AUSTRALIAN ABORTION LAW IN THE 21ST CENTURY: A JURISDICTIONAL ANALYSIS OF FLAWED LEGISLATION

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During the first quarter of the 21st century, all Australian jurisdictions enacted legislation regulating the provision of abortion services. The purpose of this article is to canvass and assess that legislation from the perspective of whether it serves to recognise a woman's right to abortion. The article contends that practical recognition of this right occurs when the law regulates abortion care in the same manner as other standard health care. The article consequently provides a comparative analysis of the legislation in each jurisdiction in terms of whether medically unjustified conditions are placed upon the lawful provision of abortion care.

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I INTRODUCTION

During the first quarter of the 21st century, all Australian jurisdictions enacted legislation dealing specifically with abortion.[1] The first jurisdiction to do so was the Australian Capital Territory ('the ACT') in 2002,[2] and the final jurisdiction to do so was Western Australia ('WA') in 2023.[3] The aim of this article is to assess such legislation from the perspective of whether it recognises a woman's right to abortion.[4] This article does not make the argument as to why women should have a right to abortion, but rather assumes that women should have this right as an essential step towards achieving the feminist goal of reproductive freedom,[5] which is 'inescapably, the core issue of women's equality and liberty'.[6] Although the concept of reproductive freedom is complex and often controversial, for the purposes of this article the following working definition will suffice: reproductive freedom constitutes 'the condition under which women are able to make truly voluntary choices about their reproductive lives'.[7]

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[1] See *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT); *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT); *Abortion Law Reform Act 2008* (Vic); Reproductive Health (Access to Terminations) Act 2013 (Tas); *Termination of Pregnancy Law Reform Act 2017* (NT); *Termination of Pregnancy Law Reform Legislation Amendment Act 2021* (NT); *Termination of Pregnancy Act 2018* (Qld); *Abortion Law Reform Act 2019* (NSW); *Termination of Pregnancy Act 2021* (SA); *Abortion Legislation Reform Act 2023* (WA). It should be noted that a number of jurisdictions had also enacted abortion specific legislation prior to the 21st century but all such pre-21st century legislation has now been superseded: see, eg, *Acts Amendment (Abortion) Act 1998* (WA); *Health Regulation (Maternal Health Information) Act 1998* (ACT).

[2] See *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT); *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT).

[3] See *Abortion Legislation Reform Act 2023* (WA). Although Queensland passed legislation in 2024 that amended the *Termination of Pregnancy Act 2018* (Qld), the primary legislation (ie *Termination of Pregnancy Act 2018* (Qld)) was enacted prior to the WA legislation: see *Health and Other Legislation Amendment Act 2024* (Qld). Similarly, NSW recently enacted the *Abortion Law Reform Amendment (Health Care Access) Act 2025* (NSW), but the primary legislation was enacted earlier: see *Abortion Law Reform Act 2019* (NSW).

[4] This article will refer to 'woman' and 'women' in the interests of clarity and consistency with terminology found in the relevant legislation. However, the author acknowledges that there will be individuals that will seek access to abortion services who do not identify as women. This issue of gender identification is a complex issue beyond the scope of this article.

[5] As Moen explains, '[a] basic assumption of feminist theory is that women have the right to reproductive freedom and control over their bodies, and that this freedom-right-control is essential if they are to have full and equal opportunity in society': Elizabeth Moen, 'Women's Rights and Reproductive Freedom' (1981) 3(2) *Human Rights Quarterly* 53, 53.

[6] Sylvia A Law, 'Rethinking Sex and the Constitution' (1984) 132(5) *University of Pennsylvania Law Review* 955, 1028. See also Ruth Colker, 'Equality Theory and Reproductive Freedom' (1994) 3(1) *Texas Journal of Women and the Law* 99.

[7] Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Temple University Press, 1992) 115. Sherwin goes on to provide a more detailed definition as follows: 'Reproductive freedom for women requires that they have control over their sexuality, protection against coerced sterilization … and access to the social and economic support necessary to care for any

This is not to say that recognising a right to abortion would thereby result in reproductive freedom (and women's substantive equality) because another crucial aspect of reproductive freedom (among many others) is the right to decide whether to become pregnant, which remains elusive in contemporary society. Nonetheless, establishing a right to abortion facilitates the conditions necessary for reproductive freedom, and if women can decide whether they wish to remain pregnant, then reproductive freedom is thereby enhanced.[8]

In terms of what constitutes legislative recognition of a woman's right to abortion, this article draws on the methodology of prior work,[9] but simplifies the legislative assessment into one question: is abortion treated by the law in the same manner as other standard health care? This question stems from the premise that the practical legal expression of a woman's right to abortion is for the law to treat abortion care purely as health care, which means that abortion must be regulated in the same manner as any standard medical procedure or health service.[10] Thus, for there to exist a woman's right to abortion, no conditions or regulations should be placed upon the lawful provision of abortion care that are not clinically justified or medically substantiated.[11] Consequently, as one might surmise from the title of this article, no jurisdiction in Australia has fully recognised a woman's right to abortion as no jurisdiction has yet achieved the goal of treating abortion care in the same manner as other standard health care. Nonetheless, the analysis embarked upon below remains useful in order to highlight how far each

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children each may choose to bear. It requires that women be free to define their roles in society according to their concerns and needs as women': at 133–4.

[8] See, eg, Rosalind Petchesky, *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom* (Longman, 1984); Lisa Smyth, 'Feminism and Abortion Politics: Choice, Rights, and Reproductive Freedom' (2002) 25(3) *Women's Studies International Forum* 335; Liz Beddoe, 'Reproductive Justice, Abortion Rights and Social Work' (2022) 10(1) *Critical and Radical Social Work* 7; Ann Furedi, *The Moral Case for Abortion: A Defence of Reproductive Choice* (Palgrave Macmillan, 2nd ed, 2021).

[9] See Mark Rankin, 'The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law?' (2011) 13(2) *Flinders Law Journal* 1, 5–7.

[10] See ibid 31, 35, 37, 45, 48; South Australian Law Reform Institute ('SALRI'), *Abortion: A Review of South Australian Law and Practice* (Report 13, October 2019) 17, 24, 48, 52; Ronli Sifris and Suzanne Belton, 'Australia: Abortion and Human Rights' (2017) 19(1) *Health and Human Rights Journal* 209, 209; Christine Forster and Vedna Jivan, 'Abortion Law in New South Wales: Shifting from Criminalisation to the Recognition of the Reproductive Rights of Women and Girls' (2017) 24(4) *Journal of Law and Medicine* 850, 850.

[11] This is not to say that abortion should be unregulated, as this would have adverse health consequences for women, but simply that it should be no more regulated than is medically necessary. That is, abortion should be regulated by the general health framework. For a discussion of how this would function in practice: see Judith Dwyer et al, 'Is There Still a Need for Abortion-Specific Laws? The Capacity of the Health Framework to Regulate Abortion Care' (2021) 46(2) *Alternative Law Journal* 141.

jurisdiction is from treating abortion care purely as health care. Prior to commencing this assessment of each jurisdiction, there are certain legislative creations that are common to all jurisdictions, and these will be canvassed at the outset.

II COMMONALITIES AND ISSUES

First and foremost, it is now the case that all Australian jurisdictions have legislated to decriminalise abortion (to varying degrees, and with contrasting levels of success), and no jurisdiction retains an offence for a 'woman who consents to, assists in, or performs a termination on herself'.[12] From a women's rights perspective, this is an irrefutably constructive development 'as one cannot have a right to a crime'.[13] Decriminalisation also reduces the social stigma often associated with abortion, and enhances access to abortion services.[14]

Nonetheless, as mentioned above, all jurisdictions continue to treat abortion care differently to other health care. The most obvious illustration of this differential treatment, or 'abortion exceptionalism',[15] is the existence of abortion specific legislation.[16] The other clear instance of such exceptionalism is that, despite

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[12] *Termination of Pregnancy Act 2018* (Qld) s 10. For similar provisions in other jurisdictions see *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT) s 3; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 8; *Abortion Law Reform Act 2008* (Vic) s 11 and *Crimes Act 1958* (Vic) s 65(2); *Criminal Code Act 1983* (NT) s 208A(4); *Abortion Law Reform Act 2019* (NSW) s 12; *Termination of Pregnancy Act 2021* (SA) s 16; *Abortion Legislation Reform Act 2023* (WA) s 4 and *Public Health Act 2016* (WA) s 202MO.

[13] Mark J Rankin, 'Recent Developments in Australian Abortion Law: Tasmania and the Australian Capital Territory' (2003) 29(2) *Monash University Law Review* 316, 317. Although the criticism should be noted that this might result in a 'shift from criminalisation to medicalisation' without any necessary recognition of women's reproductive rights: see Forster and Jivan (n 10) 856.

[14] See, eg, Ronli Sifris, 'Abortion in Australia: Law, Policy, and the Advancement of Reproductive Rights' in Mary Ziegler (ed), *Research Handbook on International Abortion Law* (Elgar Publishing, 2023) 124, 127–8 ('Abortion in Australia'). However, it should also be noted that decriminalisation does not, in itself, solve problems of access: see Tania Penovic and Ronli Sifris, 'Facilitating Safe Access to Health Care through Legislative Reform: The Australian Experience' (2024) 31 *Journal of Law and Medicine* 185, 187.

[15] Millar describes 'abortion exceptionalism' as 'the singling out of abortion from other areas of medicine on the grounds that it is special, different, or more complex or risky than is empirically justified', and further observes that '[a]bortion exceptionalism signals the various discourses and practices that differentiate abortion from routine medical care': Erica Millar, 'Abortion Stigma, Abortion Exceptionalism, and Medical Curricula' (2023) 32(3) *Health Sociology Review* 261, 261, 263. For further discussion of this term see Johanna Commins and Erica Millar, 'Exceptionalising Abortion Law: Decriminalised Jurisprudence in Australia' (2024) 33(3) *Griffith Law Review* 253, 264–6.

[16] That is, few other areas of health care are so specifically targeted by the law. It might be argued that such abortion specific legislation was necessary in order to decriminalise the practice, as all jurisdictions had created the offence of abortion in the early 20th century, but this just moves the exceptionalism proposition to the legislation that defined abortion as a crime in the first place.

ostensibly abolishing the offence of abortion, all jurisdictions nonetheless maintain a residual crime of abortion.[17]

A *The Residual Offence of Abortion*

The crime relevant to abortion that exists in all jurisdictions is that of an unqualified person performing, or assisting in the performance of, an abortion, including the provision or administration of abortifacients.[18] In all jurisdictions this constitutes a serious offence punishable by lengthy imprisonment.[19]

In all jurisdictions other than the ACT, South Australia ('SA'), and WA the applicable offences remain in the criminal law.[20] In the ACT, the *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT) ensured that all criminal law provisions on abortion were abolished,[21] yet created two new offences within the *Health Act 1993* (ACT): (1) performing a surgical abortion (as distinct from a medical abortion)[22] in a non-approved facility;[23] and (2) the performance of an abortion

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For an example of such legislation see the historical versions of *Crimes Act 1900* (NSW) ss 82–4; *Criminal Code Act 1899* (Qld) ss 224–6; *Criminal Code Act 1924* (Tas) ss 134–5.

[17] See Barbara Baird and Erica Millar, 'When history Won't Go Away: Abortion Decriminalisation, Residual Criminalisation and Continued Exceptionalism' (2024) 21(3) *History Australia* 416, 433; Commins and Millar (n 15) 266. Some jurisdictions also retain the offence of child destruction, which carries implications for gestational limits for lawful abortion: see Mark J Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35(1) *Sydney Law Review* 1 ('The Offence of Child Destruction'). This issue will be discussed further below.

[18] See *Public Health Act 2016* (WA) s 202MN(1); *Criminal Code Act 1924* (Tas) s 178D(1); *Criminal Code Act 1983* (NT) ss 208A(1)–(2); *Criminal Code Act 1899* (Qld) ss 319A(1)–(2); *Crimes Act 1900* (NSW) ss 82(1)–(2); *Crimes Act 1958* (Vic) s 65(1); *Health Act 1993* (ACT) ss 81–82; *Termination of Pregnancy Act 2021* (SA) ss 14(1)–(2). The definitions of 'qualified' and 'unqualified' in this regard differ between jurisdictions, but for the purposes of this article a broad definition/distinction will suffice as follows: a 'qualified' person is a registered health practitioner, and in many jurisdictions a registered medical practitioner. The ACT legislation provides a succinct definition of abortifacient as follows: 'abortifacient means a medicine, drug or other substance that causes a pregnancy to end prematurely': *Health Act 1993* (ACT) s 80(1).

[19] Most jurisdictions prescribe a penalty of seven years imprisonment: see *Public Health Act 2016* (WA) s 202MN(1); *Criminal Code Act 1983* (NT) ss 208A(1)–(2); *Criminal Code Act 1899* (Qld) ss 319A(1)–(2); *Crimes Act 1900* (NSW) ss 82(1)–(2); *Termination of Pregnancy Act 2021* (SA) s 14(1). In the ACT a lesser penalty of five years is imposed, and in Victoria a greater penalty of 10 years is specified: see *Health Act 1993* (ACT) ss 81–2; *Crimes Act 1958* (Vic) s 65(1).

[20] See *Criminal Code Act 1924* (Tas) s 178D; *Criminal Code Act 1983* (NT) s 208A; *Criminal Code Act 1899* (Qld) s 319A; *Crimes Act 1900* (NSW) s 82; *Crimes Act 1958* (Vic) s 65(1).

[21] That is, *Crimes Act 1900* (ACT) ss 44–6 were repealed and any common law offence of abortion was abolished: see *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT) s 3.

[22] This distinction was the result of amendments enacted by the *Health (Improving Abortion Access) Amendment Act 2018* (ACT), which will be discussed further below. The definition of 'medical abortion' is as follows: 'medical abortion means the prescription, supply or administration of an abortifacient': *Health Act 1993* (ACT) s 80(2).

[23] See *Health Act 1993* (ACT) s 83.

by an unqualified person.[24] In SA, the *Termination of Pregnancy Act 2021* (SA) removed abortion from the ambit of criminal law legislation but created the new offence of '[t]ermination of pregnancy by unqualified person' within that abortion specific legislation.[25] Similarly, in WA the *Abortion Legislation Reform Act 2023* (WA) repealed the relevant criminal code provisions on abortion,[26] but also created the offence of '[a]n unqualified person who performs an abortion' within the *Public Health Act 2016* (WA).[27]

It is beyond the scope of this article to provide a detailed analysis of these residual offences.[28] It will suffice for present purposes to point out that the existence of such abortion specific offences necessarily results in a finding that abortion care is not being treated in the same manner as other standard health care, as no other standard health care is similarly explicitly criminalised.[29] This is not to say that an unqualified person performing other medical procedures would not be subject to being charged for an offence under general health law or criminal law; the point is simply that in other forms of health care the legislature has not specifically criminalised such behaviours. That is, if an unqualified person performs surgery on another, or administers a drug outside the appropriate regulatory framework, this will constitute an offence, either under the general criminal law, or pursuant to applicable health law, but particular actions are not specified. For example, it would be a crime for an unqualified person to remove another person's appendix, but such behaviour is not expressly criminalised in the sense of it being an explicit offence for an unqualified person to remove another person's appendix; rather, it

[24] See ibid ss 81–2.
[25] *Termination of Pregnancy Act 2021* (SA) s 14.
[26] See *Abortion Legislation Reform Act 2023* (WA) s 4, which deleted *Criminal Code Act Compilation Act 1913* (WA) s 199.
[27] *Public Health Act 2016* (WA) s 202MN(1).
[28] However, it is of interest to note that there exists scant, if any, evidence that such offences address any real societal need, in that there is no material evidence that abortions performed by unqualified persons are occurring within Australia: see Baird and Millar (n 17) 420–5, 430. Baird and Millar suggest that such offences are more about 'medical control' over women's bodies for reproduction: at 418, 425; and serve to 'position abortion seekers as vulnerable and in need of protection': at 428.
[29] Voluntary assisted dying legislation in most jurisdictions also provides for specific offences with respect to that practice: see, eg, *Voluntary Assisted Dying Act 2021* (Qld) pt 9; but voluntary assisted dying is not 'standard' health care as the practice involves the intentional killing of a person. It might be argued that abortion should be similarly differentiated as the practice involves the intentional killing of the foetus, but this argument is inherently flawed as the foetus is not a person but (arguably) part of the pregnant woman's body: see below n 153.

is an offence for an unqualified person to perform surgery,[30] and the removal of an appendix constitutes an instance of surgery.

In other words, the reason such conduct is not expressly targeted by the legislature is that the need is already met by general health law and criminal law. Put simply, it is an offence in every jurisdiction for a person to provide a regulated health service without being a recognised health practitioner.[31] The same may be said of the performance of an abortion by an unqualified person: it is *prima facie* unlawful under such generally applicable health law or criminal law provisions because that would constitute the provision of a regulated health service by a person unqualified to do so. Thus, to expressly create an offence for an unqualified person to terminate a pregnancy is to distinguish abortion care from all other forms of health care for no credible medical or legal purpose. As Baird and Millar assert: '[t]he residual offences exemplify how the decriminalising Acts continue to exceptionalise abortion as a medical procedure'.[32] Furthermore, the maintenance of such offences means that each jurisdiction has, at best, only achieved partial decriminalisation of abortion.[33]

B *Conscientious Objection*

In a comparable manner, all jurisdictions expressly provide for conscientious objection with regard to abortion care, despite the fact that relevant professional standards, codes of conduct, and guidelines already provide for conscientious objection (and permit a refusal to participate on that basis) with respect to any medical procedure or health service.[34] In some jurisdictions the abortion specific conscientious objection provisions arguably reflect such standards, codes of

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[30] That is, as one cannot consent to serious bodily harm in such circumstances (see, eg, *R v Holmes* (1993) 2 Tas R 232), surgery performed by an unqualified person will constitute a serious offence in every jurisdiction. Indeed, in some jurisdictions it might constitute an aggravated offence to, eg, wounding, inflicting bodily harm, or assault occasioning actual bodily harm: see, eg, *Crimes Act 1900* (ACT) s 48A(2).

[31] See, eg, *Health Act 1993* (ACT) s 127.

[32] Baird and Millar (n 17) 417. See also Commins and Millar (n 15) 266.

[33] See Suzanne Belton, Felicity Gerry and Virginia Stulz, 'A Reproductive Rights Framework Supporting Law Reform on Termination of Pregnancy in the Northern Territory of Australia' (2018) 6(2) *Griffith Journal of Law & Human Dignity* 25, 26; Commins and Millar (n 15) 263.

[34] See, eg, Australian Health Practitioner Regulation Agency & National Boards, *Code of Conduct* (June 2022) cl 1.3(f); Australian Medical Association, *AMA Position Statement: Conscientious Objection* (March 2019); Nursing and Midwifery Board of Australia, Australian Health Practitioner Regulation Agency, *Code of conduct for nurses* (March 2018, as updated June 2022) cl 4.4(b); Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (2017) 12; Medical Board, Australian Health Practitioner Regulation Agency, *Good medical practice: a code of conduct for doctors in Australia* (October 2020) cl 3.4.6.

conduct, or guidelines, thereby making them superfluous.[35] In other jurisdictions the provisions are possibly inconsistent with those standards, codes of conduct, or guidelines, thereby creating unnecessary legal complexity and perhaps confusion amongst health practitioners as to which process should be followed.

In Victoria, Queensland and the Northern Territory ('the NT'), the abortion-specific conscientious objection provisions stipulate that if a health practitioner has a conscientious objection to abortion, that practitioner must make that objection known to the patient, and then refer or transfer the care of the patient to another practitioner or health service provider that the objecting practitioner knows, or reasonably believes, has no such objection.[36]

In the ACT, Tasmania, SA, WA, and New South Wales ('NSW'), no such direct referral is mandated. In the ACT 'an authorised person' with a conscientious objection (on religious or other grounds) may refuse to provide any abortion services.[37] However, any such conscientious objection must be 'immediately' conveyed to the person requesting abortion services.[38] The person requesting abortion services must also either be provided with information on how to locate or contact another health practitioner who the conscientious objector

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[35] One might argue that the relevant health practitioner codes of conduct and ethical standards are not law, so legislation is required to give legal substance to such standards. However, whenever those standards are repeated in legislation, a failure to meet them (eg a failure to refer a patient) does not carry a legislatively imposed penalty. In such instances the health practitioner is simply liable to disciplinary action for that failure: see, eg, *Termination of Pregnancy Act 2018* (Qld) s 9. This is essentially the same disciplinary action that might result from a failure to meet the non-legislative health practitioner standards. Furthermore, to argue that relevant health practitioner standards, codes of conduct, or guidelines carry no legal substance or consequence is to ignore the fact that a failure to meet them might well be the basis for a civil action against such a health practitioner for professional negligence.

[36] See *Abortion Law Reform Act 2008* (Vic) s 8(1); *Termination of Pregnancy Act 2018* (Qld) ss 8(2)–(3); *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11(2), 12(2). In Queensland the objecting practitioner need only 'believe' in this regard: see *Termination of Pregnancy Act 2018* (Qld) s 8(3). In the Northern Territory and Victoria the objector must 'know' that the other practitioner has no such objection: see *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11–12; *Abortion Law Reform Act 2008* (Vic) s 8(1)(b). Of course, enforcing the obligation to refer is problematic and practitioners may not do so or deliberately seek to delay that referral, which serves to 'obstruct access': Ronli Sifris, 'Conscientious Objection in Australia: A Comparison between Abortion and Voluntary Assisted Dying' (2022) 29(4) *Journal of Law and Medicine* 1079, 1086 ('Conscientious Objection in Australia').

[37] *Health Act 1993* (ACT) s 84A(1). Unless an emergency situation exists: s 84A(2). This exception to the right to conscientiously object in emergency situations applies in all jurisdictions: see *Termination of Pregnancy Law Reform Act 2017* (NT) s 13; *Abortion Law Reform Act 2008* (Vic) ss 8(3)–(4); *Termination of Pregnancy Act 2021* (SA) s 11(5); *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(3)–(4); *Abortion Law Reform Act 2019* (NSW) s 9(5); *Termination of Pregnancy Act 2018* (Qld) s 8(4); *Public Health Act 2016* (WA) s 202MI(4).

[38] *Health Act 1993* (ACT) s 84A(4)(a).

'reasonably believes' has no objection to providing the abortion services requested,[39] or transferred into another health practitioner's care that the conscientious objector reasonably believes has no such objection to providing the abortion services requested.[40]

Similarly, in SA and NSW, direct referral is mentioned as an option, but is not a requirement. That is, in SA and NSW the medical practitioner with the conscientious objection may either transfer the care of the patient directly, or simply provide information to the patient 'on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination'.[41] In both jurisdictions this obligation to provide information is also met if the medical practitioner provides information approved by the Minister (in SA) or the Secretary of the Ministry of Health (in NSW) for that purpose.[42]

In WA, a registered health practitioner that 'has a conscientious objection to abortion' must disclose that conscientious objection 'immediately',[43] but may then refuse to provide any assistance to the patient, including mere advice.[44] However, if the conscientious objector is a medical practitioner,[45] then, similar to the situation in SA and NSW, that medical practitioner must 'without delay transfer the patient's care' to another registered health practitioner or health facility that 'in the refusing practitioner's reasonable belief', can provide the requested service,[46] or 'immediately give the patient information, approved by the Chief Health Officer … about how to locate or contact' a registered health practitioner or facility of this 'kind'.[47] In Tasmania, conscientious objectors merely have an obligation to 'provide the woman with a list of prescribed health services

[39] Ibid s 84A(4)(b)(i)(A). Or provide information on how to contact or locate a medical facility 'where they reasonably believe a health practitioner working at the facility can provide the abortion service and would not refuse to do so because of a conscientious objection': s 84A(4)(b)(i)(B).
[40] Ibid s 84A(4)(b)(ii).
[41] *Abortion Law Reform Act 2019* (NSW) s 9(3)(a); *Termination of Pregnancy Act 2021* (SA) s 11(3)(a).
[42] See *Termination of Pregnancy Act 2021* (SA) s 11(4); *Abortion Law Reform Act 2019* (NSW) s 9(4).
[43] *Public Health Act 2016* (WA) s 202MH(2).
[44] Ibid s 202MH(1). A relevant health profession student may also refuse to assist on this basis: s 202MJ.
[45] It should be noted that, with medical practitioners, the refusal to participate may stem from 'a conscientious objection to abortion or for some other reason': ibid s 202MI(1)(b).
[46] Ibid s 202MI(2)(a).
[47] Ibid s 202MI(2)(b).

from which the woman may seek advice, information or counselling on the full range of pregnancy options'.[48]

This provision of lists or contact information in the above jurisdictions has been labelled 'passive referral' as distinct from the 'active referral' of actual transfer of care.[49] The problem with merely providing such lists or information, rather than actually referring or transferring the care of a patient, is that this may cause further delay as the woman concerned is then compelled to seek out such health practitioners or services at her own convenience, and often in stressful, time-critical, and complex circumstances. It is arguable that this fails to meet a health practitioner's professional ethical obligations to provide appropriate health care to their patient as it may fall short of the standards that would otherwise be applicable if conscientious objection with respect to abortion was not specifically legislated for.[50] That is, the relevant professional standards, codes of conduct, or guidelines arguably imply an obligation to directly refer the patient to another health practitioner or service provider in order to access the health care requested.[51] This referral obligation is implied on the basis of the express obligations of the conscientious objector to 'minimise disruption to patient care',[52] to 'ensure the patient has alternative care options',[53] and to act in a manner that 'appropriately facilitates continuity of care for the patient'.[54]

It is beyond the scope of this article to provide further analysis on abortion specific conscientious objection.[55] It is also unnecessary in terms of the focus of

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[48] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2).

[49] See Casey M Haining et al, 'Abortion Law in Australia: Conscientious Objection and Implications for Access' (2022) 48(2) *Monash University Law Review* 238, 258–9.

[50] See, eg, Public Health Association of Australia, *Abortion: Policy Position Statement* (September 2023) 4.

[51] See, eg, NSW Parliamentary Research Service, *Issues Backgrounder: Abortion and the Reproductive Health Care Reform Bill 2019* (Report No 3, August 2019) 10. The failure to directly refer is also condescending to the woman concerned: see Kate Gleeson, 'The Other Abortion Myth: The Failure of the Common Law' (2009) 6 *Journal of Bioethical Inquiry* 69, 81–2. See also Forster and Jivan who argue that an obligation to refer is necessary to protect the reproductive rights of women: Forster and Jivan (n 10) 859–61.

[52] Australian Medical Association (n 34) cls 1.5, 2.2. The AMA further stipulate that the conscientious objector must also 'take whatever steps are necessary to ensure the patient's access to care is not impeded': at cl 2.3.

[53] Australian Health Practitioner Regulation Agency & National Boards (n 34) cl 1.3(f).

[54] Pharmaceutical Society of Australia (n 34) 12. Cf Anna Walsh and Tiana Legge, 'Abortion Decriminalisation in New South Wales: An Analysis of the Abortion Law Reform Act 2019 (NSW)' (2019) 27(2) *Journal of Law and Medicine* 325. Walsh and Legge make the point that an obligation not to impede patient access to the service requested does not necessarily result in a further obligation to refer the patient: at 334–5.

[55] For a comprehensive discussion of all such legislative provisions, with an emphasis on the obligations of conscientious objectors, especially with regard to duties of referral, see Haining et al

this article, as the fact that all jurisdictions have specifically legislated for conscientious objection in the provision of abortion care, even though this issue is already catered for within relevant professional standards, codes of conduct, or guidelines that apply to all health care provision, thereby distinguishes abortion care from most other forms of health care.[56]

The other legislative instance of abortion specific provisions common to all jurisdictions is that of safe access zone legislation.[57] However, analysis of this issue is not required for the purposes of this article, as safe access zone legislation constitutes an example of clinically (and pragmatically) justified differential treatment, in that such legislation is necessary to secure access to a place of employment or the health service sought.[58] As mentioned earlier, this article focuses on highlighting legislative provisions that are clinically or medically unjustified, such as the maintenance of the residual offence of abortion and the specific provision for conscientious objection with respect to abortion care discussed above. These examples of abortion exceptionalism indicate that, in every jurisdiction, further law reform is required in order to realise the goal of treating abortion care in the same manner as other forms of health care. Notwithstanding this determination, this article will now examine the other aspects of the Australian legislative reforms that have occurred in the 21st century.

(n 49) 246–62. Haining et al conclude that allowing health practitioners to conscientiously object serves to impede access to abortion and causes delay in receiving that care: at 264–6. See also Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87; Ronli Sifris, 'Tasmania's Reproductive Health (Access to Terminations) Act 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22 *Journal of Law and Medicine* 900; Sifris, 'Conscientious Objection in Australia' (n 36) 1081–2.

[56] Conscientious objection is also specifically mentioned in relevant euthanasia legislation: see, eg, *Voluntary Assisted Dying Act 2022* (NSW) s 21(2)(a); *Voluntary Assisted Dying Act 2021* (SA) s 10; *Voluntary Assisted Dying Act 2019* (WA) s 9; *Voluntary Assisted Dying Act 2017* (Vic) s 7. However, as contended above, euthanasia is not 'standard' health care.

[57] See *Health Act 1993* (ACT) ss 85–7; *Public Health Act 2010* (NSW) pt 6A; *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3; *Termination of Pregnancy Act 2018* (Qld) pt 4; *Health Care Act 2008* (SA) pt 5A; *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 9–12; *Public Health and Wellbeing Act 2008* (Vic) pt 9A; *Public Health Act 2016* (WA) ss 202N–Q. For discussion of safe access zone legislation, see Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317; Mark J Rankin, 'Safe Access Zone Legislation in Australia: Determining an Appropriate Legislative Template for South Australia and Western Australia' (2020) 39(2) *University of Tasmania Law Review* 61.

[58] To emphasise this point, it should be noted that in NSW safe access zones are not limited to premises that only provide abortions, but are established around 'any premises at which medical services relating to aspects of human reproduction or maternal health are provided': *Public Health Act 2010* (NSW) s 98A.

III AUSTRALIAN ABORTION LEGISLATION

The purpose of this examination is to determine how far each jurisdiction is from treating abortion care as health care, and thereby recognising a woman's right to abortion. In this sense the practical focus is upon whether medically unnecessary or unjustified processes must be satisfied in order to perform a lawful abortion. For example, in most jurisdictions there is a requirement for two medical practitioners to agree on the appropriateness of the abortion after a certain gestation. In some jurisdictions there are further conditions — that only specialists may lawfully perform abortions, or that the provision of mandatory information concerning accessing counselling must occur prior to an abortion being lawfully performed — or an insistence that abortions may only be lawfully performed in prescribed facilities, or the imposition of an arbitrary gestational limit on the practice of lawful abortion. Although many of these processes may be medically justified or clinically necessary in specific circumstances, according to an individual patient's needs and interests,[59] to mandate such conditions in advance in every case is not medically justified or clinically necessary.[60] Thus, the legislative imposition of such conditions results in the conclusion that abortion care is not being regulated in the same manner as standard health care.

The first four jurisdictions to enact abortion specific legislation this century — the ACT, Victoria, Tasmania, and the NT — will be discussed separately, as each of those jurisdictions takes a markedly different approach. The remaining jurisdictions will be discussed as a thematic bundle, as all such legislation draws on the Victorian legislative model to varying degrees.

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[59] For example, in a particularly complex case, consulting with another health practitioner may well be medically appropriate, but to impose such consultation in advance in every case is not.

[60] It should be noted at the outset that such imposed conditions on a lawful abortion do not apply in emergency situations. In Queensland, NSW, and WA an 'emergency' situation exists when the relevant medical practitioner considers the abortion necessary in order to either save the woman's life or the life of another foetus: see *Termination of Pregnancy Act 2018* (Qld) s 6(3); *Abortion Law Reform Act 2019* (NSW) s 6(5); *Public Health Act 2016* (WA) s 202ME(5). In the NT an 'emergency' exists when 'the medical practitioner considers the termination is necessary to preserve the life of the woman': *Termination of Pregnancy Law Reform Act 2017* (NT) s 10. In SA 'emergency' is left undefined: see *Termination of Pregnancy Act 2021* (SA) s 6(3). The emergency exemption is not specifically mentioned in the ACT, Victorian or Tasmanian legislation, other than with respect to conscientious objection: see *Health Act 1993* (ACT) s 84A(2); *Abortion Law Reform Act 2008* (Vic) ss 8(3)–(4); *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(3)–(4). However, one may assume it applies in any case as a result of reasonable and appropriate clinical practice.

A *The Australian Capital Territory*

The ACT has gone through perhaps more legislative changes with respect to abortion law than any other jurisdiction, as there has been legislation dealing with aspects of abortion law and practice in 1998,[61] 2002,[62] 2015,[63] and 2018.[64] The most significant legislation was passed in 2002 with the *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT), the *Health Regulation (Maternal Health Information) Repeal Act 2002* (ACT), and the *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT). In combination this legislation achieved the objective of removing abortion entirely from the criminal law,[65] and regulating the practice solely through health law.[66]

The 2002 legislation was amended by the *Health (Improving Abortion Access) Amendment Act 2018* (ACT). This legislation substituted new sections for much of Part 6 of the *Health Act 1993* (ACT), which deals with abortion and safe access zones. The changes made to the provisions on safe access zones were too minor to warrant mention, but the 2018 legislation did clarify an issue with respect to the practice of abortion by explicitly defining (and thereby distinguishing) medical and surgical abortion.[67] This had important implications in terms of the offence of performing an abortion in a non-approved facility, as the legislation now makes it clear that only surgical abortions must be performed in such facilities.[68]

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[61] See *Health Regulation (Maternal Health Information) Act 1998* (ACT).
[62] See *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT); *Health Regulation (Maternal Health Information) Repeal Act 2002* (ACT); *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT).
[63] See *Health (Patient Privacy) Amendment Act 2015* (ACT).
[64] See *Health (Improving Abortion Access) Amendment Act 2018* (ACT).
[65] That is, by repealing *Crimes Act 1900* (ACT) ss 44–6 and abolishing any common law offence of abortion: see *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT) s 3. However, as noted above, the ACT still retains offences with regard to abortion: see *Health Act 1993* (ACT) ss 81–3.
[66] This was achieved by inserting pt 4B into the *Medical Practitioners Act 1930* (ACT): see *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT). The 2002 amendments to the *Medical Practitioners Act 1930* (ACT) were moved without amendment into the *Health Professionals Act 2004* (ACT), and then into the *Health Act 1993* (ACT) pt 6, in which the regulation of abortion currently resides.
[67] See *Health Act 1993* (ACT) s 80. Surgical abortion is now defined as 'a surgical procedure or any other procedure or act (other than the administration or supply of an abortifacient) that causes a pregnancy to end prematurely': at s 80(1). Medical abortion is defined as 'the prescription, supply or administration of an abortifacient': at s 80(2).
[68] See ibid s 83. This is a significant practical development because it means that a woman may now go to her general practitioner (in person or via telemedicine), receive a prescription for an abortifacient, and administer it herself in the comfort of her own home. To further this objective, the 2018 legislation made it clear that a pharmacist (or a person assisting a pharmacist) commits no offence by supplying an abortifacient 'in accordance with a prescription': at s 81(2).

Thus, in the ACT, a lawful surgical abortion is one performed in an approved medical facility (or an approved part of a medical facility) by a registered medical practitioner upon the pregnant woman's request,[69] (and any person may assist a medical practitioner in carrying out a surgical abortion),[70] and a registered pharmacist (or a person assisting a pharmacist) may supply abortifacients for the purposes of a medical abortion in accordance with a prescription.[71] In other words, other than the approved medical facility requirement,[72] and the conscientious objection and residual offence issues canvassed earlier in the article, abortion is arguably treated like any other medical procedure in the ACT. Furthermore, the approved medical facility requirement is not as onerous as it would first appear for two reasons: (1) as mentioned above, the approved medical facility requirement only applies to surgical abortion and does not apply to medical abortion;[73] and (2) the process for making an application to be so approved is relatively straightforward because, upon receiving an application, the Minister 'must approve the application if reasonably satisfied the medical facility is suitable'.[74]

Furthermore, unlike all the other jurisdictions discussed below, the ACT stands alone in not mandating an arbitrary gestational limit upon which further (more restrictive) regulation is required. Perhaps most significantly, unlike any other jurisdiction, in the ACT, regardless of gestation, there is no requirement to provide two medical practitioners' opinions, nor to specifically justify the abortion by reference to legislatively mandated criteria.[75] However, the ACT retains the offence of child destruction, which arguably creates an implicit upper gestational limit for lawful abortions.[76] As noted earlier, there may well be a clinically

[69] Ibid ss 80–4.
[70] Ibid s 82(2).
[71] Ibid s 81(2).
[72] Which is self-evidently not treating abortion like any other medical procedure, and which places a medically unnecessary burden on women seeking abortion. SALRI made the point that demanding a prescribed facility was 'at odds with current clinical practice and undermines equitable and effective access': SALRI (n 10) 192.
[73] See *Health Act 1993* (ACT) ss 80, 83.
[74] Ibid s 84(2).
[75] That is, in every other jurisdiction, at some point, it is mandated that the medical practitioner(s) must be satisfied of certain criteria. For example, even in the otherwise relatively progressive jurisdictions of Victoria and Queensland, at a certain gestation the legislation mandates that the medical practitioner(s) must be satisfied that the abortion is appropriate (or should be performed) 'in all the circumstances': see *Abortion Law Reform Act 2008* (Vic) s 5(1); *Termination of Pregnancy Act 2018* (Qld) s 6(1). One might argue that such a consideration is quite broad, and not overly prescriptive, but SALRI has made the point that any such specified criteria for defining lawful abortion should be avoided: see SALRI (n 10) 19, 27, 207–10.
[76] See *Crimes Act 1900* (ACT) s 42. Where that upper limit lies is open to interpretation: see Rankin, 'The Offence of Child Destruction' (n 17).

necessary upper limit for a particular abortion based upon specific medical concerns for that patient, but there should be no arbitrary legal limit set for lawful abortion.[77] This is not only clinically unnecessary, but potentially detrimental to the pregnant woman's health.[78]

B *Victoria*

There is no upper gestational limit for lawful abortion in Victoria.[79] This was one of many achievements of the *Abortion Law Reform Act 2008* (Vic).[80] This legislation was, like the ACT legislation before it, innovative and broadly supportive of a woman's right to abortion, as evidenced by the fact that abortion is arguably treated like any other health care service, provided the woman concerned is not more than 24 weeks pregnant. That is, up until 24 weeks gestation, Victoria has established a situation of abortion on demand: a woman may request an abortion, and a medical practitioner may perform that abortion.[81] In common with other medical procedures, neither counselling nor specialist opinions are required, nor is a specific approved facility mandatory. Furthermore, registered pharmacists or registered nurses may supply or administer drugs to cause an abortion, provided the woman concerned is not more than 24 weeks pregnant.[82] This recognition of other registered health practitioners reflects modern clinical practice and is conducive to patient-managed health care. Some jurisdictions limit the provision of abortion services, including medical abortion, to medical practitioners (as will be discussed below). This not only impedes access and is not evidence-based, but is also inconsistent with the regulation of

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[77] See, eg, SALRI, recommending that there be no upper limit to lawful abortion because '[a]bortions occurring later in gestation are especially likely to involve complex medical circumstances, including serious or fatal fetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the fetus is one of a multiple pregnancy; or complex personal circumstances, including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, socio-economic disadvantage, or mental health issues': SALRI (n 10) 215. See also Belton, Gerry and Stulz (n 33) 41.

[78] See Jeanne M Snelling, 'Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand' (2022) 30(2) *Medical Law Review* 216, 234–5.

[79] That is, there is no express upper limit mentioned in the *Abortion Law Reform Act 2008* (Vic), and that legislation repealed *Crimes Act 1958* (Vic) s 10, thereby abolishing the offence of child destruction.

[80] For a discussion of the manner in which the 2008 Victorian reform passed through Parliament see Jenny Morgan, 'Abortion Law Reform: The Importance of Democratic Change' (2012) 35(1) *UNSW Law Journal* 142, 157–72.

[81] See *Abortion Law Reform Act 2008* (Vic) s 4.

[82] Ibid s 6. Such health practitioners must be authorised to do so pursuant to the *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

other health care which allows for the participation of non-medical practitioner health professionals when the clinical need requires it.[83]

After 24 weeks gestation, a medical practitioner may only perform an abortion if that medical practitioner 'reasonably believes that the abortion is appropriate in all the circumstances',[84] and 'has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances'.[85] In making this assessment a registered medical practitioner must consider '(a) all relevant medical circumstances; and (b) the woman's current and future physical, psychological and social circumstances'.[86] The regulation of abortion after 24 weeks gestation is thus more restrictive,[87] and the decision is no longer solely the pregnant woman's to make,[88] but rather the relevant two medical practitioners. However, the matters which the medical practitioners must consider are broad, and are clearly matters that should be considered by medical practitioners in any case, as part of appropriate clinical practice. Nonetheless, the demand for a compulsory second practitioner opinion is not medically necessary. A medical practitioner might seek a second opinion if the individual patient's circumstances warranted it, but there is no clinically based need to make it mandatory. On this basis (and despite the positive attributes of the legislation with respect to pre-24 weeks gestation abortions discussed above), one may conclude that abortion care is not regulated in the same manner as other comparable health care in Victoria because, with other health care, it is the patient that makes the decision, and not the medical profession. This criticism — that at a certain gestation the decision-making power is taken out of the pregnant woman's hands and granted to the medical

[83] See, eg, Dwyer et al (n 11) 143.
[84] *Abortion Law Reform Act 2008* (Vic) s 5(1)(a).
[85] Ibid s 5(1)(b).
[86] Ibid s 5(2).
[87] Post-24 weeks gestation the woman concerned can also no longer access abortifacients as easily, as although a registered pharmacist or registered nurse may still supply or administer such medication, that pharmacist or nurse must be employed or engaged by a hospital: ibid ss 7(1), (3)–(4); and can only do so upon the written direction of a medical practitioner that has satisfied the above conditions with respect to performing an abortion post-24 weeks gestation (including obtaining the requisite second opinion): at ss 7(1)–(4). However, it should be noted that the definition of 'hospital' for these purposes is quite broad and incudes 'a public hospital, private hospital or day procedure centre within the meaning of the *Health Services Act 1988*': at s 7(5).
[88] As Morgan notes, the Victorian legislation 'configures women as responsible decision-makers, at least until the foetus is at 24 weeks' gestation. After that time, their responsibility is constrained by the requirements to consult with two doctors': Morgan (n 80) 172. See also Forster and Jivan, who conclude that prior to 24 weeks there exists 'an unfettered right to choose abortion … but after 24 weeks that right is removed and authority shifts from the woman herself to members of the medical profession who become gatekeepers of her right': Forster and Jivan (n 10) 854.

profession — is common to all jurisdictions other than the ACT, as all other jurisdictions (with the exception of Tasmania and the NT) broadly follow the Victorian legislative template in this and other respects.

C *Tasmania*

Tasmania has engaged in a number of legislative reforms of abortion law,[89] culminating in the *Reproductive Health (Access to Terminations) Act 2013* (Tas).[90] As a result of this legislation, the termination of a pregnancy is lawful provided that the woman concerned is not more than 16 weeks pregnant,[91] and provided the termination is performed by a medical practitioner with the woman's consent.[92] There is no requirement for counselling or the involvement of more than one medical practitioner, nor is it necessary that the abortion be performed in an approved facility. However, as only medical practitioners may provide abortions, abortion care is thereby treated differently to other forms of health care that allow for the involvement of a diverse range of health care professionals based on clinical need and patient interest.

Terminations post-16 weeks' gestation may only be performed by a medical practitioner (with the woman's consent) if that medical practitioner:

> (a) reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and
>
> (b) has consulted with another medical practitioner who reasonably believes that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.[93]

In making the above assessments, the medical practitioners 'must have regard to the woman's physical, psychological, economic and social circumstances'.[94] The second medical practitioner consulted need not have personally examined the

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[89] For a discussion of such past reforms see Rankin, 'Recent Developments in Australian Abortion Law' (n 13) 317–26.
[90] That is, this legislation certainly bettered the legislation that preceded it: see *Criminal Code Act 1924* (Tas) ss 134–5, 164 as repealed by *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 14.
[91] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4.
[92] Ibid. Terminating a pregnancy includes either using an instrument or drug to 'discontinue' the pregnancy: at s 3.
[93] Ibid s 5(1).
[94] Ibid s 5(2).

woman concerned, but at least one of the two medical practitioners must specialise in 'obstetrics or gynaecology',[95] the sourcing of which may cause delay.

Clearly, abortions post-16 weeks gestation are thereby regulated unlike any other health care. Not only is the clinically unnecessary approval of two medical practitioners required (with the further medically unwarranted demand that one be a specialist) but, unlike those imposed in Victoria post-24 weeks gestation, the mandated assessments are markedly different to those which apply in all other standard health care. Although an assessment of the health risks associated with any requested medical procedure is always part of best clinical practice (and necessary in order for the patient to make an informed decision) and that assessment may involve considering whether a requested medical procedure constitutes a greater health risk than not performing that procedure, to prohibit the requested medical procedure solely on the basis that it constitutes a greater health risk to the patient than not performing the procedure is the height of paternalism, and defines women as less than full moral persons able to make informed, rational decisions on their own behalf, and in their own interests. If such reasoning were applied to all other medical procedures, many elective surgeries (such as cosmetic surgery) would potentially be deemed unlawful.

Fortunately for women seeking abortions post-16 weeks gestation, the required assessment is also arguably redundant as childbirth is always a greater somatic risk to a woman than the termination of a pregnancy by a qualified health practitioner.[96] Therefore, the conditions for lawful abortion post-16 weeks will arguably be met in every instance. Put simply, serious somatic complications from abortion are rare, and even minor complications are uncommon.[97] It has also

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[95] Ibid s 5(3).

[96] See, eg, Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) *Oxford Journal of Legal Studies* 334, 343–4 ('The Decriminalisation of Abortion'). This is especially the case in the early stages of pregnancy when early medication abortion remains available: see Anne O'Rourke, Suzanne Belton and Ea Mulligan, 'Medical Abortion in Australia: What are the Clinical and Legal Risks? Is Medical Abortion Over-regulated?' (2016) 24(1) *Journal of Law and Medicine* 221, who make the point that there are 'negligible medical risks associated' with the use of abortifacients such as mifepristone, and that such medication has less adverse health consequences than paracetamol: at 221, 227. See also Nathalie Kapp et al, 'Medical Abortion in the Late First Trimester: A Systematic Review' (2019) 99(2) *Contraception* 77, 84. Even late term abortions remain comparatively safer procedures than childbirth, as evidenced by the fact that the maternal mortality rate for lawful abortion, throughout Australia, has been less than 1 per 100,000 for some time now: see, eg, Caroline de Costa, 'Induced Abortion and Maternal Death' (2013) 15(1) *O&G Magazine* 37, 37. Yet the maternal mortality rate for childbirth continues to be approximately 6–8 per 100,000: see, eg, Preventive Health SA, *Maternal and Perinatal Mortality in South Australia 2021* (Report, December 2024) 12.

[97] See, eg, South Australian Abortion Reporting Committee, Preventive Health SA, *Annual Report for the Year 2023* (April 2024) 14–15.

been proven for some time now that abortion does not, generally, have any deleterious psychological effects.[98] Thus, it is hard to imagine a case in which an abortion could be described as posing a greater risk to the health of a pregnant woman than childbirth itself, especially given that the woman's 'physical, psychological, economic and social circumstances' must be part of that assessment.[99] On another positive note from an access perspective, there is no longer an express nor implicit upper limit to lawful abortion.[100] Thus, although there are increased restrictions on lawful abortion post-16 weeks gestation, an abortion may be performed at any time under those conditions.

Nonetheless, it remains the case that the law stipulates conditions on post-16 weeks gestation abortions that are not medically necessary. Aspects of clinical practice may well differ with respect to different gestation abortions, but legality should not.[101] Applicable health law, professional ethics and standards, and clinical guidelines will determine best health practice in the patient's best interests in any given situation.[102] To mandate different treatment based on gestation is to treat abortion unlike any other health care.

D *The Northern Territory*

The NT has been comparatively active on abortion law reform from the late 20th century,[103] with the most recent reform occurring in 2021.[104] In the NT an abortion may lawfully be performed by a medical practitioner,[105] through

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[98] See, eg, Sarah Romans-Clarkson, 'Psychological Sequelae of Induced Abortion' (1989) 23(4) *Australian and New Zealand Journal of Psychiatry* 555.

[99] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(2).

[100] That is, no upper limit is expressed in the relevant abortion specific legislation, and that legislation also repealed the offence of child destruction: see *Criminal Code Act 1924* (Tas) s 165 as repealed by *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 14 which, if maintained, places an implicit upper limit on lawful abortion: see Rankin, 'The Offence of Child Destruction' (n 17).

[101] SALRI reported no clinical necessity for upper gestational limits to lawful abortion and concluded that any such limits would be 'inappropriate': SALRI (n 10) at 28, 242.

[102] For example, gestational limits may operate as a matter of clinical practice in specific cases: see, eg, Queensland Law Reform Commission ('QLRC'), *Review of termination of pregnancy laws* (Report No 76, June 2018) 58.

[103] The Northern Territory first engaged with abortion law reform in 1974 (ie the enactment of *Criminal Code Act 1983* (NT) s 174 based on the 1969 South Australian legislation), then in 2006 (ie the redrafting of *Criminal Code Act 1983* (NT) s 174 and the relocating of those provisions into the *Medical Services Act 1982* (NT) s 11), and then in 2017: see *Termination of Pregnancy Law Reform Act 2017* (NT). Initially this 2017 legislation allowed relatively easy access to abortion only until 14 weeks gestation, but recent amendments have extended that time period to 24 weeks gestation: see *Termination of Pregnancy Law Reform Legislation Amendment Act 2021* (NT) s 5, which amended *Termination of Pregnancy Law Reform Act 2017* (NT) s 7.

[104] See *Termination of Pregnancy Law Reform Legislation Amendment Act 2021* (NT).

[105] See *Termination of Pregnancy Law Reform Act 2017* (NT) s 6(1).

'surgical procedure' or the administration of a 'termination drug',[106] on a woman of any age,[107] and at any premises, provided the woman is not more than 24 weeks pregnant,[108] but only if the medical practitioner 'considers the termination is appropriate in all the circumstances'.[109] In making this determination the medical practitioner must have regard to:

> (a) all relevant medical circumstances; and
>
> (b) the woman's current and future physical, psychological and social circumstances; and
>
> (c) professional standards and guidelines.[110]

As explained with respect to the Victorian legislation, mandating that the relevant medical practitioner only perform an abortion when 'appropriate in all the circumstances', and compelling consideration of the above factors, is arguably superfluous as it does not add value to what a medical practitioner is obliged to do with respect to any medical procedure. That is, to act in accordance with applicable health law, professional standards and guidelines, and make an informed clinical decision on the available medical evidence and in the patient's best interests. In addition, it might be argued that specifically mandating these requirements only serves to delay the process of accessing an abortion because a medical practitioner may thereby seek to make especially sure that all such legislative requirements are met, rather than simply performing the safe and common medical procedure that is being requested.[111]

More problematic from a women's rights perspective is that the provision effectively serves to remove the abortion decision from the woman concerned. That is, the legislation makes it clear that the medical practitioner decides whether the abortion is 'appropriate in all the circumstances',[112] which serves to erode the pregnant woman's 'agency and autonomy'.[113] In all other jurisdictions, the abortion decision is initially the pregnant woman's to make, but then

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[106] Ibid.
[107] See ibid s 4. Prior to the 2017 legislation, further conditions applied if the woman was under 16 years of age: see the repealed *Medical Services Act 1982* (NT) s 11(5).
[108] See *Termination of Pregnancy Law Reform Act 2017* (NT) s 7.
[109] Ibid.
[110] Ibid. Such standards and guidelines may be set by the Chief Health Officer: see *Termination of Pregnancy Law Reform Regulations 2017* (NT) rr 5–7.
[111] The relative safety of abortion has been highlighted earlier: see above nn 96–8. The fact that it is a common procedure is based on data that suggests that approximately one third of Australian women will have an abortion: see, eg, Belton, Gerry and Stulz (n 33) 28; SALRI (n 10) 113.
[112] *Termination of Pregnancy Law Reform Act 2017* (NT) s 7.
[113] Ronli Sifris, Tania Penovic and Caroline Henckels, 'Advancing Reproductive Rights through Legal Reform' (2020) 43(3) *UNSW Law Journal* 1078, 1081.

becomes, at a certain gestation, a decision for the medical profession.[114] In the NT, it is never the woman's decision, and there exists no abortion on demand at any stage, as the medical profession is granted legal gatekeeping power in this regard for the duration of any pregnancy.[115] No other health service or medical procedure is so categorically taken out of the adult patient's hands.

After 24 weeks gestation the medical practitioner that performs the termination of pregnancy must have 'consulted with at least one other medical practitioner who has assessed the woman',[116] and each medical practitioner must consider the termination 'appropriate in all the circumstances'[117] upon an assessment of the identical issues (as quoted above) with respect to a termination of not more than 24 weeks gestation.[118] Both of the requisite two medical practitioners must have personally examined the woman concerned in arriving at this assessment, which does not reflect current clinical practice,[119] and is likely to cause delay in accessing the service, especially in remote areas.[120]

Finally, although no upper limit is mentioned in the *Termination of Pregnancy Law Reform Act 2017* (NT), the NT maintains the offence of child destruction, which may serve to place an implicit upper limit on lawful abortions.[121] This is problematic for a number of reasons,[122] not the least of which is that upper legal

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[114] That is, in Victoria, Tasmania, Queensland, NSW, SA, and WA, although the abortion decision is taken out of the woman's hands at certain gestations, at which point the abortion will only be lawful if the requisite medical practitioners conclude that it is appropriate to perform the abortion, up until those gestational limits are reached the abortion decision is solely the woman's to make. The exception to this is the ACT, in which the abortion decision remains the woman's to make regardless of gestation.

[115] There is no medical basis for this: see, eg, Forster and Jivan, who contend that '[t]here is no compelling reason to prefer medical practitioners over pregnant women and girls as the decision-makers in abortion. Even when termination requires medical advice, there is no compelling reason why practitioners should not, as in any other medical decision, provide the appropriate advice to assist the woman or girl to make the best decision for herself': Forster and Jivan (n 10) 863.

[116] *Termination of Pregnancy Law Reform Act 2017* (NT) s 9(a).

[117] Ibid s 9(b).

[118] See ibid.

[119] This requirement of two opinions has been described as outdated, unnecessary, and possessing no cogent basis: see SALRI (n 10) 348. The further requirement of that second opinion being necessarily based upon an in-person examination of the patient reinforces this description in the age of telehealth.

[120] This issue with remote patients is alleviated somewhat if the patient is not more than 14 weeks pregnant, in which case a medical practitioner may 'direct an authorised ATSI health practitioner, authorised midwife, authorised nurse or authorised pharmacist to assist in the performance of a termination': *Termination of Pregnancy Law Reform Act 2017* (NT) s 8(1).

[121] See *Criminal Code Act 1983* (NT) s 170.

[122] For example, by maintaining the offence of child destruction, the NT has arguably enacted conflicting legislation as a foetus at 24 weeks gestation is likely to be a 'child capable of being born

limits tend to have negative health consequences for women.[123] As mentioned previously, there is no medical basis for mandating such limits in every case, so maintaining gestational limits constitutes a further example of the legal exceptionality of abortion.[124]

E *The Victorian Model: Queensland, New South Wales, South Australia, and Western Australia*

In Queensland, NSW, SA, and WA, the Victorian legislation was utilised as the basic template for abortion law reform.[125] In chronological order, the relevant legislation in the jurisdictions that followed aspects of the Victorian model are as follows: *Termination of Pregnancy Act 2018* (Qld), *Abortion Law Reform Act 2019* (NSW), *Termination of Pregnancy Act 2021* (SA), and *Abortion Legislation Reform Act 2023* (WA). In all of these jurisdictions, a termination of pregnancy achieved prior to a certain gestation is lawful in a broad set of circumstances.

1 *Lawful Abortion Prior to Specific Gestation*

In Queensland, provided the termination is performed at no more than 22 weeks gestation by a medical practitioner,[126] or a registered health practitioner if the termination is achieved by use of abortifacients,[127] there now effectively exists a situation of abortion on demand.[128] This is also the case at no more than 22 weeks gestation in NSW, provided the termination is performed by 'a prescribed health

alive', and thus arguably protected by those child destruction provisions. For discussion of such issues see Rankin, 'The Offence of Child Destruction' (n 17).

[123] See, eg, World Health Organization, *Safe abortion: technical and policy guidance for health systems* (Department of Reproductive Health and Research, 2nd ed, 2012) 93–4. The Public Health Association of Australia contends that 'gestational limits are inappropriate mechanisms for regulating the provision of abortion': Public Health Association of Australia (n 50) 2.

[124] See Erica Millar, 'Maintaining Exceptionality: Interrogating Gestational Limits for Abortion' (2022) 31(3) *Social & Legal Studies* 439.

[125] One might argue that the NT legislation also utilised the Victorian model, but the fact that the abortion decision in the NT is never the woman's to make (as outlined above) constitutes a fundamental deviation from the Victorian legislation.

[126] See *Termination of Pregnancy Act 2018* (Qld) s 5.

[127] See ibid s 6A. Registered health practitioners include midwives, nurses, and any other 'practitioner prescribed by regulation': at s 6A(1).

[128] Other registered health practitioners 'in the practice of the practitioner's prescribed health profession' may assist 'in the performance of the termination', whether it be a surgical or medical termination of pregnancy: ibid s 7(2). Health profession students may also assist under supervision: at s 7(3). It is also implicit that any failure by a qualified person to comply with the conditions stipulated under the *Termination of Pregnancy Act 2018* (Qld) will not be penalised criminally, but rather the qualified person will be left to such professional disciplinary proceedings and consequences as might eventuate with non-compliance with the statutory standards of any other medical procedure: at s 9.

practitioner',[129] who has 'obtained informed consent' for the termination.[130] This is defined as consent given 'freely and voluntarily' and in accordance with applicable guidelines.[131] One might argue that the provision is thereby redundant as informed consent so defined is already 'an integral aspect of health law and practice'.[132]

In SA, provided the pregnant woman 'is not more than 22 weeks and 6 days pregnant', an abortion may be lawfully performed 'by a medical practitioner acting in the ordinary course of the practitioner's profession'.[133] The legislation also makes it clear that 'any other registered health practitioner acting in the ordinary course of the practitioner's profession' may terminate a pregnancy by administering abortifacients, provided the registered health practitioner is authorised to prescribe such medication.[134] In common with Queensland and NSW, no reasons need to be provided by the pregnant woman in requesting an abortion, and the decision is hers to make, as the medical practitioner or health

[129] *Abortion Law Reform Act 2019* (NSW) s 5(1). The original 2019 legislation only allowed for medical practitioners to perform abortions, but this was amended by the *Abortion Law Reform Amendment (Health Care Access) Act 2025* (NSW) to allow for prescribed health practitioners, which includes 'an endorsed midwife' or a nurse practitioner: *Abortion Law Reform Act 2019* (NSW) s 5(4). In common with the Queensland legislation, in terms of assistance, registered health practitioners, in the practice of their health profession, may assist the medical practitioner, including a 'nurse, midwife, pharmacist or Aboriginal and Torres Strait Islander health practitioner, or another registered health practitioner prescribed by the regulations': at s 8(1).

[130] *Abortion Law Reform Act 2019* (NSW) s 5(2). Unless an emergency situation exists, and it is not practicable to do so: at s 5(3).

[131] Ibid sch 1.

[132] SALRI (n 10) 22. However, it should be noted that such applicable guidelines, in relation to the performance of an abortion, may be decided upon by the Secretary of the Ministry of Health, and may place further burdens on informed consent with respect to abortion care than are prescribed in other forms of health care: see *Abortion Law Reform Act 2019* (NSW) s 14.

[133] *Termination of Pregnancy Act 2021* (SA) s 5(1)(a). It is submitted that 'acting in the ordinary course of the practitioner's profession' is a meaningless condition because it is fulfilled the moment the practitioner performs the termination, which includes '(a) administering or prescribing a drug or other substance; or (b) using a medical instrument or other thing': at s 3.

[134] Ibid s 5(1)(b). A 'registered health practitioner' is defined as any person (other than a student) registered under the *Health Practitioner Regulation National Law*: at s 3. It is also the case that, whether the abortion is performed by a medical practitioner or other registered health practitioner, another registered health practitioner (including a medical practitioner) 'acting in the ordinary course of the practitioner's profession' may assist in that termination of pregnancy: at s 10. As mentioned above with respect to the Victorian legislation, authorising non-medical practitioner health professionals to perform medical abortions is laudable as it enhances access to abortion services and reflects best clinical practice.

practitioner does not need to be satisfied that legislatively mandated criteria are met.[135]

In WA, provided the person concerned is not more than 23 weeks pregnant,[136] a medical practitioner 'is authorised to perform an abortion',[137] and a 'prescribing practitioner' may prescribe, supply, or administer abortion drugs for that purpose.[138] A 'registered health practitioner in a relevant health profession (other than pharmacy)' may supply or administer an abortion drug 'on the direction of a directing practitioner'.[139] Further, a pharmacist is authorised to supply an abortion drug on the basis of a relevant direction or prescription.[140] Other registered health practitioners, and relevant health profession students, may assist in the performance of an abortion at any gestation, provided that abortion is authorised under the legislation.[141] One may readily note that the conditions described in the above jurisdictions broadly reflect the Victorian model.

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[135] This is not quite correct, as certain information on counselling must be provided: *Termination of Pregnancy Act 2021* (SA) s 8; and an abortion must not be performed 'for the purposes of sex selection': at s 12(1). These issues will be discussed further below.

[136] *Public Health Act 2016* (WA) s 202MC. It should be noted that the legislation refers to 'person' rather than 'woman'. It should also be noted that if the person is under 18 years of age and the registered health practitioner considers that the patient 'does not have the capacity to consent, on their own behalf, to the abortion being performed on them because the patient has not achieved a sufficient understanding and intelligence to enable them to understand fully what is proposed', or 'it is not possible to ascertain whether the patient has the capacity to consent', then a parent or guardian may participate in the decision making process, including providing the relevant consent or refusal, but only if the patient agrees to that participation: at s 202MM.

[137] Ibid s 202MC. The performance of an abortion constitutes doing 'any act with the intention of causing the termination of the pregnancy': at s 202MB(1). It includes prescribing, supplying or administering 'an abortion drug': at ss 202MB(2)(a)–(c). It also includes 'carrying out a surgical or other procedure': at s 202MB(2)(d). However, merely 'assisting a person to do an act done with the intention of causing the termination of a pregnancy' does not constitute the performance of an abortion: at s 202MB(3).

[138] Ibid s 202MD. The definition of 'prescribing practitioner' refers to registered health practitioners that are authorised to prescribe an abortion drug under the *Medicines and Poisons Act 2014* (WA) and the relevant regulations: *Public Health Act 2016* (WA) s 202MD(1).

[139] *Public Health Act 2016* (WA) s 202MF(3). As mentioned above, permitting non-medical practitioner health professionals to perform medical abortions has a positive impact on access to abortion services, is best clinical practice, and is consistent with a patient centred approach.

[140] Ibid s 202MF(2). After 23 weeks gestation, any such prescription must be issued by a medical practitioner, while prior to 23 weeks the prescription may be issued by a prescribing health practitioner: at s 202MF(1).

[141] Ibid s 202MG. If the registered health practitioner or relevant health profession student 'knows' that the abortion is being performed 'other than as authorised' under the legislation, then such assistance is not permitted: at ss 202MG(2), (5). The definition of 'health profession' has a wide meaning pursuant to *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 5, including medical practitioners, nurses, midwives and pharmacists: see *Public Health Act 2016* (WA) ss 4, 202MA.

However, in NSW and SA, more is required in order to perform a lawful abortion. In NSW, prior to performing an abortion, the relevant registered health practitioner must also 'assess whether or not it would be beneficial to discuss with the person accessing counselling about the proposed termination',[142] and 'if, in the registered health practitioner's assessment, it would be beneficial and the person is interested in accessing counselling, provide all necessary information to the person about access to counselling'.[143] Although at first glance this echoes some features of the now repealed WA legislation of 1998,[144] unlike that WA legislation, the NSW provision does not require mandatory counselling. Instead, there is merely a requirement that an assessment be made as to whether the person concerned would benefit from access to counselling.[145] Furthermore, in practice it may have little effect, as a medical practitioner might satisfy the provision by simply asking whether the woman concerned wants information with respect to access to counselling. In SA, prior to performing an abortion (whether performed by a medical practitioner or other registered health practitioner) 'all necessary information … about access to counselling, including publicly-funded counselling' must be provided to the person seeking an abortion.[146] To mandate the provision of such information is condescending to the woman concerned, as it presumes that she has not already considered all such matters prior to deciding to terminate her pregnancy.[147] Nonetheless, in common with NSW, the SA legislation does not mandate counselling, only the provision of information about accessing counselling, so it remains the woman's prerogative whether to seek counselling, or indeed to even read the information provided.

2 *Lawful Abortion After Specific Gestation*

As highlighted previously, there are no medical or clinical reasons to mandate further conditions on lawful abortion after a specified gestation period. Thus, the imposition of such requirements must have another purpose. Most legislation is silent as to what this objective might be, but in Queensland the basis of such provisions is arguably a contested view of the status of the foetus. The *Termination of Pregnancy Act 2018* (Qld) is, with some minor changes, the

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[142] *Abortion Law Reform Act 2019* (NSW) s 7(1)(a).
[143] Ibid s 7(1)(b).
[144] See the historical versions of *Health (Miscellaneous Provisions) Act 1911* (WA) ss 334(3)(a), (5).
[145] That is, the provision of relevant access to counselling information is only mandated consequent to that assessment: see *Abortion Law Reform Act 2019* (NSW) s 7(1)(b). For a discussion of the NSW counselling provisions see Walsh and Legge (n 54) 328–31.
[146] *Termination of Pregnancy Act 2021* (SA) s 8(1). Such information need not be provided in cases of emergency: at s 8(2). This ignores the SALRI recommendation not to mandate such information provision: see SALRI (n 10) 280.
[147] See, eg, SALRI (n 10) 278–80.

enactment of the Draft Termination of Pregnancy Bill 2018 put forward by the Queensland Law Reform Commission ('QLRC') in its 2018 report.[148] The Queensland Parliament thus took what the QLRC described as the 'combined' approach.[149] This incorporates a gradualist position on the status of the foetus,[150] with restrictions on accessing abortion services increasing as the gestational age of the foetus increases because, as the QLRC explained, 'the interests of the fetus have increasing weight'[151] and 'as the fetus develops, its interests are entitled to greater recognition and protection'.[152] It is arguable that all jurisdictions other than the ACT have implicitly adopted a similar perspective on the foetus in restricting access to abortion care after a certain gestation, but Queensland stands alone in making that link more explicit by accepting the QLRC position in that regard. However, the QLRC view ignores two crucial points. First, it is arguably a doubtful, and certainly a contestable, moral/philosophical position to take as to whether the foetus has interests that warrant legal protection.[153] Second, any such legal protection afforded the foetus necessarily erodes any legal protection or rights afforded to the pregnant woman.[154] The Queensland approach thus infringes upon the rights of an actual person, on the basis of an implicit determination upon an issue that is philosophically intractable, and for

[148] See QLRC (n 102) app F.
[149] Ibid 59.
[150] See ibid 274.
[151] Ibid 6.
[152] Ibid 94.
[153] That is, whether the foetus is a moral person is open to debate. However, there is no doubt that the foetus is not a legal person. This has been the common law position for centuries, either implicitly, by virtue of the fact that the foetus cannot be the victim of homicide: see, eg, Edward Coke, *The Third Part of the Institutes of the Laws of England: Concerning High Treason, and Other Pleas of the Crown, and Criminal Causes* (W Clarke & Sons, 1791) 47–50; *R v Poulton* (1832) 5 C & P 329, 330; *R v Hutty* [1953] VLR 338, 339; *Barrett v Coroner's Court of South Australia* (2010) 108 SASR 568, 573–5; or expressly. Perhaps the most pertinent statement is made by Justice Lindenmayer, in concluding that the foetus 'has no legal personality and cannot have a right of its own until it is born and has a separate existence from its mother': *In the Marriage of F* (1989) 13 Fam LR 189, 194. Indeed, Justice Lindenmayer went so far as to label the foetus a 'non-person': at 197. See also *Attorney General (Qld) (ex rel Kerr) v T* (1983) 46 ALR 275, 277 (Gibbs CJ); *Paton v British Pregnancy Advisory Service Trustees* [1979] 1 QB 276, 279 (Baker P). Similar determinations are evident in legislation: see, eg, *Criminal Code Act 1924* (Tas) s 153(4). This lack of foetal personhood has been described as a 'fundamental premise of both civil and criminal law': SALRI (n 10) 12. It should also be noted that the *Human Rights Act 2019* (Qld) does not apply to a termination of pregnancy or 'an unborn child': at s 106. Indeed, it has recently been decided with respect to the *Human Rights Act 2019* (Qld) that 'only individuals have human rights, and an unborn child is not yet an individual': *Darling Downs Hospital and Health Service v J* [2024] QSC 330, [39]. However, it should also be noted that one may owe certain ethical obligations to an organism that is neither a moral nor legal person.
[154] See, eg, Judith Jarvis Thomson, 'A Defense of Abortion' (1971) 1(1) *Philosophy and Public Affairs* 47, 53–4; Smyth (n 8) 337; Furedi (n 8) 201–2.

which there is no societal consensus, which is a completely inappropriate determination for the law to make. As there exists a lack of philosophical and societal unanimity of opinion on the status of the foetus, the law must take 'a minimalist, morally neutral position'.[155] To do otherwise arguably 'undermines the legitimacy' of our legal system.[156] Contrary to this reasoning, all jurisdictions other than the ACT prescribe further restrictions on lawful abortion once a certain gestation has been reached. As detailed above, Victoria imposes such restrictions post-24 weeks gestation.[157] The relevant legislation in Queensland, NSW, SA, and WA reflects this approach.

In Queensland, after 22 weeks gestation only medical practitioners may lawfully terminate a pregnancy, and the medical profession (not the woman concerned) is granted the decision-making power, as a medical practitioner may only perform a termination of pregnancy if:

> (a) the medical practitioner considers that, in all the circumstances, the termination should be performed; and
>
> (b) the medical practitioner has consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed.[158]

As mentioned previously, the requirement of a second opinion is medically unjustified, and not legislatively mandated in any other standard medical procedure.[159] As to the matters that must be considered in forming this assessment, the relevant medical practitioners must consider:

> (a) all relevant medical circumstances; and
>
> (b) the woman's current and future physical, psychological and social circumstances; and

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[155] Andrew McGee, Melanie Jansen and Sally Sheldon, 'Abortion Law Reform: Why Ethical Intractability and Maternal Morbidity are Grounds for Decriminalisation' (2018) 58(5) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 594, 595.
[156] Ibid 596.
[157] See *Abortion Law Reform Act 2008* (Vic) s 5.
[158] *Termination of Pregnancy Act 2018* (Qld) s 6(1).
[159] Which is not to say that it might be best clinical practice to seek a second opinion in certain circumstances; the point is simply that it is not medically warranted to prescribe such a second opinion in all cases. Sheldon argues that the requirement of two medical practitioner opinions serves a bureaucratic rather than medical purpose: see Sheldon, 'The Decriminalisation of Abortion' (n 96) 345; and that this requirement of two opinions 'is at the heart of the medical control' of abortion: Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) *Modern Law Review* 283, 314.

(c) the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination.[160]

Thus, the legal situation in Queensland post-22 weeks gestation is almost identical to that prescribed in Victoria post-24 weeks gestation.[161] The only difference is that in Queensland the two medical practitioners must also consider 'professional standards and guidelines'[162] in arriving at a determination that the abortion should be performed 'in all the circumstances'.[163] As was the case with this aspect of the Victorian legislation, the criticism of superfluous requirements may be directed against the above provisions,[164] as a medical practitioner must contemplate all these matters in any case.[165]

The law in WA is similar to Queensland, in that, after 23 weeks gestation, a medical practitioner is only authorised to perform an abortion if he or she 'reasonably believes that performing the abortion is appropriate in all the circumstances',[166] and 'has consulted with at least 1 other medical practitioner who … also reasonably believes that performing the abortion is appropriate in all the circumstances'.[167] In forming this belief, both medical practitioners must have regard to almost identical concerns as exist in the Queensland and Victorian Acts.[168] However, the obligation to consult with another medical practitioner post-23 weeks gestation is somewhat more flexible than in those other jurisdictions, in the sense that the other medical practitioner need not necessarily be practising in WA,[169] and if that other medical practitioner does not believe that the abortion is appropriate in all the circumstances, the primary medical

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[160] *Termination of Pregnancy Act 2018* (Qld) s 6(2).
[161] Indeed, the matters listed under *Termination of Pregnancy Act 2018* (Qld) ss 6(2)(a)–(b) are taken directly from those listed under *Abortion Law Reform Act 2008* (Vic) s 5(2).
[162] *Termination of Pregnancy Act 2018* (Qld) s 6(2).
[163] Ibid s 6(1).
[164] SALRI also make the point that such criteria are inherently 'problematic', and even the broad criterion of 'in all the circumstances' is 'so vague as to be meaningless': SALRI (n 10) 209.
[165] That is, in any medical procedure the relevant health practitioner must consider all the medically relevant factors, including the patient's current and future circumstances, and applicable professional standards and guidelines.
[166] *Public Health Act 2016* (WA) s 202ME(1)(a).
[167] Ibid s 202ME(1)(b).
[168] Ibid s 202ME(2): '(a) all relevant medical circumstances; and (b) the person's current and future physical, psychological and social circumstances; and (c) the professional standards and guidelines commonly accepted by members of the medical profession that apply to the medical practitioner in relation to the performance of the abortion.' This is not an exhaustive list, as medical practitioners may also have regard to other matters when determining whether the abortion is 'appropriate': at s 202ME(3).
[169] See ibid s 202ME(4)(a).

practitioner may approach another medical practitioner for the purposes of securing the desired second opinion.[170]

In NSW, after 22 weeks gestation, the legal situation becomes more restrictive than it is in Victoria, Queensland or WA because only a 'specialist medical practitioner' may perform the termination,[171] and only if he or she and another specialist medical practitioner that they have consulted, 'considers that, in all the circumstances, there are sufficient grounds for the termination to be performed'.[172] In making this required assessment, both specialist medical practitioners must consider largely identical criteria to those that exist in Queensland.[173] As indicated earlier, there is no clinical necessity for two medical practitioner opinions in every case. Accordingly, there is certainly no clinical need for two specialist opinions, or for a specialist to perform the procedure. That is, although an abortion post-22 weeks gestation is a more serious procedure than early abortion, and in some circumstances might require second opinions or specialists, this should be decided on a case-by-case clinical basis according to good health practice and the patient's best interests, not arbitrarily by the law.[174] To dictate the necessity of such specialists in advance 'undermines patient autonomy',[175] and indicates that abortion is clearly not being treated like any other medical procedure.

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[170] See ibid s 202ME(4)(b). One may assume that the primary medical practitioner may approach any number of other medical practitioners until the opinion sought is provided. Of course, it is arguably the case that in other jurisdictions a similar practice of seeking second opinions may lawfully be initiated, but WA stands alone in specifically allowing for that practice in the relevant legislation.

[171] *Abortion Law Reform Act 2019* (NSW) s 6(1). Informed consent must also be obtained: at s 6(1)(c). 'Specialist medical practitioner' is defined as '(a) a medical practitioner who, under the Health Practitioner Regulation National Law, holds specialist registration in obstetrics and gynaecology, or (b) a medical practitioner who has other expertise that is relevant to the performance of the termination, including, for example, a general practitioner who has additional experience or qualifications in obstetrics': at sch 1.

[172] Ibid ss 6(1)(a)–(b).

[173] That is, '(a) all relevant medical circumstances, and (b) the person's current and future physical, psychological and social circumstances, and (c) the professional standards and guidelines that apply to the specialist medical practitioner in relation to the performance of the termination': ibid s 6(3). The legislation allows for the Secretary of the Ministry of Health to 'issue guidelines about the performance of terminations' and 'a registered health practitioner performing a termination, or assisting in the performance of a termination, must perform the termination in accordance with the guidelines': ibid ss 14(1), (3). Such guidelines might well restrict the practice of abortion further.

[174] SALRI recommended that neither specialists nor two medical opinions should be mandated: see SALRI (n 10) 19, 26, 28, 242, 348.

[175] Ibid 19.

In addition, the NSW legislation mandates that, in cases of an abortion at post-22 weeks gestation, the 'specialist medical practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling'.[176] Although some women might desire such information, to mandate its provision demeans a woman's decision-making ability as it presupposes that she has not already considered all such matters and seriously contemplated the termination she is requesting.[177] Nonetheless, the provision does not mandate counselling itself, which would constitute a serious insult to the pregnant woman's agency and autonomy, but rather only compels the provision of information relevant to accessing counselling. Thus, the decision to engage with counselling remains solely the woman's to make. NSW also departs from the Victorian template by demanding that post-22 weeks gestation terminations must be performed in a hospital or 'approved health facility',[178] which might well be clinically appropriate in some instances, but should not be dictated in advance.[179]

In SA, after 22 weeks and 6 days gestation, the law is similar to that in NSW, but more restrictive. Post-22 weeks and 6 days gestation, an abortion is only available in SA if performed by a 'medical practitioner acting in the ordinary course of the practitioner's profession',[180] and where both that medical practitioner and a second medical practitioner who has been consulted consider that, 'in all the circumstances':

> (i) the termination is necessary to save the life of the pregnant person or save another foetus; or
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> (ii) the continuance of the pregnancy would involve significant risk of injury to the physical or mental health of the pregnant person; or
>
> (iii) there is a case, or significant risk, of serious foetal anomalies associated with the pregnancy.[181]

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[176] *Abortion Law Reform Act 2019* (NSW) s 7(2).
[177] See SALRI (n 10) 278-80.
[178] *Abortion Law Reform Act 2019* (NSW) s 6(1)(d). Such approval is made via the Secretary of the Ministry of Health: at s 13. There is no requirement that 'any ancillary services necessary to support the performance of a termination be carried out only at the hospital or approved health facility at which the termination is, or is to be, performed': at s 6(2); and 'ancillary services' includes tests, other medical procedures, treatments and services, and the 'administration, prescription or supply of medication': at s 6(6).
[179] See, eg, Sheldon, who makes the point that this approved facility criterion is 'unsupported by any current medical evidence base': Sheldon, 'The Decriminalisation of Abortion' (n 96) 345.
[180] *Termination of Pregnancy Act 2021* (SA) s 5(2)(a).
[181] Ibid ss 6(1)(a)–(b).

These conditions echo the repealed criminal law provisions on abortion.[182] However, it should be noted that the above conditions are less severe than those of the repealed criminal law. First, the second medical practitioner referred to above only needs to be 'consulted', whereas the repealed law required both medical practitioners to have 'personally examined the woman' in arriving at their requisite opinions.[183] Second, the repealed law required the continuance of the pregnancy to constitute a 'greater risk' to the pregnant woman's health,[184] whilst the new law only requires that there be a 'significant risk' in that regard.[185] As mentioned previously, abortion is generally always safer than childbirth,[186] so the above conditions would probably be met in almost every case. This is especially likely in SA (as compared with Tasmania) as it is only necessary to show 'significant risk', rather than 'greater risk'. In addition, unlike the Tasmanian legislation, the SA legislation does not expressly mandate a comparative assessment of risk as between abortion and childbirth, so the definition of 'significant risk' is left largely untethered, subjective, and consequently vague. Indeed, it might be reasonably argued that the continuance of a pregnancy would necessarily involve significant risk to the pregnant woman's mental health if that pregnancy were unwanted. In other words, the provisions are arguably pointless. Nonetheless, the burden of meeting these additional legal criteria after a certain gestation is not medically justified, and dilutes patient autonomy because the abortion decision is thereby no longer the woman's to make and the medical profession become the legal gatekeepers to abortion care.[187]

In addition, an abortion post-22 weeks and 6 days gestation must be 'performed at a prescribed hospital' in SA,[188] information about accessing counselling must be provided,[189] and the above medical practitioners must also hold the abortion

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[182] See the repealed *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a).
[183] Ibid s 82A(1)(a). Such opinions also needed to be certified: at s 82A(4)(a).
[184] See ibid s 82A(1)(a)(i). This remans the requisite assessment in Tasmania: see *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(1).
[185] See *Termination of Pregnancy Act 2021* (SA) ss 6(1)(a)(ii), (b)(ii). There are also slight differences in terms of the foetal abnormality ground: see the repealed *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a)(ii); *Termination of Pregnancy Act 2021* (SA) ss 6(1)(a)(iii), (b)(iii); but such differences are not important as the foetal abnormality ground would be subsumed within the maternal health risk grounds for a lawful abortion.
[186] See above nn 96–8.
[187] This is also arguably contrary to the principle of self-determination, as the medical profession should not be gatekeepers to the rights of women: see Forster and Jivan (n 10) 862–3.
[188] *Termination of Pregnancy Act 2021* (SA) s 6(1)(c). A 'prescribed hospital' is that prescribed by the regulations: at s 3; *Termination of Pregnancy Regulations 2022* (SA) reg 4 and sch 1. This provision goes against the SALRI recommendation that no such approved or prescribed facility condition be included in the legislation: see SALRI (n 10) 20, 27, 192.
[189] See *Termination of Pregnancy Act 2021* (SA) s 8(1).

to be 'medically appropriate' considering '(a) all relevant medical circumstances; and (b) the professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination'.[190] As mentioned above with respect to the equivalent Victorian, Queensland, WA, and NSW provisions,[191] mandating the consideration of the above factors is arguably superfluous as applicable health law and standards would require medical practitioners to consider these issues in any case as part of appropriate clinical practice. However, the SA legislation goes beyond the above mentioned jurisdictions and imposes further compulsory assessments that medical practitioners must 'have regard to' when performing abortions post-22 weeks and 6 days gestation.[192] These matters that the medical practitioners must consider are excessive, cumbersome, and from a woman's reproductive rights perspective, insulting, including (but not limited to): whether the survival of other foetuses would be impacted in cases involving a multiple pregnancy;[193] whether foetal abnormality might have been diagnosed prior to 22 weeks and 6 days gestation;[194] whether the foetus had been exposed to 'infective agents' that may have damaged the foetus;[195] whether specialist services might have been accessed prior to 22 weeks and 6 days gestation;[196] and whether the pregnant woman has a 'medical condition … incompatible with an ongoing pregnancy'.[197] Some of the matters listed above (and others not mentioned above, but listed in the legislation) may be medically relevant in some situations, and in those situations would have to be considered by a health practitioner acting in accordance with generally applicable health law and standards. However, to mandate the consideration of all these issues is clinically unjustified and a clear statement by the SA Parliament that abortion post-22 weeks and 6 days gestation is unlike any other health care practice. Furthermore, the convoluted and numerous matters that must be considered by medical practitioners might serve to discourage medical practitioners from providing abortion services after 22 weeks and 6 days gestation.[198]

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[190] Ibid s 6(2).
[191] See, eg, *Abortion Law Reform Act 2008* (Vic) s 5(2).
[192] *Termination of Pregnancy Act 2021* (SA) s 9.
[193] See ibid s 9(a).
[194] See ibid s 9(b).
[195] Ibid.
[196] See ibid s 9(c).
[197] Ibid s 9(g).
[198] It might be argued that this was the purpose of mandating such assessments, but there is no direct evidence of this in the relevant parliamentary debates.

3 *Further Issues in New South Wales and South Australia*

The restrictive nature of abortion law in both NSW and SA is exacerbated by the problematic issues of 'born' foetuses and sex selection. In both of these jurisdictions, provision is made for when an attempted termination results 'in a person being born'.[199] In such a case, the legislation states that a health practitioner may exercise their duty to provide that person 'with medical care and treatment',[200] and that 'the duty owed by a registered health practitioner to provide medical care and treatment to a person born as a result of a termination is no different than the duty owed to provide medical care and treatment to a person born other than as a result of a termination'.[201] This is a confounding requirement.[202] Assuming that being 'born' in this context follows the common law definition of being fully extruded from the mother and exhibiting 'any sign of life, no matter how faint or fleeting',[203] it is self-evidently the case that a health practitioner does not owe the same duties to a foetus so 'born' (ie, one that may 'live' for only a moment) compared to a viable newborn. This provision is extremely insulting to the woman having the abortion, as it defines her as a mere vessel for the foetus that is so 'born'.

The other challenging subject that the legislation in NSW and SA deals with is sex selection.[204] The *Abortion Law Reform Act 2019* (NSW) makes the statement that 'Parliament opposes the performance of terminations for the purpose of sex selection.'[205] Recent guidelines provided by the Minister pursuant to s 14 of the *Abortion Law Reform Act 2019* (NSW) have expressly stated that if the request for an abortion is motivated 'for the sole purpose of sex selection', then 'the practitioner must not perform the termination, unless not performing the termination will cause significant risk to the woman's health or safety'.[206]

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[199] *Abortion Law Reform Act 2019* (NSW) s 11(1); *Termination of Pregnancy Act 2021* (SA) s 7(1).
[200] *Abortion Law Reform Act 2019* (NSW) s 11(2); *Termination of Pregnancy Act 2021* (SA) s 7(2).
[201] *Abortion Law Reform Act 2019* (NSW) s 11(3); *Termination of Pregnancy Act 2021* (SA) s 7(3).
[202] It should be noted that the NSW provisions were one of many late amendments to the Bill made by the National Party's Niall Blair. For a list of all such amendments see 'In Review: Abortion Law Reform Act 2019', *The House in Review* (Web Page, 2 October 2019) <https://thehouseinreview.com/2019/10/02/in-review-abortion-law-reform-act-2019/>.
These provisions were followed verbatim by the SA Parliament. A Bill reflecting a similar position was recently proposed at the federal level by the National Party's Senator Matthew Canavan: see Human Rights (Children Born Alive Protection) Bill 2022 (Cth).
[203] Rankin, 'The Offence of Child Destruction' (n 17) 19. See also *R v Iby* (2005) 63 NSWLR 278; *Barrett v Coroner's Court of South Australia* (2010) 108 SASR 568.
[204] See *Abortion Law Reform Act 2019* (NSW) s 16; *Termination of Pregnancy Act 2021* (SA) s 12.
[205] *Abortion Law Reform Act 2019* (NSW) s 16(1).
[206] NSW Health, Policy Directive: Framework for Termination of Pregnancy in New South Wales (17 June 2025) 7.

Similarly, in SA 'a registered health practitioner must not perform a termination of a pregnancy for the purposes of sex-selection',[207] unless 'the registered health practitioner is satisfied that there is a substantial risk that the person born after the pregnancy (but for the termination) would suffer a sex-linked medical condition that would result in serious disability to that person'.[208]

Given that the legislation in each jurisdiction does not expressly impose upon the pregnant woman concerned any obligation to justify her request for a termination, it seems unlikely that the pregnant woman would volunteer such a motivation for the termination of her pregnancy, so one would expect few refusals to perform terminations on this basis.[209] In addition, as there is no reliable evidence that the performance of abortions for the purpose of sex selection is occurring to any significant extent in NSW or SA,[210] there seems little point in the provision.[211] The condition serves only to unduly complicate what is already a complex area of law. Furthermore, the reason why a woman wants to terminate her pregnancy should be irrelevant from a legal standpoint; such reasons may be relevant from a clinical perspective but should have no bearing on the legality of the procedure.

This is not to say that sex selection in abortion is not philosophically nor morally problematic. Indeed, as it seems clear from an analysis of societies in which sex selection is comparatively common that female foetuses will be terminated more frequently than male foetuses,[212] it presents a feminist dilemma. As indicated briefly earlier, an unfettered right to abortion is necessary to protect women's

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[207] *Termination of Pregnancy Act 2021* (SA) s 12(1).
[208] Ibid s 12(2).
[209] The recent report from the Secretary of the Ministry of Health on the extent to which terminations are being performed for the purpose of sex selection (prepared pursuant to an obligation to so report under *Abortion Law Reform Act 2019* (NSW) s 16) indicates that less than 0.02 per cent of abortions in the reporting period were performed for the sole purpose of sex selection: see Secretary of the Ministry of Health, *Review of termination of pregnancy for the purpose of sex selection in NSW* (December 2020) 7, 14.
[210] See, eg, Ministry of Health (n 209) 7, 14.
[211] Another argument made by SALRI to not adopt this aspect of the NSW legislation is that any such prohibition on abortions for the purpose of sex selection would be largely unenforceable: see SALRI (n 10) 330–1.
[212] See, eg, Naryung Kim, 'Breaking Free from Patriarchy: A Comparative Study of Sex Selection Abortions in Korea and the United States' (1999) 17(3) *UCLA Pacific Basin Law Journal* 301, 317–20; April L Cherry, 'A Feminist Understanding of Sex-Selective Abortion: Solely a Matter of Choice?' (1995) 10(2) *Wisconsin Women's Law Journal* 161, 168–75; Colleen Davis and Heather Douglas, 'Selective Reduction of Fetuses in Multiple Pregnancies and the Law in Australia' (2014) 22(1) *Journal of Law and Medicine* 155, 171–2.

rights to equality,[213] bodily integrity,[214] self-determination,[215] and autonomy (among other rights),[216] yet a preference for males in sex selection abortions necessarily defines females as inferior, which negatively affects women as a class. This tension has been framed by Cherry as an example of the conflict between liberal feminism (with its focus on individual rights) and radical feminism (with its focus on substantive and collective outcomes).[217] Whilst acknowledging this complex philosophical friction, it is nonetheless this author's opinion that in the interests of reproductive freedom the abortion right must be absolute. Thus, if a woman wants to terminate her pregnancy for the purposes of sex selection, then that is her right.[218] Steps might well be taken to reduce the incidence of abortions undertaken for this reason, but those steps cannot include making that decision or termination unlawful if a woman's right to abortion is to be fully respected.[219] In any case, the above discussion amply highlights the now convoluted nature of providing lawful abortion services in NSW, and especially SA, and the clear legislative intention in both jurisdictions to regulate abortion care differently to other forms of health care by imposing conditions on the lawful practice of abortion that have no medical or clinical justification.[220]

On a more positive note, there appears to be no upper gestational limit for lawful abortions in NSW or SA.[221] This is also the case in Queensland. While retaining the offence of child destruction,[222] amendments made by the *Termination of*

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[213] See, eg, Catharine A MacKinnon, 'Reflections on Sex Equality Under Law' (1991) 100(5) *Yale Law Journal* 1281, 1308–11.

[214] See, eg, Christyne L Neff, 'Woman, Womb, and Bodily Integrity' (1991) 3(2) *Yale Journal of Law and Feminism* 327; Furedi (n 8) 124–9, 184–6; Petchesky (n 8) 378; Smyth (n 8) 343.

[215] See, eg, Petchesky (n 8) 387; Kathryn Kolbert, 'A Reproductive Rights Agenda for the 1990's' (1989) 1(1) *Yale Journal of Law and Feminism* 3; Furedi (n 8) 181–200.

[216] Furedi argues that all such rights are inextricably linked: Furedi (n 8) 126; and to deny women these rights is to deny women their humanity: at 200. All such rights may also be viewed as essential components of the overarching principle of reproductive freedom.

[217] See Cherry (n 212) 165–6, 208–16.

[218] See, eg, Walsh and Legge (n 54) 328; SALRI (n 10) 330.

[219] Obviously, this is a far broader and more complex issue than such a determination indicates. However, it is beyond the scope of this article to enter into a detailed analysis of the issue, so the above simplification must suffice.

[220] For example, the requirement in SA for two medical practitioners to make the requisite labyrinthine assessment: see *Termination of Pregnancy Act 2021* (SA) ss 6, 9; or the insistence that abortions may only be lawfully performed in prescribed hospitals: at s 6(1)(c).

[221] That is, no reference is made to an upper gestational limit in the *Abortion Law Reform Act 2019* (NSW), and NSW does not have a child destruction provision that might otherwise place an implicit limit on lawful abortions. Also see *Termination of Pregnancy Act 2021* (SA) sch 1 pt 2, repealing *Criminal Law Consolidation Act 1935* (SA) ss 82A(7)–(8), which previously placed upper gestational limits on lawful abortion.

[222] See *Criminal Code Act 1899* (Qld) s 313(1). The offence is actually labelled 'killing unborn child' but is the equivalent of the offence of child destruction in other jurisdictions.

Pregnancy Act 2018 (Qld) to the *Criminal Code Act 1899* (Qld) mean that, provided a person performs, or assists in performing, a termination of pregnancy in accordance with the *Termination of Pregnancy Act 2018* (Qld), they commit no criminal offence under the child destruction provision.[223] However, WA retains the offence of child destruction in its older form, which may place an implicit upper gestational limit on lawful abortions.[224]

IV CONCLUSION

No Australian jurisdiction fully recognises a woman's right to abortion as no jurisdiction regulates abortion care in the same manner as other standard health care.[225] As indicated at the outset of this article, the fact that all jurisdictions maintain a residual offence of abortion and specifically cater for conscientious objection to abortion necessarily results in this finding, and this initial conclusion has been reinforced throughout the course of this article by reference to the various conditions placed upon the lawful provision of abortion services that have no coherent medical basis.[226]

The predominant issue remains that, with the exception of the ACT, all jurisdictions mandate that women receive medical approval for the abortion beyond what is necessary from a clinical perspective. This is exacerbated when the approval of two medical practitioners is required.[227] Such conditions serve only to erode women's autonomy,[228] and restrict and delay access to abortion

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[223] See ibid s 313(1A) as inserted by *Termination of Pregnancy Act 2018* (Qld) s 24. However, this arguably means that any failure to meet the requirements of a lawful abortion pursuant to the *Termination of Pregnancy Act 2018* (Qld) enlivens the child destruction provisions, even for a qualified person performing or assisting in that abortion. As explained previously, in the interests of achieving legal clarity and certainty, the child destruction offence is best abolished, rather than attempting such piecemeal exceptions: see Rankin, 'The Offence of Child Destruction' (n 17).

[224] See *Criminal Code Act Compilation Act 1913* (WA) s 290.

[225] Forster and Jivan contend that the failure to treat abortion in the same way as any other health service results in the further determination that 'no jurisdiction in Australia is fully in accord with international obligations' to recognise women's reproductive rights: Forster and Jivan (n 10) 855, 862. See also Belton, Gerry, and Stulz (n 33) 25, 42–4. Sifris and Belton argue that 'treating abortion differently to other forms of healthcare is inherently discriminatory … [because] … abortion is an aspect of health care required only by women … [thus] … differential treatment that the law accords to abortion as against other forms of medical treatment … constitutes a form of discrimination against women': Sifris and Belton (n 10) 212.

[226] Millar describes this as 'abortion exceptionalism': Millar (n 15) 262–3. Millar contends that it probably stems from 'framing abortion as primarily a moral rather than medical issue': at 271.

[227] Forster and Jivan make the point that such laws grant the medical profession 'paternalistic gatekeeping responsibilities' at odds with women's basic human rights: see Forster and Jivan (n 10) 862. See also SALRI (n 10) 46.

[228] SALRI emphasised that there should be no 'specified criteria for access to lawful abortion': see SALRI (n 10) 27, 207–210; thus removing the medical profession as legal gatekeepers to the

services.[229] As Sifris asserts, this requirement that the medical profession validate a woman's reasons for an abortion 'infantilizes women and undermines basic principles of agency, autonomy, and self-determination'.[230]

With the exception of the NT (in which medical approval is required for all abortions regardless of gestation),[231] this clinically unwarranted medical profession approval only becomes necessary once a certain gestation is reached.[232] In Tasmania, NSW, and SA the medically unjustified criteria necessary for that approval can be quite extensive and do not reflect best clinical practice.[233] In Victoria, Queensland, and WA the relevant legislation requires a medical profession assessment that is consistent with good clinical practice (thereby making such requirements arguably superfluous), and no further conditions (such as specialists or prescribed facilities) are imposed. However, mandating the approval of two medical practitioners in every case has no clinical justification.[234] The only jurisdiction in which medical profession approval is not mandated is the ACT, in which no conditions (other than requiring surgical abortions to be performed in a prescribed facility)[235] are attached to a woman's request for an abortion. The ACT thus almost regulates abortion in the same manner as other

practice: at 240; and thereby ensuring that women's autonomy and decision-making power were respected: at 209.

[229] See Sheldon, 'The Decriminalisation of Abortion' (n 96) 365.

[230] Sifris, 'Abortion in Australia' (n 14) 138.

[231] Up until 24 weeks gestation only one medical practitioner need approve the abortion, but after that period the approval of two medical practitioners is required: see *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 9.

[232] In Victoria it is 24 weeks; in Tasmania it is 16 weeks; in Queensland and NSW it is 22 weeks; in SA it is 22 weeks and 6 days; and in WA it is 23 weeks. It might thus be argued that such increased conditions do not apply to the vast majority of abortions, which are performed in the first trimester; for example, in SA approximately 90% of terminations are performed in the first trimester: South Australian Abortion Reporting Committee (n 97) 9. However, from a woman's right to abortion perspective, the only question is whether the imposition of these conditions is medically justified; if not so justified, any pragmatic argument concerning the number of abortions to which the unjustified conditions are applicable is not significant.

[233] As indicated in this article, these jurisdictions differ in terms of the criteria necessary for the requisite approval, but a sample list taken from all three jurisdictions would include such requirements as: specialist approval; the provision of counselling information; the performance of the abortion in prescribed facilities; and the satisfaction of the 'greater' or 'significant' health risk assessment. Sheldon contends that all such criteria constitute 'clinically unwarranted impediments to the provision of high quality abortion services': Sheldon, 'The Decriminalisation of Abortion' (n 96) 347.

[234] See, eg, SALRI (n 10) 26, 348.

[235] See *Health Act 1993* (ACT) s 83.

standard health care,[236] and thereby comes closest to recognising a woman's right to abortion.

However, despite being the preferred legislation from a women's rights perspective, this article does not suggest that the ACT legislation be the template for other jurisdictions to adopt because the ACT legislation still creates issues for lawful abortion that have no medical justification: namely, maintaining a residual offence of abortion;[237] allowing for conscientious objection to abortion with no obligation to refer the patient to another health practitioner that has no such objection;[238] retaining the offence of child destruction which places an implicit (and arbitrary) upper gestational limit on lawful abortion;[239] and mandating that every surgical abortion be performed in a prescribed facility.[240] In order for abortion care to be regulated in the same manner as other standard health care, all such medically unjustified conditions on the practice of lawful abortion need to be removed.[241]

There is nothing clinically peculiar about the provision of abortion care that requires special laws.[242] In 21st century Australia, abortion is a common and safe medical procedure when performed in accordance with generally applicable health law and standards by qualified health professionals.[243] The further, exceptional, and medically unjustified, overregulation of abortion that the legislation canvassed in this article creates, differentiates abortion from other forms of health care, and, as a consequence, serves to deny Australian women a right to abortion.[244]

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[236] See Sifris and Belton (n 10) 211; Forster and Jivan (n 10) 854–5; Victorian Law Reform Commission, *Law of Abortion* (Final Report 15, March 2008) 7. The ACT model, but with no mandated approved facility, and with no gestational limit, was also the model preferred by SALRI: see SALRI (n 10) 18, 239.

[237] See *Health Act 1993* (ACT) ss 81–2.

[238] See ibid s 84A.

[239] See *Crimes Act 1900* (ACT) s 42.

[240] See *Health Act 1993* (ACT) s 83.

[241] The Public Health Association of Australia has recently stated that '[a]bortion is a safe, common procedure that should be regulated in the same way as other medical procedures … without additional conditions': Public Health Association of Australia (n 50) 1; and that the practice should be 'regulated under existing health care legislation': at 4.

[242] See Commins and Millar (n 15) 263.

[243] See, eg, SALRI (n 10) 113; Belton, Gerry and Stulz (n 33) 28.

[244] Furthermore, the imposition of such conditions on the practice of lawful abortion care implies that Australian legislatures do not consider women rational beings capable of making their own health decisions. In other words, such laws implicitly proclaim, to varying degrees, that women are not full moral or legal persons.

Thus, in terms of what legislation is required to effectively recognise a woman's right to abortion, it is quite minimalist: remove all offences specific to abortion from the law,[245] and repeal all the abortion legislation discussed in this article.[246] Once this is achieved, general health law and relevant health practitioner regulatory standards and codes of conduct will regulate the provision of abortion care, consistent with proper clinical practice, and in the patient's best interests,[247] as is the case for all other standard health care.[248] In such a legal environment, a woman may approach her health practitioner at any stage of her pregnancy,[249] request an abortion, and have that request granted.[250] In other words, women would thereby have a right to abortion.

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[245] Such offences might be found in either criminal law or health law, and might be expressly applicable to abortion, such as the residual offence of abortion discussed earlier in this article, or might be potentially applicable to abortion, such as the offences of child destruction or concealment of birth. For examples of the offence of child destruction, see *Crimes Act 1900* (ACT) s 42; *Criminal Code Act Compilation Act 1913* (WA) s 290; *Criminal Code Act 1983* (NT) s 170. For examples of the offence of concealment of birth, see *Criminal Law Consolidation Act 1935* (SA) s 83; *Crimes Act 1900* (ACT) s 47; *Criminal Code Act 1899* (Qld) s 314; *Criminal Code Act Compilation Act 1913* (WA) s 291.

[246] Other than those provisions establishing safe access zones, which are required for clinical or pragmatic reasons of access to employment and health care: see Rankin, 'Safe Access Zone Legislation in Australia' (n 57) 63; Commins and Millar (n 15) 269.

[247] At this point abortion becomes solely a health issue, as was recommended by SALRI: see SALRI (n 10) 27, 52.

[248] There is no question that the general health framework is quite capable of regulating abortion, as it does with respect to all other health services: see, eg, Dwyer et al (n 11). As Sheldon explains, 'abortion services might simply be regulated by the same mass of general criminal, civil, administrative and disciplinary regulations that govern all medical practice': Sheldon, 'British Abortion Law' (n 159) 316. The amount of legislation applicable to health care is too voluminous to recite in full here, but, taking SA as the example, at least the following Acts would apply to the regulation of abortion: *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Civil Liability Act 1936* (SA); *Health and Community Services Complaints Act 2004* (SA); *Health Care Act 2008* (SA); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Therapeutic Goods Act 1989* (Cth). Similar amounts of legislation would apply in all other jurisdictions.

[249] That is, there is no clinical necessity to confine all aspects of the practice solely to medical practitioners: see SALRI (n 10) 26, 175; and there is no medical basis for upper gestational limits on lawful abortions: at 20–1, 27–8, 242.

[250] Either by that health practitioner, or if that health practitioner has a conscientious objection to abortion, by another health practitioner to which the patient's care was transferred by the objecting health practitioner, pursuant to generally applicable conscientious objection guidelines. Depending on the gestation and complexity of the procedure the abortion might have to be performed in a particular facility, or by particular specialists, and more than one medical practitioner might need to be involved, but that would be decided on a case-by-case basis determined solely on a clinical need assessment.