SUBMISSION TO SOUTH AUSTRALIAN LAW REFORM INSTITUTE
ABORTION LAW REFORM

Introduction

Thank you for the opportunity to attend a Consultation Session on June 5th, and to lodge a written submission. I am a gynaecologist and write in my private capacity and not on behalf of my institutions. Below, I set out an executive summary in dot point form (pages 1 and 2), following the format of the terms of reference, then specifically cover the majority of the 31 Consultation Questions under the 10 listed headings (pages 3 to12). I include my Curriculum Vitae and a list of health care colleagues who have subscribed to this document (pages 15 to 20). It is my intention to provide a fresh, evidence-based perspective on some difficult issues, so as to improve the outcome for all concerned. If needed, I'd be grateful for the opportunity to submit a supplementary report after attending the June 5th consultation.

Executive Summary- key points

1. Current Law
   a. Effectiveness and availability:
      - No SA woman has been denied an abortion.
      - No doctors or women have been prosecuted.
      - "Backyard abortion" has been eradicated.
      - Proposal of Early Medication Abortion (EMA) as the solution for rural/ regional women is contrary to the evidence that it is the least safe option in a rural/regional setting.
   b. Safety
      - Induced abortion is a medical procedure and only a medical practitioner is trained and indemnified to manage key aspects, including informed consent.
      - NHMRC guidelines (1993) on informed consent should be implemented to address deficiencies in consent process (below).
      - Counsel women about the superior safety of early surgical abortion over EMA.
      - After 8 weeks, maternal mortality from abortion increases 38% per week, resulting in abortion beyond foetal viability (22 weeks) having a higher maternal mortality than delivery by vaginal birth or Caesarean.
      - Surgical abortion (Dilatation and Evacuation) and medical abortion in the 2nd and 3rd trimester cause foetal pain because of pain-capability.
      - Improve practice by transitioning from abortion to live delivery preference from 22 weeks.
      - Address the culture of dimissal with regards to long term complications of abortion ie preterm birth, mental ill health and breast cancer
      - Culture of dismissal impacts on patient care and is analogous to a situation in 1960's when the US National Cancer Institute denied the causal link between smoking and lung cancer, and opposed the Surgeon General's warning on cigarette packs.
      - Improve mental health outcomes for women through independent counselling to:
        -screen for intimate partner violence, ambivalence and coercion

-offer effective community-based alternatives to abortion
-screen for high risk mental health scenarios and counsel against abortion
-offer Perinatal Palliative Care for life-limiting foetal conditions

- Inform women that abortion may increase breast cancer risk in 3 ways and full term pregnancy is protective.
- Inform women of preterm birth risk, the associated complications and preventative measures.

2. Removal of offences from CLCA
   a. Sections relating to safety ("back yard" abortion) and accountability - retain or transfer to Health Care Act.
   b. Insert new sections into CLCA or Health Care Act relating to:
      - outlawing specific abortion procedures
      - mandating independent non-directive counselling and funding for pregnancy support services
      - preserving conscientious objection for all persons
      - mandating safety requirements for EMA, especially in rural/regional SA
      - ensuring best practice by mandating practice improvement, regular practice audit and review of training of abortion providers.
   c. Amend domestic violence laws to include abortion coercion.
   d. Availability and access to induced abortion- 2 distinct approaches to ending a pregnancy.
3. Other relevant matters
   a. Conscientious objection in perspective.
   b. Omit exclusion zones or add inclusion zones.

Discussion of Consultation Questions under 10 Headings

1. The role of the Criminal Law

In the 50 years since amendments to legally permit abortion in SA were made to the Criminal Law Consolidation Act (CLCA) of 1935, there is no evidence that women seeking an abortion in SA have been denied their choice under the current law (1969), or that any doctors or women have been prosecuted. Nevertheless, for the important reason of patient safety and to keep the door closed on 'backyard' abortion, the following types of abortion should remain illegal. These are best understood by considering the implications of repealing the following sections of the CLCA.

- Repeal of 81 (1) – would permit any woman to perform her own abortion;
- Repeal of 81 (2) – would reduce the punishment of assault with intent to cause abortion from life imprisonment to that of assault (<5years imprisonment). The repeal of the offence of unlawfully causing an abortion means that any person who forcibly causes a woman to abort a pregnancy or causes her to have an abortion under pressure or duress will not commit a specific offence but will have to be charged under general offences such as assault. These provisions will be much more difficult to enforce.
- Repeal of 82 – would permit unregulated (black market) sale of abortion-related products.
- Repeal of 82A(1)(a)- would permit persons other than a legally qualified medical practitioner to perform abortion (surgical and medication). Thus the legal requirement for doctor involvement is removed. The opinion of 2 doctors is currently required except "when the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman" when only 1 is required.
- Repeal of 82A(1)(a)(ii)- would permit surgical and medication abortions to be performed outside of a hospital ('of prescribed class') or purpose-built medical facility (like the Pregnancy Advisory Centre at Woodville Park).

i.e. repealing these sections compromises patient safety and may permit a return to 'backyard' abortion, which the current legislation eradicated.
Recommendation: Retain these well-worded, clauses [81(1)&(2),82-82(A)(1)] either in the Criminal Consolidation Act 1935 or "cut and paste" into the Health Care Act.

[Note: Whilst Early Medication Abortion does not require a hospital setting for commencement, it does require pre-treatment assessment relying on pathology testing (swabs, cervical screening test, blood tests) and ultrasound, and for the patient to be within ready reach of a hospital to manage potential complications which may require emergency surgical evacuation of the uterus. For rural and regional women in particular, all these requirements can only be met in a hospital setting. Hence, for the safety reasons explained under section 9 below, the pre- and post-treatment requirements mandate all women, and rural and regional women especially, to be within 30 minutes of a

hospital or purpose built facility of prescribed class. The same safety standard applies to the medical management of miscarriage as per the SA Perinatal Practice Guideline which lists no immediate access (>30 minutes) to emergency facilities as an exclusion criteria. On page 12, the guideline further stipulates, “Access to 24-hour telephone advice and emergency facilities within 30 minutes of a woman’s place of residence including O negative blood and surgical management are conditions of undertaking medical treatment of miscarriage.”[1]]

In addition, the following procedures should be explicitly outlawed:

1) Intact Dilatation and Evacuation (D & E), also known as “partial birth Abortion”, and non-intact D & E (dismemberment abortion) on a living foetus.[2,3]
2) Harvesting/removal of foetal organs/tissue from aborted babies for sale or any purpose other than pathological diagnosis.
   [Note: The combination of repealing section 82(A)(4) (no reporting) together with 83(1) and (2) (concealment) opens the door to selling foetal body parts as in the recent Planned Parenthood scandal in USA. These sections should stand in the criminal code or be transferred to the Health Care Act.]
3) Modification of the technique of abortion so as to harvest intact foetal organs for sale or any other purpose.
4) Abortion for the purpose of selecting the preferred sex of the baby for social reasons.
5) Abortion for an unwanted but otherwise healthy baby capable of surviving outside the womb.[4]
6) Abortion beyond the first trimester which, through inadequate foetal pain relief, fails to address the possibility of foetal pain suffered during abortion (babies become pain capable in the second and third trimester, as evidenced by foetal surgeons and numerous studies).[5]
7) Abortion for foetal disability or life-limiting foetal condition (such as anencephaly), especially for those rare cases diagnosed late in pregnancy, without thorough counselling about all relevant treatment options (such as intrauterine or neonatal surgery) and perinatal palliative care (PPC).
   [Note: PPC enables parents to continue the pregnancy so as to purposefully cherish the limited time they have and to reframe their parenting goals so that they will “have no regrets”.[6] When available, 37-87% of couples will choose PPC.[7] Further research is needed to identify the best model of care.[7] Literature comparing outcomes of delivery and PPC with abortion in cases of anencephaly shows significantly better mental health outcomes for mothers who do not abort.[8,9,10] See section 3 on pages 5 to 7 regarding gestational limits on abortion.]
8) When abortion produces a born-alive baby, resuscitation and other life-saving medical care is intentionally withheld or delayed so as to accelerate neonatal death, or an infanticidal act performed by any person.
   [Note: Data available on request from SA Health indicates that from 2000-2009 there were 72 live-born terminations ie 72 babies were born alive and left to die.[11,12,13,14] Rather, the standard should be that abortion providers

should be required to provide life-sustaining care to a child who is born alive,
or that the child should be transferred to a hospital willing to do so.]

9) Performance of medical or surgical abortion without RANZCOG-approved training and accreditation.

2. Who should be permitted to perform or assist in performing terminations?

Surgical abortion is an inpatient procedure which requires essential anaesthetic and nursing staff. Beyond the first trimester, medication abortion requires inpatient management with medical and midwifery assistance.

Termination of pregnancy, be it by medication or surgery, is a medical procedure which requires thorough medical management of all aspects, including informed consent. Fully informed consent can only be obtained by a qualified medical practitioner.

Based on NHMRC guidelines, in the process of obtaining informed consent, a doctor is required to give the patient information in 12 domains, including complications.[15] Only an appropriately trained and accredited medical practitioner is able to adequately explain what the potential complications are, their incidence in his/her hands, what measures are taken to reduce the risk of complications occurring and, should any occur, how the respective complications are managed.

The politicization of science has produced a culture of dismissal within the medical profession with regards to potential long term complications of abortion ie preterm birth, mental ill health and breast cancer.[16] This phenomenon is a barrier to patient consent and care, and is analogous to a situation in the 1960's when the National Cancer Institute denied the causal link between smoking and lung cancer, and opposed the Surgeon General's 1964 warning on cigarette packs.[16]

As with any other medical procedure, women under 16 years should require the consent of their parents or legal guardian.

3. Gestational Limits and Grounds for Termination of Pregnancy of pregnancy

In this section, it's important to differentiate between 2 ways of ending a pregnancy which are clinically and ethically distinct:

1. Abortion, where mother and baby are separated with the intention of producing a dead baby.
2. Delivery, where mother and baby are separated with the intention of producing a live baby.

Why abortions after 22 weeks by Last Menstrual Period (LMP) should be banned.

Foetuses at 22 weeks by LMP (20 weeks post fertilization) are human beings who feel and react to the pain of abortion procedures and are capable of surviving ex-utero.[4]

There is considerable evidence that the foetus may experience pain.[4] Not only is there an ethical obligation to provide foetal anaesthesia and analgesia during foetal surgery, but it has also been shown that pain and stress may affect foetal survival and neurodevelopment.[4] It is therefore recommended to provide adequate pain relief during potentially painful procedures during in utero life.[4]

Survival of extremely premature infants has improved dramatically since the gestational limit for abortion in SA was set at 28 weeks in 1969, to the point where survival of infants is possible at 22 weeks gestation.[4] The ability of extremely preterm infants to survive depends on the amount of expert care received when they are separated from their mother's womb and underscores the fact that these infants are complete, separate human beings.[4]
If a mother decides that she does not want to continue to carry an unborn child after the child has reached the capacity to survive outside of the womb, that mother can undergo a delivery which allows her child the optimum chances of survival.[4]
This would end the mother's pregnancy while simultaneously allowing the viable child the best chances of survival.[4] In fact, beyond 20 weeks of gestation, the immediate risk of death to the mother from elective abortion procedures exceeds the mother's risk of death from delivery.[17] One study has shown that, compared to abortions performed at 8 weeks gestation, the risk of death increases exponentially by 38% for each additional week of gestation.[17]

In the case of a viable foetus, the most rapid and safest delivery for both the mother and the foetus is Caesarean section, which can be accomplished in 30 minutes from decision to separation as standard obstetrical procedures require.[16] In contrast, most elective abortion procedures performed after 22 weeks require days to accomplish and carry a greater risk of immediate maternal death than vaginal birth or Caesarean section.[17]

Late term abortions also result in greater risk of long term complications than abortions performed earlier in the pregnancy.[16] Examples of increased risk include:

- Increased risk of preterm birth in subsequent pregnancies,
- Increased risk of adverse psychological outcomes such as depression, substance abuse and suicide and
- Increased risk of subsequent breast cancer if the late term abortion occurs before 32 weeks, if the mother had not brought a previous pregnancy to term, and if the mother subsequently delays bringing another child to term.

Should SA ban abortion after the first trimester?

There are several reasons that it is reasonable for our society to draw a line on abortion after the first trimester. The second and third trimester foetus feels pain. Abortion after the first trimester is more dangerous for a woman. Almost all abortions after the first trimester are done for elective reasons. Women have ready access to abortion before the second trimester. If a woman's life is in danger from her pregnancy, her obstetrician can deliver her regardless of the laws regarding abortion, because there is always an exception for the life of the mother. After viability, a medically indicated delivery does not involve intentionally killing the foetus (as abortion does), but merely separating the foetus from his mother. Most countries in the world do not allow abortions after the first trimester.[18] What good reasons are left to allow abortion after the first trimester?

4. Consultation by the Medical Practitioner

   As recommended in the June 2018 White Paper entitled Abortion Reform in Australia[19], a medical practitioner should be required to refer to an independent counsellor whose main tasks are:

   1. to screen women requesting abortion for coercion, ambivalence, and intimate partner violence.
   2. to offer women with an unplanned pregnancy community-based alternatives to termination of pregnancy, such as the New Zealand Crisis Pregnancy Service model of Hassan et al.[20]
   3. to screen for women who are at higher risk for mental health problems after abortion (ie those with previous mental health problems, those undertaking abortion for foetal abnormality, those who become distressed at the time of their abortion, and those who react negatively to abortion) and counsel them to consider options other than abortion and/or seek post-abortion counselling early.[21]

5. Conscientious objection

   Health care practitioners who have a conscientious objection to termination of pregnancy should not be required to refer to a non-objecting practitioner for three good reasons:

   a. Compulsory referral contravenes the ethical principle of cooperation (acting as an accessory) and mandates the punishment of conscientious objectors including the threat of deregistration eg case of Dr Mark Hobart of Sunshine,VIC.[22]
   b. A formal referral is not required for any medical treatment, including abortion. SA abortion clinics will accept women without a medical referral. Most such clinics are staffed by GP's and no-one needs a referral to see a GP. In fact, patients can see any doctor and any specialist, without a referral. Referrals serve only 2 functions- the transfer of medical information, and to allow a private patient to claim from Medicare.
   c. Even amongst abortionists, there is a spectrum of conscientious objection which informs their practice: some will only perform termination for foetal anomaly and never for social reasons, some will only terminate in the 1st trimester, most would refuse sex-selective abortion on social grounds at any gestation, and the vast majority would refuse late term abortion for any

indication.

Recommendation: Retain the current, well-worded, clause [82(A)(5)] either in the Criminal Consolidation Act 1935 or "cut and paste" into Health Care Act. The law should only require that objecting practitioners:
1) honestly and respectfully inform patients about their conscientious objection and inability to refer for abortion or to be directly involved in the abortion procedure.
2) not be professionally disadvantaged because of their objection.
3) be free to discuss with others the rationale for their objection.

The Statutes Amendment (Abortion Law Reform) Bill 2018 seeks to repeal section 82(A)(6), which seeks to remove the duty of a doctor to assist in the event of a medical emergency.
Recommendation: Retain the following sentence in the criminal code or transfer it to the Health Care Act: "Nothing in subsection (5) affects any duty to participate in treatment which is necessary to save the life of the mother."

6. Counselling

See section 4 above.
The 2018 White Paper on Abortion Review[19] recommends a review of counselling requirements at abortion as follows:
Medicare item numbers for non-directive counselling (4001, 81000, 81005 and 81010) exclude 'GPs, psychologists, social workers and mental health nurses who have a *direct pecuniary interest in a health service that has as its primary purpose the provision of pregnancy termination services."*

Furthermore, there is no law in Australia that requires someone providing a counselling service to have either qualifications or experience. This means that abortion clinics may not be using qualified counsellors. At the very least women should be informed and advised to seek independent counselling *before* going directly to an abortion clinic.

A review is needed into what counselling requirements, if any, are required and mandated for abortion clinics. It is essential that pre-termination counselling meeting minimum requirements and information on support services is offered to women who directly present at clinics, without having had the opportunity for prior counselling. Inadequate counselling prior to a procedure is a risk factor for negative mental health effects after an abortion.

Recommendation: It should be mandated that women are offered and can receive adequate non-directive counselling through referral to an independent counsellor. Time to make a considered decision prior to a termination procedure should be provided for.

7. Protection of women and service providers and safe access zones.

The downside of safe access zones
The enactment of so-called 'safe access zones' makes pregnancy support services unlawful within the zones, sacrifices valid democratic rights of

citizens, and denies potential support to vulnerable women who have been co-erced or are ambivalent about having an abortion. It also has the potential to provide an unfair business advantage to a private abortion provider, such as Marie Stopes International Australia, should the same or a similar provider set up business in SA in the future. The Bill denies protection to the persons who are most frequently harassed and threatened near abortion clinics

namely, peaceful prayer vigilers. Participants in the 40 Days for Life prayer vigil are required to sign a peace pledge.[23]

The White Paper[19] make the following points about safe access zones and proposes inclusion zones and repeal/amendment of laws that criminalise people offering information in safe access zones:

1.Context
People offering pregnancy support to women outside clinics in a manner that is not harassing or intimidating, are being caught within new safe access zones laws in some jurisdictions. These laws prohibit any communication outside clinics about abortion that may be perceived to be opposed to it and so include the presence of those offering information about pregnancy support. Criminal penalties apply.

2.Inclusion Zones

If exclusion zones are enforced around abortion clinics, effectively prohibiting all offers of pregnancy support within these zones, then 'inclusion zones' or areas of exemption within these zones, should also be mandated. Inclusion zones meaning 'inclusion of choice' are needed to ensure all women considering an abortion have a choice right up until the time of the procedure, particularly for women who go directly to a clinic without having the opportunity to see an independent options counsellor. Inclusion zones or 'exemptions' would be safe places for women to access independent counselling and available pregnancy support services. For example, this could be at or around a pregnancy support centre within an exclusion zone.

3.Repeal or Amendment of Laws that Criminalise People offering Information in Safe Access Zones
Laws in some Australian jurisdictions that make it illegal for people to offer information on support available to women (whilst not physically or emotionally harassing in any way) in zones that cover broad geographical areas around abortion clinics should be repealed or amended. It should not be a crime for otherwise law-abiding citizens to offer information to people if it is done in a polite and respectful manner. Women and couples who are supported after contact with volunteers near clinics, say this was the only time

they were offered a real option to continue their pregnancy.

> *Recommendation:* Exclusion zones should not be enforced around abortion clinics but, if they are, then 'inclusion zones' or areas of exemption within these zones, should also be mandated.

8. Collection of data about terminations of pregnancy.

   Collection of data about terminations of pregnancy is essential for clinical audit and practice improvement. For instance, the 2016 SA Pregnancy Outcome data showed Early Medication Abortion is failing to empty the uterus 12x more often than early surgical abortion.[24] This is clinically significant and should be impacting on patient counselling and clinical practice.

   Recommendation: Section 82(A)(4)a-d, which relates to accountability, should remain in the criminal code or be transferred to the Health Care Act.

9. Rural and Regional Access

   Many rural women prefer to come to Adelaide for their TOP for reasons of anonymity, just as some Adelaide women prefer to drive past several Adelaide hospitals to have their TOP in anonymity in the Copper Triangle. At present, the accessibility of city-based abortion services for rural women is greatly increased by the Patient Assistance Travel Scheme (PATS), which includes accommodation, and because they are given priority and same-day service at the Pregnancy Advisory Centre, Woodville Park. Increasing the availability of abortion services to rural women primarily refers to increasing their access to Early Medication Abortion (EMA). However, greater caution is needed when EMA is administered to remote and isolated women, for the following reasons:

   a. If one defines 'safety' in terms of maternal mortality (death rate) and morbidity (ie the complication rate), then Early Medication Abortion (EMA) is less safe than early surgical abortion. For this reason, now retired Canberra academic and prochoice activist, Renata Klein, was a staunch opponent of EMA, describing it as 'a return to backyard abortion'.[25]
   b. Eleven times as many women die from early medication abortion compared with early surgical abortion.[26] The first Australian fatality from EMA- associated infection occurred at a Marie Stopes Clinic in 2010.[27]
   c. For every death from EMA there are 70 reported (and up to 700 unreported) severe and life-threatening adverse events from complications such as severe bleeding, serious infection (including Clostridium Sordellii) and ruptured ectopic pregnancy. Whilst surgical abortion facilitates the early diagnosis of ectopic pregnancy, medication abortion masks it, creating the potential for delayed diagnosis and higher maternal morbidity and mortality.[28]
   d. The latest Pregnancy Outcome in SA report (2016) notes that, on page 51, EMA failed to empty the uterus at a rate of 9.8% compared with 0.8% for surgical abortion (vacuum aspiration).[24] Of 1,455 women who had an initial EMA, 122 progressed to a surgical procedure. In this regards, EMA was 12 times more likely to fail than surgical abortion. In 2009, Niinimakiet al reported a four-fold higher overall complication rate (haemorrhage, infection, incomplete abortion, need for surgical re-evacuation) for medical (20%) vs surgical abortion (5.6%).[29]
   e. Women in rural and remote areas are at greater risk of complications from EMA due to non-availability of pre-treatment ultrasound (to

confirm viability and dates, and to exclude multiple pregnancy, molar pregnancy and an ectopic pregnancy) and post-treatment access to a hospital providing vacuum aspiration to complete the abortion or for the control of haemorrhage. The workload and stress of doctors providing early medication abortion will increase, especially in rural South Australia, due to the increased number of consultations required and the need to provide emergency care for up to 2 weeks after commencing a medication abortion. A South Australian study by Mulligan and Messenger found that women undergoing medication abortion had more symptoms (side effects) and had higher rates of emergency admissions.[30] Furthermore, the prescription of medication abortion via telemedicine, so-called tele-abortion, to remote rural women who can't access a blood test, clinical examination for a smear test and STI swabs, is, in itself, unsafe practice.[31]
Offering EMA to geographically isolated women who can't access adequate pre- and post-medication abortion care is unsafe.

Recommendation: It should be mandated that access to 24-hour telephone advice and emergency facilities within 30 minutes of a woman's place of residence including O negative blood and surgical management are conditions of undertaking Early Medication Abortion.

10. Incidental.

There are 5 incidental items:

1. Practice Improvement Mandate

That informed consent for termination of pregnancy (TOP) be obtained as per NHMRC guidelines,[15] so as to ensure that women are fully informed as to the nature of their pregnancy, all their options, and all potential complications of abortion.
We recommend an urgent update of SA Health TOP consent forms with separate forms for medication and surgical abortion,[32] and comprehensive patient information containing all relevant information, including all potential long term side effects, pertaining to the complete range of surgical and medication abortion procedures performed at various gestations.

2. Domestic Violence Laws to Include Abortion Coercion[19]

Laws on domestic violence should be amended to recognise that a woman who consents to an abortion under duress due to coercion from her partner, or another person, is not providing valid consent and that this is a form of domestic violence.

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3. Regular Audits on All Practices in Relation to Termination of Pregnancy[19]

Government performance audits should be conducted regularly, in relation to all practices around termination of pregnancy specifically, whether performed through government health departments or in private practice. These should include an assessment against best practice guidelines and standards of care. In particular, controls should be examined around pre-termination counselling at practices with a pecuniary interest in providing terminations. These controls should ensure independent counselling can be obtained by all women pre and post-termination and that this meets minimum time and quality requirements. The

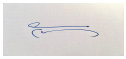
SA Health Minister should work with independent NGOs concerned with this area of women's health to review all practice in relation to termination of pregnancy.

4.New Medicare Items for Pregnancy Support Services that provide Case-based Ongoing Care for Women encountering Problems in Pregnancy[19]
That new MBS (Medicare) items be introduced for options with unexpected or problematic pregnancies, other than abortion, i.e. one-stop support services in pregnancy.

5.Review of Training of Abortion Providers to ensure Best Practice particularly in Pre-Decision Protocols and Post Abortion Follow-up[19]
The SA government should review the education of abortion providers (in training programs across medical colleges and in undergraduate and graduate degree curriculum) and abortion service practice models, particularly pre-decision protocols. Models should include identification and guides on ambivalence in decision-making, coercion and the process to enable informed consent - e.g. the adequacy of information provided to women on human development within the womb.

Conclusion
I thank SALRI for the opportunity to make recommendations on reform of abortion law and care in SA, and trust that the arguments presented will carry appropriate weight in your deliberations.

Yours faithfully,



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2. AAPLOG statement on D and E bans. File attached.
3. Top 10 myths about abortion. File attached.
4. AAPLOG Statement on Post-Viability Abortion Bans. File attached.
5. AAPLOG fact sheet on fetal pain dated 13 Feb 2019. File attached.
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11. SA Health stats for babies born alive and left to die. File attached.
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23. Peace Statement for participants in 40 Days for Life. File attached.

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31. https://www.mariestopes.org.au/abortion/home-abortion/

32. Southern Adelaide Local Health Network Consent to Medical Treatment form for Termination of Pregnancy. File attached.

List of health care practitioner co-signatories

I have authority from the health care practitioners listed below, most of whom are involved in women's health, including obstetricians and gynaecologists, to include them as co-signatories. If required, signatures can be provided at a later date.

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Book Chapter

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