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SUBMISSION TO THE VICTORIAN LAW REFORM COMMISSION

THE LAW OF ABORTION

The Royal Women's Hospital (the Women's) of Grattan Street Carlton is pleased to make the following submission to the Victorian Law Reform Commission (LRC) in respect of the referral of aspects of the law governing termination of pregnancy in the State of Victoria by the Victorian Attorney-General. The Women's would welcome the opportunity to clarify to the Commission any of the issues raised in this submission.

The Women's notes that the LRC is, in undertaking its review, to have regard to current practices, the existing law in Victoria and other Australian jurisdictions, community standards, and is to advise without altering "current clinical practice"¹.

Historical perspective

Set out in Appendix A to this submission is an excerpt from Janet McCalman's history of The Royal Women's Hospital, *Sex and Suffering*².

The history of the Royal Women's Hospital shows only too well what a difference the Menhennit ruling in Victoria in 1969 made to women's health. No longer were women coming to the hospital with sepsis, including clostridial infections and uterine gangrene following a so-called "back-yard" abortion at the hands of an unqualified "practitioner", and doctors were able to offer termination services in the knowledge that their practices were not perceived as illegal.

Current practice

The Women's is the largest specialist hospital in Australia dedicated to improving the health of all women. The Women's is committed to providing women with the highest quality of clinical care, health information and support services possible and ensuring they are active partners in decision-making about their health.

Each year The Women's provides a range of obstetric, gynaecological, cancer, mental health and support services to a diverse community of women. The community that uses our hospital is made up of women born in 165 countries and speaking 60 different languages and following about 40 separate faiths.

Comprehensive women's health care includes the provision of abortion services. Between 2500 and 3000 abortions are performed annually at The Women's. This is around one sixth to one seventh of the estimated total for Victoria³. Many women travel to The Women's from Victorian country areas and interstate (mainly from Tasmania and southern NSW) to access abortion services. It is estimated that around one third of Australian women will have an abortion at some stage in their lives⁴. Timely access to safe abortion services is a necessary component of any health system.

Abortion is a women's health issue. Abortion, whether medical or surgical, is one of the safest procedures available in the health system when it is performed by qualified health professionals, with proper equipment, appropriate medical technique and in sanitary conditions⁵. It is therefore in the interests of women seeking an abortion, and of the health professionals who care for them, that abortion should be addressed in *health* legislation and not criminal law.

Medical practice is best regulated through health law. The quality and safety of health care does not benefit from creating exceptions to this principle. It is not appropriate to separate out abortion from other medical procedures and create a different set of rules for it. Creating an exception for abortion means the procedure would be set apart from the regulatory framework that otherwise guides good practice, identifies problems and informs the processes of service planning, development and safety and quality improvement.

There is significant community confusion about the current status of abortion. In focus groups run by The Women's to obtain feedback from women about health information on our website, women were not sure if we provided abortion services and, if we did, if we were permitted to communicate this openly on our website.

In another focus group, women wanted information about abortion services provided by The Women's to be easily accessible on our website. Participants were adamant that information needed to be listed using the word *abortion* (not *termination of*

pregnancy) in order to diminish the sense of shame and secrecy surrounding the procedure.

While the crime of “unlawful abortion” remains in the *Crimes Act 1958*, questions are raised about when abortion is not unlawful, who makes the decision, and the circumstances in which women can access this medical service. The regulation of abortion in *health* legislation will provide clarity for both women and health professionals, and reduce confusion in the community.

A woman's decision about her pregnancy needs to be informed by accurate, unbiased information about *all* of her options. Exercising these options depends on access to timely and appropriate medical care. Results from the *Australian Survey of Social Attitudes* in 2003⁶ and 2005⁷ include the finding that around 80% of the population either agree or strongly agree that a woman should have the right to choose whether or not she has an abortion. In 2005 79.4%, and in 2003, 81% of people agreed that women should have the right to choose an abortion.

These levels of support are echoed in the findings from the *Australian Election Study* surveys. A recent monograph by Ian McAllister and Juliet Clark, from the Research School of Social Sciences at Australian National University, analyses trends in public opinion including access to abortion since 1979. In 2004, 58.5% of people thought that women should be able to obtain an abortion readily when they want one, compared with 37.2% who thought that women should be allowed an abortion only in special circumstances. In twenty five years of surveys, support for banning abortion has never been higher than 6.4%; in 2004 support for banning was only 4.3%⁸.

The Women's offers women with unplanned pregnancies or whose circumstances have changed or who, in a much wanted pregnancy, face the devastation of learning, sometimes in quite an advanced state, of a fetal abnormality, a comprehensive service. This includes access to counselling, referrals, assessment and medical and surgical procedures, based on a doctor's judgment of clinical need and what is medically and legally appropriate. Our services are provided by multidisciplinary teams of allied health and medical and nursing professionals, whose practice is evidence-based and benchmarked against international and, where available, national standards.

Abortion is not treated any differently from other procedures relating to women's sexual and reproductive health. Normal practice is that a doctor will discuss with the woman options relevant to her particular situation. Together, they will work out the best treatment, including considering the risks and benefits of different options. This is the basis for consent. Where relevant and appropriate, these decisions will involve the woman's partner.

Recently, several medical practitioners at The Women's have been authorised to prescribe the drug mifepristone to women who have a particular clinical need for medical abortion. This is the first step in the introduction of medical abortion with mifepristone, which is a well-established method of abortion in many parts of the world including the UK, the USA, New Zealand, and clearly preferred by many women (almost 60% in Scotland for instance⁹). It is essential that any legislation introduced in Victoria allows for the continued development of this technique in the interests of current best practice being available to Australian women.

For example, words along the lines of the following will need to be incorporated in any legislation drafted to cover both medical and surgical abortion:

“an abortion is lawful when carried out by a registered medical practitioner or under the supervision of a registered medical practitioner by a registered midwife or nurse.”

This recommendation is consistent with the conclusions of the House of Common's Science and Technology Committee report into scientific developments relating to the Abortion Act 1967 in the United Kingdom¹⁰.

No health care professional may act without the consent of the patient (or from an authorised third party decision-maker or court order) so it is superfluous to specify in legislation that the consent of the woman is a legal requirement for abortion.

(To act without consent would leave the health practitioner open to a claim in assault and/or battery, as well as to disciplinary proceedings.)

Legislation needs to only provide for *when* an abortion is lawful and provide the framework for safe, quality health care without impinging upon the actual professional judgment of health care professionals. It is not appropriate to try and *proscribe* medical (or best) practice, if it means shifting the focus from quality care and the exercise of professional judgment to technical compliance with a check-list.

Women's social and medical circumstances, their reasons for experiencing an unwanted pregnancy and ways in which they cope with abortion are diverse and complex. It should be the responsibility of the health service to respond to each woman's unique situation and experience with skilled and comprehensive services according to her individual needs. The undoubted right to confidentiality that enables a woman to trust her doctor with sensitive health information needs to be protected, not intruded upon, by the law. The Women's experience is that women request termination of pregnancy for many different but well-founded reasons. The Menhennit ruling¹¹ has provided a sound and durable set of principles for determining when this is necessary for her health and well-being.

Some Australian jurisdictions require two doctors to certify when an abortion is necessary¹².

The Women's would view such legislation to be an impediment to the current decision-making process and current practice which provides for timely access to safe abortion services, and is fortified in this view by the recent report, *Scientific Developments Relating to the Abortion Act 1967*, by the UK Parliament's Science and Technology Committee¹³. This report concluded that the signature of two doctors was an unnecessary requirement for a lawful abortion.

Likewise, the Women's does not support *compulsory* counselling of women seeking a termination of their pregnancy or other imposed requirements such as a *compulsory* "cooling off" period or the viewing of ultrasound images¹⁴. It is our experience that women make their own informed decisions about the range of support services they require, depending on their individual needs and circumstances.

Currently, where there are questions about the appropriate response to an unplanned pregnancy, a woman or her practitioner is always, as with any medical consultation or procedure, able to seek a second opinion. Requiring agreement by two doctors before performing an abortion, or compulsory counselling, or a cooling off period will result in unnecessary duplication of the decision-making process. Such requirements would restrict women's access to necessary and timely care. They could also have the effect of making the procedure less safe, by delaying timely intervention in pregnancies of later gestation.

The law cannot anticipate each and every scenario in which a woman may need to terminate a pregnancy. Therefore it is submitted that it is not appropriate to set out in legislation the actual process of decision-making that a doctor or other health professionals must follow.

Pregnancy Advisory Service

The Women's Pregnancy Advisory Service (PAS) responds to about 7000 new calls from women every year. The service measures itself against national and international standards of practice to ensure that women who use the service receive a high standard of counselling, information, and advocacy to support them in their decisions and timely access to clinical and other services.

The Women's is Victoria's main public service provider for women with unplanned pregnancy and provides multi-disciplinary psycho-social, clinical, medical and surgical services for women. It has done this for 30 years, and before then, The Women's provided medical, surgical and social support to women suffering from the consequences of illegal and 'backyard' abortion. The Women's has a significant role in the provision of training and consultation to health professionals in this area.

PAS services are provided as part of a broad spectrum of women's sexual health and reproductive services, ensuring that every woman who contacts the service is provided with independent, skilled and professional support and is offered referral to a full range of reproductive choices, including abortion, antenatal care and parenting support or other child care arrangements. It provides services to women who are disadvantaged and dealing with issues such as domestic violence, assault, crisis, homelessness, or mental illness, and women who are culturally and linguistically diverse, or newly arrived refugees or migrants.

PAS has a well developed knowledge of the complexities and issues facing women with unplanned pregnancy. The experience of working with women, who may be vulnerable socially as well as emotionally, motivates PAS in its high standards of practice, which it considers fundamental to any service providing responses to women in this situation.

Because demand for services at The Women's exceeds capacity, PAS prioritises services to:

- Women experiencing access barriers; homelessness, financial difficulty, language and cultural barriers, Aboriginal and Torres Strait Islander women, women with mental health issues or other disabilities, young women, isolated women, newly arrived migrants or asylum seekers.
- Women who have disclosed recent or current domestic violence or sexual assault and/or who are at risk of violence or other form of coercion;
- Women at risk of self harm or other harm;
- Women who report being in a crisis in relation to the pregnancy;
- Women in the mid trimester;
- Women describing ambivalence regarding the pregnancy;
- Women requesting post termination support.

PAS assesses all women individually. It offers information, counseling about decision-making and post abortion counseling. It refers women within the hospital, for example, to antenatal clinics, social work support, genetic counseling or clinical assessment and surgical services for abortion, as well as to other relevant external services.

Abortion after the first trimester

The issues around termination of pregnancy become more complex as gestation advances. Our experience is that the circumstances surrounding requests for second trimester abortion show considerable variation, and are increasingly specific and individual, with increasing gestation. The reasons for requesting a mid-trimester termination of pregnancy arise in the context of a woman's health, diagnosed foetal conditions, delays caused by inequitable access to ultrasound or genetic testing and/or extreme social hardship.

Some of the reasons women may need a termination of pregnancy in second or third trimester include:

- Maternal health

Where the woman develops or is diagnosed with a medical disorder (such as a mental illness, cancer, renal disease or pre-eclampsia) either related to or coincident with her pregnancy, but which is further compromised by her continuing the pregnancy.

- Fetal health

If a fetus has been diagnosed late in the pregnancy with a condition which is known to be lethal, such as anencephaly (absent brain), continuing the pregnancy will make no difference to the fetal outcome but will cause the women and her family great medical and emotional distress.

There are many fetal conditions (such as microcephaly {small brain} or intracranial haemorrhage causing brain destruction) that can only be recognised and diagnosed late in pregnancy as fetal brain development is ongoing during the second and third trimesters.

Some fetal abnormalities are less threatening to fetal survival and quality of life but none the less causing serious harm to the mother's mental health. Such harm may be causally related to, or exacerbated by, a woman's individual life experiences including her experience of the diagnosed abnormality.

There are other conditions that occur late and may be anticipated. For example, abnormalities of the corpus callosum (the interconnecting brain) can only be seen after 20 weeks. Another example is autosomal recessive microcephaly, a severe neurological disorder which has a recurrence risk of 1 in 4 but is only able to be diagnosed on ultrasound or fetal MRI reliably after 26-28 weeks gestation. For these conditions it is imperative that the diagnosis be as definitive as is possible. At present, the available diagnostic modalities are most predictive at later gestations. A woman carrying a fetus with these conditions will want as much information as possible before deciding whether or not to continue her pregnancy whilst being acutely aware of advancing gestation.

It should be noted that many women who receive a diagnosis of a significant fetal abnormality continue with their pregnancies.

- Maternal illness causing severe disability in the fetus

For example, if a woman is infected with cytomegalovirus during pregnancy (an infection which may occur at any gestation and is typically an asymptomatic maternal illness) it is known that if fetal infection occurs, particularly when it results in fetal abnormality as seen on ultrasound, there is a more than 90% chance of an ongoing severe neuro-developmental disorder for the fetus.

- Inequitable resourcing around Victoria

Currently, women's ability to secure timely access to genetic and ultrasound screening in pregnancy varies. Women in country areas, or who speak English as a second language or who have limited income may not be able to get an appointment for screening until twenty weeks or even later.

Where a woman has not had access to available screening programs until late in her pregnancy, gestational limits on abortion entrench inequality in the health system. Gestational limits would mean that a woman who has access to these resources early in pregnancy to diagnose Down Syndrome has a different set of treatment options than a woman who has the same diagnosis but has not been able to access the same resources until late pregnancy

- Pregnancies that break social, cultural or religious taboos

Women may conceal their pregnancy out of fear of the consequences of having broken a social, religious or cultural taboo, including the fear of violence if the pregnancy is disclosed.

- Other

Some women may not recognise that they are pregnant. This may occur in young women, women who are peri-menopausal or women with irregular menstrual cycles.

A recent study by the University of Southampton reports research with women about the reasons for requests for second trimester abortion¹⁵. This research provides important insight into this issue, and makes recommendations about education for women that would encourage earlier presentation to health services.

Gestational limits

In any of these circumstances, setting a gestational limit to lawful abortion will result in harm to the woman's health and wellbeing that could be prevented. It also runs the risk of forcing women to seek an abortion outside of the medical system.

The Menhennit ruling does not prescribe any gestational upper limit for when an abortion is not unlawful. It is the woman's health that is the paramount consideration. That is the current Victorian law.

As was recognised in the English case of *Bourne*:

*“The unborn child in the womb must not be destroyed unless the destruction of that child is for the purpose of preserving the yet more precious life of the mother”*¹⁶

The Women’s does not support the introduction of legislation which differentiates between periods of gestation—for example, the Western Australian provisions. Further, were such provisions to be introduced into Victoria women would be faced with a barrier to obtaining an abortion after say 20 weeks that currently does not exist.

Role of the practitioner

The Women’s has developed a set of policies and guidelines to direct counselling, referral and clinical practice in regards to abortion, including termination of mid trimester pregnancy¹⁷. Like many hospitals around Australia, The Women’s has developed a formal termination review process for supporting staff and reviewing decisions relating to late termination. This consists of a Clinical Practice Guideline (CPG) to assist decision-making in complex cases and a Termination Review Panel (TRP) to act as a “sounding board” for the health professionals involved in any proposed clinical course of action. These processes have emerged from the recognition of the need to have a robust process of accountability for all complex decisions which might otherwise cause disquiet amongst health professionals and the wider community¹⁸. The Women’s has reviewed this process and will continue to revise it in response to evidence and changes in practice.

Since 2004, the hospital has publicly reported on pregnancy loss due to termination of pregnancy after 20 weeks in its annual *Quality of Care Report*¹⁹. All such terminations in Victoria are also reported on annually by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

The Women’s supports the systematic collection of data about the total number of abortions in Victoria (as in the United Kingdom, New Zealand and South Australia), in the interests of ensuring appropriate service provision and establishing a framework to develop effective prevention strategies for unplanned pregnancy.

The quality and safety of abortion, as part of sexual and reproductive health care for women in Victoria, would be improved by comprehensive monitoring processes. This in turn would improve knowledge about demand for abortion and the development of

targeted strategies to reduce unplanned and unwanted pregnancies. Furthermore, information could be used to inform planning for the development of services across Victoria and a Victoria-wide strategy for women's sexual and reproductive health.

The appropriate model for legislation

The Australian Capital Territory (ACT) was the first jurisdiction in Australia to remove abortion from its criminal statutes. The *Health Act* 1993 (ACT) was amended to provide for an abortion to be performed by a registered medical practitioner in a "medical facility".²⁰ The ACT has however, retained the offences of child destruction²¹ (unlawfully and either intentionally or recklessly by act or omission preventing the child from being born alive) and childbirth-grievous bodily harm²² (unlawfully and either intentionally or recklessly by act or omission inflicting grievous bodily harm on the child before the child is born alive).

The Women's supports the ACT model, but with modifications to encompass medical abortion, and the removal of the requirement that abortions be performed in a "medical facility", which connotes surgical abortion only.

In late 2001 Tasmania enacted section 164 (1) of the Criminal Code which provides that for abortion to be lawful two registered medical practitioners must certify in writing that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the woman than if the pregnancy was terminated, and that the woman must give informed consent.²³

The Women's does not support the need for 2 doctors to certify when an abortion is lawful.

The Women's termination review process for late abortions is set out elsewhere in this submission.

(Perhaps some kind of "licensed" facility may be specified in the legislation so that the processes and policies for late abortion are "approved" in the same way policies are approved by the Infertility Treatment Authority for infertility treatment procedures under the Infertility Treatment Act Victoria without undue interference in clinical decision making).

Conscientious objection

The Criminal Law Consolidated Act 1935 (SA) provides that any doctor who has a conscientious objection to performing an abortion is excused except in circumstances where there is immediate danger to the life or health of the woman. This exemption for conscientious objectors is also to be found in the Western Australian statute.²⁴

The Women's supports there being such a provision in any legislation introduced in Victoria but does not require such a provision to be inserted in any proposed legislation, as it is a health practitioner's ethical responsibility in any event to refer to another appropriate provider if he or she is precluded because of a particular belief from providing a particular service²⁵. The provision should not therefore be confined to only doctors.

Crime of unlawful child destruction

It is submitted that s 10 of the Crimes Act should be repealed.

The crime of unlawful child destruction should not apply in circumstances where a late abortion has been carried out *lawfully*, and that an exception should be recognised for medical practitioners who in good faith and in order to preserve the woman's life perform a late termination.

In other words the ruling in *Bourne's* case should prevail as law in Victoria:

*"The unborn child in the womb must not be destroyed unless the destruction of that child is for the purpose of preserving the yet more precious life of the mother."*²⁶

The criminal law would still presumably need to deal with offenders, who for example, assault pregnant woman and cause injury with intent to harm the fetus. The criminal law should be clear that a lawful late abortion does not equate with unlawful child destruction.

Law reform

It is submitted that laws on abortion should be uniform - that is, the same all around the country.

Recently, the Federal Attorney General noted that surrogacy laws were not uniform, and noted the desirability of there being a consistent approach²⁷. The Women's

hopes that the Victorian Law Reform Commission's review and advice to government will encourage other States to introduce new abortion laws.

Victoria has the opportunity to introduce legislation that will be a model for similar legislation in NSW and Queensland, and hopefully for uniform legislation in the future.

Conclusion

The Women's position on abortion law is that abortion is a health issue. As such, it is in the interests of women seeking abortion, and of the health professionals who care for them, that abortion should be addressed in health legislation and not criminal law. The Women's believes regulation of abortion in health legislation will provide clarity for both women and health professionals and therefore supports reform of the law as it relates to abortion in Victoria.

FOOTNOTES

¹ Victorian Law Reform Commission (2007) *The Law of Abortion Information Paper* Terms of Reference, p4

² See Appendix A: J McCalman, (1998) Sex and Suffering "Emerg and Gynae" pp 305 - 310

³ Grayson N, Hargreaves J & Sullivan EA (2005) *Use of routinely collected national data sets for reporting on induced abortion in Australia*, AIHW Cat No. PER 30, Sydney, <http://www.npsu.unsw.edu.au/NPSUweb.nsf/page/ps17>, 08/11/07, Table 3.2, p33

⁴ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Termination of Pregnancy A Resource For Health Professionals*, November 2005, <http://www.ranzcog.edu.au/womenshealth/pdfs/Termination-of-pregnancy.pdf>, p5

⁵ World Health Organisation (2003), 'Safe abortion services: the public health challenge', *Safe Abortion: Technical and Policy Guidance for Health Systems*, http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf, 07/11/07, p14

⁶ Gibson R et al (2004) *The Australian Survey of Social Attitudes 2004* [computer file], Australian Social Science Data Archive, The Australian National University, <http://assda-nesstar.anu.edu.au/webview/index.jsp>, 5/11/07

⁷ Wilson S et al (2006) *The Australian Survey of Social Attitudes 2005* [computer file], Australian Social Science Data Archive, The Australian National University, <http://assda-nesstar.anu.edu.au/webview/index.jsp>, 5/11/07

⁸ McAllister, I, Clark J (2007) *Trends In Australian Political Opinion*, Monograph, Australian Social Science Data Archive, <http://assda.anu.edu.au/aestrends.pdf>, 5/11/07, see p30 for a graph of results, p63 for the questions and results

⁹ Information Services Division Scotland, *Chart: Percentage of abortions performed in Scotland by method 1992-2006*, <http://www.isdscotland.org/isd/1919.html>, 08/11/07

¹⁰ Science and Technology Committee (2007) *Scientific Developments Relating To The Abortion Act 1967 Press Notice*, 31 October 2007, http://www.parliament.uk/parliamentary_committees/science_and_technology_committee/scitech311007a.cfm, 07/11/07, p1. The full report can be found at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf>,

¹¹ R v Davidson (1969) V.R 667

¹² For example, Western Australia (where over 20 weeks gestation), Tasmania and South Australia.

¹³ Science and Technology Committee, *Scientific Developments Relating To The Abortion Act 1967 Press Notice*, opcit, p1

¹⁴ Science and Technology Committee, Ibid, pp1-2

¹⁵ Ingham R, Lee E, Clements S, Stone N (2007) *Second-trimester abortions in England and Wales*, Centre for Sexual Health Research, University of Southampton: see *Media Release*, 19 April 2007, http://www.soton.ac.uk/mediacentre/news/2007/apr/07_54.shtml, 08/11/07, or for a complete version of the report <http://www.psychology.soton.ac.uk/research/cshr/>, under "Publications", 08/11/07

¹⁶ Extract from paper to the Medico Legal Society of Victoria by John Barry Barrister at Law (as he then was) entitled "*The Law of Therapeutic Abortion*" published in the Proceedings of the Medico-Legal Society of Victoria (1939) Melbourne and quoted by Menhennit J in *R v Davidson [1969] VR 667* at pp 669-670

¹⁷ See Appendix B: *Clinical Practice Guideline Termination Review Process*

¹⁸ In 2000 a lawful abortion carried out at The Women's attracted media scrutiny and led to Senator Julian McGauran accessing information from the hospital's file from the State Coroner's Office. Senator McGauran then lodged a notification with the Medical Practitioners Board of Victoria alleging unprofessional conduct on the part of several medical practitioners in circumstances where the medical practitioners were found to have acted in accordance with the Menhennit ruling. The Board, after legal action to protect the Hospital's medical records from being produced to the Board following the issue and execution of a search warrant, failed, ultimately found that there was no evidence of any unprofessional conduct.

¹⁹ Copies of the 2004, 2005 and 2006 *Quality of Care Reports* are available on The Women's website <http://www.thewomens.org.au/PublicationsNewsletters>, 07/11/07

²⁰ s.82 Health Act 1993 (ACT)

²¹ s.42 Crimes Act 1900 (ACT)

²² s.43 Crimes Act 1900 (ACT)

²³ s.164(2) Tasmanian Criminal Code

²⁴ s.334(2) Health Act 1911 (WA)

²⁵ AMA *Code of Ethics 2004 Editorially Revised 2006*, Position Statement, 20/11/06, <http://www.ama.com.au/web.nsf/tag/amacodeofethics>, 07/11/07

²⁶ Extract from paper to the Medico Legal Society of Victoria by John Barry Barrister at Law (as he then was) entitled "*The Law of Therapeutic Abortion*" published in the Proceedings of the Medico-Legal Society of Victoria (1939) Melbourne and quoted by Menhennit J in *R v Davidson [1969] VR 667* at p 669-670.

²⁷ Nader C (2007) 'Ruddock bid on surrogacy', *The Age*, April 6 2007, http://www.theage.com.au/news/national/ruddock-bid-on-surrogacy/2007/04/05/1175366408411.html?s_cid=rss_age#, 07/11/07

APPENDIX A

EXCERPT FROM *SEX AND SUFFERING*

“EMERGE AND GYNAE”

APPENDIX B

CLINICAL PRACTICE GUIDELINE

TERMINATION REVIEW PROCESS

Purpose

The termination review process exists to:

- Support clinical staff in decisions and practice around late termination of pregnancy (refer *Note*²⁸).
- Consider whether further opinions or assessment are required before implementing clinical recommendations
- Provide management "sign-off" for difficult and potentially controversial decisions around late termination of pregnancy
- Add authority to decisions made in order to support the entire clinical team involved in care
- Where clinical recommendations are not supported, ensure that a mechanism exists to provide for appropriate ongoing care for the woman.

What is a termination review panel?

A termination review panel (TRP) is a multidisciplinary panel of suitably qualified and experienced staff convened to assist and support the clinical team in their practice where late termination is being contemplated.

The membership of each TRP will be drawn from a designated group of staff in accordance with a defined composition: there is not a standing committee.

Each TRP will be chaired by a person with delegated authority from the CEO to approve (or refuse permission for) the agreed clinical course of action.

It is anticipated that relevant clinical issues will have been addressed and recorded prior to the TRP meeting. The TRP will comprise a group of senior clinicians and clinician managers, who have the breadth of experience and skills to determine whether all relevant areas have been covered, and to determine the capacity of staff to deliver the care recommended; it will decide whether the hospital can support and implement a clinical recommendation. The focus is thus more on reflecting on recommendations for clinical practice than clinical decision making.

In what circumstances is a termination review panel convened?

In summary, TRP approval is required prior to:

- Pregnancy termination from 23 weeks to 36 weeks and 6 days where there is a non-lethal fetal abnormality or non-obstetric indication.
- Fetocide as a first step in pregnancy termination from 23 weeks onwards, including in the presence of a fetal abnormality likely to be incompatible with life or an accepted obstetric indication.

A treating clinician may refer any case to a TRP regardless of these guidelines.

When may a termination of pregnancy be performed?

Case law (the 1969 Menhennit ruling) has established that termination of pregnancy in Victoria may be performed when it is "necessary to preserve a woman from serious danger to her life or her physical or mental health, not being merely normal dangers of pregnancy and childbirth, which the continuance of the pregnancy would entail; and in the circumstances not out of proportion to the danger to be averted".

The following guidelines apply at the Women's:

Prior to 23 weeks gestation	Pregnancy termination may be performed, in accordance with the Menhennit ruling, without prior approval by a TRP, regardless of whether fetocide by intracardiac injection of potassium chloride or any other means is planned as a first step in a pregnancy termination.
Obstetric Indications:	Termination of pregnancy, in accordance with the Menhennit ruling, for accepted obstetric complications (including but not limited to severe pre-eclampsia, prolonged ruptured membranes, severe antepartum haemorrhage, intrauterine infection) may be performed at any gestation without reference to a TRP, provided that fetocide (as a first step in pregnancy termination) shall not be performed without the approval having first been obtained from a TRP.

From 23 weeks of gestation onwards, where a fetal abnormality likely to be incompatible with life is diagnosed:	Pregnancy termination may be performed in accordance with the Menhennit ruling, without reference to a TRP, provided that fetocide (as a first step in pregnancy termination) shall not be performed without the approval of a TRP having first been obtained.
From 23 weeks of gestation onwards, up to 36 weeks and 6 days gestation, where there is a non-lethal fetal abnormality or non obstetric indication:	Pregnancy termination may only be performed with the prior approval of a TRP. This includes cases where early delivery with a view to adoption is under consideration, as well psychologically or socially indicated inductions of labour.
Other situations:	A treating clinician may refer a case to a TRP whether or not the clinician recommends termination or supports a patient request for pregnancy termination. A clinician may also refer a case to TRP when termination would be permitted within these guidelines without TRP approval.
Staff will be strongly supported by the hospital in the provision of patient care which is in accordance with these guidelines.	

Arranging a TRP meeting

Contact the personal assistant to the Clinical Directors, Women's Services, who will convene the meeting.

- In normal circumstances, the meeting will be held by the end of the next working day.
- The referring clinician needs to ensure that the following forms are completed and copies provided for each member of the panel at the meeting (originals will be filed in the medical record):
 - Fetal abnormality *proforma*
 - Termination of pregnancy *proforma*
 - TRP *checklist*

Membership of Termination Review Panel

- **Chair:** Chief Executive or Chief Medical Officer
- **Obstetrician/gynaecologist** with senior management role
- **Obstetrician** drawn from "volunteer" panel with experience in fetal anomaly work
- **Neonatal paediatrician: Nursing director or senior midwife**
- **Consultant obstetrician** managing the case under discussion
- **Other coopted members** as agreed between the referring clinician and the panel chair.

Decisions and records of a TRP

A record sheet will be completed for each meeting and filed in the patient's confidential medical record and will be the only document of a decision of a TRP.

The patient's medical record is exempt from disclosure and protected by privacy laws. It is expected that the TRP will operate by consensus, but each decision must be "signed off" by the Chair, who also therefore has power of veto.

The decision made will be signed on the record sheet by the chair of the panel.

The patient's surname, UR number and meeting date will be entered in the TRP register.

The Directors of Women's Services must be notified of any termination to be performed following TRP approval; the Director of Birthing Suites must be advised if the procedure is to be undertaken in Delivery Suite.

Copies of forms provided to panel members must be destroyed at the end of the meeting, so that this clinical information is confined to the patient record.

Review of TRP decisions

A TRP may recommend further investigations and/or opinions and/or reconvene to discuss the case after a period of reflection.

If the clinical team and/or patient are dissatisfied with the outcome of the TRP, review may be requested. The referring clinician should discuss in the first instance with the

chair of the convened panel and if a satisfactory resolution is not achieved, with the CEO. Possible courses of action include reconvening the same panel, convening a new panel, or review/decision by the CEO.

²⁸ *NOTE:*

Termination of pregnancy refers to the ending of a pregnancy whatever the fetal outcome. Prior to sufficient development for survival, fetal demise is universal, but with increasing gestation after 23 weeks there are increasing chances of pregnancy termination by induction of labour or other means resulting in livebirth. Pregnancies are most commonly terminated after 23 weeks as a result of obstetric complications, when livebirth is almost always the desired outcome. In exceptional circumstances livebirth may not be the desired outcome, for example sometimes in the presence of a severe fetal abnormality.