

How the current law affects services

Abortion in South Australia is governed by the Criminal Law Consolidation Act 1935 (SA) Division 17, Sections 81, 82 and 82A.¹ The law was amended in 1969 with the addition of Section 82A Medical Termination of Pregnancy. This reform enabled development of high quality abortion services in public and private hospitals. Expectations of women's rights, community attitudes to abortion and methods of abortion have significantly changed since 1969. Nearly fifty years later, this law is outdated and contributes to numerous problems for women and service providers when accessing and providing contemporary best practice health care.

Section 82A, Medical Termination of Pregnancy, outlines the conditions under which abortion is legal:

- 1(a) If the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman—
 - 1(a)(i) That the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or
 - 1(a)(ii) That there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped and where the treatment for the termination of the pregnancy is carried out in a hospital, or a hospital of a class, declared by regulation to be a prescribed hospital, or a hospital of a prescribed class, for the purposes of this section.

1(a) Medical practitioner requirements

The current law does not give a right to decide to have an abortion. Rather, it maintains the position of the medical profession as the gatekeepers of women's reproductive lives by denying women full agency for their decision. It specifies the circumstances in which medical practitioners can perform an abortion. The requirement that two legally qualified medical practitioners examine the woman is difficult and expensive and an unnecessary use of medical resources. It can contribute to delay in access where two doctors might not be available. The current law does not allow for contemporary models of health care to be implemented in a society that experiences workforce and financial constraints in the broader healthcare sector.

1(a)(i) Relative risk assessment

Medical and surgical abortion is highly effective with a low rate of complications making it safer than continuing a pregnancy and childbirth.

Prescribed hospital requirement

The prescribed hospital requirement is a significant impediment to the availability and standard of care because it limits the premises where abortions can be provided. For women who need an early medication abortion two visits to a prescribed hospital, 48 hours apart, for the taking of tablets, are currently required. Best clinical practice standards recommend that the woman be given medication to take at home at a time of their convenience.²

The two visit requirement is exceptionally burdensome for women who travel from regional or rural areas to Adelaide to access abortion services, negatively impacting work, family and other commitments. Developments in modern health care provision using telemedicine enable women elsewhere in Australia to obtain early medical abortion in this way. The law precludes women in regional and rural South Australia from accessing abortion care via telemedicine.³

Two month residency requirement

- (2) Subsection (1)(a) does not refer or apply to any woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy.

This clause arose from SA politicians' concern when the law was first introduced in 1969 that SA would become the 'abortion capital of Australia'. This residency clause is completely out of step with the normal practice of health care provision in Adelaide for people from Broken Hill, Mildura, Alice Springs, Darwin and remote Northern Territory for care that is not available in their local area. Abortion care for women from these areas needs to be included in the reciprocal health care agreements that manage and fund these arrangements.

Conscientious objection

- (5) no person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this section to which he has a conscientious objection, but in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it

The AMA Code of Conduct 2016 states that access to medical care must not be impeded based on conscientious objection, and that information must be provided so that care can be sought elsewhere.⁴ In the case of conscientious objection mandatory referral to another medical practitioner who does not hold a conscientious objection should be a legal duty.

Certification and mandatory reporting

- (4) The Governor may make regulations:
- (a) for requiring any such opinion as is referred to in subsection (1) to be certified by the legally qualified medical practitioners or practitioner concerned in such form and at or within such time as may be prescribed and for requiring the preservation and disposal of any such certificate made for the purposes of this Act; and
 - (b) for requiring any legally qualified medical practitioner who terminates a pregnancy, and the superintendent or manager of the hospital in which the termination is carried out, to give notice of the termination and such other information relating to the termination as may be prescribed to the Director-General of Medical Services; and
 - (c) for prohibiting the disclosure, except to such persons or for such purposes as may be prescribed, of notices or information given pursuant to the regulations; and
 - (d) declaring a particular hospital or a class of hospitals to be a prescribed hospital or a prescribed class of hospitals for the purposes of this section; and
 - (e) for providing for, and prescribing, any penalty, not exceeding two hundred dollars, for any contravention of, or failure to comply with, any regulations.

Although not mandated by Section 82A the form COR19 is required by regulation to be completed by the doctor performing an abortion and signed by them and a second doctor who has also examined the woman.

The COR 19 documents personal detail not required for any other health service and includes specific details of the abortion care and treatment provided. Data from the COR 19 forms the basis of reports released by the Pregnancy Outcomes Unit annually and tabled in SA Parliament.

The COR19 does not meet the requirements for the analogous situation of the ethical collection and use of data for research as outlined in the NHMRC Statement on the Ethical Conduct in Human Research.⁵ It is argued by service providers that information required to be completed on the COR 19 is a gross invasion of women's privacy.

Doctors identify the regulation of abortion in the criminal law as a reason for their reluctance to provide a second opinion for the notification form. The COR19 form intimidates doctors who can be reluctant to provide the second opinion because the COR19 form gives the impression of a potential for criminal liability.

Child destruction clause

- (7) The provisions of subsection (1) do not apply to, or in relation to, a person who, with intent to destroy the life of a child capable of being born alive, [defined in (8) as a foetus of 28 weeks gestation] by any wilful act causes such a child to die before it has an existence independent of its mother where it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

The interpretation of this clause and its relationship to the ‘born alive rule’, have given rise to Departmental concern and consequent service limitations to 24 week gestation limit for abortion in SA.

Service providers have advised women that the opinion of Crown Law is that even procedures meeting the requirements of Clause 1 may be criminal if the pregnancy is ‘capable of being born alive’.

Hence, services are not offered beyond 24 weeks gestation.

Gestation becomes the determining factor rather than the health of the woman.

There is strong opinion that removal of the child destruction clause would eliminate the ambiguity currently perceived by medical practitioners.

The 2008 Victorian Law Reform Commission Report, strongly recommended removal of all references to child destruction from abortion laws.⁶ The Victorian parliament heeded this advice in 2008 when they repealed the sections of their criminal code relating to abortion.⁷

Conclusion

The repeal of all sections in the criminal law relating to abortion will improve access, bring abortion provision into the twenty-first century and show respect for women’s autonomy.

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- 1 <https://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT%201935.aspx>
 - 2 O’Rourke A, Belton S and Mulligan E, 2016, ‘Medical Abortion in Australia: What Are the Clinical and Legal Risks? Is Medical Abortion Over-regulated?’ *Journal of Law and Medicine*, 24.1, 221-238.
 - 3 See Tabbott Foundation www.tabbot.com.au; Mulligan E, 2016, *The advent of telemedicine abortion has had a broad impact on Australian abortion services*. https://www.eiseverywhere.com/file_uploads/68f39018a2692eca05bb104e0298c9ec_130_EaMulligan.pdf.
 - 4 AMA Code of Ethics 2016. <https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016>
 - 5 NHMRC. 2007. Australian Code for Responsible Conduct of Research. https://www.nhmrc.gov.au/_files_nhmrc/file/publications/r39_australian_code_responsible_conduct_research_150811.pdf
 - 6 Victorian Law Reform Commission, 2008. Law of Abortion. Final Report. <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>.
 - 7 www.legislation.vic.gov.au/Abortion-law-reform-Act-2008.