Human Rights Law Centre

Abortion as healthcare in law

Submission by the Human Rights Law Centre

19 December 2022 |

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Human Rights Law Centre

The Human Rights Law Centre uses strategic legal action, policy solutions and advocacy to support people and communities to eliminate inequality and injustice and build a fairer, more compassionate Australia. We work in coalition with key partners, including community organisations, law firms and barristers, academics and experts, and international and domestic human rights organisations.

The Human Rights Law Centre acknowledges the Traditional Owners of the unceded lands on which our workplaces sit, and the work of Aboriginal and Torres Strait Islander peoples, communities and organisations to unravel the ongoing injustices imposed on First Nations people through colonisation. We support the self-determination of Aboriginal and Torres Strait Islander peoples.

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1. Executive summary

Abortion is healthcare. Access to abortion is a human right.

Over recent years, governments across Australia have increasingly recognised abortion as healthcare by decriminalising abortion and taking steps to support better access to abortion care. Better access means better health outcomes for women and all people who experience pregnancy.

Western Australia has a unique opportunity to demonstrate its commitment to the health and equality of women and all people who experience pregnancy by comprehensively reforming the state's outdated abortion laws. While the McGowan Government introduced safe access zones laws in 2021, Western Australia is the only state yet to fully decriminalise abortion by qualified persons. Abortion is legal in most circumstances in Western Australia. However, the regulation of abortion care through an exception in the criminal law has a chilling effect on service provision and patient care.

Landmark reforms made to the state's abortion laws in 1998 played an important role in legalising abortion in a wide range of circumstances, however these reforms have failed to keep up with medical practice, human rights standards and community expectations. The laws are now outdated and include a number of medically unnecessary rules that act as a barrier to timely and compassionate abortion care. There is a critical lesson to learn from this – inflexible laws about health procedures, which can only be changed by parliament, will not keep up with advances in medical practice and therefore risk comprising good health outcomes for patients.

Restrictive abortion laws lead to delayed treatment and suboptimal health outcomes, particularly for people living remotely and people who face systemic discrimination in the healthcare system, such as Aboriginal and Torres Strait Islander women and women with disability. No other health procedure has been regulated in law like abortion. It is time to start treating abortion like all other healthcare and focusing on achieving the best possible reproductive health outcomes for all.

In this context, the Human Rights Law Centre warmly welcomes the Government's Discussion Paper on the reform of abortion laws. In particular, we commend the Government's focus on abortion as vital healthcare and on improving access to timely and safe abortion care. We would like to see abortion treated like other healthcare matters in law, which would mean not having a special law for abortion. However we recognise that this may not be considered politically feasible and have therefore recommended alternative reforms that are still consistent with human rights.

This submission is largely limited to recommendations about legislative reform, drawing from our extensive experience of working with health experts and law-makers across Australia, including in Western Australia, on abortion law reform. It addresses the legislative change proposals in the Discussion Paper and makes additional recommendations about further reforms. We emphasise, however, that it is critical that law reform be accompanied by action by the Western Australian Government to support universal access to abortion care, particularly for First Nations women, women of refugee and migrant backgrounds, women with disability, transgender and gender diverse people, and people in regional and remote areas.

1.1 Recommendations

1. Use gender-inclusive language in Western Australia's reformed abortion laws.

2. Repeal the abortion offences in section 199 of the *Criminal Code Act 1913*.

3. Abolish sections 334(5)-(6) of the *Health (Miscellaneous Provisions) Act 1911* (**the Act**), which force patients to receive counselling and see two doctors prior to being allowed to access abortion care, and reform the law to make clear that an abortion may be performed in any circumstance with the patient's consent (as with any other medical procedure).

4. Abolish existing rules and the medical panel requirement in section 334(7) of the Act, which apply to abortions from 20 weeks gestation.

5. If it is deemed necessary to include criteria in law (as opposed to clinical standards and guidelines) that medical professionals must comply with in relation to performing an abortion, these criteria should:
    a. be limited to pregnancies of more than 24 weeks gestation; and
    b. require only that two doctors confer with each other about whether an abortion is appropriate in the patient's circumstances; and
    c. be clear that these additional rules do not apply in situations of medical emergency.

6. Remove the requirement in section 334(7) of the Act for health facilities to secure Ministerial approval before being allowed to perform abortions, at any gestation.

7. Replace the existing conscientious objection provisions in section 334(2) with a limited right to conscientious objection for individual health practitioners, relating only to not providing or directly participating in abortion treatment, and include clear legal duties on those practitioners to:
    a. disclose their objection and treat their patients with dignity and respect; and
    b. refer, or transfer the care of, the patient to a health practitioner or service that is known to not have a conscientious objection as quickly as possible; and
    c. perform, or assist in, the termination of a pregnancy in cases of medical emergency where an abortion is necessary to save a person's life or prevent serious harm.

8. To support equitable and timely access to good quality and unbiased abortion information and care, the Western Australian Government should:
    a. Ensure that non-compliance with the above conscientious objection duties by health practitioners can be considered by existing complaints-handling and professional regulatory bodies.
    b. Establish an ongoing monitoring process to ensure that communities across Western Australia are not being left without access to reproductive healthcare.
    c. Carry out an assessment of the availability of all-options pregnancy information and care services, and ensure there is a free all-options pregnancy information service for Western Australians through which people can access unbiased abortion information and care.

9. Respect the decision-making capacity of mature minors and abolish the current requirements in sections 334(8)-(11) of the Act for young people under 16 to obtain parental/guardian consent or permission from a court for an abortion.

10. Draft Western Australia's abortion laws in a way that will support abortion care by trained health practitioners, including nurse-led care, into the future.

1.2 Using gender-inclusive language

While most people needing abortion care identify as women, many gender diverse people, transgender men and intersex people experience pregnancy and face systemic discrimination in healthcare. The recommendations in this submission are intended to be gender-inclusive to reflect the diverse identities who experience pregnancy. We urge the WA Government use gender-inclusive language in the drafting of its new abortion laws.

Recommendation 1: *use gender-inclusive language in Western Australia's reformed abortion laws.*

2. Reproductive rights are human rights

Western Australia has a duty, through Australia's ratification of key human rights treaties, to guarantee safe access to abortion services and post-abortion care.[1]

The right of a person to control if and when they have children is fundamental to their health and life. The UN Committee on the Elimination of Discrimination Against Women has recommended the decriminalisation of abortion in all cases and noted that the abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services is gender-based violence.[2] It has also observed that laws that criminalise or restrict medical procedures needed by women discriminate against women and threaten their basic rights to life, health and bodily autonomy.[3] Without access to quality abortion care, maternal mortality and illness rates increase because women are delayed medical treatment, and sometimes forced to turn to unsafe options or self-harm. The World Health Organisation has found that the fewer the restrictions on abortion, the lower the rate of maternal death and illness.[4]

People forced to carry pregnancies to term against their have suffered serious physical and psychological harm and the UN Human Rights Committee has stated that governments must provide safe, legal and effective access to abortion to prevent this.[5] It has also found that being forced to carry a pregnancy can violate the freedom from torture and cruel, inhuman or degrading treatment.[6]

The Human Rights Committee has also observed that restrictive abortion laws can perpetuate wrongful stereotypes of women as "reproductive instruments"[7] and as incapable of making decisions about their own bodies.

2.1 The limited interests of a foetus

The fundamental principles of equality and non-discrimination require that the human rights of the person carrying a pregnancy – to life, health and bodily autonomy – are given priority over any interest in prenatal life.

Neither international law nor Australian law recognise a right to life in a foetus. The drafters of the *International Covenant on Civil and Political Rights* rejected a proposal to extend the right to life to prenatal life.[8] The Australian Government has said that the right to life under the *International Covenant*

[1] Committee on Economic, Social and Cultural Rights, *General comment No 22: Sexual and reproductive health* E/C. 12/GC/22 (2016) [28].
[2] Committee on the Elimination of Discrimination Against Women. *General Recommendation No 35: Gender-based violence against women, updating General Recommendation No. 19,* UN Doc. CEDAW/C/GC/35 (2017).
[3] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health,* A/54/38/Rev 1 (1999) [11]: United Nations Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional protocol, concerning communication no.2324/2013,* UN Doc. CCPR/C/116/D/2324/2013 (9 June 2016) [7.9]-[7.11].
[4] World Health Organisation, *Safe abortion: technical & policy guidance for health systems* (2015).
[5] UN Human Rights Committee, *General comment no. 36, Article 6 (right to life),* UN doc. CCPR/C/GC/35 (2019).
[6] Human Rights Committee, *Views: Communication No 2425/2014,* 119th sess, UN Doc CCPR/C/119/D/2425/2014 (17 March 2017) ('*Whelan v Ireland*'). See also Juan Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment*, A/HRC/31/57 (5 January 2016) [43].
[7] Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication no 2324/2013*, CCPR/C/116/D/2324/2013 (17 November 2016) [7.11]
[8] United Nations General Assembly Official Records, Annex, 12 Session, Agenda Item 33 [96], [113] [119], UN Doc A/C.3/L.654.

on Civil and Political Rights was "not intended to protect life from the point of conception but only from the point of birth."[9]

This is because protecting a right to life before birth conflicts with human rights protections for women and people who are pregnant. Or as the European Court of Human Rights has put it in relation to the right to life: "the unborn child is not regarded as a 'person'" and that "if the unborn do have a 'right' to 'life' it is implicitly limited by the mother's rights and interests", including her rights to life, health and privacy.[10]

3. Responses to Discussion Paper proposals

3.1 Properly decriminalise abortion

Abortion is legal in most circumstances in Western Australia. However, the regulation of abortion is through an exception created by section 199 of the *Criminal Code Act 1913* (**the Criminal Code**) that allows an abortion to be performed in accordance with section 334 of the *Health (Miscellaneous Provisions) Act 1911* (**the Act**). Abortion is still therefore, tethered to the criminal law, rather than being treated as a healthcare matter in law.

The Discussion Paper indicates that it is the Government's intention to remove the abortion offence in the *Criminal Code*, while still retaining an offence relating to an 'unqualified person' performing or assisting in an abortion.

The Human Rights Law Centre welcomes the repeal of section 199 of the Criminal Code. The use of the criminal law to regulate access to abortion perpetuates the harmful stigma and discrimination that has been attached to abortion for too long. It is also completely at odds with contemporary community values.

In 2005, the Public Health Association of Australia observed that the legal status of abortion directly affects the planning, safety and quality of reproductive health services and called for all state and territory governments to remove abortion from criminal law.[11] More recently, a parliamentary inquiry in Queensland observed that the decriminalisation and reform of abortion laws in Victoria in 2008 allowed medical practitioners to "focus on practicing in accordance with evidence based clinical standards to address women's health care needs, free of the threat of criminal proceedings".[12]

The Discussion Paper has indicated that it would still be an offence for an "unqualified person" to perform an abortion, similar Victoria's laws. This offence provision arose from a recommendation of the Victorian Law Reform Commission in 2008, and it was the history of "backyard abortionists" that led the Commission to make this recommendation. It is important to realise however, that it is the criminalisation of abortion and a lack of affordable services that create a market for unqualified operators and suppliers: if abortion services are affordable, confidential and accessible across Western Australia, women will not need to turn to unqualified people to access the healthcare they need.

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[9] Peter Arnaudo, Attorney–General's Department, Hansard - Joint Standing Committee on Treaties Reference: Treaties tabled 14 May and 4 June 2008 16 June 2008, 7, https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommjnt%2F10940%2F0001;query=Id%3A%22committees%2Fcommjnt%2F10940%2F0002%22.

[10] *Vo v France*, App No 53924/00, Eur. Ct HR, 80 (2004); *A, B and C v Ireland*, App No 25579/05, Eur Ct HR 237-238 (2010).

[11] Public Health Association of Australia, *Abortion in Australia: Public Health Perspectives* (2005) 12.

[12] Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into Law Governing Termination of Pregnancy in Queensland* (Report No 24. August 2016) 63.

We are not aware of unqualified people holding themselves out as qualified abortion providers in Western Australia. If there are, existing offence provisions in health laws such as the *Health Practitioner Regulation National Law (WA) Act 2010*, as well as laws criminalising assault, may adequately address a situation in which an unqualified person holds themselves out as qualified to perform a medical procedure, including abortion. Further, the *Therapeutic Goods Act 1989* (Cth) restricts who can supply mifepristone and misoprostol.

The Government should further inquire into whether the 'unqualified person' offence is actually needed. If it is retained, we recommend that the law be clear that a person does not commit an offence by consenting to or assisting in an abortion on themselves.

Recommendation 2*: Repeal the abortion offences in section 199 of the Criminal Code.*

3.2 Informed consent should not require mandatory counselling or two doctors

Western Australia's laws should be framed in a way that respects the autonomy of women and all people who experience pregnancy and their right to control what happens to their body.[13] Western Australia's abortion laws currently fail to do this by altering the accepted standard for informed consent in healthcare and mandating that patients see a second doctor for counselling.

Counselling, when freely chosen, can be an important aspect of dealing with an unintended pregnancy. Accurate, confidential and impartial counselling about options should be available to all people as a choice. No one should be compelled to receive counselling in order to access abortion care.

In its extensive review of abortion laws, the Victorian Law Reform Commission found that the provision of counselling is a "clinical matter best left to professional judgment based on a woman's circumstances".[14] The Commission "did not find evidence that forcing women into counselling is necessary or advisable."[15] It recommended against any requirement for counselling or a referral to counselling.

There is no medical or legal need to subject patients to mandatory counselling or to a legal requirement to see two doctors before accessing abortion care. Such an approach undermines an individual's right to bodily autonomy by requiring third party authorisation. This effectively tells patients that they are not competent or cannot be trusted to make decisions about their bodies. It is inconsistent with an adult's usual legal role as primary decision-maker about medical procedures to their own bodies. In addition, and as noted in the Discussion Paper, requiring patients to see a second doctor and to receive counselling can increase costs and cause delays, which in turn can expose patients to greater medical risk, especially those who have to travel long distances or who face discrimination in navigating the health system.[16]

Obtaining informed consent from patients prior to undertaking a medical procedure is a standard legal requirement in healthcare, and in WA, the *Consent to Treatment Policy* outlines what is expected of health professionals. This standard is appropriate for abortion care.

Western Australia should abolish mandatory counselling and the legal requirement to see two doctors in order to access abortion care currently found in section 334(5)-(6) of the Act. The criteria in section 334(3) should also be removed – the only requirement for an abortion should be the patient's consent, consistent with the *Consent to Treatment Policy*. This would bring the state's laws into line with other states and territories around Australia, such as Queensland and Victoria.

Recommendation 3*: Abolish sections 334(5)-(6) of the Act, which force patients to receive counselling and see two doctors prior to being allowed to access abortion care, and reform the law to make clear that*

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[13] Consistent with the requirements of the right to health in the *International Covenant on Economic, Social and Cultural Rights*. See Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health* E/C.12/GC/22 (2016) [28]. See also see Centre for Reproductive Rights, *Safe and Legal Abortion is a Woman's Human Right* (Briefing Paper, 2011).
[14] Victorian Law Reform Commission, *Law of Abortion: Final Report* (March, 2008), [8.139].
[15] Ibid, [8.122].
[16] As is recognised in the Department of Health's Discussion Paper (18 November 2022), at page 10.

an abortion may be performed in any circumstance with the patient's consent (as with any other medical procedure).

3.3 Law should facilitate high quality abortion care after 24 weeks gestation

The law should support patients and their doctors to make the best possible medical decision for each patient's circumstances. Inflexible laws about when a medical procedure can take place make it harder for medical professionals to do their jobs and for patients to make decisions about what is best for their lives.

Currently, Western Australia's abortion laws are forcing vulnerable women to fly interstate, at considerable physical, emotional and financial cost, to access care that they should be able to receive in their home state.[17]

Western Australia's laws stand alone in Australia with an outdated requirement for a medical panel of six doctors (appointed by the Health Minister) to consider every case in which a patient needs an abortion from 20 weeks gestation. For an abortion to proceed, two doctors from the panel need to agree that an abortion is justified based on a severe maternal or foetal medical condition.

The use of legislated medical panels, or a mandated requirement for particular specialists to be involved, in the decision as to whether a person can receive an abortion has been widely criticised, in particular for causing delays and discriminating against people in regional and remote areas. In 2019, the South Australian Law Reform Institute's (**SALRI**) comprehensive review of abortion noted that such requirements can be "bureaucratic and cumbersome", and impose greater barriers on people living regionally and remotely and Aboriginal and Torres Strait Islander people.[18] Notably, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**) has said that panels have "been shown to lead to delays and result in later termination of pregnancy."[19]

The Discussion Paper proposes dissolving the medical panel, which the Human Rights Law Centre strongly supports. It also proposes replacing the medical panel with a requirement that two doctors agree that an abortion is appropriate and shifting the gestation at which this requirement applies from 20 to 24 weeks.

The reality of mid-to-later gestation abortions

Abortions from the mid-to-later stages of pregnancy are uncommon – in Western Australia, less than 1% of all abortions performed occur from 20 weeks gestation.[20] They are typically required in complex and distressing circumstances, such as a severe maternal condition or a fatal foetal condition being diagnosed at the 20-22 week scan in the context of a much-wanted pregnancy. Multiple health professionals will be involved in these cases as a matter of good clinical practice.

It is critical that in these circumstances, patients and doctors are not rushed into decision-making by strict laws. During a parliamentary inquiry into the reform of Queensland's abortion laws in 2018, two women spoke about what it is like to know there is a tight time limit on making a decision after receiving a devastating foetal diagnosis:

- Ashleigh's pregnancy was terminated at 21 weeks: "*I have been asked many times over the last four years if I regret my decision. The answer is no. I regret that I did not have more time. I regret that*

[17] The Department of Health's Discussion Paper (18 November 2022) acknowledges this is happening (p 11). This has also been reported to the Human Rights Law Centre by health service partners in Western Australia.
[18] South Australian Law Reform Institute, *Abortion: a review of South Australian law and practice* (2019), 241.
[19] Ibid.
[20] As stated in the Department of Health's Discussion Paper (18 November 2022), 7.

I had to essentially choose between more time and asking for permission or rushing it through. I regret rushing it but I do not regret having my abortion."[21]

- Zena's pregnancy was terminated at almost 22 weeks: "*When we went for our morphology scan, we were 21 weeks…I was not told my results were urgent or that I had to see my doctor quickly. This time, looking back, was so crucial, but we thought it was all normal. …Hubby and I were on different pages, to be honest. I would have liked more time, yes. I do feel that I would have liked more time. I felt rushed. It was close to Christmas. There were a lot of things going around—a lot of legislation and everything. It was so confusing. It was such a hard time already."*[22]

The role of legislation in medical care

In the ACT, abortion was decriminalised without any additional laws being introduced that require women to seek approval from two doctors or satisfy additional legal criteria at any stage of pregnancy. Two doctors may be involved in a patient's care, especially for complex cases, but this is about normal clinical practice and medical professionals working with their patients to determine their care needs, rather than a focus compliance with inflexible laws.[23] In this way, abortion is regulated no differently in law to other medical procedures in the ACT.[24] The Human Rights Law Centre supports this approach.

As with other medical procedures, professional guidelines and clinical directives tell medical practitioners how to manage a termination of pregnancy, and the *Health Practitioner Regulation National Law* provides a framework for the registration and accreditation of health practitioners.[25] Treating abortion like other health procedures allows health practitioners to focus on their patient's clinical interests, consistent with modern medical practice. In addition, and unlike laws, professional guidelines and directives can be updated promptly to keep up with advances in medicine that improve health outcomes.

We note that RANZCOG's 2019 statement on late termination of pregnancy refers to the special circumstances and realities of people needing an abortion beyond 20 weeks gestation. The statement supports the availability of abortion after 20 weeks and is critical of "arbitrary" gestational age "cut-offs", in particular because of their impact on women facing barriers to timely access to the necessary specialist services.[26] Further, the most recent comprehensive review of abortion laws and practice in Australia, carried out by SALRI in 2019, recommended that there be no specified criteria or set gestational limits in law for when an abortion can be performed, in line with the ACT approach.[27]

We recognise however, that politically, Western Australia's reformed abortion laws will need to include additional legal criteria for medical professionals to comply with in those rare cases in which an abortion is required in the mid-to-later stages of pregnancy. These additional rules should be limited to pregnancies of

[21] Ashleigh Foley's statement to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Public Briefing-Inquiry into the Termination of Pregnancy Bill 2018: Transcript of Proceedings, Townsville (10 September 2018) 21-25.
[22] Zena Mason's statement to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Public Briefing-Inquiry into the Termination of Pregnancy Bill 2018: Transcript of Proceedings, Cairns (11 September 2018) 22-26.
[23] *Health Act 1993* (ACT) pt 6. This also aligns with the approach in Canada.
[24] Note that there are provisions in the *Health Act 1993* (ACT) that limit access to abortion to approved facilities and restrict the role of other registered health practitioners, such as nurses and pharmacists. These provisions should not be replicated in Western Australia because they are likely to result in inequitable access to best practice abortion care, particularly for women in regional and remote areas.
[25] "Health practitioner" is a defined term in sch 2, s 5 of the *Health Practitioner Regulation National Law (Western Australia) Act 2010* and includes people in the medical, nursing, midwifery and pharmacy professions.
[26] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Late abortion* (Nov 2019).
[27] SALRI, above n 18, 239, recommendation 21.

more than 24 weeks gestation and require no more than the involvement of two medical practitioners conferring with each other and agreeing that an abortion is appropriate in the patient's circumstances.

Patients should not be required to see a specialist, nor undergo a second examination as a legal requirement – the law must allow for medical practitioners to work with their patients to determine what is needed in each case. The law must also allow medical professionals to respond urgently and disregard compliance with these additional rules in cases of medical emergency. The above approach would align with existing clinical practice and the approach in Victoria.[28]

As the Discussion Paper has noted, patients facing the difficult decision as to whether to terminate a pregnancy midway through need time – to undergo scans and tests, for their doctors to determine a diagnosis, to themselves understand the diagnosis, to seek further medical advice, to talk to their families and to make a decision. Patients who face systemic discrimination in the health system, such as Aboriginal and Torres Strait Islander women and women with a disability, are likely to need additional time to find the right supports and information. Additional inflexible legal rules (such as a medical panel or specialised practitioner requirement) will only make it harder for doctors to focus on the best interests of their patients and cause the most harm to the most vulnerable patients.

Recommendation 4: *Abolish existing rules and the medical panel requirement in section 334(7) of the Act, which apply to abortions from 20 weeks gestation.*

Recommendation 5: *If it is deemed necessary to include criteria in law (as opposed to clinical standards and guidelines) that medical professionals must comply with in relation to performing an abortion, these criteria should:*

- *be limited to pregnancies of more than 24 weeks gestation; and*
- *require only that two doctors confer with each other about whether an abortion is appropriate in the patient's circumstances; and*
- *be clear that these additional rules do not apply in situations of medical emergency.*

Removing the requirement for Ministerial approval

The Discussion Paper proposes removing the current requirement in section 334(7)(b) of the Act for Ministerial approval for a health facility to perform abortions after 20 weeks gestation. This requirement has meant that there are only two medical facilities in the whole of Western Australia that provide this service. This lack of services, together with the above medical panel requirement, is seeing too many women being forced to fly interstate for care that they should be able to access in their home state.

Law reform should ensure that all West Australians can access abortion care in a timely way and it should also support developments in medical practice being applied in practice to benefit patients (without needing to go through a lengthy law reform process). This means not limiting access to abortion services to Ministerially-approved hospitals or facilities. Reforms in many jurisdictions have excluded such a requirement, including Victoria, Queensland and the Northern Territory.

Recommendation 6: *Remove the requirement in section 334(7) of the Act for health services to secure Ministerial approval before being allowed to perform abortions, at any gestation.*

[28] *Abortion Law Reform Act 2008* (Vic) s 5. This is also consistent with SALRI's alternative recommendation, see above n 18, [11.6.6] and recommendation 23.

3.4 Duties on health practitioners who conscientiously object

It is critical that every person is able to access unbiased health information and care so that they can make the best decision about their health and life. Encountering a doctor with a conscientious objection to abortion impedes timely access to this vital and lawful health service.

It is important to understand that a conscientious objection is a refusal to provide healthcare that is otherwise legal, legitimate and medically appropriate.[29] This is fundamentally different to a refusal to provide treatment based on legitimate medical or legal reasons.

Current law in Western Australia unjustifiably prioritises a doctor's right to religious expression over a patient's rights – including to bodily autonomy, healthcare, non-discrimination and equality. Section 334(2) of the Act allows any person, hospital or institution to refuse to participate in the provision of an abortion. There is no corresponding legal duty on healthcare professionals towards the health or rights of their patients. This is dangerous and inconsistent with both the ethical duties of healthcare professionals and international human rights law.

Western Australia's abortion laws are unique in Australia for legislating a right for institutions to refuse to provide abortion care. Institutions are not humans and do not hold human rights. The United Nations Committee on the Elimination of Discrimination against Women has urged states to preclude institutional conscientious objection.[30] The UN Human Rights Committee and the Special Rapporteur on Freedom of Religion or Belief have also indicated that conscientious objection "should only be permitted, if at all" for individual medical practitioners.[31] Western Australia's new abortion laws should limit conscientious objection to individual health practitioners only.

Individual health practitioners do have a right to freedom of thought, conscience and religion and to manifest their religion or beliefs. However, the right to manifest a belief is not absolute and must be balanced against other competing rights, such as a patient's right to health, equality and bodily autonomy.[32] Further, as the Australian Medical Association (AMA) made clear in previous submissions, 'doctors who conscientiously object…still have ethical and professional obligations to patients and others who may be directly affected'.[33]

Abortion is a time-sensitive procedure and delays mean that patients undergo abortions at later gestations, which increases the risks to their health. Health professionals with a conscientious objection, who choose their occupation and sit in a position of power over their patients, should therefore be understood as a threat to their patient's health, especially where they fail to quickly refer them to a service that they know can provide unbiased abortion information or care. This threat is especially acute in regional and remote areas where there are very few doctors available – time delays caused by objecting doctors can cause health complications and force vulnerable people to travel hundreds of kilometres at their own cost to access basic healthcare.[34]

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[29] Australian Medical Association, *Conscientious Objection - 2019* (2019), https://www.ama.com.au/position-statement/conscientious-objection-2019.
[30] See e.g. Committee on the Elimination of Violence against Women, *Concluding Observations: Romania*, para. 33(c), UN Doc. CEDAW/C/ROU/CO/7-8 (2017).
[31] Special Rapporteur on Freedom of Religion or Belief, *Gender-based violence and discrimination in the name of religion or belief*, UN doc. A/HRC/43/48 (2020) [43].
[32] UN Human Rights Committee, General Comment No. 22: Freedom of Thought, Conscience or Religion, UN Doc. CCPR/C/21/Rev.1/Add.4 (1993). The scope of these concepts are clarified at [4].
[33] Australian Medical Association, Submission to Human Rights Law Unit, Australian Government Attorney General's Department, Religious Freedom Bills – First Exposure Drafts, 31 October 2018, 3.
[34] See discussion in SALRI, above n 18, part 17.

Consistent with the Medical Board of Australia and the Nursing and Midwifery Board's respective codes of conduct, Western Australia's abortion laws should be reformed to provide, at most, for a limited right to conscientious objection for health practitioners in relation to *not providing* or *directly participating* in abortion treatment.[35] It is crucial that the law also include clear corresponding duties on objecting health practitioners to

- disclose their objection and treat their patients with dignity and respect; and
- refer, or transfer the care of, the patient to a health practitioner who is known to not have a conscientious objection as quickly as possible; and
- perform, or assist in, the termination of a pregnancy in cases of medical emergency where an abortion is necessary to save a person's life or prevent serious harm.[36]

Legislating these duties on objecting health practitioners is not only consistent with their ethical duties,[37] it is consistent with Western Australia's international human rights obligations. UN treaty bodies have made it clear that governments must put in place measures to ensure that people are not impeded from accessing reproductive healthcare because of conscientious objection, and are referred to unbiased health services who can help them.[38]

Enforcing conscientious objection duties on health professionals

The enforcement of the above duties on objecting health professionals is a significant concern. For example, a 2019 study in Victoria identified incidents of doctors subverting, misusing or directly contravening conscientious objection duties, with some reporting that it was 'common practice' for doctors in rural areas to refuse to refer women seeking an abortion to someone who could advise them.[39]

The Human Rights Law Centre has also been provided with examples of women in different parts of Australia being obstructed by doctors who oppose abortion, for example by being told that "abortion is illegal", that they were "meant to be a mother", and that their baby would ask from heaven "why did you kill me?'" We have also spoken to health professionals in Western Australia who have expressed deep concern about the number of women who arrive at their clinic having attended multiple doctors who failed, or refused, to refer them to services that provide all-options information and care.

To address the risks that non-compliance with conscientious objection duties pose, we recommend that Western Australia's reformed abortion laws make it clear that non-compliance with conscientious objection duties can be considered as part of existing health complaints-handling and professional regulatory bodies,

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[35] Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia* (October 2020) [3.4.6]; Nursing and Midwifery Board of Australia, *Code of conduct for nurses* (March 2018) 4.4(b).
[36] This aligns with approaches in New South Wales, Victoria and Queensland. It is also consistent with the UN Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* A/54/38/Rev 1 (1999) [11]; UN Committee on Economic, Social and Cultural Rights, *General Comment No 22 (2016) on the right to sexual and reproductive health*, UN doc. E/C.12/GC/22 (2016) [43].
[37] See e.g. Australian Medical Association, above n 29.
[38] Committee on Economic, Social and Cultural Rights, *General Comment No 22 (2016) on the right to sexual and reproductive health*, UN doc. E/C.12/GC/22 (2016) [43]; Committee on the Elimination of Discrimination against Women, *General Recommendation 24: women and health*, UN Doc. A/54/38/Rev 1 (1999) [11]. While it has not been considered by any Australian courts that we are aware of, a Canadian appeal court found in 2019 that a duty to provide an 'effective referral' struck the right balance between equitable access to healthcare and freedom of religion: *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario* [2019] ONCA 393.
[39] Louise Anne Keogh et al, 'Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspective of abortion service providers', *BMC Medical* (31 January 2019).

such as the Health and Disability Services Complaints Office.[40] The Government should also establish an ongoing monitoring process to ensure that communities across Western Australia are not being left without access to reproductive healthcare.

Given the barriers to care that are created by objecting doctors, particularly in regional and remote areas, and the obligation on Western Australia to put in place measures to ensure healthcare services are accessible and available to all without discrimination,[41] we recommend that the Government also carry out an assessment of the availability of all-options pregnancy information and care services. This information should support the establishment of a free all-options pregnancy information service for Western Australians, through which people can access information about where they can obtain abortion care.

Recommendation 7: *Replace the existing conscientious objection provisions in section 334(2) with a limited right to conscientious objection for individual health practitioners, relating only to not providing or directly participating in abortion treatment, and include clear legal duties on those practitioners to:*

- *disclose their objection and treat their patients with dignity and respect; and*
- *refer, or transfer the care of, the patient to a health practitioner or service that is known to not have a conscientious objection as quickly as possible; and*
- *perform, or assist in, the termination of a pregnancy in cases of medical emergency where an abortion is necessary to save a person's life or prevent serious harm*

Recommendation 8: *To support equitable and timely access to good quality and unbiased abortion information and care, the Western Australian Government should:*

- *Ensure that non-compliance with the above conscientious objection duties by health practitioners can be considered by existing complaints-handling and professional regulatory bodies.*
- *Establish an ongoing monitoring process to ensure that communities across Western Australia are not being left without access to reproductive healthcare.*
- *Carry out an assessment of the availability of all-options pregnancy information and care services, and ensure there is a free all-options pregnancy information service for Western Australians through which people can access unbiased abortion information and care.*

4. Other critical reforms

4.1 Respecting the decision-making capacities of young people

Where a young person is considered a mature minor and capable of making medical decisions, decisions they make about their health should be respected.[42] This is standard medical practice that is consistent with medical law. Currently, Western Australia's abortion laws depart from this standard and require consent

[40] See for example section 9 of the *Termination of Pregnancy Act 2018* (Qld) which refers to compliance with these duties being a relevant consideration when a complaint is made.
[41] Committee on Economic, Social and Cultural Rights, *General Comment No 22 (2016) on the right to sexual and reproductive health*, UN doc. E/C.12/GC/22 (2016) [43]; UN Human Rights Committee, *General comment no. 36, Article 6 (right to life),* UN doc. CCPR/C/GC/35 (2019) [8].
[42] Also known as a '*Gillick* competent' child following the decision in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

from a parent or guardian or permission from a court for young people under 16 years of age to be able to access abortion care.[43] This risks causing harm, particularly for young people at risk of family violence.

The Human Rights Law Centre is surprised and concerned that the Discussion Paper does not propose reforming this part of the existing abortion laws.

Forcing a teenager who is capable of making health decisions to disclose their pregnancy and get parental consent or go through court risks causing serious physical or psychological harm, including attempts at procuring an abortion for themselves, or considering self-harm or suicide. This is a particular concern where the young person has a violent parent, is in foster care or where the pregnancy is the result of rape or incest. The law should facilitate decision-making in the best interests of a young person, and in some cases, this will mean not disclosing a pregnancy to parents or guardians.

Recommendation 9: *Respect the decision-making capacity of mature minors and abolish the current requirements in sections 334(8)-(11) of the Act for young people under 16 to obtain parental/guardian consent or permission from a court for an abortion.*

4.2 Supporting nurse-led care and other health practitioners in the future

Laws that strictly limit who is permitted to perform an abortion to doctors create another barrier to people accessing good quality abortion care. For example, there is evidence that nurse-led care is a safe way of improving access to early medication abortions and where legal, may help expand access in regional and remote areas where the shortage of trained providers is a particularly acute issue.[44]

Nurse-led care is currently a crime in Western Australia. In contrast, jurisdictions that have more recently reformed their abortion laws, such as Queensland and the Northern Territory, allow a broader range of professionals, including nurses, midwives, Aboriginal and Torres Strait Islander health workers and pharmacists to assist with an abortion,[45] while South Australia provides for health practitioners[46] (not just medical practitioners) to perform medication abortions in certain circumstances.[47] In the future, clinical practice may advance to allow a greater role for trained health practitioners who are not doctors, which may improve access to affordable abortion care. It is important that the law facilitate advancements in clinical practice, rather than restrict them through overly prescriptive rules.

Recommendation 10: *Draft Western Australia's abortion laws in a way that will support abortion care by trained health practitioners, including nurse-led care, into the future.*

[43] Section 334(8) of the Act.
[44] Marie Stopes Australia, *Nurse-led medical termination of pregnancy in Australia: legislative scan* (2022), https://resources.msiaustralia.org.au/Nurse-led-MToP-in-Australia-legislative-scan.pdf.
[45] *Termination of Pregnancy Act 2018* (Qld) s 7; *Termination of Pregnancy Law Reform Act 2017* (NT) s 8.
[46] Note that "health practitioner" is used here as the defined term in the *Health Practitioner Regulation National Law (Western Australia) Act 2010* (WA) and includes people in the medical, Aboriginal and Torres Strait Islander health, nursing, midwifery and pharmacy professions.
[47] *Termination of Pregnancy Act 2021* (SA), s 5(1)(b).