury); *Abortion Law Reform Act 2008* (Vic) s 8 (where emergency refers to threat to life); *Termination of Pregnancy Law Reform Act 2017* (NT) s 10 (where emergency refers to threat to life); *Termination of Pregnancy Act 2018* (Qld) s 8.

[29] D Dalby, 'Hospital Death in Ireland Renews Fight Over Abortion', *The New York Times* (14 November 2012), http://www.nytimes.com/2012/11/15/world/europe/hospital-death-in-ireland-renews-fight-over-abortion.html.

[30] It should be acknowledged that there is often difficulty in determining with certainty whether in a given situation a woman's life is truly at risk. This means that in practice a doctor who opposes abortion may actually wait until it is too late and then claim that the obligation did not arise because it was not clear that the woman's life was at risk. See C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 14.

woman's: right to life; right to health; right to privacy and autonomy; right to equality and freedom from discrimination; and right to be free from torture or cruel, inhuman or degrading treatment or punishment. Here, we focus on a woman's right to health as this right is directly referential to a doctor's ethical obligation to prioritise a patient's health and wellbeing.[31]

At one end of the spectrum is the view that the right of a patient to receive timely and effective health care should at all times be paramount. Those who support this view argue that the potential negative consequences for women of a doctor's conscientious objection to abortion render it impossible to balance the rights of doctor and patient; they argue that respect for a doctor's conscientious objection invariably results in an infringement of women's rights. This position is to some extent reflected in Sweden, for example, where conscientious objection to abortion is not permitted under law.[32] Thus pursuant to this approach, the beliefs of individual doctors should never trump the health and wellbeing of people in need of a medical service.[33] At the other end of the spectrum is the view that doctors should not only be allowed to refuse to provide abortion services or provide any information about abortion services, they should be allowed (or even required) to actively discourage women from terminating their pregnancies. This position is reflected in the laws of a number of jurisdictions in the United States. A key motivation behind these laws is to dissuade women from accessing abortion services.[34]

In addition to the views occupying either end of the spectrum, there are also various positions that fall somewhere on the spectrum. One such position is the position that has been adopted in Tasmania, Victoria the Northern Territory and Queensland, that is, a doctor with a conscientious objection to abortion may refuse to participate in the procedure but must direct the patient to a practitioner without such a conscientious objection. While this position appears to go beyond the requirements of the Australian Medical Association's *Code of Ethics*,[35] it closely reflects the position adopted in a number of other countries[36] as well as other ethical codes and guidelines of the medical profession itself. For example, in its *Rights-Based Code of Ethics*, the International Federation of Gynecology and Obstetrics states that a doctor has a right to conscientious objection but that in such circumstances a patient has a right to be referred to a doctor without such a conscientious objection. The Code directs that members should:

> [a]ssure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to

[31] For an analysis of restrictions on abortion as a violation of the right to health, see R Sifris, 'Restrictive Regulation of Abortion and the Right to Health' (2010) 18(2) *Medical Law Review,* 185.
[32] See A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 91; A Heino et al, 'Conscientious Objection and Induced Abortion in Europe' (2013) 18 *European Journal of Contraception and Reproductive Health Care* 231.
[33] C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 18.
[34] See, for example, Center for Reproductive Rights, *2012: A Look Back* (2013), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/USLP_endofyear_Report_1.9.12.pdf.
[35] The *Code of Ethics*, as revised in 2016, states that: "If you refuse to provide or participate in some form of diagnosis or treatment based on a conscientious objection, inform the patient so that they may seek care elsewhere. Do not use your conscientious objection to impede patients' access to medical treatments including in an emergency situation" See: https://ama.com.au/system/tdf/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016.pdf?file=1&type=node&id=46014.
[36] See, for example, A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 107.

> procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.[37]

The World Medical Association's *Declaration on Therapeutic Abortion* also affirms the obligation to refer. It states that:

> If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw, while ensuring the continuity of medical care by a qualified colleague.[38]

Similarly, the World Health Organization has stipulated that:

> Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health care facility, in accordance with national law.[39]

Thus it seems that, despite the significant controversy which the obligation to refer has provoked in Australia, it is in fact a position that has been adopted by a number of respected organisations representing the health-care and medical community on a global scale. It seems that there is a widely adopted view within the health-care community that good medical care requires continuity of care. This sentiment is reflected at the local level in the *Code of Ethical Practice* of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which states that:

> [d]octors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if … the therapy required is in conflict with the doctor's personal belief/value system.[40]

Thus the imposition of an obligation to refer seems like a reasonable way to balance the rights of a doctor against the rights of a patient; it also seems to be an approach which is adopted by a number of key medical organisations both locally and globally. **We submit that South Australia should adopt an obligation to refer provision similar to that which exists in Victoria, Tasmania, the Northern Territory and Queensland.**

The question nevertheless arises, what should be the approach in areas where the doctor with a conscientious objection is the only doctor within a reasonable geographical proximity of the patient, rendering the obligation to refer of little practical utility should a woman not be in a position to travel. We strongly urge the Law Reform Institute to give serious thought to this issue and to the plight of women who may have no point of access to services.

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[37] International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003), http://www.figo.org/sites/default/files/uploads/wg-publications/wsrr/Rights-Based_%20Code_of_Ethics_October%202003%20-%20Copy%20-%20Copy.pdf.

[38] World Medical Association, *Declaration on Therapeutic Abortion*, a*dopted by the 24th World Medical Assembly, Oslo, Norway, August 1970* (*amended by the 35th World Medical Assembly, Venice, Italy, October 1983; 57th WMA General Assembly, Pilanesberg, South Africa, October 2006),* http://www.wma.net/en/30publications/10policies/a1/.

[39] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed, 2012) at 69.

[40] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Code of Ethical Practice* (2006) at 6.

Protection of women and service providers and safe access zones

Legislation providing for safe access zones around clinics which provide abortion services has been introduced in the majority of Australian jurisdictions, namely Tasmania, the Australian Capital Territory, Victoria, Northern Territory, Queensland and New South Wales.[41]

The authors of this submission have conducted semi-structured, in depth interviews throughout Australia with people able to comment on the effects of anti-abortion picketing outside clinics and effectiveness of safe access zones.[42] This research was extensively quoted by Justice Nettle in the recent High Court decision of *Clubb v Edwards; Preston v Avery*[43] in which the High Court upheld Victoria and Tasmania's safe access zone legislation. **The general consensus among our interviewees is that the activities of anti-abortionists outside clinics is harmful to both patients and staff who work at clinics and that safe access zones go a long way towards helping combat this problem.**

Anti-abortionists frequently describe themselves as sidewalk counsellors seeking to render assistance to women.[44] This characterisation differs markedly from what we heard from interviewees who spoke of their unwelcome intrusions into the personal space of patients and staff. Examples of anti-abortionists' conduct provided to us include:

- approaching, following or walking alongside people approaching clinic premises;
- dispensing brochures or plastic foetal dolls;
- displaying posters with distressing words or images, such as photographs of dismembered foetuses;
- castigating patients and staff as murderers;
- chasing, photographing, heckling, threatening and verbally abusing patients and staff;
- preventing patients from exiting their cars or obstructing clinic entrances.

Clinic staff spoke of pervasive concerns about the anti-abortionists' unpredictable behaviour. One interviewee perceived 'the physical threat' of harm as 'imminent'[45] and expressed safety concerns about anti-abortionists purporting to be patients, as described here:

> My biggest fear was they were going to send up a plant, and the plant would come and see me…and something would happen, or they would expose me, or target where I live, or target the kids. Because they'd done that with other doctors…. What am I going to do if … I all of a sudden think shit, you're a plant, or you've got an ulterior motive. That was my number one

[41] See *Reproductive Health (Access to Terminations) Act 2013* (Tas), *Health (Patient Privacy) Amendment Act 2015* (ACT), *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic); *Termination of Pregnancy Law Reform Act 2017* (NT) Part 3; *Termination of Pregnancy Act 2018* (Qld); *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018* (NSW).

[42] For an in-depth discussion of the Victorian component of this research see: Ronli Sifris and Tania Penovic, 'Anti-abortion protest and the effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 *Monash University Law Review* 317 (special issue on the law of protest).

[43] [2019] HCA 11 para 281.

[44] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017; Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) at 107.

[45] Interview with a nurse practitioner and midwife working in reproductive health, 27 March 2017.

> fear. I don't care about being slandered or things like that. It was more a safety threat. Or that they would target my house, or my kids ...will there be any physical harm out of this? Are they going to target my car when I come to work?[46]

The picketing of clinics by anti-abortionists has frequently had a negative impact on staff and patients entering and leaving clinics which provide abortion services. Such activities not only invade the privacy of women who are already in a vulnerable situation, they also undermine their health and well-being. For example, the conduct of anti-abortionists stigmatises abortion and the women seeking to terminate a pregnancy. In our interview with Susie Allanson, former clinical psychologist at the East Melbourne Fertility Control Clinic, we were told of the importance of a supportive environment for patient well-being and the deleterious impact of an unsupportive or discriminatory environment.[47] Similar views were expressed by a social worker, who told us that evidence-based research has consistently found that the impact of an abortion should not be traumatic, long lasting and negative but that there are risk factors which contribute to negative consequences and these include stigma, misinformation, shame and guilt, all of which are associated with the picketing of clinics.[48] This risk is particularly high for women with a history or sexual or physical violence or other vulnerabilities.[49] Picketing activity outside a clinic in Albury, New South Wales, was reportedly been linked with teenage girls engaging in self-harm and attempted suicide.[50]

Our interviews have revealed that generally speaking, safe access zones are achieving their objectives of protecting the right of patients and staff to privacy, facilitating safe access to health services without fear and reducing misinformation and stigma. This is particularly the case in Victoria where anti-abortion picketing has historically been more of an issue than in Tasmania.[51] Of the thirteen health professionals we spoke to in Victoria, all took the view that the zones were operating to distance anti-abortionists from clinics and prevent them from targeting individuals. The activities of anti-abortionists have accordingly been de-individualised; sending 'a wonderful positive message … that society won't condone that sort of behaviour' targeted at women accessing health services.[52]

Safe access zones do not prevent anti-abortionists from expressing their views. They impose limitations within a tailored geographic space, operating to ensure that anti-abortionists do not engage in targeted harassment and abuse. Safe access zones protect human rights. They protect the privacy, safety and dignity of women seeking health care services and staff requiring access to their workplace. They prevent human rights abuses, including acts of gender-based violence.[53]

South Australia and Western Australia are the only Australian jurisdictions where these activities are not proscribed by law. We have spoken with health professionals in South Australia and understand that the picketing of clinics, which intensifies in the lead-up to Easter and Christmas, is an ongoing

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[46] Interview with a nurse practitioner and midwife working in reproductive health, 27 March 2017.

[47] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017.

[48] Interview with a social worker, Melbourne, 20 March 2017.

[49] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, 22 March 2017.

[50] M Davey, 'Albury's only abortion clinic: protests "push women to point of self-harm"' 9 December 2014 *The Guardian* at https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide

[51] Interview with a social worker, Melbourne, 20 March 2017.

[52] Interview with a social worker, Melbourne, 20 March 2017.

[53] See generally Tania Penovic and Ronli Sifris, 'Expanding the feminisation dimension of international law: targeted anti-abortion protest as violence against women' (2018) 7(2) *Cambridge International Law Journal* 241.

problem for staff, patients and others seeking access to premises in which abortions are provided. As in other jurisdictions where clinics have been picketed by anti-abortionists, these activities have caused significant anxiety and distress and have stigmatised and shamed women seeking abortions.

Accordingly, we submit that South Australia should introduce safe access zone legislation which is modelled on the Victorian legislation. We would be happy to provide the Institute with further information about our research findings.

Rural and Regional Access

Throughout Australia, geography poses a significant barrier to access. For example, in Tasmania, there is a lack of public provision of abortion and, following the closure of clinics in both Launceston and Hobart, there is now only one private provider of surgical abortion services in that State, located in Hobart.[54] Therefore, women who are located in the North West of the State (for example) have to either travel to Hobart or interstate to access a surgical abortion. Similarly, there are areas of regional and remote Queensland which are completely lacking in abortion providers. So too in South Australia there are difficulties accessing abortion in certain rural areas. As discussed above, it is increasingly common for General Practitioners to oversee early medication abortions. In areas where specialists and / or hospitals are few and far between this may be the best option for women. It may also be appropriate for other qualified health practitioners to be permitted to oversee such a termination. In addition, as stipulated above, in areas where the doctor with a conscientious objection is the only doctor within a reasonable geographical proximity of the patient, we strongly urge the Law Reform Institute to give serious thought to whether (and if so in what circumstances) conscientious objection should be permitted.

There is also a link between financial and geographic barriers to access. For example, women living in rural or remote areas who need to travel to access abortion services will often face additional costs, such as transportation and accommodation costs, which add to the existing burden of overcoming barriers of distance.[55] Further, financial and geographic disadvantage often compound other forms of disadvantage, leading to presentation at a clinic at a later stage of gestation and the additional costs and potential complications that accompany abortion at such a later stage of gestation.[56] Thus forms of disadvantage compound, resulting in multiple barriers to access. **Accordingly, we submit that consideration should be given to increasing the availability of abortion in rural areas and of early medication abortion in areas where it may be the only option; financial barriers to access should be addressed alongside geographical barriers, though it should be acknowledged that South Australia has a strong history of providing public funding for abortions.**

[54] Gina Rushton, 'Tasmania's main surgical abortion provider has shut up shop' *BuzzFeed* (12 January 2018).

[55] Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, *Inquiry in laws governing termination of pregnancy in Queensland* (August 2016) 73.

[56] See for example Mridula Shankar et al, 'Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-Sectional Study' (2017) 41(3) *Australian and New Zealand Journal Public Health* 309.

Keeping abortion within the public health system

The provision of abortion services in South Australia has been located within the public health system. **While aspects of the state's abortion laws require modernisation, the provision of abortions in the public system is one aspect of South Australia's medical system that should not change.**

In other jurisdictions, where public abortion services are more limited, the cost of the procedure has constituted a barrier to access. In combination with the costs of transportation and accommodation, the costs of obtaining an abortion have resulted in women delaying medical procedures and not obtaining the care they require. By providing abortions within the public health system, South Australia provides a valuable health care paradigm, with public healthcare services freely available to women. While we are not opposed to abortions being provided within the private system, **we submit that abortions should remain within the public health system.**

Conclusion

We submit that South Australia should reform its laws so as to decriminalise abortion and remove other barriers to access while keeping abortion within the public health system. This would be a significant symbolic statement of the value that the State places on women's health and women's rights more broadly. It would also be significant from a practical perspective as it would enhance women's ability to procure a medical service that only women require.