

# Chapter 3 Current Clinical Practice

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# Current Clinical Practice



### OVERVIEW

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

### INCIDENCE OF ABORTION

- 3.4 A 2007 study by the Guttmacher Institute New York and the World Health Organization of worldwide estimates of the rate of induced abortions shows a decrease in recent years. In 1995 the estimate was 35 abortions per 1000 women aged 15–44 years, decreasing to 29 per 1000 in 2003.<sup>3</sup> The decrease was most marked in developed countries, particularly in the former Soviet Union, and coincided with substantial increases in contraceptive use in the region.<sup>4</sup>
- 3.5 The study notes that unintended pregnancy is the cause of abortion. Every year 51 million unintended pregnancies in developing countries result from women not using contraception, with a further 25 million occurring because of incorrect or inconsistent use of contraception, or method failure.<sup>5</sup> It states that meeting the need for contraception and improving the effectiveness of use 'are crucial steps toward reducing the incidence of unintended pregnancy'.<sup>6</sup>
- 3.6 Rates in jurisdictions similar to Australia in 2003 vary from 15 per 1000 women in Canada, to 17 in England and Wales, and 21 in the US and New Zealand.<sup>7</sup>
- 3.7 Accurate rates for Australia are difficult to come by. A 1990 study estimated the rate of abortions at 19.6 per 1000 women, and the number just below 80 000.<sup>8</sup> The Guttmacher study estimates that Australia's rate in 1996 was 22 abortions per 1000 women, and that it decreased to 20 by 2003.<sup>9</sup>
- 3.8 The Australian Institute of Health and Welfare's (AIHW) National Perinatal Statistics Unit analysed data from Medicare and the National Hospital Morbidity Database to produce estimates of abortion in Australia in 2003 and 2004.<sup>10</sup> It estimated the overall number of abortions in Australia in 2003 at 84 218 and the rate at 19.7 per 1000 women aged 15–44 years.<sup>11</sup> In 2004 the estimated number was 83 210 and the rate 19.3 per 1000 women aged 15–44 years. The estimates were obtained by combining data from the two sources, with different methodologies used for each state to take account of different inclusions or exclusions of procedures, and different legislation. The rate of abortion has changed little since 1990.
- 3.9 The AIHW reports also provide data for each state and territory. In 2003 the estimated number of abortions in Victoria was 19 896 and the rate 18.5.<sup>12</sup> In 2004 the estimated number was 20 772 and the rate 19.1.<sup>13</sup> In both years the Victorian rate was below the national rate. The AIHW data provides breakdowns for each year and these are consistent. In each year women aged 20–24 have the highest rate of abortion and the majority of abortions occur in women aged 20–34.<sup>14</sup>
- 3.10 In Victoria data is collected by the Department of Human Services (DHS) from every public and private hospital and day procedure centre—this is known as the Victorian Admitted Episode Dataset (VAED). DHS provided VAED data on abortions to the commission.<sup>15</sup> The DHS data

shows both lower rates and lower numbers of abortion than the AIHW study. In 2003/04 the estimated number was 19 350, dropping to 18 756 in 2006/07. A national study in 1996 reported 21 603 abortions in Victoria, which may indicate that the number of abortions is falling,<sup>16</sup> but we cannot draw this conclusion from these two data sets as they are unlikely to be directly comparable. The DHS data shows the rate dropping from 17.94 in 2003/04 to 16.95 in 2006/07.<sup>17</sup>

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

*unrestrictive abortion laws do not predict a high incidence of abortion, and by the same token, highly restrictive abortion laws are not associated with low abortion incidence. Indeed, both the highest and lowest abortion rates (worldwide) were seen in regions where abortion is almost uniformly legal under a wide range of circumstances.*<sup>18</sup>

- 3.12 Rather, the rate of abortion is related to the rate of unplanned pregnancy, and the availability and use of contraception.<sup>19</sup> That is, as contraceptive use and effectiveness of use increase, abortion incidence declines. The factors that do correspond are unsafe and safe abortions with illegal and legal abortions respectively.

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

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

- 3.14 A World Health Organization study released in 1964 had shown Australia to have the highest death rate due to abortion among 12 countries studied. In Victoria illegal abortion was among the top four causes of death in pregnancy.<sup>20</sup>

- 3.15 A recent study looking at data from the Women’s Pregnancy Advisory Service (PAS) contextualises abortion decisions.<sup>21</sup> Almost one-quarter (24.9%) of women who contacted PAS did so less than one week after becoming aware of the pregnancy<sup>22</sup> and two-thirds contacted PAS within two weeks. The average gestation of the pregnancy was seven weeks at the time of first contact with PAS. Eighty-five per cent of gestation recorded was between 4 and 11 weeks.

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

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

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

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

4 *Ibid* 1343.

5 *Ibid* 1344.

6 *Ibid* 1344.

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

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

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

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

11 Grayson (2005) above n 10, 32.

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

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

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

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

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

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

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

19 *Ibid* 1343–4.

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

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

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

23 1107 women out of 3827.



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

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

### ABORTION SERVICES

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

### PUBLIC PROVIDERS

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

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

#### PRIVATE PROVIDERS

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

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



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

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

### ABORTION AT LATER GESTATION

- 3.36 Abortions at later gestation account for a very small percentage of overall abortions. The AIHW study found that throughout Australia 94.6% of abortions occurred before 13 weeks gestation,<sup>43</sup> 4.7% occurred after 13 weeks but before 20 weeks and 0.7% occurred after 20 weeks. In 2005 there were 309 abortions post 20 weeks gestation, out of a total number of abortions of approximately 18000.<sup>44</sup> As discussed throughout this chapter, abortions post 20 weeks are available in the public and private hospital system in Victoria, though in hospitals are provided almost exclusively in cases of fetal abnormality. Late abortions for psychosocial reasons are available only through one private clinic. The medical profession characterise the reasons for late abortions as either 'fetal abnormality' or 'psychosocial', meaning any reason that goes to the physical or mental health of the woman.<sup>45</sup> When hospitals are unable or unwilling to provide a late abortion, some refer patients to the private clinic.<sup>46</sup>

### CURRENT PRACTICE

- 3.37 Most late abortions performed in public hospitals are undertaken at the Women's and Monash due to the expertise in those institutions. Both hospitals have set up termination review panels to consider all requests for abortion after certain gestations.<sup>47</sup> At the Women's the cut-off for referral to the panel is 23 weeks gestation; Monash is 24 weeks. These cut-off points were determined with reference to possible fetal viability, following investigation of doctors at the Women's for the offence of child destruction after a 32-week abortion in 2000.<sup>48</sup> They are designed to ensure decisions are made consultatively, and to support the doctor making the decision.<sup>49</sup>
- 3.38 The Women's and Monash have developed expertise in the area of fetal abnormality, and have dedicated Fetal Management Units.<sup>50</sup> Decisions about late abortion are made through these units. The units receive fetal abnormality referrals at any gestation, from 12–14 weeks right through to term. Referrals are received from within the hospitals, the rest of Victoria, interstate and overseas. The units comprise multidisciplinary teams of obstetricians, social workers, midwives, geneticists, genetic counsellors, paediatricians, paediatric sub-specialists, ultrasonographers and a psychiatrist. Input can be sought from other appropriate sub-specialists, such as paediatric cardiologists. The Mercy Hospital for Women has a comparable but smaller multidisciplinary unit, although it does not perform any abortions.
- 3.39 At the Women's the termination review panel comprises a member of the executive who chairs the panel, a neonatal paediatrician, two medical divisional directors, one nursing divisional

- director, and the obstetrician managing the pregnancy. The chair, and therefore the executive of the hospital, has the power of veto.
- 3.40 At Monash the panel is constituted by the clinicians involved in the woman's care—obstetrician, ultrasonologist, geneticist, paediatrician, midwives, and resident staff—as well as a GP practising outside the hospital. An opinion may be sought from a member of the hospital executive and the hospital lawyer, but they do not have a power of veto.<sup>51</sup>
- 3.41 The panels at both hospitals do not always approve abortions that are supported by the Fetal Management Units.<sup>52</sup> When considering requests for late abortions hospital panels consider the views of the nursing and medical staff who care for the women. If an abnormality is minor or the psychosocial reasons are considered less than compelling staff may be distressed if an abortion was to be undertaken.<sup>53</sup>
- 3.42 A two doctor process also applies at the only private clinic in Melbourne that conducts late abortions. As part of the clinic's registration requirements, an abortion after 24 weeks must not be performed without the woman first attending a separate consultation with a doctor with counselling credentials.<sup>54</sup> This process builds in a second opinion, and provides another practitioner so that the final decision is a consultative one rather than one made by one doctor alone with the consent of the patient. It does, however, build in further delay.
- 3.43 Throughout the review we heard differing views from medical practitioners and staff about the role of the doctor in the decision to provide abortion after 24 weeks. Some believed that patient **autonomy** and informed consent were the only relevant considerations. Most found the support of colleagues in a consultative decision-making process useful. Decisions to undertake an abortion after 24 weeks are seen by medical staff involved as 'controversial and difficult ethical decisions'<sup>55</sup> and 'onerous'.<sup>56</sup> The role of the doctor, and how many doctors should be involved in the decision, is considered further in Chapter 6.
- 3.44 The commission heard many criticisms of hospital panels and committees in consultations.<sup>57</sup> Panels have to be convened very quickly because of the **gestational limits** that have been set, making consistent membership impossible. We heard that inconsistent membership can lead to inconsistent decisions. It may also mean that various considerations are given different priority because the panels do not have formal guidelines for decision making. Unanimity is not required for panel decisions, which can lead to one person with strong views dominating the process and disproportionately affecting the outcome.
- 38 World Health Organization Geneva, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003) 14.
- 39 Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion, Evidence-Based Clinical Guideline No 7* (2004) 29. There follows a full discussion of the possible risks of abortion and incidence: 29–35.
- 40 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005) 10.
- 41 Eg consultation 2 (Endeavour Forum).
- 42 House of Commons, Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07: Volume 1*, HC 1045–1 (2007) 44–49.
- 43 Grayson (2005) above n 10, xvi; 42. This is a percentage of abortions where gestation is recorded. Gestation was not recorded in 5% of cases. There is no breakdown by state.
- 44 Figure of 309 obtained from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the year 2005*, 13, Table 7 <[www.health.vic.gov.au/perinatal/downloads/ccopmm\\_annrep05.pdf](http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf)> at 12 February 2008. Overall number of abortions from Renee Switzer, 'Extra baby bonus? Teen abortions fall', *The Sunday Age* (Melbourne), 21 October 2007, 5.
- 45 For instance, see division of data into 'fetal abnormality' and 'psychosocial' in the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44.
- 46 Medical Panel meetings 25 October 2007 and 3 November 2007. Consultation 24 (Fetal Management Unit—Royal Women's Hospital). In consultation 26, Professor Healy said the Monash Medical Centre did not, to his knowledge, make any referrals to the clinic.
- 47 For a comprehensive outline of the panel process at each hospital see Nicole Woodrow, 'Termination Review Committees: Are They Necessary?' (2003) 179 (2) *Australian Medical Journal* 92.
- 48 Ibid 92. As noted throughout this report, charges were not laid.
- 49 The Royal Women's Hospital, *Termination Review Process* <<http://intranet.thewomens.org.au/TerminationReviewProcess?printView=true>> at 10 September 2007.
- 50 All information about the Fetal Management Unit was obtained in consultation 24 (Fetal Management Unit—Royal Women's Hospital).
- 51 Woodrow (2003) above n 47, 93.
- 52 Information provided at Medical Panel meetings 25 October 2007 and 13 November 2007; consultation 24 (Fetal Management Unit—Royal Women's Hospital).
- 53 Information provided by Dr Christine Tippet, Director Maternal Fetal Medicine, Monash Medical Centre, 20 February 2008.
- 54 All private hospitals and day centres have to comply with the requirements of the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002*. The Secretary of DHS can also set additional requirements as a condition of re-registration of a hospital/day centre. See also Carol Nader, 'Women face wait for late abortions', *The Age* (Melbourne), 13 October 2005.
- 55 Woodrow (2003) above n 47, 94.
- 56 A Briefing Compiled by Pro-Choice Forum, *Late Abortion: A Review of the Evidence—A Briefing Compiled by Pro-Choice Forum* (2004) 24.
- 57 Consultations 9 (Croydon Day Surgery), 24 (Fetal Management Unit—Royal Women's Hospital); Medical Panel Meetings 25 October 2007 and 13 November 2007.



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

3.51 UK studies have also found that in most cases of late presentation for abortion the woman has not recognised or not realised she was pregnant for various reasons, including: continuation of menstruation; menstruation was usually irregular so missing periods were not noticed; no physical symptoms of pregnancy; and use of contraception masking any signs of pregnancy.<sup>68</sup>

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

*The truly heart-rending circumstances that confront women considering termination at this stage and the expensive, time consuming and arduous experience of doing so, it is imperative that the law should impose no great difficulty or distress for these women ... Arguably, the trauma related to terminations at this stage demand even more respect from the law for the woman's autonomy, privacy and dignity, while the codification of justifications after particular gestations undermines the values, compelling women and couples to explain themselves and seek to measure up to standards of behaviour set by those who have no knowledge of their particular circumstance, and in most instances, the traumatic experience of considering termination at this stage of pregnancy.<sup>72</sup>*

3.53 The commission heard that forcing a woman to proceed with an unwanted pregnancy has a greater negative impact than abortion, even at later gestation.<sup>73</sup> Adoption is no longer common. When it does occur it is an open process, with a stronger emphasis upon agreed contact and exchange of information than historic adoption processes. If abortion is denied some women may feel that they are forced to continue with unwanted pregnancy, go through birth, and then enter a relationship with a child with the attendant societal expectations that brings.

3.54 The commission notes there are relatively few studies on outcomes for women who are forced to continue with unwanted pregnancies; however, several studies have found that such women have poorer psychological outcomes than those able to have an abortion. They show more signs of mental illness, emotional stress, guilt, and anxiety.<sup>74</sup> Women who carry

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

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

60 Dickinson (2004) above n 59, 340.

61 Woodrow (2003) above n 47, 94.

62 *Ibid* 94.

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

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

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

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

67 *Ibid*.

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

69 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the year 2005*, Table 7, 13: <[www.health.vic.gov.au/perinatal/downloads/ccopmm\\_annrep05.pdf](http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf)> at 12 February 2008.

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

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

72 Submission 227 (Reproductive Choice Australia).

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

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



unwanted pregnancies to term are more likely to smoke, to drink, to delay obtaining **prenatal** care and to give birth to low birth weight infants who they are less likely to breastfeed. They are more likely to be depressed and unhappy after the birth than mothers with wanted children, and to spank and slap their children more frequently.<sup>75</sup>

- 3.55 Some studies have also found that poor outcomes extend to the child, who is more likely to have psychiatric problems, delinquency, and less education than other children.<sup>76</sup> Unwanted children have lower quality relationships with their mothers, show poorer social adjustment, school performance, and as adults appear more likely to have poor self-esteem, to engage in criminal behaviour, to be on welfare, and to obtain psychiatric services.<sup>77</sup>

#### RELEVANCE OF VIABILITY

- 3.56 Many submissions to the commission raised the issue of fetal viability.<sup>78</sup> In Chapter 6 we discuss options for abortion law reform, one of which includes a gestational limit.
- 3.57 Viability was a very important concept for decriminalisation opponents. Some argued that it was unacceptable that women with fetuses of the same gestational age were treated differently by hospitals. Some were given significant paediatric intervention following very premature birth, while others sought abortions at the same stage of pregnancy.<sup>79</sup> A range of gestational ages was proposed for a gestational limit in the law, generally between 20 and 24 weeks. Some felt that 12 weeks was the correct cutoff.<sup>80</sup>
- 3.58 Most decriminalisation supporters, including the Paediatric State Committee of the Royal Australasian College of Physicians, did not support gestational limits or fetal viability as the policy basis upon which it should be established:
- [T]he possibility of criminal sanction for practitioners involved in such situations also represents a constraint upon both the decision making and the availability of sometimes necessary procedures. Doctors acting in good faith in difficult situations should not have to fear criminal sanction.*<sup>81</sup>
- 3.59 Many people were concerned that introducing viability into the law would leave the law open to ongoing and continued public controversy.<sup>82</sup> They pointed to the experience in the US where abortion law remains heavily contested due to its reliance on viability in setting gestational limits.
- 3.60 The medical profession recognises 22–26 weeks gestation as a ‘grey zone’, where some fetuses have survived, most with ongoing disability, through major medical intervention.<sup>83</sup> These survival rates do not apply to fetuses with existing disability, where survival depends on the nature and extent of the disability. Victorian Women with Disabilities Network felt that post viability, women deciding whether to have an abortion could centre on the fetus’s likelihood of survival considering the serious health problems it has, as well as the risk to their own physical and mental health.<sup>84</sup>
- 3.61 A recent UK parliamentary inquiry considered whether the 24-week limit in its abortion legislation should be altered. Abortions can still be obtained in the UK post 24 weeks, though the tests to be satisfied are more stringent. The UK line is based on viability.<sup>85</sup> The House of Commons Science and Technology Committee looked at evidence on scientific and medical developments since the law was last amended in 1990, and concluded there was no justification for lowering the limit. It found no evidence that survival rates before 24 weeks gestation had significantly improved since the last amendment.<sup>86</sup> It also found no evidence to indicate that fetuses are sentient, or consciously feel pain, especially before 24 weeks.<sup>87</sup>
- 3.62 The commission heard from some medical practitioners, and others, that 24 weeks may be an appropriate line to draw at a clinical practice level, but not in legislation.<sup>88</sup> One submitter thought that professional guidelines should be developed for all terminations post 24 weeks.<sup>89</sup> In effect such guidelines already exist as public hospitals have developed their own and DHS imposes a regime on the only private clinic that undertakes such abortions. One submitter thought that abortions post 24 weeks should only be performed in hospitals due to the differing nature of late abortion procedures.<sup>90</sup>

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

## FETAL TESTING: ABORTION AND DISABILITY

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

## DIAGNOSIS OF ABNORMALITY

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

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

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

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

75 Reproductive Choice Australia, *RU 486/Mifepristone: A Factual Guide to the Issues in the Australian Debate*, 17 <[www.reproductivechoiceaustralia.org.au/Articles/RU486\\_final-Feb06.pdf](http://www.reproductivechoiceaustralia.org.au/Articles/RU486_final-Feb06.pdf)> at 12 February 2008.

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

77 Reproductive Choice Australia, above n 75, 17.

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

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

80 Submission 400 (Mrs Lisa Brick).

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

82 Eg consultation 12 (Reproductive Choice Australia).

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

84 Submission 384 (Victorian Women with Disabilities Network).

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

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

87 *Ibid* 22–26.

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

89 Consultation 14 (Anonymous).

90 Consultation 26 (Professor David Healy).

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

92 Consultation 14 (Anonymous).

93 Baker (2006) above n 37, 81.

94 *Ibid* 105.

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

96 *Ibid* 112.

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

98 *Ibid* 17.

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



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

### ACCESS TO TESTING

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

### REACTION TO TEST RESULTS

- 3.73 Genetic counselling is offered by the three major maternity hospitals in Melbourne. A booklet jointly produced by the hospitals states:

*The counsellor's role is to help you and your partner clarify your feelings, values and beliefs about diagnostic testing and what it might lead to ... Are you prepared to have a*

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

- 3.74 While this suggests the full range of options are available to women, this is not necessarily the case. Although all maternity hospitals provide fetal testing, many, including most **denominational hospitals**, do not provide abortions. These hospitals generally refer women who want to consider abortion to the Women's or Monash. This referral causes some delay and means these women are further advanced in their pregnancy by the time they receive advice about their options.<sup>106</sup>
- 3.75 Of the hospitals that do provide abortions, the final decision to proceed with late abortions is made by a hospital panel, not the woman and her caregivers, as would be the case for all other decisions in clinical practice. Access to fetal testing therefore impacts not only on the stage at which a woman might seek an abortion, but also on whether she will have access to abortion at all. Access to late abortion is discussed earlier in this chapter.
- 3.76 Abortion is not an automatic outcome after a diagnosis of fetal abnormality at any stage. Of all the women referred with fetal abnormalities to the Women's Fetal Management Unit, only 10% choose to terminate their pregnancy. This is also the case in the UK, where abortion for fetal abnormality is allowed at any gestation.<sup>107</sup> The Women's undertakes approximately 100 late (after 18 weeks) abortions a year for fetal abnormality. Approximately half are before 20 weeks and half post 20 weeks.<sup>108</sup>
- 3.77 The unit undertakes to give broad, impartial, detailed counselling about the particular fetal abnormality and inform the woman how or whether the fetal condition may be treated, both before and after birth. It may discuss abortion for some conditions as one of the possible management options. The woman sees all relevant specialists before making a decision about whether to continue the pregnancy and the unit aims to assist her to understand the implications for either decision.
- 3.78 Diagnosis of many fetal abnormalities is not possible until later gestation.<sup>109</sup> Throughout the reference we heard from doctors that accurate diagnosis of fetal abnormality, and the implications of the abnormality, is an extremely complex area. 'Diagnosis' often relates more to the level of risk of existence of an abnormality, rather than certainty.<sup>110</sup>
- 3.79 Ultrasound screening is offered to all women at 18–20 weeks because the fetus is almost fully developed and is large enough to study. Many structural abnormalities are not apparent until at least this gestation. Some serious abnormalities are not diagnosable until even

100 Ibid.

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

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

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

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

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

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

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

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

109 Major structural malformations such as spina bifida, major cardiac or neurological malformations and major limb defects are usually not diagnosable before the 18–20 week scan. Nor is hydrocephalus ('water on the brain') which is one of the most common birth defects. Many structural malformations are associated with a substantial risk of genetic disorder, which parents will want diagnostic testing to verify before considering abortion. Some conditions, like cytomegalovirus (CMV) infection and mild ventriculomegaly, result in serious disability in only a small percentage of cases, eg 10% for CMV, and a 'normal' or only mildly disabled child in most cases. Serious long-term disability will not be apparent until approximately 32 weeks. With multiple pregnancies, serious abnormality or death of one twin is not uncommon.

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

110 Consultation 32 (Associate Professor Lynn Gillam).



later, sometimes much later. The existence, and significance, of some abnormalities only becomes apparent at later gestation. For example, it may not be apparent that a fetus is seriously affected by cytomegalovirus infection (a common herpes virus) until the late second or early third trimester.<sup>111</sup>

- 3.80 Another example is mild dilation of the cerebral ventricles. Most babies will be normal, but a few will develop **severe hydrocephalus**. Which group a particular fetus belongs to will not be known until approximately 32 weeks gestation. The woman is in a very difficult situation if she is forced to make a decision about abortion long before this because she will receive uncertain prognostic information rather than the more accurate diagnostic information at later gestation.<sup>112</sup>
- 3.81 Victoria has maintained a Birth Defects Register (VBDR) since 1982, which is overseen by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The council acknowledged the relationship between antenatal screening and abortion in its most recent annual report:

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

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

### FETAL ABNORMALITY IN ABORTION LAW?

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

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

- 3.88 Factors considered by parents include the severity of the abnormality and the impact it would have on the child, themselves as carers, and other immediate family members, including existing children and those not yet born. Prior attitudes and beliefs about abortion are also an important factor. The decision is an extremely distressing one, and there is no indication it is taken lightly by parents or doctors.<sup>126</sup>
- 3.89 The ethical issues raised by fetal testing and abortions for fetal abnormality are extremely complex and difficult to resolve.<sup>127</sup> Screening for fetal abnormality has been described as a 'double-edged sword', placing women in a difficult and distressing position when the results of screening are not as they had hoped.<sup>128</sup> The prevalence and acceptance of prenatal screening and testing raise concerns about eugenics, as well as arguments that parents decide to abort 'not because of a eugenic unwillingness to bring disabled people into the world, but because of the social implications of bringing up a disabled child'.<sup>129</sup>
- 3.90 This issue is broader than the commission's terms of reference. As a community we have probably not yet directly confronted the full social ramifications of the increased use of fetal testing. In the UK<sup>130</sup> and South Australia<sup>131</sup> the law specifically recognises severe fetal abnormality as a ground for abortion. The key term in both statutes—'seriously handicapped'—is not defined.<sup>132</sup>
- 3.91 Legislation that specifically allows abortion for fetal abnormality is open to criticism for devaluing the existence of people who live with disabilities.<sup>133</sup> The UK Disability Rights Commission said of the UK legislation:
- The section is offensive to many people; it reinforces negative stereotypes of disability and there is substantial support for the view that to permit terminations at any point during a pregnancy on the ground of risk of disability, while time limits apply to other grounds set out in the Abortion Act, is incompatible with valuing disability and non-disability equally.*<sup>134</sup>
- 3.92 The Disability Discrimination Legal Service submission cautioned against simplistic consideration of this issue. It was concerned about such a provision being implemented in Victoria without the views of the disability community being taken into account. If the ground was included in Victorian abortion law the service called for a definition of 'serious handicap', noting that moral judgments about what constitutes

- 111 Information provided by Dr Michael Permezel, Mercy Hospital for Women, 22 February 2008. Cytomegalovirus infection is associated with increased fetal mortality, but often results in no adverse outcome. In a small percentage of cases it causes fetal damage, manifesting mainly in microcephaly (small head circumference as a result of the brain not developing properly), blindness, and deafness: Philip Baker (ed *Obstetrics by Ten Teachers* (18th ed, 2006) 203.
- 112 Information provided by Dr Michael Permezel, Mercy Hospital for Women, 22 February 2008.
- 113 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44, 12.
- 114 Of such pregnancies 3.8% resulted in a perinatal death and only 28.3% survived beyond 28 days of birth: Consultative Council on Obstetric and Paediatric Mortality and Morbidity Victorian Perinatal Data Collection Unit, *Victorian Birth Defects Bulletin No. 4* (December 2007) 3 <[www.health.vic.gov.au/perinatal/downloads/bdr\\_bulletindec07.pdf](http://www.health.vic.gov.au/perinatal/downloads/bdr_bulletindec07.pdf)> at 12 February 2008.
- 115 *Ibid* 3.
- 116 The Royal Women's Hospital, *Clinical Report 2007*, 62 <[www.thewomens.org.au/uploads/downloads/HealthProfessionals/Publications/ClinicalReport/Clinical\\_Report.2007.pdf](http://www.thewomens.org.au/uploads/downloads/HealthProfessionals/Publications/ClinicalReport/Clinical_Report.2007.pdf)> at 28 February 2008.
- 117 Under the *Births, Deaths and Marriages Act 1996* s 12(3)(a), notice must be given to the Registrar in all cases of stillbirth. A stillborn child is defined in s 4(1) as a child of at least 20 weeks gestation having exhibited no signs of life after birth.
- 118 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, above n 44, Table 6, 12.
- 119 *Ibid* Table 7, 13.
- 120 This includes some abortions after 20 weeks gestation. DHS advised that VAED data on such abortions should be treated with caution due to limitations in the relevant coding classification. The figure provided should therefore be considered an approximation of the total number. The Council on Obstetric and Paediatric Mortality, however, are certain that their data as to post-20 week abortions is accurate.
- 121 DHS data is presented by financial year: obtained from correspondence Dr C W Brook, Executive Director, Rural and Regional Health and Aged Care Services, DHS, 12 March 2008. Data on birth defects is presented by calendar year. Birth defects data is from: Consultative Council on Obstetric and Paediatric Mortality and Morbidity Victorian Perinatal Data Collection Unit (December 2007) above n 114, 3. The report does not give an overall figure for birth defect cases reported, but states that in 2005, 392 birth defect cases reported to the VBDR had a chromosomal anomaly, which presented 15% of all reported birth defects. This would make the overall number of birth defects approximately 2600.
- 122 Medical Panel meetings 25 October 2007 and 13 November 2007; consultations 1 (Fertility Control Clinic); 6 (Women's Health Victoria); 8 (Choices Clinic—Royal Women's Hospital); 9 (Croydon Day Surgery); 10 (Health Services Commissioner); 12 (Reproductive Choice Australia); 16 (Women's Health Goulburn); 24 (Fetal Management Unit—Royal Women's Hospital); 26 (Professor David Healy); 30 (Australian Medical Association Victoria).
- 123 Consultation 24 (Fetal Management Unit—Royal Women's Hospital); submission 410 (Professor Doreen Rosenthal).
- 124 Consultations 24 (Fetal Management Unit—Royal Women's Hospital), 26 (Professor Healy), 31 (RANZCOG), 32 (Associate Professor Lynn Gillam), 33 (Dr Lachlan de Crespigny).
- 125 A Briefing Compiled by Pro-Choice Forum (2004) above n 56, 22. Drawing on data from Department of Health [UK] *Publications and Statistics* <[www.publications.doh.gov.uk](http://www.publications.doh.gov.uk)> at 12 February 2008. See also Nuffield Council on Bioethics, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues* (2006) 61–63.
- 126 Consultations 9 (Croydon Day Surgery), 16 (Women's Health Goulburn North East), 26 (Professor David Healy), 31 (RANZCOG), 32 (Associate Professor Lynn Gillam), 33 (Dr Lachlan de Crespigny); submissions 231 (Public Health Association of Australia—Women's Health Special Interest Group), 261 (Gippsland Women's Health Service), 410 (Key Centre for Women's Health in Society).
- 127 Kristin Savell, 'Turning Mothers Into Bioethicists: Late Abortion & Disability' in Belinda Bennett et al (eds) *The Brave New World of Health* (forthcoming 2008).
- 128 Clare Williams et al, 'Women as Moral Pioneers? Experiences of First Trimester Antenatal Screening' (2005) 61 *Social Science & Medicine* 1983. Also Savell (forthcoming 2008) above n 127.
- 129 J Wyatt, 'Medical Paternalism and the Fetus' (2001) 27 *Journal of Medical Ethics* supp II ii, 15, quoted in Savell (forthcoming 2008) above n 127, 9.
- 130 See discussion in Chapter 2.
- 131 See discussion in Chapter 2.
- 132 See *Abortion Act 1967* (UK) s 1(1)(d); *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(b)(ii).
- 133 South Australia's legislation has been criticised in this way: Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29 (2) *UNSW Law Journal* 207. See also Jacqueline Laing, 'The Prohibition on Eugenics and Reproductive Autonomy' (2006) 12 (1) *University of New South Wales Law Journal Forum* 42.
- 134 Disability Rights Commission, Statement on section 1(1)(d) of the Abortion Act (5 July 2003) quoted in Savell (forthcoming 2008) above n 127, 5.



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

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

*The formulation of public policy and law about abortion on the basis of foetal characteristics is quite different from a woman deciding that in her circumstances she is unable to take on the tasks of raising a child. An individual woman seeking an abortion is not necessarily making a judgment about the intrinsic value of life with disabilities. Few people would want to underestimate the difficulties and sorrows often involved in raising children, with or without disabilities.*<sup>135</sup>

3.94 Some people argue that abortion law should contain a specific ground of serious fetal abnormality to reflect the current widespread clinical practice of discussing the option of abortion with a woman when there are adverse test results.<sup>136</sup> The commission is strongly of the view that this step should not be taken. While there was generally no support in consultations and submissions for the inclusion of a specific ground of fetal abnormality, there was support for legislation to be framed to allow for the continuation of current medical practice that provides for such abortions.

3.95 The commission believes that the most appropriate legal approach to fetal abnormality is to relate it to the psychological and emotional impact on a pregnant woman of maintaining or terminating her pregnancy.<sup>137</sup> Three possible options for abortion law reform are outlined in Chapter 6. If new legislation is based on one of the options that allows an abortion to be lawfully performed only when particular grounds are satisfied, serious fetal abnormality is most accurately characterised as a matter that has an impact upon the health of the women concerned.<sup>138</sup> This characterisation would allow an abortion to be lawfully performed without the need to specify fetal abnormality as a ground. If legislation is based on one of the options that allows abortion to be lawfully performed on the basis of the woman's consent, the most appropriate way to deal with fetal abnormality is to regard it as one of the many matters that may influence a woman's private decision to terminate her pregnancy.<sup>139</sup>

### CURRENT AND FUTURE ACCESS ISSUES

- 3.96 Abortion services within the few public hospitals that provide them are restricted by administrative decisions about overall service provision.<sup>140</sup> Decisions are based on funding, availability of surgery time and staff, and balancing the demand for this service with the many others that must be provided in public hospitals.
- 3.97 All public providers advised the commission they are unable to meet demand for abortion services. The Women's has approximately 5000 requests for abortion per year and provides approximately 3000.<sup>141</sup> Some of these are funded through public health (the hospital's funding) and some by the patient claiming through Medicare. Of the 2000 requests where service cannot be provided, referral is made mostly to private clinics, where a Medicare rebate can be claimed but does not fully cover the cost of an abortion.
- 3.98 Costs at private clinics vary according to gestation, and are competitive at earlier gestations due to the number of clinics providing services. Part of the cost is covered by Medicare. As with many services, clinics offer reduced rates to low-income earners with health care, pension or student cards. Abortions above 15 weeks gestation involve a more complex procedure and therefore increased cost, which may create access issues for some women. Providers told us that if cost is a barrier they try to find an arrangement that ensures the service is not refused.
- 3.99 At gestations above 20 weeks, because there is only one private provider and the procedure is more complex again, costs are higher and may be a barrier for some women. Public hospitals provide abortion at later gestation only in cases of fetal abnormality. Access to late abortion for other reasons is therefore dependant on means.

## RURAL AND REGIONAL ISSUES

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

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

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

*women living in rural and regional areas are more likely to experience anti-choice attitudes by medical practitioners. Hospitals and doctors are more readily able to avoid their responsibility to provide reproductive health services, including termination of pregnancy, because it is difficult to attract health professionals to these areas. As a consequence, those that do provide services to these areas have significant influence over what information is made available to pregnant women. This coupled with the indeterminate legal status of termination presents doctors in rural and regional areas with the opportunity to deny women access and information about these services.*

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

135 Pringle (2006) above n 133, 217.

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

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

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

139 Model C, and early abortion under Model B.

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

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

142 See Carolyn Nickson et al, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30 (4) *Australian and New Zealand Journal of Public Health* 329; Elly Taylor, 'The Difficulties Young Rural Women Face in Trying to Obtain Surgical Terminations of Pregnancy' (Unpublished Postgraduate Diploma in Gender Studies Thesis, The University of Melbourne, 2007).

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

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

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

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

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



### TRAINING AND AVAILABILITY OF STAFF

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

## RU486—MIFEPRISTONE

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



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

- 3.118 It is also important to note that availability of medical abortion has not been shown to increase the rate of abortion. In European countries where mifepristone has been available for some time there has been no increase in the overall rate or number of abortions,<sup>167</sup> but there has been a dramatic increase in the proportion of abortions performed at earlier gestations. In France, the proportion of abortions performed at or before seven weeks gestation increased from 12% in 1987 to 20% in 1997, while in Scotland, the proportion of all abortions that occur before 10 weeks gestation has increased from 51% in 1990 to 67% in 2000. Similarly, in Sweden, the proportion of abortions performed before nine weeks increased from 45% in 1991 to 65% in 1999.<sup>168</sup>
- 3.119 Mifepristone became available in the US in September 2000. Although there are obviously many other factors that determine the abortion rate in the US, there is no indication that it led to an increase in abortions. Indeed the abortion rate in the US began to decline before 2000. The rate in 1997 was 21.9 per 1000 women aged 15–44; in 2001 it was 21.1; and in 2005 the rate was 19.4.<sup>169</sup>
- 3.120 The likely increase in availability of medical abortion in the future must be taken into account in abortion law reform. Family Planning Australia’s submission noted that future access to mifepristone means that ‘legislators need to be careful not to restrict clinical options in a way that affects potential safe abortion procedures and practices’. This has been a problem with legislation in other jurisdictions, including the UK and New Zealand. The issues in those jurisdictions, and recommendations for how medical abortion should be considered in any new Victorian legislation, are considered in Chapter 8.

### REGULATION OF MEDICAL PRACTICE OF ABORTION

- 3.121 Medical practice for abortion is comprehensively regulated in Victoria. Many people in consultations and submissions emphasised the importance of abortion being viewed as a women’s health issue, rather than an issue for criminal law. There was strong support for the removal of the Crimes Act provisions<sup>170</sup> and for abortion to either be regulated in the same way as other health procedures<sup>171</sup> or for provisions about abortion to sit in health legislation.<sup>172</sup>

### GENERAL REGULATION OF HEALTH PRACTITIONERS

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

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



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

### REGISTRATION OF CLINICS—DHS REGULATION

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

### REGISTRATION OF BIRTHS AND DEATHS

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

### PUBLIC HOSPITALS

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

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

### PROFESSIONAL ORGANISATION GUIDELINES

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

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

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

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

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

186 *Health Services Act 1988* s 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

