Reproductive
Health Care Reform
Working Group

Reproductive Health Care Reform Bill 2019

FAQs

July 2019

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Summary of the bill:

The Reproductive Healthcare Reform Bill has been developed by a group of MPs (Alex Greenwich, Trevor Khan, Penny Sharpe and Jo Haylen) with input from the Health Minister Brad Hazzard. It has also been developed in consultation with women's, health and legal groups including a coalition of over 70 individual organisations.

The bill seeks to codify the common law arrangement with regards to women seeking pregnancy terminations in NSW. The bill is closely based on the approach taken by Victoria and more recently Queensland as abortion has been taken out of the Crimes Act and replaced with a bill that is health focused.

The reform essentially does six things:

1) **Removes regulation of abortion from the Crimes Act** and puts it in a standalone health act. The law that currently regulates terminations is found in sections 82 to 84 of the *Crimes Act 1900* (NSW) and has remained unamended, despite significant social and technological change, since the *Crimes Act 1900* (NSW) was first enacted.

2) **Allows medical practitioners to administer a termination to a person who is not more than 22 weeks pregnant.**[1]

3) **Allows medical practitioners to administer a termination to a person who is more than 22 weeks pregnant if they fulfil a test** which requires the medical practitioner to consider:

- The person's relevant medical circumstances;
- The person's current and future physical, psychological and social circumstances; and
- The relevant professional medical practitioner standards and guidelines.

After consideration of these factors, the medical practitioner must be satisfied that, in all the circumstances, the termination should be performed and consult another medical practitioner who, after considering those factors, must also be satisfied that the termination should be performed.[2]

The test to be undertaken by the medical practitioners is a codification of the test set down by Kirby P in *Superclinics*.[3] **It does not constitute an expansion of the law, indeed in the *Superclinics* case, the test only had to be considered by one medical practitioner, whereas in the bill, it has to be considered by the two medical practitioners.**

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[1] Reproductive Health Care Reform Bill 2019 (NSW) cl 5.
[2] Ibid cl 6.
[3] See judgment of Kirby P in *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

4) **Creates an offence for unqualified persons who administer or assist with the performance of a termination.**[4]

5) **Provides that a person who consents to, assist in, or performs a termination on themselves does not commit an offence**[5] **and abolishes any common law offence relating to procuring a person's miscarriage.**[6]

6) **Provides a statutory protection for medical practitioners, or other registered health practitioners, who conscientiously object to performing or assisting in the performance of a termination.** The bill requires the medical practitioner to disclose their objection to the person seeking a termination as soon as practicable, as well as, promptly refer the person to another health practitioner who the first health practitioner believes does not have a conscientious objection to the performance of the termination.[7]

What is the current law?

The law that currently regulates terminations is found in sections 82 to 84 of the *Crimes Act 1900* (NSW) and has remained unamended, despite significant social and technological change, since the *Crimes Act 1900* (NSW) was first enacted. Sections 82 to 84 prohibit "unlawfully" performed terminations without specifying what the word "unlawfully" means.

As a result, the courts have interpreted this to mean that terminations are lawfully available only if a medical practitioner forms an honest belief on reasonable grounds that termination is necessary to preserve a woman from serious danger to her life or physical or mental health.[8]

This complex legal test requires the courts to determine whether a termination is "unlawful" on a case by case basis and has created uncertainty among doctors about their obligations and liabilities under this common law framework.[9]

Why is change needed?

The possibility of criminal prosecution of both health professionals and women impedes the provision of a full range of safe, accessible and timely reproductive services for New South Wales women. It leads to **women experiencing fear and stigma at a time when they are making an incredibly difficult choice. It also disproportionately impacts women who are already disadvantaged, including women in low socioeconomic groups; victims of domestic violence; victims of**

[4] Reproductive Healthcare Reform Bill 2019 (NSW) sch 2 cl 2.1 item 2.
[5] Ibid cl 10.
[6] Ibid sch 2 cl 2.1 item 4.
[7] Ibid cl 8.
[8] *R v Wald* [1971] 3 DCR (NSW) 25.
[9] K Gleeson, 'The other abortion myth – the failure of the common law' (2009) 6 *Bioethical Inquiry* 69, p 74.

sexual assault; women in rural, regional and remote areas; and Aboriginal and Torres Strait Islander women.[10]

New South Wales' current laws create uncertainty among doctors about their obligations and liabilities. This complexity was illustrated in the judgment of Priestly JA in the *Superclinics* case. His Honour said:

> As the law stands it cannot be said of any abortion that has taken place and in respect of which there has been no relevant court ruling, that it was either lawful or unlawful in any general sense. All that can be said is that the person procuring the miscarriage may have done so unlawfully. Similarly the woman whose pregnancy has been aborted may have committed a common law criminal offence. In neither case however, unless and until the particular abortion has been the subject of a court ruling, is there anyone with authority to say whether the abortion was lawful or not lawful. The question whether, as a matter of law, the abortion was lawful or unlawful, in such circumstances has no answer.[11]

It is also important to recognise that the availability of reproductive health services are not equally available to all women in New South Wales. A recent study by Shankar[12] observed that women who are socially, geographically, and economically disadvantaged, have limited choice and access to abortion. As was noted by the QLRC, **women in rural, regional and remote areas may have to travel long distances to access termination services and face additional costs. What may also be observed that those difficulties will likely mean that terminations occur later, leading to poorer health outcomes.**[13] In the Victorian Law Reform Commission's (VLRC) report, it was observed that impediments to access for regional, rural and remote women cause significant delays, leading to later terminations.[14]

What is the reform based on?

In 2007 the VLRC was commissioned to undertake a review of abortion law in Victoria. The Commission undertook 36 meetings and received over 500 submission before submitting a lengthy report to the Victorian Government. This resulted in the development and passing of Victoria's Abortion Law reform Bill. In 2017, the Queensland Law Reform Commission (QLRC) was also issued with terms of reference to review Queensland's abortion laws. The QLRC received almost 1200 submissions and produced a report containing 28 recommendations for legislative reform which resulted in Queensland's Termination of Pregnancy Bill 2018.

Both the Victorian and Queensland Bills were similar in effect, removing abortion by registered health practitioners from the Crimes Act but retaining offences for

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[10] Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) p 41.
[11] *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47, 83.
[12] Shankar et al, 'Access, equity and costs of induced abortion services in Australia: a cross-sectional study' cited in Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) p 41.
[13] Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) p 41.
[14] Victorian Law Reform Commission, *Law of abortion* (Final report no. 15, March 2008) p 47.

unqualified persons. Both bills provided for the right of women to choose to terminate a pregnancy in the earlier stages of the pregnancy and for the termination of a pregnancy after a defined period where two medical practitioners consider that the person's relevant medical circumstances and other factors justify the termination. Both bills made provision for conscientious objection by health practitioners.

The New South Wales bill draws extensively on both of the Law Reform Commission reports and the legislative outcomes of Victoria and Queensland.

What is the difference between a 'medical' and 'surgical' termination?

Terminations can be either 'medical' or 'surgical' procedures. The terms are defined below:[15]

Medical abortion: The use of pharmaceutical drugs to induce a termination of pregnancy, commonly by the combined use of the drugs mifepristone and misoprostol (which are available together as 'MS-2 Step').

Surgical abortion: Procedure by which the contents of a woman's uterus are surgically removed to terminate a pregnancy, commonly by means of dilation and curettage.

How many abortions are performed in NSW?

It is estimated approximately 20,000 terminations are presently performed each year in New South Wales. It is one of the most common surgical procedures.

This estimate is drawn from information gathered by the QLRC in June 2018 that made the follow observations:[16]

- It is estimated that half of all pregnancies are unplanned and half of unplanned pregnancies are terminated;
- Between a quarter and one third of Australia women experience a termination;
- In 2003, it was estimated there were 84,000 terminations in Australia;
- The termination rate has been steadily falling from 21.9 per 1000 women aged 15-44 in 1995 to 19.7 per 1000 in 2003. It is further estimated that the termination rate has continued to decline from 14.2 per 1000 in 2010 to 10.6 per 1000 in 2013.

Following the introduction of abortion law reform in Western Australia in 1998, the termination rate fell from 19.7 per 1000 in 1999 to 16.4 per 1000 in 2012. In the Australian Capital Territory, it has been suggested that termination rates have remained stable since abortion law reform in 2002.[17]

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[15] Definitions extracted from Additional Glossary of Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018).

[16] Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) pp 32 – 33.

[17] Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) p 34.

At what stage of a pregnancy do terminations occur?

The VLRC's *Law of Abortion* report found that 94.6 per cent of abortions occur before 13 weeks and 4.7 per cent occur after 13 weeks but before 20 weeks. A very small percentage, less than 1 percent, of terminations are performed after 20 weeks.[18]

In evidence to the QLRC inquiry, the following evidence was received and accepted by the Commission:

> The vast majority of abortions in Australia (around 94%) take place within the first trimester of pregnancy and they are requested for a variety of socio-economic and medical reasons. There is no logical medical or social reason, in 2018, to impose any kind of limitation (eg, 12 or 14 weeks) on these, and this would complicate the situation for women having to make a decision about abortion towards the end of the first trimester, because of the diagnosis of a severe fetal abnormality on antenatal screening tests ... About 5% of abortions in Australia take place between 14 and 20 weeks gestation and are almost always done for medical reasons including severe fetal abnormality that could not be diagnosed earlier in the pregnancy or serious medical conditions in the mother. The remaining one percent (approximately) are also mostly done after 20 weeks for severe fetal abnormality or serious medical conditions in the woman; abortions at greater than 20 weeks in Queensland are almost all done at one of a very small number of hospitals with very dedicated and experienced staff, and involve a number of maternal fetal medicine specialists and other doctors, other health professionals and counsellors as required, taking part in the decision-making with the woman and her partner, and assisting the couple through the process.[19]

In the VLRC report, the following was observed in respect of the incidences of abortions based on the greater availability of medical terminations:

> 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, 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.[20]

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[18] Victorian Law Reform Commission, *Law of abortion* (Final report no. 15, March 2008) p 32.
[19] Queensland Law Reform Commission, *Review of termination of pregnancy laws* (Report no. 76, June 2018) p 70.
[20] Victorian Law Reform Commission, *Law of abortion* (Final report no. 15, March 2008) p 50.

What happened in Victoria after the introduction of their laws?

In an article published in 2017 by Keogh[21], the impact of abortion law reform in Victoria was analysed. Amongst the consequences noted was the reduced provision of abortion after 20 weeks of pregnancy and the increase in the use of medical terminations. There was no evidence of an increase in overall access to terminations services. This is consistent with the overall trend across Australia which is seeing a reduction in the number of terminations performed.

What safeguards are in place to protect women?

The bill provides, as with all other medical procedures, that terminations must be performed by qualified medical practitioners applying the relevant professional medical practitioner standards and guidelines.[22] The bill retains heavy penalties for terminations performed by unqualified persons.[23]

The bill does not affect the operations of other general requirements under health regulation and clinical practice which require medical practitioners to be suitably qualified and credentialed and to act within their scope of practice. The bill also does not affect the laws that govern consent to medical treatment and the usual requirements under the general law relating to consent for medical or surgical treatment.

Will medical practitioners be forced to perform abortions?

No. The bill has a comprehensive provision allowing for conscientious objection of medical practitioners and other registered health practitioners involved in the process. If a person asks a medical practitioner or other registered health practitioner to: perform a termination, assist in the performance of a termination, consult as the second medical practitioner on a termination post-22 weeks gestation, or provide advice on a termination, the registered health practitioner will not be compelled to fulfil the request if they have a conscientious objection.[24]

There is a procedure however that the medical practitioner will have to follow in order to avail themselves of the protection of the conscientious objection provision in the bill. The procedure is as follows:

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[21] L A Keogh et al, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18.

[22] Reproductive Health Care Reform Bill 2019 (NSW) cls 5-6.

[23] Ibid sch 2 cl 2.1 item 2.

[24] Reproductive Health Care Reform Bill 2019 (NSW) cl 8.

- The registered health practitioner will have to disclose to the person who made the request that they have a conscientious objection as soon as practicable; and
- The registered health practitioner must refer the person or transfer their care, without delay, to another health practitioner or health service provider who, in the health practitioner's belief, does not have a conscientious objection.

The conscientious objection in the bill mirrors the approach to conscientious objection in Victoria and Queensland.

Can pregnant women be prosecuted under the reform?

No. Under this reform, a person who consents to, assist in, or performs a termination on themselves does not commit an offence.[25]

The need to ensure that pregnant women cannot be prosecuted for performing a termination on themselves is most clearly distilled in the recent case of *DPP (NSW) v Lasuladu*,[26] where the 26-week pregnant Ms Lasuladu tried to obtain a termination but was refused on the basis that her pregnancy was past 20 weeks and ultimately procured a black market termination drug to procure her miscarriage.

Ms Lasuladu was convicted of the offence of procuring her own miscarriage as she was unable to access a termination due to the uncertainty surrounding termination law in New South Wales. Under the proposed reform, doctors would have certainty over the performance of termination and Ms Laduladu would not have been convicted, but rather the unqualified person who supplied the black market termination drug would be the one who proceedings would be brought against.

What happens if medical practitioners don't follow the law?

Health practitioners (doctors, nurses, midwives, etc.) must be registered under the Health Practitioner Regulation National Law. The national law sets out a framework for the registration and discipline of registered health practitioners and establishes national boards that set standards, codes and guidelines that registered health practitioners must meet. Registered health practitioners must comply with relevant registration and accreditation standards, professional standards, including codes of ethics, codes of conduct and competency standards, policies and guidelines.

The bill does provide that in considering a matter under another act about a registered health practitioner's professional conduct or performance, regard may be had to whether the practitioner performs a termination or assists another practitioner to

[25] Reproductive Health Care Reform Bill 2019 (NSW) cl 10.
[26] [2017] NSWLC 11.

perform a termination other than as authorised or contravenes the conscientious objection provisions. Noncompliance with the bill may result in a finding that a practitioner's conduct is in some way unsatisfactory or unprofessional and possible disciplinary action.[27]

The bill does not alter the existing laws under which a medical or other health practitioner who administers surgical or medical treatment to a person has a duty to exercise reasonable skill and care and may be civilly or criminally responsible for harm that results from a failure to do so. For example, a medical or other health practitioner who does not obtain the required consent of the patient for a termination may be criminally responsible for assault.

This approach directly mirrors the framework in Victoria and Queensland.

Will 'backyard abortions' still be a crime?

Yes. The bill inserts into the *Crimes Act 1900* (NSW) the offence of Termination of a pregnancy performed by an unqualified person which makes it an offence for an unqualified person to perform or assist in the termination of a pregnancy for material or financial gain. The offence is punishable by 7 years imprisonment. The Director of Public Prosecutions will have to approve the commencement of prosecutions under the section.[28]

[27] Reproductive Health Care Reform Bill (NSW) cl 9.
[28] Ibid sch 2 cl 2.1 item 2.